MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on March 26, 1993, at 3:00 p.m.

ROLL CALL

Members Present:
Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

Staff Present: Tom Gomez, Legislative Council
Laura Turman, Committee Secretary

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

Committee Business Summary:

Hearing:	HB 225, HB 315
Executive Action:	HB 274, HB 551, HB 315, HB 225, HJR 15, HB 389, HB 220

HEARING ON HB 315

Opening Statement by Sponsor:

Rep. Bruce Simon, House District 91, said HB 315 is a simple bill. It strikes three words, "not including corticosteroid" from the code. In the past, a bill was passed to not allow optometrists to use corticosteroid. Rep. Simon said in the last six years, there have been no complaints regarding optometrists' use of topical drugs. Twenty-nine states allow optometrists to use topical steroids, with zero complaints in nearly every state. Rep. Simon said optometrists have been educated and trained in the use of these drugs. The bulk of ophthalmologists in Montana are located in the larger cities, leaving a large portion of the

population without ophthalmologist care or requiring them to travel long distances to see one. Optometrists and ophthalmologists work together, make referrals, and have similar educational backgrounds.

Proponents' Testimony:

Kevin McBride, Optometrist in Billings, provided written testimony. (Exhibit #1)

Kent Harrington, Optometrist at Malmstrom Air Force Base in Great Falls, provided written testimony. (Exhibit #2)

William Simons, Optometrist in Helena, provided written testimony. (Exhibit #3)

Paul Kathrien, Optometrist in Great Falls and member of the Montana State Board of Optometry, said the Board unanimously favors the change in the Montana State Code. They feel it will especially benefit those individuals in rural areas. HB 315 will allow optometrists in Montana to practice on the same level as optometrists in neighboring states. Mr. Kathrien said it is important that new graduates come to Montana, and HB 315 will encourage that. Mr. Kathrien provided a copy of the Candidate Guide of the National Board of Examiners in Optometry. (Exhibit #4) Optometrists without certification will not be grandfathered into HB 315. In addition, all new licensees must be therapeutically certified before they begin practice in Montana. Safeguards already exist in optometry laws, and there is an Optometry Oversight Committee to be called into action when a complaint in filed. No such complaints have ever been filed.

Chairman Eck asked other proponents to HB 315 to identify themselves.

Mike Simons, Optometrist from Missoula.

Dr. Bob Sherer, Optometrist in Great Falls.

Jim Reeves, Great Falls.

Patrick Stibel, Great Falls.

Mindy Sterner, Great Falls.

Doug McBride, Optometrist in Billings.

Kim Calnan, Optometry Student from Montana.

Larry LaRock, Optometrist in Butte.

Jamie Barney, Optometrist in Livingston.

Tom Fergerson, Optometrist in Missoula.

Dan Shea, private citizen, said HB 315 is vital to keeping the cost of health care in the state down.

Opponents' Testimony:

Roger Furlong, Ophthalmologist in Missoula, went over his educational background. Dr. Furlong said he had concerns about patient welfare. There are many eye diseases with varied treatments and causes. He urged the Committee total clinical experience in treating eye problems when discussing HB 315. He urged the Committee not to concur in the bill.

Gloria Hermanson, Executive Director of the Montana Academy of Ophthalmology, provided information about steroids and the history of optometric legislation in Montana to the members of the Committee. (Exhibit #5) Ms. Hermanson said when HB 315 was heard in the House, the ophthalmologists tried to amend the bill to include a "patient safety measure". That amendment was defeated.
The Academy feels there is still a problem with HB 315 because there is no mandatory referral amendment to the bill. Ms. Hermanson said she had no amendment to offer at this time because she would prefer to work out an amendment with the optometrists that is agreeable to all. The Academy's foremost concern is patient safety.

Jerry Loendorf, Montana Medical Association, said optometrists are highly educated individuals who do a lot of good for the people of Montana. Ophthalmologists do the same. However, the training of the two are different. Mr. Loendorf went over highlights of a study of cataract surgery outcomes. (Exhibit #6) Mr. Loendorf said the outcomes of this study should not mean that HB 315 should not pass.

Questions From Committee Members and Responses:

Sen. Rye asked William Simons where the line should be drawn, and were there things that optometrists never will be qualified to do. Mr. Simons said both professions have evolved, and the education changes. The profession of optometry will continue to evolve.

Sen. Rye asked Rep. Simon if there was a bill comparable to HB 315 four years ago. Rep. Simon said this was not the first time this bill had appeared before the Committee.

Sen. Christiaens asked Kent Harrington about his use of steroids at Malmstrom Air Force Base. Mr. Harrington said VA hospitals, federal reservations, and military bases do not subject themselves totally to state laws in order to operate efficiently. Mr. Harrington said his commander has decided what is reasonable for him to do.

Sen. Christiaens asked Mr. Harrington whether other optometrists in Great Falls who work at Malmstrom are allowed to use steroids until they leave the base. Mr. Harrington said that was correct.

Sen. Christiaens asked Mr. Harrington if there had been any problems associated with the use of the steroids. Mr. Harrington said there had been none.

Sen. Christiaens asked if there had been problems reported associated with the use of topical steroids during the last couple of years. Roger Furlong said steroids can cause blinding. They are used to treat serious problems, and can create serious problems.

Sen. Christiaens asked Roger Furlong if the problems had then come from the ophthalmologists, because optometrists are not able to use them. Dr. Furlong said his information was not from the state of Montana.

Sen. Christiaens asked if someone could address his question regarding the use of topical steroids in Montana. Paul Kathrien said measures had been taken to guarantee that the use of therapeutic drugs would be safe. No complaints have been made to the Optometry Board, the Medical Board or the Pharmacy Board.

Sen. Christiaens said there was a letter regarding protocol, which he appreciated and thought it was a good idea. (Exhibit #7)

Chairman Eck asked Mr. Kathrien what kinds of standards would be developed in the protocol. Mr. Kathrien said there may be time conditions for referrals to ophthalmologists. Because optometrists are primary eye care providers, there are going to be cases when the expected result does not appear. In those cases, referrals will be made to ophthalmologists. Mandatory referrals in the law are not workable because treatment standards can change. Protocols can be changed by the board.

Sen. Towe asked Kevin McBride how he responded to the ophthalmologists' contention that, in Montana, optometrists only have to have 100 hours of training, pass a written exam, no clinical experience is required, they have no medical degree, no background in treating disorders of the eye. Mr. McBride said the education that optometrists receive is thorough to treat and recognize certain problems.

Sen. Towe asked Mr. McBride what his educational background was. Mr. McBride said he had a bachelor's degree in biology and chemistry and completed a four year program.

Sen. Towe asked Mr. McBride if that were the case for most of the optometrists today. Mr. McBride said 90% of entering optometry students have a bachelor's degree. The vast majority have an 8-year education.

Sen. Towe asked Mr. McBride about the diseases and disorders covered in optometrists' training. Mr. McBride said there is a lot of training in pharmacology, pathology of the eye, and there are clinical rotations to gain experience. The 100 hours mentioned referred to a "refresher" course that all optometrists went through after the passage of a bill during the 1987 Legislature. The course updated all optometrists to the same point.

Sen. Towe asked Roger Furlong how he responded to this educational background which "should qualify" optometrists to make educated referrals. Dr. Furlong said all diseases cannot be detected and correctly treated. Ophthalmologists have a greater total education. He agrees that the majority of what optometrists do would be appropriate, but there is no safeguard in HB 315 for those who do not act appropriately. The consumers of health care will be the ones to pay.

Sen. Towe asked Dr. Furlong if the four year optometric degree was not adequate. Dr. Furlong said it was a confusing area. The number of eye diseases where steroids are used in treatment is very high. Most eye diseases treated with steroids will not have complications, but the question is what level of bad outcome is acceptable.

Sen. Klampe asked Dr. Furlong for examples of problems associated with steroid eye treatment. Dr. Furlong said steroid eye medications can cause permanent glaucoma, but these cases are extreme and rare. There are other cases of herpes infections worsening rapidly with the use of steroid treatments.

Sen. Klampe asked Kevin McBride what optometry schools offered clinical experience. Mr. McBride said all schools offered clinical experience, without exception. Some schools offer externship rotations where students work in VA hospitals.

Sen. Klampe asked Mr. McBride for the number of hours of clinical experience. Mr. McBride said he had given numbers that a fourth year student would go through, which was 1300.

Sen. Klampe asked Mr. McBride what portion of clinical hours were spent working with diseases rather than drugs. Mr. McBride said it would probably be 20%-30%, but said he could not offer an accurate number.

Sen. Klampe asked if 29 states had adopted laws allowing optometrists to prescribe topical steroids, and were there states that had rescinded the law. Paul Kathrien said some states had restricted the use of topical steroids by rescinding a mandatory referral amendment.

Closing by Sponsor:

Rep. Simon said he viewed HB 315 as a "turf issue". The real

issue is safety, and it has been clearly demonstrated that optometrists are able to deliver health care safely and at a lower cost. HB 315 is also about access. Many Montanans cannot easily get to visit an ophthalmologist. Rep. Simon said it was interesting that air force bases allowed the use of topical steroids, when they have so much invested in their pilot's vision. Regarding the amendment proposed by the ophthalmologists in the House Committee, there were problems with the time of referral. Rep. Simon said it was not good to write protocols into Montana law.

HEARING ON HB 225

Opening Statement by Sponsor:

Rep. Steve Benedict said HB 225 comes from a request by the Department of Corrections and Human Services and addresses a specific problem regarding voluntary admissions to the chemical dependency program at Galen. Currently, there are no screening requirements, and many voluntary admissions are individuals who might not need the comprehensive services at Galen. There are certified chemical dependency counselor services in every county in the state, and they are free to individuals who need the evaluation. HB 225 will go a long way in reducing the waiting period for those who truly need services at Galen. Rep. Benedict said the bill is very simple.

Proponents' Testimony:

Darryl Bruno, Administrator of the Alcohol and Drug Abuse Division, provided written testimony. (Exhibit #8)

Mike Rupert, President of the Chemical Dependency Programs of Montana, said they are in favor of HB 225.

Opponents' Testimony:

Dan Shea, concerned citizen, said the language in HB 225 was confusing. Mr. Shea said it does not specify that those involved are already incarcerated. The language is unclear regarding when patients can leave treatment. Mr. Shea said the language should be "cleared up".

Questions From Committee Members and Responses:

Sen. Christiaens said 1500 admissions were made to Galen in 1992, and of those 550 received detoxification only and then were discharged. Sen. Christiaens asked Darryl Bruno why those patients were discharged after detoxification only. Mr. Bruno

said that was the only service for which they were at Galen. Most of those patients are from neighboring counties where there is no detoxification.

Sen. Christiaens asked Mr. Bruno where else they could receive services, and were they at Galen because of cost. Mr. Bruno said they were indigent clients.

Sen. Christiaens asked Mr. Bruno where those individuals would receive detoxification services at no cost in the future. Mr. Bruno said those individuals would still be admitted to Galen. HB 225 is about voluntary admissions to the in-patient program.

Sen. Christiaens asked Mr. Bruno if that meant the figure regarding detoxification did not mean much. Mr. Bruno said that was correct.

Sen. Christiaens asked Mr. Bruno how many people were going to Galen for treatment less than the normal 28-day treatment plan, and how many people were going for a longer program. Mr. Bruno said currently the 14-day program has not been implemented. There are 15 beds for the longer treatment plan available.

Sen. Christiaens asked Mr. Bruno how many patients were going into the longer treatment program. Mr. Bruno said most of the 15 beds were full most of the time.

Sen. Christiaens asked Mr. Bruno if individuals could not receive treatment similar to the 14-day treatment plan somewhere in the community. Mr. Bruno said many of the individuals could be served in the community, and they eventually are. If all communities now have intensive out-patient services, individuals should be served there to make the beds available for those who need in-patient services.

Sen. Christiaens asked Mr. Bruno if the Department had money in the budget to cover of intensive out-patient service costs in communities. Mr. Bruno said it was "on going".

Sen. Christiaens asked Mr. Bruno if all programs were offering out-patient services at no charge if the individual is indigent. Mr. Bruno said billing was done on a sliding fee schedule.

Sen. Christiaens asked Mr. Bruno if individuals were then being charged for the services, and it was not the same as Galen. Mr. Bruno said the services at Galen are not free, either. The services at Galen are based on a patient's ability to pay.

Sen. Rye asked Mr. Bruno what a "forced volunteer" program was. Mr. Bruno said forced volunteers are individuals that judges have sent to treatment.
Sen. Rye asked Mr. Bruno if it were comparable to the "voluntary" tax paying system. Mr. Bruno said there is a waiting list to get into Galen, but HB 225 will not deny services to people in need

of in-patient treatment. 50%-60% of the patients are of the forced voluntary nature.

Sen. Towe asked Mr. Bruno if the facility defined in 53-24-103 was Galen. Mr. Bruno said it was the Galen program.

Sen. Towe said that the "approved private treatment facility" or public treatment facility which "must be in the region in which the applicant resides." Sen. Towe asked Mr. Bruno if there were an approved treatment facility in every region. Mr. Bruno said there was, either public or private.

Sen. Towe asked Mr. Bruno if Deaconess Hospital in Billings was such a facility. Mr. Bruno said the Rimrock Foundation in Billings was.

Sen. Towe asked Mr. Bruno why services would be considered not appropriate. Mr. Bruno said the services which are not appropriate probably need a higher level of intensive out-patient services.

Sen. Towe asked Mr. Bruno if he were talking about quality of care instead of cost. Mr. Bruno said that was correct.

Chairman Eck asked Mr. Bruno how the decision was made whether in-patient or out-patient services would be the most appropriate. Mr. Bruno said there are patient placement criteria.

Norma Jean Boles, Manager of Standards and Quality Assurance, said she authored the patient placement criteria. Ms. Boles said it is based on national criteria and determines which care is the most appropriate. It is an effective system, basing the services on patients' behavior.

Chairman Eck asked Mr. Bruno if, on Page 3, Subsection 3, the language addresses follow-up care. Mr. Bruno said that was correct. It was eliminated from the bill as a "housekeeping" measure.

Chairman Eck asked Mr. Bruno what Subsection 4 addressed. Mr. Bruno read that section, and said that was all current law. There is no change in Subsection 4.

Sen. Christiaens asked Rep. Benedict about his opening statement referring to "(treatment) in lieu of jail time" which was not specifically stated in the bill. Rep. Benedict said HB 225 was a good, simple bill. It is a good bill for the chemically dependent, and the idea behind the bill is that there are too many judges who want to commit individuals to the 28-day program at Galen without knowing whether or not the individual needs that kind of treatment. Any voluntary admission, under HB 225, needs to go through a chemical dependency counselor in a community to determine if there are services available to that individual in the community. Rep. Benedict said HB 225 was "such a simple

bill, (he) didn't understand all the confusion."

Chairman Eck asked Mr. Bruno if there were financial advantages to a community in sending an individual to Galen, because the state of Montana would pay for the treatment. Mr. Bruno said the state would pay whether the patient were at Galen or in the community because the funds are federal, block grant dollars. The more individuals that can be served in the communities, the better.

Sen. Christiaens said he had heard from the Department of Corrections and Human Services about the shrinking ear-marked dollars going back to the communities. Unless that money is made up from increased federal chemical dependency block grants, there is not more money going to communities. Sen. Christiaens said he would like to see figures about the numbers of individuals who will be treated. During the past two years, people have not been able to receive treatment at Galen, and individuals who quit were not replaced.

Mr. Bruno said the same 87 treatment beds at Galen are being maintained. There may be a problem with understaffing, which may force the closure of a wing. HB 225 would probably only reduce the number of people coming to Galen by 60 individuals. HB 225 will also free up the waiting list, which people are inappropriately put on. This will free up spaces for those who need the treatment. Mr. Bruno said the ear-marked dollars have stayed the same.

Closing by Sponsor:

Rep. Benedict said if there are shrinking federal dollars, and the out-patient services are not available in communities, killing HB 225 will not help that situation at all. If those who don't really need to be at Galen can be eliminated, chemically dependent individuals can be treated. Cutting down on the waiting list to Galen does those individuals a big favor. Rep. Benedict said he did not understand Dan Shea's misunderstanding of the bill, because page 3 and Page 4 of HB 225 are current law.

EXECUTIVE ACTION ON SB 389

Discussion:

Sen. Towe said he had been trying to work with the industry on SB 389 to try and reach an agreement. Sen. Towe said the current agreement is one he feels "luke warm" about, and suspects industry feels the same way. Sen. Towe provided a bill with amendments. (Exhibit #9) Monitoring has been taken out of the Statement of Intent. Page 2 has been stricken because there is

now a different reference to funding. Section 1 is the repeal of the Hannah Amendment, and it has been stricken. However, it will reappear later in the bill. Section 1 is now the study to be done by the Air Quality Advisory Council as requested by the industry. Sen. Towe went over the first page of amendments. (Exhibit #9)

Sen. Christiaens asked who "they" referred to. Sen. Towe said "they" were Jeff Chaffee and the Department of Health which is the administrative body to insure this act is enforced.

Sen. Mesaros asked Sen. Towe if the Department did all the studies. Sen. Towe said the industry had asked the Air Quality Advisory Commission appointed by the Department do the study. Sen. Towe said he was not completely comfortable with this.

Sen. Towe continued reading the first page of amendments. (Exhibit #9) Based on the results of the three studies, the 1995 Legislature must determine whether further study of health effects of sulfur dioxide in the Billings/Laurel area is necessary. Sen. Towe went back to Page 4 of the SB 389 (Exhibit #9). If SB 318 passes, it will rewrite this section of SB 389. This section gives the Department the authority to charge a larger per ton fee in certain areas if a higher fee is necessary and the Legislature appropriates the funds for it. Sen. Towe said an amendment would be put into the appropriation bill which will provide an appropriation of $200,000 for this biennium for the three studies. The funding will come from the per ton fees. The new Section 2 specifically gives the Department rulemaking authority to comply with the federal Clean Air Act. Section 4 will be stricken, and the new material on the last page of the hand out will replace it. This involves the higher state air quality standards. Sen. Towe said the most important part of the bill is part 2(2) on the last page of the hand out, and read this new section. This states that the Department will determine how much should be done by each company. Once a goal is reached, the time frame will be determined, and industries must comply or administrative penalties will apply. The Department must make a status report to the 1997 Legislature.

Motion:

Sen. Towe moved these amendments. (Exhibit #9)

Discussion:

Sen. Christiaens asked Sen. Towe how many other areas the Department of Health negotiated. Sen. Towe said most areas of Environmental Protection Agency work are negotiable, but the Department has ultimate authority.

Sen. Christiaens asked Sen. Towe if the appropriation was in HB 2 as in came to the Senate. Sen. Towe said he "doubted it."

Sen. Christiaens said Sen. Towe was being "pretty optimistic." Sen. Towe said the point was there was no general fund money needed, the studies are paid for by the industry. Sen. Towe said he hoped there would not be problems with this appropriation.

Sen. Christiaens said he would like to hear from the Department of Health regarding their manpower situation considering the recent budget cuts. Bob Reich, Department of Health Air Quality Bureau, said special appropriations would be needed, such as fees, to work on studies for specific areas.

Sen. Christiaens asked how many Full Time Equivalents (FTE) would be needed. Mr. Reich said the studies would be done by private consultants, so there would be no additional FTE's.

Sen. Towe said it was contemplated there would be a $200,000 appropriation for the biennium, but he wanted it to be clear that amount would be available.

Sen. Christiaens asked Sen. Towe if it were his intention that the studies would be contracted instead of done by the Department. Sen. Towe said that was what the industry requested, and "it may not be the best idea."

Tom Ebzery, Exxon spokesman, said the reason why the Air Quality Advisory Council was chosen is because the Department of Health has already determined they want the state standards. If the Department does the study, and they already want the state standards, and industry has concerns that the decision has already been made. The Council will coordinate the study to be done by a private expert consulting firm or contractor.

Sen. Christiaens asked Sen. Towe about the need for a literature search. Sen. Towe said work has been done, but when specific information is requested, it is not available. A literature search on the health risks associated with sulfur dioxide could be beneficial, and it could focus on the need for monitors in Billings. Sen. Towe said he was nervous about the Air Quality Council doing all of it.

Chairman Eck asked Sen. Towe if he was satisfied to let some action on SB 389 be taken in the House. Sen. Towe said it may have to be because the amendments have not been seen by the Department or some of those most anxious for action on the air pollution in Billings. Sen. Towe said he did not have time to do this, and something has to be adopted today. Sen. Towe did ask to talk with all people from the industry, and much has been worked out. The higher air quality standards requested will be put into place, "it just won't be immediate". Sen. Towe said if the studies show it is not necessary, it may not happen.

Sen. Mesaros asked if a true compromise had been reached with the amendments.

Ted Doney, Billings Generation, Inc., said they are in agreement with the amendments, and they have assured Sen. Towe if the amendments are adopted, they will not oppose the bill.

Chairman Eck said the compromise has not yet included other individuals from Billings who had testified. Sen. Towe said that was correct.

Sen. Klampe asked Sen. Towe if the funding for SB 389 was based on the $3.00 per ton fee of sulfur dioxide emissions. Sen. Towe said the impact of the bill has been limited to the area in which there is a SIP (State Implementation Plan) recall, which is the Billings-Laurel area.

Sen. Klampe asked if that included Colstrip or East Helena. Sen. Towe said they would not be paying any additional fees, it was just the area in Billings that would pay, and it would be closer to $5.00 per ton.

Sen. Klampe asked Sen. Towe if the other areas would benefit from the study, shouldn't they pay fees too? Sen. Towe said talk had focused around the area in which there was a sulfur dioxide emissions problem. While it is probably true that everyone in the state will benefit from the studies, the focus of the attention is in Billings, and they should "pay the burden" at this point.

Chairman Eck asked Sen. Towe if he were intending to adopt all the amendments. Sen. Towe said he was.

Sen. Towe asked the Committee to adopt the amendments as they were presented (Exhibit #9), and he would work with Tom Gomez, Legislative Council, to make sure they are written in proper form. Sen. Towe said there was one more significant item which hadn't yet been mentioned. There are three parts to the standards, a one-hour standard which had an allowance of 18 excedances. Sen. Towe had originally suggested that be lowered to one excedence, but there were many objections. Therefore, rather than put the number of excedences into the statutes, industry would prefer that it remain part of regulations which can be changed. Sen. Towe referred the Committee to the last page of the handout.

Vote:

The motion to adopt the amendments (Exhibit #9) passed unanimously. Sen. Franklin was not present for the vote.

Discussion:

Sen. Towe asked for permission to add "with concurrence of the Department" into the amendments. Chairman Eck allowed the addition without objection.

Motion:

Sen. Towe moved SB 389 DO PASS AS AMENDED.

Discussion:

Sen. Christiaens asked if the SIP needed to be completed within 18 months. Sen. Towe said federal law required it to be done within 18 months near the date of the hearing on SB 389. Then the goals must determined within 18 months, and they may have as much as 5 years to comply with the goals.

Vote:

The motion that SB 389 DO PASS AS AMENDED carried UNANIMOUSLY. Sen. Franklin not voting.

Discussion:

Sen. Towe said there was a commitment from Montana Power that they would not oppose SB 389 in the House. A spokesman said that was correct.

Sen. Towe asked Exxon, Cenex, Conoco, BGI and Montana Sulfur if they would not oppose the bill in the House. All industries said they would not oppose the bill in the House.

Sen. Rye said Sen. Towe had done "brilliant" work in melding contrasting view points into an acceptable bill. Sen. Rye commended Sen. Towe for doing an "extraordinary job."

Sen. Christiaens asked if there were proxy votes for Sen. Franklin and Sen. Hager. Chairman Eck said they would be allowed to vote on SB 389.

EXECUTIVE ACTION ON HB 220

Discussion:

Sen. Christiaens asked if anyone had looked at the OSHA requirements in regard to this issue. Sen. Christiaens said he was informed there were OSHA standards, and if they were complied in, there was no problem. He said he was not sure if that was true or not, but wanted to know if anyone had looked into it.

Chairman Eck said she was not aware of anyone mentioning it.

Sen. Christiaens said he was told by a hospital that federal law applies because of the OSHA standards.

Chairman Eck asked that someone explain the compromised worked out with the Department of Health.

Dayna Shepard, attorney with the Department of Health, said she had worked with Drew Dawson, the Bureau Chief of the Emergency Medical Services Bureau, and a group of firefighters. A list of amendments was agreed to (Exhibit #10), and Ms. Shepard said it is an improvement. HB 220 provides for a system of notification in emergency situations when a patient is transported to a health care facility so that the health care facility must respond to a request or inquiry from an emergency care provider of possible exposure to an infectious disease. The Ryan White Act requires a specific notification system so facilities must inform a designated officer in the emergency medical services organization that there was an infectious air born disease, and there may have been exposure.

Chairman Eck asked to what "aerosol" referred. Ms. Shepard read the Ryan White Act definition of "aerosol". Basically, she said, it is a disease that can be contracted by breathing the same air.

Sen. Christiaens asked Tim Bergstrom what had happened since the Committee heard the bill regarding the request to St. Peter's Hospital and the incident which occurred in December. Tim Bergstrom, Montana State Fireman's Association, said the discussions with the Department of Health, and Drew Dawson, it has become clear that the system must be upgraded. The amendments designate an individual who must receive the requests for exposure notification. Regarding the Helena incident in December, Mr. Bergstrom said the people at the health care facility were not aware of the laws concerning the notices for requests of exposure notification, so they were refused. Mr. Bergstrom said there had around 10 hours of meetings with the Department of Health to arrive at a workable solution. The current Montana statue does not comply with the Ryan-White Act regarding aerosols, and the amendments would make the statute consistent with the Act. Nothing has been done regarding confidentiality.

Sen. Christiaens said he had concerns that the Helena hospital had not replied even after two months, so he did some checking. Sen. Christiaens said he was told there was always someone available, 24 hours per day, for the acceptance of such forms. If it's not in the law that states the administrator, or nurse or physician, that they will accept the form, maybe it should be amended to specifically include such language.

Mr. Bergstrom provided copies of HB 220 with the amendments. (Exhibit #11). He referred the Committee to the last page, the new section drafted by the Department of Health and Environmental Sciences. Mr. Bergstrom read this section. It specifically addressed Sen. Christiaens' concern.

Sen. Christiaens said he did not think this section addressed his concern because two people were involved: a disease control officer, who works a 40 hour week, and one alternate. Hospitals are open 24 hours per day, 7 days per week. Sen. Christiaens

said it would be cleared up if it were indicated that the supervising official in that facility would be always available to receive the forms. As it is, there would be times when neither one of the two designated individuals would be there.

Mr. Bergstrom said there was a time period of 48 hours for oral notification, and 72 hours for written notification, for a hospital to respond.

Sen. Christiaens said he understood that part, but asked Mr. Bergstrom when the form would be accepted.

Dayna Sheperd said Subsection 1 provides the authority for the health care facility to develop their own internal procedures to comply with HB 220. They did not feel the law should be too specific because all health care facilities have their own schedules.

Sen. Christiaens asked Ms. Sheperd about the problem of only two people working 40 hour weeks. Ms. Sheperd said it could be developed in rule that there be an individual and an alternate assigned for varying shifts. The law would state there must be those two people, but the internal procedure would allow the facility to name others for different shifts if they chose to do so.

Sen. Christiaens asked Ms. Sheperd if she would have a problem with language stating there must be a designee at all times. Ms. Sheperd said the Department would not have a problem with that language.

Sen. Christiaens said that way, no matter when an individual goes to a health care facility, there will be someone available to receive notification forms. Ms. Sheperd said she understood Sen. Christiaens' concern, and that would still allow facilities flexibility in complying with the law.

Sen. Christiaens asked Tom Gomez if new language could be added to the new section 7 covering that issue. Mr. Gomez said he would add the language in Sub 2.

Chairman Eck said when the amendments were moved, it would include that caveat. Chairman Eck said she would like the Lewis and Clark Health Department to comment on the amendments. (Exhibits #10 and #11)

Mary Beth Ferderes, Director of the Community Health Services Division of the Lewis and Clark City/County Health Department, said she had reviewed the amendments, and thinks they reflect a good compromise which is workable. Ms. Ferderes said they would recommend approval of HB 220 with these amendments.

Motion:

Sen. Towe moved the amendments, with Sen. Christiaens' additional language. (Exhibit #10)

Discussion:

Sen. Towe asked Dayna Sheperd to walk the Committee through the new section 2, and the definitions of "exposure" and "provider". Ms. Sheperd said the "provider" is the emergency care provider.

Sen. Towe asked Ms. Sheperd what happened after an exposure. Ms. Sheperd said the emergency care provider would request that a designated officer make a formal inquiry.

Sen. Towe asked Ms. Sheperd who makes the inquiry, and to whom the inquiry is made. Ms. Sheperd said it is made to the health care facility.

Sen. Towe asked Ms. Sheperd to whom the "health care facility" referred. Ms. Sheperd said it was the hospital.

Sen. Towe asked Ms. Sheperd if the designated person filled out the form and what happened to it. Ms. Sheperd said the form states the date and time of transportation, the name of the designated officer submitting the form, and questions about whether the patient has an infectious disease. The hospital will respond by saying that there was an infectious disease, or there was not an infection disease.

Sen. Towe asked Ms. Sheperd if this took place between two designated officers. Ms. Sheperd said that was correct.

Sen. Towe asked Ms. Sheperd what happened if there was a communicable disease. Ms. Sheperd said a designated officer from the emergency care providers will inform the fireman, for example, that there may have been exposure to an infectious disease. There are different procedures for different diseases, and those would be followed.

Sen. Towe asked Ms. Sheperd if HB 220 authorized the hospital to specify what disease it was. Ms. Sheperd said it did.

Sen. Towe asked Ms. Sheperd if "exposure" applied only to open wounds. Ms. Sheperd said the determination, if there was an exposure, is left to persons at the scene of treatment, because they would know about contact with an open wound, for example.

Sen. Towe asked Ms. Sheperd if the care providers were wearing gloves and if there was an open wound, there may not have been an exposure. Ms. Sheperd said that was correct.

Sen. Christiaens said, because of race, there might be emergency care providers who would automatically request this information. For example, it is known there is a high rate of tuberculosis on Indian reservations. Ms. Sheperd said TB is an airborne disease,

and the health care provider does not need to request information about exposure, because the information is automatically requested.

Sen. Christiaens said that was the case if they were diagnosed, but he was saying that some emergency care providers would want to have exposure notification automatically for individuals of certain races. Ms. Sheperd said that would be allowed under HB 220.

Sen. Christiaens said he had concerns about having higher incidents of requests because of race. Tim Bergstrom said HB 220 does not require a test of any patient for any reason, except the existing law requires a request for notification in the case of HIV. In the case of TB, the notification is automatic, but HB 220 does not require a health care facility to give any test to any patient.

Chairman Eck asked Mr. Bergstrom if any substantive changes had been made in Section 5. Mr. Bergstrom said the changes were made in January by the Legislative Council, and those changes were in regards to gender.

Sen. Towe asked Ms. Sheperd if air borne infectious diseases were treated differently, and if the health care facility had to take the initiative. Ms. Sheperd said that was correct, the hospital had to notify the emergency care provider and the Department of Health.

Sen. Towe asked Ms. Sheperd if the names were never included. Ms. Sheperd said, "absolutely."

Sen. Towe asked Ms. Sheperd about Section 3, the physician's obligation to tell the health care facility who must tell the emergency care providers. Ms. Sheperd said that was correct.

Sen. Towe asked Ms. Sheperd if this referred to any disease, or just air borne diseases. Ms. Sheperd said it referred to any infectious disease.

Sen. Towe asked Ms. Sheperd if that included HIV. Ms. Sheperd said it did. Ms. Sheperd said if a physician, in the course of treatment, finds that a patient has an infectious disease, he must tell the health care facility.

Sen. Towe asked Ms. Sheperd if the hospital had an affirmative duty to notify the emergency care provider. Ms. Sheperd said they did, and that was referred to in Section 3, Subsection 2. Oral notification must take place within 48 hours, and written notification within 72 hours. That law already exists, and it is in compliance with the Ryan-White Act.

Vote:

The motion to adopt the amendments with Sen. Christiaens' addition passed UNANIMOUSLY.

Motion/Vote:

Sen. Klampe moved HB 220 BE CONCURRED IN AS AMENDED. The motion carried UNANIMOUSLY. Chairman Eck said she would carry the bill on the Floor of the Senate.

EXECUTIVE ACTION ON HJR 15

Discussion:

Tom Gomez said the amendments (Exhibit #12) change the Resolution so that it compliments the Clinton Administration for granting the Oregon waiver. It urges the Administration to give other states flexibility regarding Medicaid Waivers, and the rest of the changes are grammatical.

Chairman Eck asked if the title could be changed to "Commending." Mr. Gomez said he would change it.

Sen. Rye said he could live with "Commending".

Sen. Towe asked Mr. Gomez why he did not take out Line 25 on Page 1 and Lines 1 and 2 on Page 2. Sen. Towe said it was no longer pertinent. Mr. Gomez said he'd left the language in the Resolution because it was not clear what the Clinton Administration was going to do regarding other states. This was something that President Clinton specifically addressed, but no decisions had been made.

Sen. Towe said the language should read, "... the initial refusal to..." at the end of Line 24 on Page 1.

Motion/Vote:

Sen. Towe moved the adoption of the amendments. (Exhibit #12) The motion carried UNANIMOUSLY.

Motion/Vote:

Sen. Christiaens moved HJR 15 BE CONCURRED IN AS AMENDED. The motion carried UNANIMOUSLY.

EXECUTIVE ACTION ON HB 315

Motion:

Sen. Christiaens moved HB 315 BE CONCURRED IN.

Discussion:

Sen. Christiaens said he made that motion because an optometrist working at a federal institution can use topical steroids, but cannot once away from the federal institution. The education optometrists have is adequate, and allowing physician assistants to use such drugs with much less clinical experience creates inconsistencies. For that, and because there will be a protocol developed, Sen. Christiaens said HB 315 should be concurred in.

Sen. Rye said he agreed with Sen. Christiaens, and he would vote for the bill. Sen. Rye said he suspects that the high number of optometrists has allowed them to out-lobby ophthalmologists. As a lay person, he said he does not feel qualified to decide "turf battles" such as this bill.

Sen. Klampe asked Kevin McBride how many clinical hours were devoted to studying prescription and the use of topical steroids by optometrists. Mr. McBride said he could not give a specific answer to that question.

Sen. Klampe asked Mr. McBride how many hours he spent in his school studying topical steroids. Mr. McBride said there was no delineation of clinical hours specifically for the use of pharmaceuticals.

Sen. Klampe asked Mr. McBride how many clinical hours are spent working on diseases. Mr. McBride said 1300 hours was the number of clinical hours. He gave this figure during his testimony.

Sen. Klampe asked Mr. McBride how many of those 1300 hours were devoted to making glasses. Mr. McBride said making glasses was not the only traditional optometric procedure.

Sen. Klampe asked Mr. McBride how many hours were spent on traditional optometric procedures. Mr. McBride said every patient's eyes are examined to determine if they are healthy or not. Optometrists do not determine what glasses are needed and send the patient away. Every patient is evaluated from the standpoint of ocular health to determine if that patient is normal, or if there is a problem. For example, diabetes has ocular manifestations. Mr. McBride said this could be picked up during an evaluation, and the patient would then be referred to a physician.

Sen. Klampe asked Dr. Randall how important this issue is to ophthalmologists, and how dire would it be if it were passed. Dr. James G. Randall, Ophthalmologist in Missoula, said "it makes no difference" to him.

Sen. Klampe asked Dr. Randall for the importance of HB 315 in terms of the state. Dr. Randall said he had not read the study

on cataract surgery that was mentioned in testimony. 96% of patients who come in for cataract surgery will not need any post operative care. Only a few will have problems, and there is a difference in the care of those who have problems. Dr. Randall said the extra years an ophthalmologist receives pays off.

Sen. Christiaens asked Dr. Randall if he were talking about an individual who had cataract surgery, and then having follow-up problems. Dr. Randall said that was correct.

Sen. Christiaens said that only an ophthalmologist would have performed the surgery, and therefore, the follow-up problems would not be caused by the optometrist. Dr. Randall said the problems would not be "caused" by anyone, they just occur. The difference is optometrists did not detect these problems as frequently as did the ophthalmologists.

Sen. Christiaens asked Dr. Randall if he had documentation supporting that. Dr. Randall said that information was presented in testimony, from the Montana Medical Association. The study was in the Journal of Epidemiology.

Sen. Klampe asked Dr. Randall how "dire" it would be if HB 315 passed. Dr. Randall said it would make no difference to him, but would make some difference to the patients. It will be, in many instances, more convenient for the patient in terms of receiving needed medication, but there will be some problems. Dr. Randall said he appreciated no blame being laid for problems that may occur.

Chairman Eck asked Dr. Randall about the protocol being established, and if he thought a protocol was adequate. Dr. Randall said he has been practicing for 10 years, and he has discovered that the "only thing that matters is the medical record." It doesn't matter what was wrong with the patient, and it doesn't matter what the doctor did, the only thing that matters is how it looks on paper when it is reviewed later by attorneys and reviewing commissions. Dr. Randall said, for the vast majority of optometrists, there will be no problem. For some, however, there will be problems with or without restrictions. Dr. Randall said that if the Committee wished to do something as a safeguard for the public, there should be a referral limit of one week included in the bill.

Sen. Towe asked Mr. McBride for what the steroids would be used. Mr. McBride said the steroid would be used for patients who come in, who have difficulties, and he knows what the problem and treatment is.

Sen. Towe asked Mr. McBride if he was treating a disorder or disease. Mr. McBride said, with the bill passed in 1987, optometrists are treating many "red eye" problems, some of which have inflammation present. That would appropriately be treated with topical steroids, but Mr. McBride cannot use them because of

the current laws.

Sen. Towe asked if optometrists could use and prescribe topical steroids. Mr. McBride said optometrists have been very conservative and quick to refer, and they are confident about taking on new responsibilities.

Sen. Towe asked Mr. McBride if there was a board that handled the licensing of optometrists. Mr. McBride said there was.

Sen. Towe asked Mr. McBride if that board could be persuaded to write up some protocols. Mr. McBride said the board has stated that they are willing to develop a protocol, and work with ophthalmologists on it.

Sen. Towe asked Dr. Randall if that gave him some level of comfort. Dr. Randall said it did not because the Board of Optometry does not have experience relating to the practice of medicine. The people on the Board of Optometry do not necessarily have the expertise.

Sen. Towe asked Dr. Randall if ophthalmologists had the expertise that could be lended to the Board of Optometry. Dr. Randall said he was not skilled in political matters, but would be willing to work out differences. A compromise would have to include a referral.

Sen. Towe said this was significant, because if the protocols were developed, and they are not followed, there is immediate serious liability. Sen. Towe said that gave him some level of comfort.

Mr. McBride said he felt the Board of Optometrists did have some expertise relating to the treatment of eye disease. There was a case of an optometrist being reprimanded. Mr. McBride said the Board would be quick to act on any problems presented.

Sen. Towe said his feeling was to let the optometrists "give it a try" but if a protocol is not developed within two years, it can be put into the statute. Dr. Randall said it would be unlikely he would hear from ophthalmologists.

Sen. Towe asked Paul Kathrien if a protocol would be developed, and that it would be sent to the ophthalmologists present, Dr. Randall and Dr. Furlong. Mr. Kathrien said the protocol could be put together with consultation from Dr. Randall and Dr. Furlong.

Sen. Klampe asked how the protocol would work in terms of HB 315 passing now. Sen. Towe said the Committee was accepting something in good faith, Mr. Kathrien's word that a meaningful protocol would be developed.

Mr. Kathrien said a protocol would be developed before any patients were treated (with topical steroids).

Sen. Christiaens said HB 315 is not effective until October 1993, and there is plenty of time for differences to be worked out.

Sen. Towe said he wanted to be sure that ophthalmologists are consulted, and that the final product is presented to them. If the ophthalmologists are not satisfied, Sen. Towe said the Legislature should know about it.

Vote:

The motion that HB 315 BE CONCURRED IN carried UNANIMOUSLY.

EXECUTIVE ACTION ON HB 274

Discussion:

Tom Gomez said there were amendments proposed by Rep. Brown, (Exhibit #13) and there were questions during the hearing on HB 274 regarding the eighth amendment.

Sen. Christiaens said it had to do with psychiatrists and psychologists, and their credentials to do gambling counseling.

Sen. Klampe asked if it were assumed that a psychiatrist had adequate training to do gambling counseling. Sen. Christiaens said that was his recollection. Sen. Christiaens said these are multiple compulsive disorders, and other issues are oftentimes involved.

Sen. Mesaros said that raised the question about the necessity of HB 274.

Sen. Klampe said the bill was "absolutely necessary" because currently, there are individuals who are not very highly qualified treating gambling disorders.

Sen. Mesaros said, as he sees it, HB 274 creates a specialist who can only treat gambling addiction, but not other disorders.

Sen. Christiaens said HB 274 would create another type of specific counselor. Currently, there is no one licensed as a gambling addiction counselor, and the only place to get the necessary training, that he is aware of, is in Minnesota. The Rimrock Foundation in Billings is the only facility that advertises the treatment of gambling addictions, but there was testimony stating there was no one qualified working there.

Sen. Klampe said the qualifications on Page 3, Lines 18-24 convinced him the bill was needed. These qualifications are not extreme, and they do not set another profession, but it is a little more "fussy" about who can treat problem gamblers.

Sen. Christiaens told Sen. Klampe that all that had been stricken from the bill.

Sen. Klampe said that was part of a proposed amendment, and those parts had not yet been stricken.

Sen. Christiaens said that was what every chemical dependency counselor was already doing. They have 2000 hours, and one year of supervised work experience.

Sen. Klampe said they were chemical dependency counselors, and without that in the law as it is written, an individual would not have to be a chemical dependency counselor first. Only one year of supervised work experience would be needed.

Motion:

Sen. Christiaens moved HB 274 be TABLED.

Discussion:

Sen. Christiaens said he made that motion because he did not see a need for the bill. If this kind of bill is to be passed, he would like to see the gambling interests put money from the proceeds into the treatment for those who are addicted.

Chairman Eck said that maybe the proposed amendments should not be passed, but other amendments should be.

Sen. Towe asked why the amendments were being pushed. Chairman Eck said it had something to do with costing money if the amendments were not passed. Under the bill, the Department would not develop standards and implement certification systems, and this would cost money.

Sen. Towe said those who would be licensed as gambling counselors already are licensed as psychologists or professional counselors.

Chairman Eck said the certification of problem gambling counselors was new, they had never before been certified. Sen. Towe said that was correct, but those who would be certified under the bill already have licenses as counselors.

Sen. Klampe said chemical dependency counselors must complete 60 hours of gambling specific training to bring them up to the level of professional counselors, social worker or psychologist.

Sen. Towe asked if HB 274 would authorize an additional group of people to do gambling counseling, those who do not already have licenses as professional counselors, social workers or psychologists. At the present time, it looks like the only individuals who can do gambling counseling are professional

counselors, social workers and psychologists.

Sen. Klampe said it was his understanding from the testimony that at the present time "just about anyone" can call themselves a gambling addiction counselor. Chairman Eck said that was her understanding as well.

Sen. Klampe said if that was the case, the situation should be improved. This bill goes a long way towards improving the situation.

Sen. Rye said the licensed professional counselor from Missoula who testified as an opponent correctly pointed out that this bill would create a "Pandora's box" regarding certification for treating various disorders. Sen. Rye said that gambling addictions are often accompanied by other "intertwining" addictions.

Sen. Christiaens told Sen. Klampe that future bills would include certifications for treating anorexia or bulimia, and asked, "where does it stop?"

Sen. Mesaros said the level of all counselors should be elevated, and special certificates for each area should not be developed.

Sen. Klampe said there was no specialization in the field of counseling.

Vote:

The motion to TABLE HB 274 passed 6-2, with Chairman Eck and Sen. Klampe voting "no".

EXECUTIVE ACTION ON HB 551

Discussion:

Chairman Eck said HB 551 was a short bill concerning mandatory drug information courses.

Motion:

Sen. Towe moved that HB 551 be amended by adding a period after the word "treatment" on Line 17 and striking the rest of that paragraph.

Vote:

The motion carried UNANIMOUSLY.

Motion:

Sen. Franklin moved HB 551 BE CONCURRED IN AS AMENDED.

Discussion:

Sen. Christiaens said the bill states there will be a mandatory dangerous drug information course, and a judge may order that an individual may undergo treatment. When that individual is incarcerated, they go to the Department of Corrections, and whether or not a judge orders treatment, it may or may not happen. Sen. Christiaens said there was no effective drug treatment course in prison, and an individual sentenced to less than five years would never get into the treatment. The waiting list for intensive treatment is more than 18 months long, and most individuals sit in county jails for a minimum of 6 months prior to going to trial. Sen. Christiaens said what HB 551 requires "will never happen."

Substitute Motion:

Sen. Christiaens moved HB 551 BE NOT CONCURRED IN.

Discussion:

Sen. Rye asked Sen. Christiaens if he would prefer a motion to TABLE to avoid an Adverse Committee Report on the Floor of the Senate.

Substitute Motion:

Sen. Christiaens withdrew his previous motion and moved HB 551 BE TABLED AS AMENDED.

Vote:

The motion to TABLE HB 551 AS AMENDED passed UNANIMOUSLY.

EXECUTIVE ACTION ON HB 225

Discussion:

Sen. Christiaens said a lot of the problems with the Galen program over the last two years has been that "the Department of Corrections and Human Services has purposely not done the things they need to do at Galen, with the ultimate plan to close the facility." As a member of the Prison Advisory Council, Sen. Christiaens said four years ago the Department said Galen would be closed, and all treatment would take place in communities. There wasn't a single community-based program that was going to provide treatment at that time. Today, they'll tell you treatment is available in every region, but Sen. Christiaens said he was not sure that intensive out-patient treatment was

available in all regions. It is considered nationally to be equal to a 28-day in-patient program. Sen. Christiaens said he was "bothered" by HB 225.

Chairman Eck said it seemed to her the thrust of the bill was not to allow judges to send individuals to a treatment program if the individual did not need it.

Motion:

Sen. Franklin moved HB 225 BE NOT CONCURRED IN.

Substitute Motion:

Sen. Franklin moved HB 225 BE TABLED.

Discussion:

Sen. Franklin said having worked in other cities, she has found that when the state-run facilities are closed, there is no place for people to go at all. Sen. Franklin said she believes that is the case and she would "stake her life on it". Sen. Christiaens agreed.

Sen. Franklin said she did not want to get into the discussion of privatization, but there is another agenda she is "quite" concerned about.

Sen. Towe asked Sen. Franklin what that had to do with HB 225, which states that before an individual goes to Galen, a certified counselor must agree that is where the individual should go. Sen. Franklin said people will be turned away, and a waiting list will exist, longer than current ones.

Sen. Christiaens said if you have ever been involved with intervention, you will know that individual will agree to go to treatment, but 24 hours later, they may not go. Also, if an individual checks himself in, he needs treatment at that moment, not 24 or 48 hours later.

Sen. Towe asked Sen. Christiaens if HB 225 would help remedy that situation. Sen. Christiaens said this bill makes it difficult to get into treatment.

Chairman Eck said it was already difficult to get in.

Sen. Christiaens said if an individual shows up at the door of Galen, they take that individual.

Sen. Towe asked Sen. Franklin if there was a waiting list (at Galen). Sen. Franklin said there was a waiting list for spaces, but not for that kind of treatment. Chairman Eck said they take individuals for 24 hours, and then they are put on a bus.

Sen. Christiaens said patients are put on the bus for two reasons: first, if a patient decides to leave after "sobering up", or if the team who does the evaluation says the patient does not need treatment.

Sen. Rye recalled the comment about "forced voluntary", which must happen rather frequently, and he does not see "evil intent" in the bill. Sen. Rye sees it as trying to clear up some problems.

Sen. Franklin said limiting the admissions is oftentimes the ultimate result of such a bill.

Sen. Towe said those kinds of safeguards exist in the law already, and he feels it works well and is a good idea.

Substitute Motion:

Sen. Towe moved HB 225 BE CONCURRED IN.

Discussion:

Sen. Christiaens said he had concerns about funding. Sen. Towe said the bill would save money.

Sen. Christiaens said, according to the Fiscal Note, funding would come from "some" of the additional federal chemical block grant. Sen. Christiaens said he would like specific language stating the federal block grant "will" pay for costs.

Vote:

The motion HB 225 BE CONCURRED IN CARRIED, with Sen. Franklin and Sen. Christiaens voting "no".

ADJOURNMENT

Adjournment: Chairman Eck adjourned the hearing at 6:50 p.m.

Dorothy Eck

SENATOR DOROTHY ECK, Chair

Laura Turman

LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 3-26-93

NAME	PRESENT	ABSENT	EXCUSED
Eck	✓		
Franklin	✓		
Klampe	✓		
Hager	✓		
Towe	✓		
Mesaros	✓		
Rye	✓		
Christiaens	✓		

FC8

Attach to each day's minutes

SENATE STANDING COMMITTEE REPORT

March 27, 1993

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration House Bill No. 315 (third reading copy -- blue), respectfully report that House Bill No. 315 be concurred in.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

m- Amd. Coord.
N Sec. of Senate

Sen. Christiaens
Senator Carrying Bill

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SENATE STANDING COMMITTEE REPORT

March 27, 1993

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration House Bill No. 225 (third reading copy -- blue), respectfully report that House Bill No. 225 be concurred in.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

M — Amd. Coord.
N Sec. of Senate

Dorothy Eck
Senator Carrying Bill

691030SC.Sma

SENATE STANDING COMMITTEE REPORT

March 29, 1993

MR. PRESIDENT:
We, your committee on Public Health, Welfare, and Safety having had under consideration House Joint Resolution No. 15 (third reading copy -- blue), respectfully report that House Joint Resolution No. 15 be amended as follows and as so amended be concurred in.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Title, line 5.
Strike: "URGING"
Insert: "COMMENDING"

2. Title, line 6.
Strike: "AND CONGRESS TO GRANT THE"
Insert: "FOR ITS DECISION GRANTING A"
Following: "FEDERAL"
Insert: "MEDICAID"

3. Title, line 7.
Strike: "REGARDING MEDICAID IN ORDER"

4. Title, line 8.
Following: "PLAN"
Strike: "TO TAKE EFFECT"
Insert: "; AND URGING FLEXIBILITY FOR OTHER STATES SEEKING WAIVERS UNDER THE MEDICAID PROGRAM"

5. Page 1, line 11.
Following: "federal"
Insert: "Medicaid"

6. Page 1, line 16.
Strike: "discourages"
Insert: "was discouraging to"
Strike: "from"

7. Page 1, lines 19 through 22.
Strike: lines 19 through 22 in their entirety

8. Page 1, line 24.
Following: "but the"
Insert: "initial"

Amd. Coord.
Sec. of Senate

Sen. Towe
Senator Carrying Bill

701231SC.San

9. Page 1, line 25.
Strike: "shows"
Insert: "showed"

10. Page 2, lines 4 through 7.
Following: "1992,"
Strike: remainder of line 4 through "1990" on line 7
Insert: "seeking reconsideration of its waiver request; and
WHEREAS, on March 19, 1993, the Clinton administration granted Oregon's waiver request, allowing the state to implement the Oregon Health Plan"

11. Page 2, line 11.
Following: line 10
Insert: "(1)"

12. Page 2, line 12
Following: "States"
Strike: "Congress grant"
Insert: "Secretary of Health and Human Services be commended for their decision granting"

13. Page 2, line 15.
Following: line 14
Insert: "(2) That the Clinton administration grant other states seeking waivers the flexibility needed to enable these states to try new or different approaches to the delivery of health care services or to reform the health care system."

14. Page 2, lines 17 through 19.
Following: "Delegation," on line 17
Strike: remainder of line 17 through "Representatives" on line 19
Insert: "the United States Secretary of Health and Human Services"

-END-

SENATE STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 389 (first reading copy -- white), respectfully report that Senate Bill No. 389 be amended as follows and as so amended do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Title, lines 4 and 5.
Following: ""AN ACT" on line 4
Strike: remainder of line 4 through "DIOXIDE;" on line 5

2. Title, lines 5 through 7.
Following: "REQUIRING" on line 5
Strike: remainder of line 5 through "ENVIRONMENT" on line 7
Insert: "HEALTH STUDIES IN THE BILLINGS AND LAUREL AREA WHERE THERE ARE MAJOR INDUSTRIAL SOURCES OF SULFUR DIOXIDE"

3. Title, lines 8 through 10.
Following: "DIOXIDE;" on line 8
Strike: remainder of line 8 through "DIOXIDE" on line 10
Insert: "PROVIDING AIR QUALITY STANDARDS FOR SULFUR DIOXIDE TO BE IMPLEMENTED IN 1997"

4. Page 1, line 16.
Strike: "sections 3 and 4"
Insert: "section 2"

5. Page 1, line 17.
Strike: "3(1)"
Insert: "2"

6. Page 1, lines 19 through 22.
Following: "monitoring" on line 19
Strike: remainder of line 19 through "annually." on line 22
Insert: "consistent with subchapter V of the federal Clean Air Act, 42 U.S.C. 7661, et seq."

7. Page 1, line 24.
Following: "point"
Insert: "within a facility"

8. Page 2, line 7 through page 3, line 9.
Strike: page 2, line 7 through page 3, line 9 in their entirety

9. Page 3, lines 12 through 21.
Strike: section 1 in its entirety
Renumber: subsequent sections

10. Page 3, line 25 through page 4, line 12.
Strike: "department" on page 2, line 25
Insert: "air pollution control advisory council established in 2-15-2106
Following: "shall" on page 3, line 25
Strike: remainder of page 3, line 25 through page 4, line 12.
Insert: ", with the concurrence of the department, commission studies in the Billings and Laurel area where there are major industrial sources of sulfur dioxide. The studies must be conducted by credible, unbiased consultants who are experienced in the kind of studies described in this section. The studies must include:

(a) a literature search and analysis regarding the effects of sulfur dioxide on human health, including sensitive populations. The literature search and analysis must include:

(i) a review and analysis of studies by the environmental protection agency concerning the health effects of sulfur dioxide;

(ii) a review and analysis of sulfur dioxide health-related studies conducted in the Billings and Laurel area; and

(iii) a review and analysis of other studies concerning the health effects of sulfur dioxide;

(b) a review and analysis of the feasibility of conducting scientifically valid, epidemiological health studies in the Billings and Laurel area; and

(c) a study to determine whether additional enhanced ambient monitoring is useful in adequately protecting human health. The purpose of this study is to determine the adequacy of existing ambient monitoring in the Billings and Laurel area and must address the need for monitoring for ambient air concentrations of sulfur dioxide at 5-minute intervals and in a manner that detects concentrations of sulfur dioxide up to 5 parts per million.

(2) The air pollution control advisory council shall report the results of these studies to the 1995 legislature. Based on those results, the 1995 legislature shall determine:

(a) whether further study on the health effects of sulfur dioxide in the Billings and Laurel area is necessary;

(b) whether the studies in subsection (1)(b) would produce credible results; and

(c) whether additional enhanced ambient monitoring is necessary to adequately protect human health.

(3) If the 1995 legislature determines that further health studies are warranted as provided in subsection (2), then it shall provide for those studies, the results of which the air

pollution control advisory council shall report to the 1997 legislature.

(4) With the advice of the air pollution control advisory council, the department shall conduct a study of the current 1-hour standard applicable in Montana, including the number of allowable occurrences that exceed the standards, and recommend to the 1997 legislature what standard and number of occurrences that exceed the standards should be applicable to the Billings and Laurel airshed."

Renumber: subsequent subsection

11. Page 4, lines 14 through 16.
Following: "for the" on line 14
Strike: remainder of line 14 through "[section 4]" on line 16
Insert: "studies must be provided pursuant to 75-2-211(5)"

12. Page 4, line 18.
Strike: "**requirements**"
Following: "may"
Insert: ", upon adequate opportunity for a hearing involving affected industries,"

13. Page 4, line 19.
Following: "monitoring"
Insert: "consistent with subchapter V of the federal Clean Air Act, 42 U.S.C. 7661, et seq."

14. Page 4, line 20 through page 5, line 5.
Strike: page 4, line 20 through page 5, line 5 in their entirety
Renumber: subsequent subsection

15. Page 5, line 10 through page 6, line 3.
Strike: section 4 in its entirety
Insert: "NEW SECTION. **Section 3. Air quality standards in 1997 -- modeling studies -- report.** (1) Except as provided in subsection (3), the following ambient air quality standards for sulfur dioxide become effective on July 1, 1997:

(a) 0.10 parts per million, 24-hour average, not to be exceeded more than once per year; and

(b) 0.02 parts per million, annual average, not to be exceeded at any time.

(2) Upon approval by the environmental protection agency of a revised state implementation plan for sulfur dioxide in the Billings and Laurel area, the department shall:

(a) conduct modeling studies to analyze ambient sulfur dioxide emissions from major industrial sources. Findings based upon the modeling studies must be the basis for negotiations with

each source. The department shall then, in consultation with the affected source and after a public hearing, establish a goal for each source to attain compliance with the standards contained in subsection (1) and a feasible timeframe necessary to meet that goal;

(b) make a status report to the 1997 legislature.

(3) The standards contained in subsection (1) replace existing standards on July 1, 1997, unless:

(a) the air pollution control advisory council makes a finding, with the concurrence of the department, that the health studies completed pursuant to 75-2-206 demonstrate that the existing standards are adequate to protect human health;

(b) the department makes a finding that the affected sources have made sufficient changes to provide an adequate margin of safety for the health and welfare of citizens in the Billings and Laurel area; or

(c) the 55th legislature by statute imposes existing or other ambient air standards."

Renumber: subsequent section

16. Page 6, line 5.
Strike: "1, 3, and 4"
Insert: "2 and 3"

17. Page 6, line 8.
Strike: "1, 3, and 4"
Insert: "2 and 3"

18. Page 6.
Following: line 8
Insert: "NEW SECTION. **Section 5. Coordination instruction.** If House Bill No. 318 is passed and approved, then the reference to "75-2-211(5)" in [section 1 of this act] is void and the code commissioner is instructed to change this reference to "[section 12 of House Bill No. 318]".

-END-

SENATE STANDING COMMITTEE REPORT

March 29, 1993

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration House Bill No. 220 (third reading copy -- blue), respectfully report that House Bill No. 220 be amended as follows and as so amended be concurred in.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Page 1, line 15.
Following: line 14
Insert: "(1) "Airborne infectious disease" means an infectious disease transmitted from person to person by an aerosol, including but not limited to infectious tuberculosis."
Renumber: subsequent subsections

2. Page 1, line 17.
Following: "THE"
Strike: "PERSON WHOSE NAME IS"
Insert: "emergency services organization's representative or alternate whose names are"

3. Page 1, lines 18 through 21.
Following: "AS" on line 18
Strike: remainder of line 18 through "DISEASE" on line 21
Insert: "the persons responsible for notifying the emergency services provider of exposure"

4. Page 2, line 4.
Following: line 3
Insert: "(5) "Exposure" means the subjecting of a person to a risk of transmission of an infectious disease through the commingling of the blood or bodily fluids of the person and a patient or in another manner as defined by department rule."
Renumber: subsequent subsections

5. Page 2, line 8.
Following: "an"
Strike: "unprotected"

6. Page 2, line 11.
Following: "MENINGITIS,"
Strike: "HERPES SIMPLEX VIRUS, TETANUS,"

ADV Amd. Coord.
Sec. of Senate

Sen. Eck
Senator Carrying Bill

7. Page 2, line 13.
Following: line 12
Insert: "(8) "Infectious disease control officer" means the person designated by the health care facility as the person who is responsible for notifying the emergency services provider's designated officer and the department of an infectious disease as provided for in this chapter and by rule."
Renumber: subsequent subsections

8. Page 2, line 15 through page 3, line 2.
Strike: subsection (7) in its entirety

9. Page 3, line 5.
Following: "of"
Strike: "unprotected"

10. Page 3, line 6.
Following: "(1)"
Insert: "(a)"

11. Page 3, line 16.
Following: "attends"
Insert: "a patient prior to or during transport"

12. Page 3, line 17 through page 4, line 7.
Following: "transporting" on page 3, line 17
Insert: "a patient"
Following: "facility" on page 3, line 17
Strike: remainder of page 3, line 17 through "exposure" on page 4, line 7
Insert: "and the emergency services provider has had an exposure, the emergency services provider may request the designated officer to submit the required form to the health care facility on the emergency services provider's behalf. The form must be provided for in rules adopted by the department and must include the emergency services provider's name and other information required by the department, including a description of the exposure. A designated officer shall submit the form verifying that there was an exposure"

13. Page 4, line 8.
Strike: "in the report"
Insert: "on the form"

14. Page 4, line 11.
Strike: "report"
Insert: "form"

15. Page 4, line 15.
Following: line 14
Insert: "(c) Upon receipt of a request from a designated officer, the health care facility shall notify the designated officer in writing:

(i) whether or not the patient was infected with an infectious disease;

(ii) whether or not a determination has been made; and

(iii) the name of the disease and the date of transport if the patient was infected.

(d) The designated officer shall then notify the emergency services provider.

(2) If a health care facility receiving a patient determines that the patient has an airborne infectious disease, the health care facility shall notify the designated officer and the department within 48 hours after the determination has been made. The department shall, within 24 hours, notify the designated officer of the emergency services provider who transported the patient."

16. Page 4, line 17.
Strike: "unprotected"

17. Page 5, line 6.
Strike: "organization employing the emergency services provider"
Insert: "emergency services provider who attended the patient prior to or during transport or who transported the patient with the infectious disease."

18. Page 5, line 8.
Strike: line 8 in its entirety

19. Page 5, line 10.
Strike: "HAS been"
Insert: "was"

20. Page 5, line 16.
Strike: "unprotected"

21. Page 5, line 18.
Following: "anyone,"
Insert: "including the emergency services provider who was exposed,"

22. Page 6, lines 3 and 4.
Following: "OF AN" on line 3
Insert: "emergency services provider's"
Following: "ORGANIZATION" on line 3

Strike: remainder of line 3 through "PROVIDER" on line 4

23. Page 6, line 7.
Following: "contact"
Strike: "a"
Insert: "an exposed"

24. Page 6, line 8.
Strike: "WHO FILED THE REPORT"

25. Page 6, line 9.
Strike: "unprotected"

26. Page 6, line 10.
Following: line 9
Insert: "**Section 5.** Section 50-16-705, MCA, is amended to read:
"**50-16-705. Rulemaking authority.** The department shall adopt rules to:
(1) define what constitutes an ~~unprotected~~ exposure to an infectious disease;
(2) specify the infectious diseases subject to this part;
(3) specify the information about an ~~unprotected~~ exposure that must be included in a report of ~~unprotected~~ exposure; and
(4) specify recommended medical precautions and treatment for each infectious disease subject to this part.""
Renumber: subsequent sections

27. Page 11.
Following: line 11
Insert: "NEW SECTION. **Section 7. Health care facility and emergency services organization responsibilities for tracking exposure to infectious disease.** (1) The health care facility and the emergency services organization shall develop internal procedures for implementing the provisions of this chapter and department rules.
(2) The health care facility shall have available at all times a person to receive the form provided for in 50-16-702 containing a report of exposure to infectious disease.
(3) The health care facility shall designate an infectious disease control officer and an alternate who will be responsible for maintaining the required records and notifying designated officers in accordance with the provisions of this chapter and the rules promulgated under this chapter.
(4) The emergency services organization shall name a designated officer and an alternate.
NEW SECTION. **Section 8. Codification instruction.** [Section 7] is intended to be codified as an integral part of Title 50, chapter 16, part 7, and the provisions of Title 50,

chapter 16, part 7, apply to [section 7]."

-END-

TESTIMONY ON HOUSE BILL 315

FRIDAY, MARCH 26, 1993

KEVIN W. MCBRIDE, O.D.

Madam Chairperson and members of the committee,

For the Record my name is Dr. Kevin McBride and I am an optometrist in a private practice in Billings. My educational background includes a B.S. degree in Biology and Chemistry from George Fox College. Then, after one year of graduate work in chemistry at Oregon State University I completed the four year doctoral program in optometry at Pacific University College of Optometry. I am currently the President of the Montana Optometric Association. I am here offering testimony in support of HB 315 which will allow optometrists with special training and additional board certification to use topical steroids.

The key to the safe use of these medications by optometrists is proper education and training. The educational background of optometrists currently includes extensive education in the use of therapeutic pharmaceutical agents. Optometry school is a four year program and admission into optometry school requires courses in biology, chemistry, human anatomy, physiology, and microbiology. At Southern California College of Optometry this year, 90% of those admitted had completed at least a bachelor's degree.

As a part of eight-plus years of college education, an optometrist must complete a doctoral program covering a broad range of subjects. Optometric education includes over 500 hours of education in courses related to the diagnosis and treatment of eye diseases. Their preparation includes courses in ocular pharmacology, human anatomy and physiology, clinical medicine,and anatomy of the eye and visual system. Clinically, optometric interns will examine and treat patients in a clinical setting resulting in an average of 1300 patient contacts. Fourth year students average 30 hours per week in patient contacts. Once optometrists are licensed, Montana law mandates a minimum of 12 hours per year of continuing education.

May I direct your attention to the letter in your informational booklet from Dr. Les Walls, the Dean at Pacific University College of Optometry. Dr. Walls offers a unique perspective in that he has earned degrees in optometry and medicine. He practiced family medicine in Hartville, Ohio, in the 1970s and worked first-hand with optometrists in providing treatment of eye disease. Dr. Walls states that

in the area of Oregon in which he resides, most primary care physicians, including general

practitioners, family practitioners, internists, and pediatricians, state that they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic course work and clinical experience. May I remind you that these physicians treat eye disease on an unrestricted basis. On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals.

Dr. Walls states that patients, particularly in a state such as Montana, will be the beneficiary of modern optometric practice.

Family Practitioners, dentists and podiatrists all enjoy unrestricted use of diagnostic and therapeutic drugs within their scope of practice. Optometry's pharmacology training equals and often exceeds these groups, yet we are restricted in the use of therapeutics, even though optometry has an exceptional record in providing safe patient care. This safe patient care is illustrated by the fact that optometry has one of the lowest malpractice rates of all health professionals, and there is essentially no difference in premium rates between optometrists in states where drug legislation has been enacted and states without therapeutic privileges. My malpractice insurance this year for a $1 million policy carries a yearly premium of $179.00.

Presently 31 states including Montana have passed legislation allowing optometrists to use certain medications to treat eye disease. Only two of these 31 states do not allow topical steroid use by Optometrists. Optometrists are fully aware that systemic problems may be associated with some eye disease and we will continue to refer patients when appropriate to internists, ophthalmologists, and other specialty providers.

The use of topical steroids is an appropriate addition to optometry's scope of practice, and Doctors of Optometry will use them safely and judiciously in providing improved access and more cost-effective vision care for all Montanans.

Members of the Committee, I ask your support of HB 315.

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 3-26-93
BILL NO. HB 315

PROPONENT TESTIMONY
HOUSE BILL 315

KENT HARRINGTON, O.D.

Madam Chairperson and members of the committee,

For the record, my name is Dr. Kent Harrington. I have practiced optometry since 1989 at Malmstrom Air Force Base in Great Falls, Montana. I completed my Bachelor of Science Degree at the University of Missouri, and my four-year Doctor of Optometry Degree from the University of Missouri. I then spent an additional year in residency training at the VA Medical Center at Albuquerque, New Mexico. I stand before you today in support of House Bill 315 for the following reasons:

At Malmstrom, where optometrists and physicians practice in a non-competitive environment, optometrists are allowed to use topical steroids for treatment of eye disease. Since 1989, more than 22,000 patients have been seen by optometrists with no reported problems with respect to use of medications.

Malmstrom began allowing optometrists to use topical steroids in 1989 for a number of reasons. First and foremost was the diagnostic and therapeutic expertise demonstrated by optometrists.

even though primary care of eye disease can be treated by the optometrists, physicians and physician's assistants, most eye disease treated with topical steroids is referred to the optometrists who have demonstrated their ability to use these medications safely and effectively.

I want you to understand that Malmstrom takes the use of all medications by practitioners seriously. A credentialing process is in place whereby my education and clinical experience was evaluated before I was given privileges to use these medications. A quality assurance program is in place at Malmstrom which periodically reviews records from physicians, dentists, and optometrists. There is not an ophthalmologist on staff at Malmstrom;

nor do I have cases routinely reviewed by ophthalmologists. In the four years since topical steroids have been used by optometrists, the quality assurance review process has not found one problem nor received any complaint related to the use of medications including topical steroids.

I ask you support of House Bill 315 for the rest of the optometric profession in Montana.

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 3-26-93
BILL NO. HB 315

TESTIMONY ON HOUSE BILL 315

FRIDAY, MARCH 26, 1993

WILLIAM H. SIMONS, O.D.

Madam Chairperson and members of the Senate Public Health Committee

My name is Bill Simons. I am a practicing optometrist in Helena, Montana. I completed the 4 year pre-medical program at Carroll College with a Bachelor of Arts Degree in Biology and received my Doctorate Degree in Optometry from the Southern California College of Optometry.

I stand before you today in support of House Bill 315 for the following reasons.

Numerous comparisons will be made today between optometry and ophthalmology. The optometrists are saying they do have proper education, competence, and clinical training to prescribe topical steroids. Ophthalmologists attempt to dispute these claims. Who can be an impartial judge of optometry's abilities in this area? The American Public Health Association, which represents over 52,000 public health professionals and community health leaders in 77 health occupations in the U.S. is an outside and impartial judge of health care issues in the United States. In 1990, a resolution encouraging state legislators to permit certified optometrists the use of therapeutic pharmaceutical agents was overwhelmingly approved by this body. Interestingly enough, ophthalmology one year later tried to have this resolution rescinded, but were unanimously rejected by the Governing Council of the American Public Health Association.

In a rural state like Montana, access to eye care is an important issue. One hundred and forty five optometrists currently provide eye care services to 61 Montana communities. 41 ophthalmologists provide services to only 17 Montana communities. This wide distribution of Montana optometrists assures good access to primary eye care. This is important to the patient in terms of convenience, important to the employer in terms of time away from work, and important for early diagnosis and treatment -- what preventative eye care is all about.

Studies indicate that optometrists nationally charge considerably less than ophthalmologists for similar services. When comparing fees under the Medicare program, the average optometric charges were lower in every code category for office visits. For example,

a comprehensive exam charge for a new patient is 26% less when billed by the average optometrist. Furthermore, the 1993 Medicare directory points out another interesting access and cost issue. Currently, 99 optometrists accept assignment for Medicare in 42 communities across the state. In comparison, only 21 ophthalmologists in 8 communities accept assignment. Thirteen of these ophthalmologists reside in Billings, leaving only 8 to cover the rest of the citizens of Montana. Great Falls, for example, has only 1 ophthalmologist accepting Medicare assignment, compared to 11 optometrists who do. Bozeman is another example, with only 1 ophthalmologist who participates, compared to 6 participating optometrists. Butte has no participating ophthalmologists and 4 optometrists who do. This illustrates that the Medicare recipients of Montana are more cost-effectively served by their local optometrists.

In closing, it's important to realize that as the profession of optometry continues to grow and evolve, we must come before this legislative body to make these changes and prove our competence. The professions of medicine and dentistry are allowed to incorporate new developments in their fields by board action.

There have been elements which have been opposed to growth and progress of the optometric profession for 75 years, using the arguments of inadequate optometric education, optometric incompetence, and risk to the public health and safety. There was opposition to licensure in the early 1900s; opposition to advanced doctor degrees for optometry in the 1940s; opposition to optometric testing of glaucoma in the 1960s; opposition to use of diagnostic eye drugs in the 1970s; and now opposition to the use of topical steroids. In each instance these arguments have proved wrong, and the factual results have been in the public interest.

For these reasons I ask your support of HB 315.

Senate Public Health,
Welfare + Safety Committee
Exhibit #4
3-26-93
HB-315

CANDIDATE GUIDE

1993

National Board of Examiners in Optometry®

Pred Forte®

(prednisolone acetate) 1%

sterile ophthalmic suspension

ALLERGAN PHARMACEUTICALS

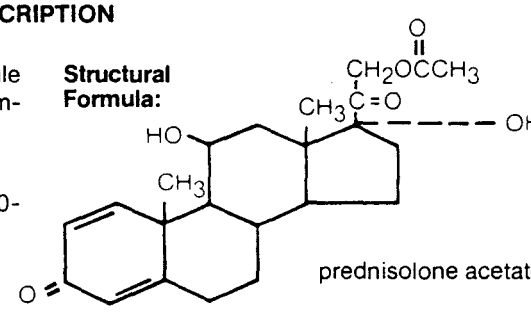
DESCRIPTION

Pred Forte (prednisolone acetate) 1% sterile ophthalmic suspension is a topical anti-inflammatory agent for ophthalmic use.

Chemical Name:

11β,17,21-Trihydroxypregna-1,4-diene-3,20-dione 21-acetate

Structural Formula:



prednisolone acetate

Contains:

prednisolone acetate (microfine suspension) 1.0%

with: benzalkonium chloride, polysorbate 80, boric acid, sodium citrate, sodium bisulfite, sodium chloride, edetate disodium, hydroxypropyl methylcellulose and purified water.

CLINICAL PHARMACOLOGY

Prednisolone acetate is a glucocorticoid that, on the basis of weight, has 3 to 5 times the anti-inflammatory potency of hydrocortisone. Glucocorticoids inhibit the edema, fibrin deposition, capillary dilation and phagocytic migration of the acute inflammatory response as well as capillary proliferation, deposition of collagen and scar formation.

INDICATIONS AND USAGE

Pred Forte is indicated for the treatment of steroid responsive inflammation of the palpebral and bulbar conjunctiva, cornea and anterior segment of the globe.

CONTRAINDICATIONS

Pred Forte is contraindicated in acute untreated purulent ocular infections, acute superficial herpes simplex (dendritic keratitis), vaccinia, varicella and most other viral diseases of the cornea and conjunctiva, ocular tuberculosis, and fungal diseases of the eye. It is also contraindicated for individuals sensitive to any components of the formulation.

WARNINGS

In those diseases causing thinning of the cornea, perforation has been reported with the use of topical steroids.

Since Pred Forte contains no antimicrobial, if infection is present, appropriate measures must be taken to counteract the organisms involved.

Acute purulent infections of the eye may be masked or enhanced by the use of topical steroids.

Use of steroid medication in the presence of stromal herpes simplex requires caution and should be followed by frequent mandatory slit-lamp microscopy.

As fungal infections of the cornea have been reported coincidentally with long-term local steroid applications, fungal invasion may be suspected in any persistent corneal ulceration where a steroid has been used, or is in use.

Use of topical corticosteroids may cause increased intraocular pressure in certain individuals. This may result in damage to the optic nerve, with defects in the visual fields. It is advisable that the intraocular pressure be checked frequently.

Posterior subcapsular cataract formation has been reported after heavy or protracted use of topical ophthalmic corticosteroids.

Contains sodium bisulfite, a sulfite that may cause allergic-type reactions, including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than in nonasthmatic people.

PRECAUTIONS

General: Patients with histories of herpes simplex keratitis should be treated with caution.

Carcinogenesis, mutagenesis, impairment of fertility: No studies have been conducted in animals or in humans to evaluate the potential of these effects.

Pregnancy Category C: Prednisolone has been shown to be teratogenic in mice when given in doses 1-10 times the human dose. There are no adequate well-controlled studies in pregnant women. Prednisolone should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Dexamethasone, hydrocortisone and prednisolone were ocularly applied to both eyes of pregnant mice five times per day on days 10 through 13 of gestation. A significant increase in the incidence of cleft palate was observed in the fetuses of the treated mice.

Nursing Mothers: It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk. Systemically administered corticosteroids are secreted into breast milk in quantities not likely to have a deleterious effect on the infant. Nevertheless, caution should be exercised when topical corticosteroids are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions include increased intraocular pressure, which may be associated with optic nerve damage and defects in the visual fields; posterior subcapsular cataract formation; secondary ocular infections from fungi or viruses liberated from ocular tissues; and perforation of the globe when used in conditions where there is thinning of the cornea or sclera. Systemic side effects may occur rarely with extensive use of topical steroids.

OVERDOSAGE

Overdosage will not ordinarily cause acute problems. If accidentally ingested, drink fluids to dilute.

DOSAGE AND ADMINISTRATION

Shake well before using. Instill one to two drops into the conjunctival sac two to four times daily. During the initial 24 to 48 hours, the dosing frequency may be increased if necessary. Care should be taken not to discontinue therapy prematurely.

NOTE: Keep this and all medications out of the reach of children.

HOW SUPPLIED

Pred Forte® (prednisolone acetate) 1% sterile ophthalmic suspension is supplied in plastic dropper bottles in the following sizes:

1 mL—**NDC** 11980-180-01
5 mL—**NDC** 11980-180-05
10 mL—**NDC** 11980-180-10
15 mL—**NDC** 11980-180-15

Note: Protect from freezing.

Caution: Federal (U.S.A.) law prohibits dispensing without prescription.

Revised May 1989

Allergan America, Hormigueros, Puerto Rico 00660

PR 7392 30-8/M

MONTANA ACADEMY OF OPHTHALMOLOGY

23 S. LAST CHANCE GULCH ▲ HELENA, MONTANA 59601 ▲ (406) 449-2334

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 3-26-93
BILL NO. HB 315

CORTICOSTEROIDS FACT SHEET

DRUG DESCRIPTION

Steroid is the generic name for any of numerous compounds including sterols (solid steroid alcohols such as cholesterol), bile acids, heart poisins, toxic saponins, sex hormones, and other various hormones and glycosides. *Corticosteroids* (**kor**-ti-ko-**steer**-oids) are those that have certain properties characteristic of the hormones secreted by the *adrenal cortex*, the surface layer of the adrenal glands, a pair of complex endocrine organs near the kidney. The adrenal cortex produces steroids such as sex hormones and hormones concerned especially with metabolic functions. In ocular medicine, corticosteroids are used for intraocular inflammation, allergic reaction of the eye or eyelids, and post-operative care.

RISKS

Possible adverse effects from corticosteroids include induced bacterial, viral or fungal infections of the eye or cornea; glaucoma; and cataracts. Steroids can mask symptoms, making accurate diagnosis more difficult. Misdiagnosis of medical problems and misuse of corticosteroids are major risks. Even with a thorough medical background, it is difficult to differentiate a trivial inflammatory condition from much more serious disorders. For example, common causes of inflammation of the eye ("red eye") include juvenile rheumatoid arthritis, ulcerative colitis, syphilis, herpes simplex, sarcoidosis, toxoplasmosis, tuberculosis, HIV (the AIDS virus), histoplasmosis, pars planitis, and others. Various cancers of the eye can also masquerade as red eye.

PROPER USE

The proper use of steroids -- even in topical form -- requires a thorough medical background enabling the physician to make the correct diagnosis and adequately monitor dosage and length of use. To safely administer corticosteroids, one must understand the drug's effect on all parts of the human body, not just its effect on the eye; the patient's other medical conditions and the possible contraindications for corticosteroids; and how corticosteroids interact with other medications. Medical school is the only educational program that teaches how a drug interacts on the body as a whole and on each individual organ. Without this training there is a high risk of misdiagnosis or misuse.

NATIONWIDE LEGISLATIVE STATUS
(including Washington D.C. and Puerto Rico)

Recognizing the risks of corticosteroids, twenty-two states prohibit their use

(over)

in optometry licensing statutes. Of the thirty-two states that allow optometrists to use Therapeutic Pharmaceutical Agents (TPA), two specifically exclude corticosteroids. Three states permit use, but only for an extremely limited period of time. Two states rejected permission for steroid use for two consecutive legislative sessions.

MONTANA LEGISLATIVE BACKGROUND

The 1987 legislative session allowed optometrists to prescribe antibiotic eye medicines and remove foreign bodies from the eye's surface. The legislation as first introduced by an optometrist legislator would have granted optometrists the same privileges as Medical Doctors in prescribing medications. The legislature specifically excluded treatment of glaucoma and use of certain medications such as corticosteroids because they are complex and involve blinding eye disease. In 1989, legislation was again introduced to allow optometrists to treat glaucoma. Again, the attempt failed.

EYE DOCTORS

There are two groups of eye care professionals who refer to themselves as eye doctors: ophthalmologists and optometrists. There are vast differences in their education and training.

Ophthalmologists are M.D.'s who have graduated from medical school and have a comprehensive medical background. A four-year undergraduate degree is required to enter medical school. After medical school, ophthalmologists complete a one year internship of general medical training followed by three to four more years of residency training specializing in eye care. The internship includes approximately 4,000 hours of direct patient care. The residency includes a minimum of 698 hours of instruction, 3,000 out patient visits with major management responsibilities for at least 2,000 cases. By observing, treating, and overseeing the care of patients with eye problems, ophthalmology residents develop diagnostic, therapeutic, and manual skills and clinical judgement. Then, to become Board Certified, ophthalmologists must hold valid and unrestricted medical licenses and pass a written and oral examination. As physicians, ophthalmologists are trained to evaluate a patient's general health and make judgements about the need to refer to other physicians for treatment. Within the field of ophthalmology, many ophthalmologists subspecialize in areas such as glaucoma and retinal diseases. Ophthalmologists do everything from prescribing glasses to performing surgery.

Optometrists are visual care specialists who graduated from schools of optometry not affiliated with medical schools. There are no national minimum requirements to enter optometry school, though most schools require at least two years of undergraduate education. In their four-year program, optometrists are trained to refract the eye and prescribe corrective lenses. They do not receive a general medical education or comparable training to diagnose and treat disorders and diseases of the eye. Their clinical training is significantly less than an ophthalmologist's both in hours and patient contacts. They may have little if any exposure to eye disease. There are no national standards for optometric training, and no externally set standards for accrediting optometric schools. Traditionally, they perform visual examinations and prescribe and sell eyeglasses and contact lenses. To be licensed to use therapeutic medication in Montana, optometrists must complete a course of approximately 100 hours and pass a written examination. No clinical experience is required.

MONTANA ACADEMY OF OPHTHALMOLOGY

23 S. LAST CHANCE GULCH ▲ HELENA, MONTANA 59601 ▲ (406) 449-2334

March 11, 1993

Kevin W. McBride, O.D.
President
Montana Optometric Association
36 S. Last Chance Gulch
Helena, MT 59601

Dear Kevin,

Thank you for taking the time today to discuss matters relating to House Bill 315. Optometrists support HB 315 in good faith; ophthalmologists oppose the bill in good conscience because of concern for patient safety. Open communication is important to help illuminate areas where we can agree or compromise.

We cannot compromise on patient safety. In your letter of March 5th to Dr. Priddy you raise the issues of posterior segment, mandated referral, and clinical protocol. The Montana Academy of Ophthalmology believes there is potential for delayed referral of patients who may have vision-threatening disease. Delayed referral increases the risk for a less-than-ideal result for the patient. Our amendments to HB 315 are intended to minimize this risk.

We recognize that conscientious Montana optometrists with sound professional judgement will refer high risk cases without such a requirement. However, there are some optometrists who are not inclined to refer on a timely basis or whose diagnostic skills are substantially below par. The mandatory referral requirement will add a degree of safety for patients seeing those optometrists for steroid therapy.

We understand that the optometrists disapproved of the specific wording of the acuity requirements for referral. We cannot in good conscience drop all requirements for mandatory referral, but are willing to reconsider some of the conditions. We welcome your suggestions for appropriate wording. Although the Board of Optometry appears to do an excellent job in regulating the practice of Optometry, in our view, it has difficulty regulating therapy issues. A guideline or rule from the Board of Optometrists on this issue does not offer the same margin of patient safety as statutorily mandated referral. Quality peer review is extremely challenging; detection, intervention, and reversal of substandard care is even more difficult.

The Montana Academy of Ophthalmology has made a major compromise in offering to withdraw opposition to the steroid bill in exchange for an amendment requiring mandatory referral for the patient losing vision. Our

compromise will allow optometrists certified in therapy to use steroids without a protocol, and will not interfere with the Board of Optometrists' establishment of rules, guidelines, or protocols for the profession of optometry.

Thank you for your willingness to discuss this matter further.

Sincerely,

Steve JT

Steve W. Weber, M.D.
Legislative Chairman

cc: James Randall, M.D., President, Montana Academy of Ophthalmology
T.J. Priddy, M.D., President-Elect, Montana Academy of Ophthalmology
Gloria Hermanson, Executive Director

SWW/jt

Exhibit #5
3-26-93
HB-315

MONTANA ACADEMY OF OPHTHALMOLOGY

23 S. LAST CHANCE GULCH ▲ HELENA, MONTANA 59601 ▲ (406) 449-2334

HISTORY OF OPTOMETRIC THERAPY BILLS

When optometrists want to practice medicine and treat eye disease, they have two options:

1. Go to medical school. (Some have done this.)

2. Go to the legislature.

The legislature can give optometrists all medical and surgical privileges that ophthalmologists earned, replacing eight or nine years of medical school, internship, and residency with the quick and easy passage of one bill. Is there any wonder why optometrists lobby so hard?

Optometrists rely on state legislatures to change their practices from traditional optometry to the practice of medicine and surgery. Their legislative strategy is well-orchestrated and generally effective. They have introduced therapeutic pharmaceutical bills in every state legislature. When they lose a bill, they come back with an expanded version. When they win a bill, they come back with an expanded version. Optometrists use their very high numbers to out-lobby ophthalmologists. They depend on the strategy of compromise, introducing very broad spectrum therapy bills with full expectation that legislators, confused by the arguments, will be happy to settle the issue by splitting the request down the middle. For instance, when Montana optometrists introduced their bill in 1987, they asked for the privilege to prescribe all medications in the United States Pharmacopeia. Was this a reasonable request? Of course not. Was it effective? Most assuredly. The legislature "compromised" and gave the optometrists authority to prescribe topical antibiotics.

Optometrists claim that expansion of practice to include therapeutic pharmaceuticals is a nationwide trend. **What are the facts on therapy bills nationwide?**

* **Thirty-two states allow optometrists to use some therapeutic medications.** Of these, two specifically exclude corticosteroids. (Montana and North Dakota)

* **Twenty states (including Puerto Rico and the District of Columbia) specifically prohibit optometric therapy.** California is representative of these states with no therapy bill. In California, optometrists are not allowed to use any medications. They are not allowed to use the topical antibiotics that are authorized to Montana optometrists. Are patients suffering in California because there is no optometric treatment? Are optometrists in California going broke because they can't prescribe medication? Is eye disease different in California than it is in Montana? The answer to all of these questions is "NO." Then, why don't California optometrists have

medical privileges? The answer is that ophthalmologists won the lobbying battle in the California legislature.

Regarding corticosteroids specifically:
(Includes Washington, D.C. and Puerto Rico)

*** Twenty-two states specifically prohibit optometric use of steroids:**
Alabama, Arizona, California, Delaware, District of Columbia, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New York, North Dakota, Pennsylvania, Puerto Rico, South Carolina, Vermont

*** Thirty states allow optometrists to use corticosteroids.**

Of these:

*** Six specifically authorize *topical* steroids:**
Colorado, Missouri, Ohio, Utah, Washington, Wisconsin

*** Two states permit and specify steroids:**
Arkansas, Rhode Island

*** Sixteen states permit topical pharmaceuticals but do not specify steroids:**
Alaska, Connecticut, Florida, Georgia. Idaho, Iowa, Kentucky, Maine, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, West Virginia, Wyoming

*** Three permit use only for an extremely limited period of time AND require referral to an ophthalmologist:**
Indiana, South Dakota, Texas

*** One does not specify steroids, but imposes time restrictions AND requires referral to an ophthalmologist:**
Virginia

*** Two impose time restrictions for topical steroids:**
Kansas, Tennessee

North Carolina requires collaboration with a physician. West Virginia limits treatment to the anterior segment. Nineteen states permit topical anti-inflammatories only.

In 1992, twenty-two states considered therapy legislation. Seventeen states defeated the legislation. It passed in only five states. If the Montana legislature wants to conform to the national trend, it would defeat this bill.

Given the massive national and state optometric lobbying effort, why aren't there extensive optometric therapy bills in every state? We believe that the reason is that legislators, in considering this complex issue of awarding medical privileges, are choosing to side with neither the optometrists nor the ophthalmologists, but with the people who elected them -- the potential patients who might suffer from inappropriate advancement of medical privileges.

NEWS OF EYE CARE

FOR IMMEDIATE RELEASE

Contact: Linda Andersen
Tom Celebrezze
415/561-8500

PATIENTS AT GREATER RISK WHEN OPTOMETRISTS PROVIDE POSTOPERATIVE CARE

Results of research supported by the American Optometric Association show that patients managed by optometrists after cataract surgery may have worse final vision. Optometrists, who are not medical doctors, are more likely to miss postoperative complications, the study shows.

The study, "Patient Outcomes with Co-managed Postoperative Care After Cataract Surgery," was conducted by Battelle Medical Technology Assessment and Policy Research Center, Washington, D.C., and published in the January issue of the **Journal of Clinical Epidemiology**.

The report focuses on critical differences in cataract surgery outcomes when postoperative care is provided either by an ophthalmologist (a medical doctor), as is traditionally the case, or by an emerging "co-management" arrangement in which a

patient's postoperative care is relinquished to an optometrist not under the ophthalmologist's direct, personal supervision.

Ophthalmologists are medical doctors who receive four or more years of postgraduate training in medical and surgical treatment of eye disease after graduating from medical school. Optometrists have two to four years of college and four years of optometric college, but do not attend medical school and are not medical doctors.

"Of greatest concern is the finding that optometrists failed to detect 40% of the postoperative complications following cataract surgery," said B. Thomas Hutchinson, MD, president of the American Academy of Ophthalmology. "It's possible that additional complications went undetected because only half the patients saw an ophthalmologist again after being referred to optometrists for co-management."

The study findings support concerns expressed by the Congressional Office of Technology Assessment (OTA) when co-management arrangements were first beginning. In its 1988 Report to Congress, the OTA warned that there may be "potential risks in allowing optometrists the expanded role in providing postoperative care for cataract patients" in settings separate from ophthalmologists' offices.

"A few eye surgeons and others may have looked at co-management as a way to reduce costs while delivering adequate eye care," Dr. Hutchinson said. "However, this study demonstrates the critical need for continued patient management by a medically trained ophthalmologist because many of these complications, if not properly treated, will result in substantial vision loss or blindness."

"The objective of postoperative care is to detect those few patients who have a sight-threatening problem in time to prevent further damage," he said. "Their own study shows that optometrists were less likely to identify those patients than the ophthalmologists in the study."

Currently, 1.3 million cataract surgeries are performed annually in the United States, at a cost of $3.5 billion.

One argument originally advanced in favor of optometric management after cataract surgery is that it would be cheaper. However, an editorial in the same issue of the **Journal** notes that despite the fact that patients with the most difficult cataract problems were managed by ophthalmologists alone, the presumably healthier group co-managed by optometrists required 33 percent more postoperative visits (4.8 on average) than those managed by ophthalmologists alone (3.6 on average).

"A misleading figure in the study is the claim that the overall accuracy of optometrist assessment of postoperative complications is 95.9 percent," said Jack M. Dodick, MD, president of the American Society of Cataract and Refractive Surgery. "The fact is the vast majority of patients who undergo cataract surgery fortunately have no complications; therefore, the accuracy figure simply reflects that optometrists mostly saw patients without complications and called them normal. The important and alarming finding is that optometrists did not detect 40 percent of subsequently recognized complications."

The authors concluded that only 93 percent of patients who received optometric management achieved an optimal visual acuity, compared with 98 percent of patients who were treated by ophthalmologists alone in a separate U.S. Food and Drug Administration study. This five percent difference in a typical year could represent 65,000 eyes of patients with reduced visual acuity. Since ophthalmologist-only care was not studied directly within this study, the authors drew the comparison from FDA data they reviewed.

"The difference in outcomes of care between providers is particularly surprising in that the ambulatory centers that were studied were showcase centers for co-management and deliberately chosen by the American Optometric Association," said Jonathan C.

Exhibit # 6
3-26-93
HB-315

Javitt, MD, MPH, of the Worthen Center for Eye Care Research at Georgetown University. "Despite an extraordinary level of commitment on part of the ambulatory surgical centers, a significant number of patients with complications were not identified by their optometrists."

# # #

Ophthalmologists are medical eye doctors who specialize in eye and vision care. In diagnosis and treatment of eye diseases, ophthalmologists provide comprehensive eye exams, prescribe corrective lenses, prescribe and administer medicines and perform surgery. The American Academy of Ophthalmology, with more than 20,000 members, is the world's largest association of eye physicians and surgeons.

2/93

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 3-26-93
BILL NO. HB 315

BOARD OF OPTOMETRISTS
DEPARTMENT OF COMMERCE

111 N. JACKSON

STATE OF MONTANA

(406) 444-4294

HELENA, MONTANA 59620-0407

March 5, 1993

Representative Bruce T. Simon
House District 91
Capitol Station
Helena, Montana 59620

Dear Representative Simon:

RE: CORTICOSTEROID PROTOCOL

The Board of Optometrists will develop standards of care and referral protocols for the management of patients requiring the prescription of corticosteroids.

These standards of care and referral protocols are currently being developed by the Board for a wide variety of eye conditions. It is interesting to note that, to the best of our knowledge, no other health care professional board in Montana has adopted standards of care or referral protocols. The Board of Optometrists will consult with Montana ophthalmologists as it develops these standards of care and referral protocols.

We anticipate our first meeting concerning these issues will be scheduled shortly with the Board of Optometrists' adoption of these standards of care and referral protocols occurring on or before October 1, 1993.

Sincerely,

Larry J. Bonderud O.D.

Larry J. Bonderud, O.D.
President

cc: Montana Optometric Association
Montana Academy of Ophthalmology

TESTIMONY FOR **HB 225**

This bill, introduced at the request of the department, is in response to two recommendations (attached) from the legislative interim committee on the study of the Montana state hospital.

1. The Alcohol and Drug Abuse Division (ADAD) of the Department of Corrections and Human Services develop a community-based alcohol and drug pre-admission screening program similar to the screening process in place for the Mental Health System.

2. The committee is fully aware of and is deeply concerned about the long waiting list for the Alcohol and drug treatment program at Galen and recommends that the 53rd legislature consider ways of improving access to the program.

This bill will deal with both recommendations and also address policy issues of ADAD which include promoting Montana Chemical Dependency Center (MCDC) at Galen as a responsive, effective and innovative residential chemical dependency program and not a minimum security facility, a homeless shelter etc, and hopefully ensure treatment on demand by virtually eliminating the waiting list at MCDC .

This bill will require a pre admission screening process and greatly enhance our ability to improve access to MCDC.

The means of accomplishing this mission will be to **require community based assessments from certified counselors and confirmations from state approved chemical dependency programs.** In order to receive inpatient treatment at MCDC a voluntary admission must **first receive an assessment from a certified counselor** that he/she is chemical dependent and **second, receive confirmation from a state approved chemical dependency program** that the level of services are not available or appropriate in the community.

Thus, ensuring only chemically dependent individuals **requiring inpatient services** will be referred to MCDC. Furthermore, having professionals in charge of the confirmation and arranging the referral will decrease the no show rate which has been a major problem with the waiting list.

This bill applies to all voluntary admissions to the Montana State Hospital at Galen which include:

- Individuals voluntarily seeking treatment;
- DUI offenders coming from the ACT school, justice of the peace referral, attorney recommendations or self referral;
- Verbal recommendations from courts for domestic abuse, sexual misconduct disorderly conduct and etc;
- Department of family service referrals for child abuse and neglect;
- Department of Social and Rehabilitative Services for project work.

Court Ordered, involuntary commitments, emergency commitment of intoxicated persons and persons incapacitated by alcohol i.e. detox and any individual with legal papers would be excluded from this bill and would be referred directly. However, their access to inpatient treatment services will be enhanced with passage of this bill.

In Fy 92 there were approximately 1500 admissions to Galen for chemical dependency services. Approximately 550 individuals received detoxification services only and were discharged, the rest of the individuals over 950 were transferred to the inpatient programs for chemical dependency treatment services. 492 or 52% of the individuals who were transferred to inpatient treatment had been on a waiting list for over 30 days.

We estimate, at the present time, a minimum of 120 inappropriate individuals a year are scheduled for inpatient treatment at MCDC-Galen, however only about 50% or 60 arrive. Cost savings from passage of this bill will result in a variety of ways as inappropriate referrals cost MCDC one to two days of detox, a physical exam, manpower and other resources i.e, phone calls, interview and placement time, paperwork and transportation costs. Additionally,this becomes very disruptive to the individual when their needs could be met in the community.

Section 3 is amended to clarify the responsibilities of the MCDC inpatient programs for discharged clients and is not a significant change. It is the responsibility of the MCDC program to refer discharged clients back to community programs. It is the responsibility of the community program to arrange for supportive services.

The Alcohol and Drug Abuse Division urges passage of the Bill as it will ensure the most **efficient and effective** process of providing needed services to greater numbers of chemically dependent individuals **on demand** at the Montana Chemical Dependency Center.

Respectfully Submitted

Darryl L. Bruno

Administrator, Alcohol and Drug abuse Division

Exhibit #8
3-26-93
HB-225

RECOMMENDATIONS

Committee on the Montana State Hospital
(As of August 18, 1992)

Montana State Hospital Operations

- That the Montana State Hospital develop at Warm Springs a subacute infirmary of good clinical quality. (Passed unanimously)
- That the Montana State Hospital discontinue providing liscensed acute hospital care at Galen. (Passed 8 to 4)
- That the nursing home at Galen be discontinued. (Passed 9 to 5)

Galen Alcohol and Drug Treatment Program

- That the Montana State Hopsital continue to operate an inpatient chemical dependency program at Galen as part of a comprehensive public and private system of care. (Passed 10 to 1)
- That chemical dependency program at Galen administered by the Alcohol and Drug Abuse Division of the Department of Corrections and Human Services develop a subacute medical detoxification program that meets all current medical protocols. (Passed unanimously)
- That the Alcohol and Drug Abuse Division of the Department of Corrections and Human Services develop a community-based alcohol and drug treatment pre-admissions screening program similar to the screening process in place for the mental health system. (Passed unanimously)
- The Committee on the Montana State Hospital is fully aware of and is deeply concerned about the long waiting list for admission to the alcohol and drug treatment program at Galen and recommends that the 53rd Legislature consider ways of improving access to the program. (Passed unanimously)

Alternative Uses

- That the 53rd Legislature explore the feasibility of placing at Galen a veteran's home consisting of new or old buildings and facilities. (Passed unanimously)

Mental Health Services

- That the Department of Corrections and Human Services continue to support a system of care for the mentally ill that emphasizes treatment in the least restrictive environment within a continuum of state and privately-provided services and establish the role of the Montana State Hospital at Warm Springs as providing intensive inpatient services for the severely mentally disabled with the goal of returning patients to the community when feasible. (Passed unanimously)
- That the Department of Corrections and Human Services expand case management and crisis intervention programs within the community mental health regions. (Passed unanimously)

MS. LAURA TURMAN

3/24/93
EDS

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 3-26-93
BILL NO. SB 389

LC 1123/01

Senate BILL NO. 389

INTRODUCED BY

A BILL FOR AN ACT ~~ENTITLED: "AN ACT ESTABLISHING AMBIENT AIR QUALITY STANDARDS FOR SULFUR DIOXIDE; REQUIRING A STUDY OF THE EFFECT OF SULFUR DIOXIDE ON HEALTH AND THE ENVIRONMENT;~~ REQUIRING Health Studies in the Billings and Laurel area where there are major industrial sources of sulphur dioxide. REQUIRING MONITORING OF AMBIENT AIR CONCENTRATIONS OF SULFUR DIOXIDE; REQUIRING THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES TO ASSESS A FEE ON major industrial sources of sulphur dioxide in geographical areas of the state where the EPA has called for revision of the SIP for compliance with federal air quality stds. ~~FACILITIES THAT EMIT SULFUR DIOXIDE;~~ AND AMENDING SECTION 75-2-206, MCA."

STATEMENT OF INTENT

A statement of intent is required for this bill in order to provide guidance to the board of health and environmental sciences in adopting rules pursuant to [sections 2 ~~and 4~~].

[Section 2(1)] provides the department with the authority to require continuous sulfur dioxide emission monitoring ~~for any facility that emits more than 250 tons of sulfur dioxide annually or for each emission point or stack within a facility that emits 50 or more tons of sulfur dioxide annually.~~ Consistent with Subchapter II of the federal Clean Air Act 42 U.S.C. § 7661 et seq. In deciding whether to require continuous emission monitoring at a particular facility or emission point within a facility, the department shall consider:

(1) the location of the facility or emission point relative to sulfur dioxide high-impact areas;

(2) how close the facility or emission point is to exceeding emission standards; and

(3) uncertainty about the effect of sulfur dioxide on susceptible populations adjacent to the facility or emission point.

~~In adopting the fee on the emission of sulfur dioxide required by [section 4], the board shall establish a formula that proportionately increases the amount of the fee each year until 1998, when the sulfur dioxide fee plus the annual fee required under 75-2-211 must equal the minimum fee prescribed under the federal Clean Air Act. Assuming an initial base fee of $9 per ton, the initial sulfur dioxide fee should be set at $3 per ton of sulfur dioxide actually emitted, for a total fee of $12 per ton. In the first year, the minimum total fee on the emission of sulfur dioxide may not be less than $12 per ton.~~

~~[Section 1] is intended to replace Rule 16.8.820, Administrative Rules of Montana. For the purpose of determining compliance with the standards in [section 1], sulfur dioxide must be measured by the pararosaniline method as more fully described in Title 40, Part 50 (Appendix A) Code of Federal Regulations (1979), or by an updated method required by federal law.~~

~~In conducting the health study required pursuant to~~

~~75-2-206, the department shall focus upon the effect of sulfur dioxide on sensitive populations in high-impact areas located near major industrial sources of sulfur dioxide. An example of such a high-impact area is the Lockwood area, near Billings. The department should also address the potential for cumulative effects and the result of prolonged exposure to sulfur dioxide. Attainment for sulfur dioxide emissions should not disqualify an area from status as a high-impact area for the purposes of this study.~~

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

~~NEW SECTION.~~ Section 1. ~~Ambient air quality standards for sulfur dioxide. A person may not cause or contribute to concentrations of sulfur dioxide in the ambient air that exceed any of the following standards:~~

~~(1) 0.50 parts per million, 1-hour average, not to be exceeded more than once per year;~~

~~(2) 0.10 parts per million, 24-hour average, not to be exceeded more than once per year; and~~

~~(3) 0.02 parts per million, annual average, not to be exceeded at any time.~~

Section 2. Section 75-2-206, MCA, is amended to read:

"75-2-206. Study of effects of sulfur dioxide on health and environment. (1) ~~To the extent that funds are available,~~ the ~~board~~ department shall ~~conduct~~ an ongoing study in certain areas of Montana where there are major industrial sources of sulfur dioxide. The study shall must concentrate on the effects ~~on human health and the environment of ambient sulfur dioxide concentrations separately and in conjunction with particulates~~ of sulfur dioxide in high-impact areas on human health, particularly respiratory effects to sensitive populations and the potential for cumulative effects from prolonged exposure. The purposes of the study are to guide decisionmaking about air quality management in high-impact areas and to determine whether existing sulfur dioxide standards are adequate to protect the health of sensitive populations.

(2) ~~Notwithstanding other funding sources to pay funding for the study, the board may accept funds and grants from private and public sources is from the fee on the emission of sulfur dioxide provided for in [section 4].~~"

NEW SECTION. Section 3. Sulfur dioxide -- additional monitoring requirements. (1) The department may adopt rules to require continuous sulfur dioxide emission monitoring for:

~~(a) any facility that, including all emission points and stacks within the facility, emits more than 250 tons of sulfur dioxide annually; or~~

~~(b) each emission point or stack within a facility that emits 50 or more tons of sulfur dioxide annually.~~

Billings/Lockwood Area (See proposed amendment Senator Towe #4, dated 3/23/93)

Studies shall be provided pursuant to [Section 12(4) of HB 318]

upon adequate opportunity for a hearing involving affected industries,

consistent with Subchapter II of the federal Clean Air Act, 42 USC § 7661, et seq.

The Air Advisory Council described in 75-2-121

Exhibit #4
3-26-93
SB-389

~~(2) In areas with major industrial sources of sulfur dioxide, the department shall ensure that monitoring occurs for ambient air concentrations of sulfur dioxide at 5-minute intervals and in a manner that detects concentrations of sulfur dioxide up to 5 parts per million.~~

~~(3)~~ (2) The department shall annually prepare and make public a report on sulfur dioxide monitoring data and on other information related to sulfur dioxide emissions for each major emitting facility and urban community.

~~NEW SECTION. Section 4. Fee on emission of sulfur dioxide. The board by rule shall assess a sulfur dioxide fee on a facility that emits sulfur dioxide. The sulfur dioxide emission fee must be paid when the facility obtains an air quality permit obtained pursuant to 75-2-211. The sulfur dioxide fee must be:~~

~~(1) assessed in addition to the annual fee required under 75-2-211;~~

~~(2) assessed on each ton of sulfur dioxide that is actually emitted;~~

~~(3) set initially at a minimum of $3 per ton, and increased proportionately each year until 1998 according to a formula developed by the board. By 1998, the sulfur dioxide fee plus the annual fee required under 75-2-211 must equal the minimum fee prescribed by the federal Clean Air Act, 42 U.S.C. 7401, et seq.; and~~

(See last page of handout)

~~(4) adjusted annually after 1998 to account for changes to the consumer price index, as required by the federal Clean Air Act, 42 U.S.C. 7401, et seq.~~

NEW SECTION. Section 5. Codification instruction. [Sections 1, 3, and 4] are intended to be codified as an integral part of Title 75, chapter 2, part 2, and the provisions of Title 75, chapter 2, part 2, apply to [sections 1, 3, and 4].

-End-

Proposed Sen. Towe Amendments
3/23/93

10. Page 2, line 15.
Strike: "$12"
Insert: "$14"

11. Page 2, line 17.
Strike: "$12"
Insert: "$14"

12. Page 2, line 18 through page 3, line 9.
Strike: page 2, line 18 through page 3, line 9 in their entirety

13. Page 3, lines 12 through 21.
Strike: section 1 in its entirety
Renumber: subsequent sections

14. Page 3, line 25 through page 4, line 12.
Following: "conduct" on page 3, line 25
Strike: remainder of page 3, line 25 through page 4, line 12.
Insert: studies in the Billings and Laurel area where there are major industrial sources of sulfur dioxide. The studies must ~~include:~~ be conducted by credible, unbiased consultants experienced in the kind of studies described in this paragraph.

(a) a literature search and analysis regarding the effects of sulfur dioxide on human health, including sensitive populations. The literature search and analysis must include:

(i) a review and analysis of studies by the environmental protection agency concerning the health effects of sulfur dioxide;

(ii) a review and analysis of sulfur dioxide health-related studies conducted in the Billings and Laurel area; and

(iii) a review and analysis of other studies concerning the health effects of sulfur dioxide.

(b) a review and analysis of the feasibility of conducting scientifically valid, epidemiological health studies in the Billings and Laurel area; and

(c) a study to determine whether additional ~~continuous emission monitoring and~~ enhanced ambient monitoring ~~are~~ is useful and ~~cost-effective~~ in adequately protecting human health. The purpose of these studies is to determine the adequacy of ~~both~~ enhanced ambient monitoring ~~and continuous emission monitoring~~ in the Billings and Laurel area. In this connection, the study must address the need for monitoring for ambient air concentrations of sulfur dioxide at 5-minute intervals and in a manner that detects concentrations of sulfur dioxide up to 5 part per million."

(2) The ~~department~~ Commission shall report the results of these studies to the 1995 Legislature. Based on those results, the 1995 legislature must determine:

(a) whether further study on the health effects of sulfur dioxide in the Billings and Laurel area is necessary;

(b) whether the study in subsection (2)(~~a~~) would produce credible results; and

(c) whether additional enhanced ambient monitoring is necessary to adequately protect human health.

(3) If the 1995 legislature determines that further health studies are warranted as provided in subsection (2)(~~b~~), then it shall provide for such studies, the results of which the

Air Advisory Council

~~department~~ shall report to the 1997 legislature."

15. Page 4, line 16.
Strike: "4"
Insert: "3"

16. Page 4, line 18.
Following: "may"
Insert: ", upon adequate opportunity for a hearing involving affected industries,"

17. Page 4, line 19.
Following: "monitoring"
Insert: "consistent with subchapter V of the federal Clean Air Act, 42 U.S.C. 7661, et seq.

18. Page 4, line 20 through page 5, line 5.
Strike: page 4 line 20 through page 5, line 5 in their entirety
Renumber: subsequent subsection

19. Page 5, line 12
Strike: "a facility that emits sulfur dioxide"
Insert: "any major industrial source of sulfur dioxide that is located in a geographical area of the state where the U.S. environmental protection agency has called for revision of the state implementation plan for compliance with air quality standards under the federal Clean Air Act, 42 U.S.C. 7401, et seq.

20. Page 5, lines 13 and 14.
Following: "paid" on line 13
Insert: "annually"
Following: "facility" on line 13
Strike: remainder of line 13 through "to" on line 14
Insert: "pays the fee required in"

21. Page 5, line 20.
Strike: "$3"
Insert: "$5"

22. Page 5, line 25.
Strike: "7401, et seq."
Insert: "7661a"

23. Page 6, line 3.
Strike: "7401, et seq."
Insert: "7661a"

24. Page 6, line 4.
Following: line 3
Insert: "NEW SECTION. **Section 4. Air quality standards for sulfur dioxide -- compliance studies -- report.** (1) Once the environmental protection agency approves revision of the state implementation plan for compliance with federal air

Exhibit #4
3-26-93
SB-389

PROPOSED AMENDMENTS - SB 389

1. Page 3, Proposed Senator Towe Amendment 14, dated 3-23-93
Following: "legislature:
Insert: (4) Upon the advice of the Air Advisory Council, the department shall conduct a study of the current 1-hour standard applicable in Montana, including the number of exceedences allowed, and recommend to the 1997 legislature whether that standard and number of exceedences should be applicable to the Billings and Laurel airshed.

2. Page 6, line 4.
Following: line 3
Insert: NEW SECTION. Section 3, Air Quality Standards in 1997 -- Modeling Studies -- Report.
(1) Except as provided in (3) below, the following ambient air quality standards for sulfur dioxide become effective on July 1, 1977:
(a) 0.10 parts per million, 24-hour average, not to be exceeded more than once per year; and
(b) 0.02 parts per million, annual average, not to be exceeded at any time.

(2) Upon approval by the Environmental Protection Agency of a revised State Implementation Plan for sulfur dioxide in the Billings/Laurel area, the department shall:
(a) conduct modeling studies to analyze ambient sulfur dioxide emissions from major industrial sources. Findings based upon the modeling studies shall be the basis for negotiations with each source. The department shall then, and upon a public hearing, in consultation with the affected source, establish a goal for each source to attain compliance with standards contained in 1. above and a feasible time frame to meet that goal; and
(b) make a status report to the 1997 legislature pursuant to subsection (a) above.

(3) The standards contained in 1. above will replace existing standards on July 1, 1997, unless:
~~(a)~~ health studies completed pursuant to section 1, demonstrate that the existing standards are adequate to protect human health; or
(b) the ~~Environmental Protection Agency determines~~ department makes a finding that the affected sources have made sufficient changes to provide an adequate margin of safety for the health and welfare of citizens in the Billings and Laurel area; or
(c) the 55th Montana legislature by statute imposes existing or other ambient air standards.

(a) The Air Quality Advisory Council makes a finding that the

MONTANA PETROLEUM ASSOCIATION
A Division of the
Rocky Mountain Oil and Gas Association

Janelle K. Fallan
Executive Director

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Exhibit 9-A
3-26-93
SB-389

March 17, 1993

To: Sen. Dorothy Eck, Chairperson, Committee on Public Health
From: Janelle Fallan, Executive Director
Re: SB 389

Sen. Eck, you requested from me more information about the Montana refineries' specific pollution control projects, and their goals for those projects. I hope this summary provides the information you need.

Cenex -- Laurel

Currently building a desulphurization unit, due to be completed by October of 1993. The unit will reduce SO_2 emissions by 40%. Cenex's goal is emissions of 4000 tons per year, down from the current 7000-8000 tons per year. This project will result in additional reduction of 4000 tons of SO_2 emissions from vehicles, as it produces cleaner-burning fuels.

Conoco -- Billings

Completed its $140 million coker project in May of 1992, which reduced its SO_2 emissions by about 500 tons per year. Conoco plans no other major projects at this time.

Exxon -- Billings

Developing a contractual agreement with Billings Generation Inc. for BGI to process product coke and a waste gas stream from Exxon at a net reduction of 1500 tons/year of SO_2 emissions. Has reduced SO_2 emissions 3000 tons per year since 1986. Will produce low-emission diesel fuel resulting in area emission reduction of 3500 tons per year.

Montana Refining -- Great Falls

In the design and permitting phase for new $11 million diesel and gas oil desulphurizer. Completion expected by December of 1993, if state permits can be obtained. Will reduce refinery SO_2 emissions by 35%, to 1095 tons per year. Total expected SO_2 reduction is 1000 tons per year from vehicles burning cleaner fuels.

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 3-26-93
BILL NO. HB 220

AMENDMENTS TO HOUSE BILL NO. 220

INTRODUCED BY SIMON, KENNEDY, HANSEN, FAGG, VOGEL, WINSLOW, BURNETT, SCHWINDEN, BRUSKI-MAUS, REAM, HARPER, SWIFT

1. Page 1, line 14.
Following: "apply:"
Insert: (1) "Airborne disease" means a disease transmitted from person-to-person by an aerosol, including but not limited to, infectious tuberculosis."

2. Page 1, line 15.
Strike: "(1)"
Insert "(2)"

3. Page 1, line 17.
Strike: "(2)"
Insert: "(3)

4. Page 1, line 17.
Following: "THE"
Strike: "PERSON"
Insert: "emergency service organization's representative, and alternate,"

5. Page 1, line 17.
Following: "WHOSE"
Strike: "NAME"
Insert: "names"

6. Page 1, line 17.
Following: "NAME"
Strike: "IS"
Insert: "are"

7. Page 1, line 18 through line 21.
Following: "AS" on line 19
Strike: "DESIGNATED" on line 19 through "DISEASE" on line 21.
Insert: "the person responsible for notifying the emergency services provider of exposure."

8. Page 1, line 22.
Strike: "(3)"
Insert: "(4)"

9. Page 2, line 4.
Strike: "(4)"
Insert: "(6)"

10. Page 2, line 6.
Strike: "(5)"
Insert: "(7)"

11. Page 2, line 8.
Following: "an"
Strike: "unprotected"

12. Page 2, line 11.
Following: "MENINGITIS,"
Strike: "HERPES SIMPLEX VIRUS, TETANUS,"

13. Page 2, line 12.
Following: "RULE."
Insert: "(8) "Infectious disease control officer" means the person designated by the health care facility who is responsible for notifying the emergency service provider's designated officer and the department of an infectious disease as provided for in this chapter and by rule."

14. Page 2, line 13.
Strike: "(6)"
Insert: "(9)"

15. Page 2, line 15.
Strike: "(7)"
Insert: "(5)"

16. Page 2, line 16 through page 3, line 2.
Following: "means:" on line 15
Strike: page 2, line 16 through page 3 line 2 in their entirety.
Insert: "the subjecting of a person to a risk of transmission of an infectious disease through the commingling of the blood or bodily fluids of the provider and a patient, or in another manner as defined by department rule."

17. Page 3, line 5.
Following: "of"
Strike: "unprotected"

18. Page 3, line 16.
Following: "attends"
Insert: "a patient prior to or during transport"

19. Page 3, line 17 through page 4, line 7.
Following: "facility" on line 17
Strike: page 3, line 17 through page 4, line 7 in their entirety
Insert: "and the emergency service provider has had an exposure, the provider may request the organization's designated officer to submit the required form to the health care facility on

the provider's behalf. The form shall be provided for in rules adopted by the department and shall include the provider's name and other information required by the department, including a description of the exposure. A designated officer shall submit the form verifying there was an exposure.

20. Page 4, line 14.
Following: "50-16-1007(10)."
Insert: "(c) Upon receipt of a request from a designated officer, the health care facility must notify the designated officer in writing:
(i) of whether or not the patient was infected with an infectious disease; and
(ii) of whether a determination has not been made; and
(iii) of the name of the disease and the date of transport if the patient was infected.
(d) The designated officer shall then notify the emergency service provider."

21. Page 4, line 15.
Following: "50-16-1007(10)." on line 14
Insert: "(3) If a health care facility receiving a patient determines that the patient has an airborne infectious disease, the health care facility must notify the department within 48 hours after the determination has been made. The department shall notify the designated officer of the emergency service provider who transported the patient within 24 hours."

22. Page 4, line 17.
Strike: "unprotected"

23. Page 5, line 5 through 6.
Following: "officer" on line 5
Strike: "of" on line 5 through "provider," on line 6.
Insert: "of the emergency services provider who attended the patient prior to or during transport, or transported the patient with the infectious disease."

24. Page 5, line 8.
Strike: "WHO SUFFERED THE UNPROTECTED EXPOSURE"

25. Page 5, line 10.
Following: "~~may have~~"
Strike: "HAS been"
Insert: "was"

26. Page 5, line 16.
Strike: "unprotected"

27. Page 5, line 18.
Following: "anyone,"
Insert: "including the emergency service provider who was

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exposed,"

28. Page 6, line 3.
Following: "OF AN"
Insert: "emergency services provider's"

29. Page 6, line 3.
Following: "organization"
Strike: "EMPLOYING AN EMERGENCY SERVICES PROVIDER"

30. Page 6, line 7.
Following "contact"
Strike: "a person of exposure"
Insert: "an exposed person"

31. Page 6, line 8.
Strike: "WHO FILED THE REPORT"

32. Page 6, line 9.
Strike: "unprotected"

33. Page 11, line 11.
Following: "both"
Insert: "**Section 6.** Section 50-16-705, MCA, is amended to read:

50-16-705. Rulemaking authority. The department shall adopt rules to:

(1) define what constitutes an ~~unprotected~~ exposure to an infectious disease;

(2) specify the infectious diseases subject to this part;

(3) specify the information about an ~~unprotected~~ exposure that must be included in a report of ~~unprotected~~ exposure; and

(4) specify recommended medical precautions and treatment for each infectious disease subject to this part."

34. Page 11, line 11.
Following: "both"
Insert: NEW SECTION. "**Section 7. Health care facility and emergency services organization responsibilities for tracking exposure to infectious disease.** (1) The health care facility and the emergency services organization shall develop internal procedures for implementing the provisions of this chapter and department rules.

(2) The health care facility shall designate an infectious disease control officer, and alternate, who will be responsible for maintaining the required records and notifying designated officers in accordance with the provisions of this chapter and the rules promulgated under this chapter.

(3) The emergency services organization shall name a designated officer and alternate."

HOUSE BILL 220 AS IT READS WITH AMENDMENTS

Section 1. Section 50-16-701, MCA, is amended to read:

50-16-701. Definitions. As used in this part, the following definitions apply:

(1) "Airborne disease" means a disease transmitted from person-to-person by an aerosol, including but not limited to, infectious tuberculosis.

(2) "Department" means the department of health and environmental sciences provided for in 2-15-2101.

(3) "Designated officer" means the emergency service organization's representative, and alternate, whose names are on record with the department as the person responsible for notifying the emergency services provider of exposure."

(4) "Emergency services provider" means a person employed by or acting as a volunteer with a public or private organization that provides emergency services to the public, including but not limited to a law enforcement officer, firefighter, emergency medical technician, paramedic, corrections officer, or ambulance service attendant.

(5) "Exposure" means the subjecting of a person to a risk of transmission of an infectious disease through the commingling of the blood or bodily fluids of the provider and a patient, or in another manner as defined by department rule.

(6) "Health care facility" means a health care facility as defined in 50-5-101.

(7) "Infectious disease" means a communicable disease transmittable through an exposure, including the diseases of human immunodeficiency virus, hepatitis B, hepatitis C, hepatitis D, communicable pulmonary tuberculosis, meningococcial meningitis, and other diseases that may be designated by department rule.

(8) "Infectious disease control officer" means the person designated by the health care facility who is responsible for notifying the emergency service provider's designated officer and the department of an infectious disease as provided for in this chapter and by rule. The infectious disease control officer's name shall be on record with the department.

(9) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless.

Section 2. Section 50-16-702, MCA, is amended to read:

50-16-702. Notification of exposure to infectious disease -- report of exposure to disease. (1)(a) If an emergency services provider acting in an official capacity attends a patient prior to or during transport or assists in transporting to a health care facility and the emergency service provider has had an exposure, the provider may request the organization's designated officer to submit the required form to the health care facility on the provider's behalf. The form shall be provided for in rules adopted by the department and shall include the provider's name and other

information required by the department, including a description of the exposure. A designated officer shall submit the form verifying there was an exposure.

(b) If the exposure described in the report occurred in a manner that may allow infection by HIV, as defined in 50-16-1003, by a mode of transmission recognized by the centers for disease control, then submission of the report to the health care facility constitutes a request to the patient's physician to seek consent for performance of an HIV-related test pursuant to 50-16-1007(10).

(c) Upon receipt of a request from a designated officer, the health care facility must notify the designated officer in writing:

(i) of whether or not the patient was infected with an infectious disease;

(ii) of whether a determination has not been made; and,

(ii) of the name of the disease and the date of transport if the patient was infected.

(d) The designated officer shall then notify the emergency service provider.

(2) If a health care facility receiving a patient determines that the patient has an airborne infectious disease, the health care facility must notify the designated officer and the department within 48 hours after the determination has been made. The department shall notify the designated officer of the emergency service provider who transported the patient within 24 hours.

Section 3. Section 50-16-703, MCA, is amended to read:

50-16-703. Notification of precautions after ~~unprotected~~ exposure to infectious disease. (1) After a patient is transported to a health care facility, a physician shall inform the health care facility within 24 hours if the physician determines that the transported patient has an infectious disease.

(2) The health care facility shall orally notify within 48 hours after the time of diagnosis and notify in writing within 72 hours after diagnosis the designated officer of the emergency services provider who attended the patient prior to or during transport, or transported the patient with the infectious disease.

(3) The notification must state the disease to which the emergency services provider was exposed and the appropriate medical precautions and treatment that the exposed person needs to take.

Section 4. Section 50-16-704, MCA, is amended to read:

50-16-704. Confidentiality -- penalty for violation -- immunity from liability. (1) The names of the person who suffered the exposure and the person diagnosed as having an infectious disease may not be released to anyone, including the emergency service provider who was exposed, except as required by department rule concerning reporting of communicable disease or as allowed by Title 50, chapter 16, part 5.

(2) A person who violates the provisions of this section is guilty of a misdemeanor and upon conviction shall be fined not less

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than $500 or more than $10,000, imprisoned in the county jail not less than 3 months or more than 1 year, or both.

(3) A health care facility, a representative of a health care facility, a physician, or the designated officer of an emergency service provider's organization may not be held jointly or severally liable for providing the notification required by 50-16-703 when the notification is made in good faith or for failing to provide the notification if good faith attempts to contact an exposed person are unsuccessful.

Section 5. Section 50-16-705, MCA, is amended to read:

50-16-705. Rulemaking authority. The department shall adopt rules to:

(1) define what constitutes an exposure to an infectious disease;

(2) specify the infectious diseases subject to this part;

(3) specify the information about an exposure that must be included in a report of exposure; and

(4) specify recommended medical precautions and treatment for each infectious disease subject to this part.

Section 6. Section 50-16-1007, MCA, is amended to read:

50-16-1007. Testing -- counseling -- informed consent -- penalty. (1) An HIV-related test may be ordered only by a health care provider and only after receiving the written informed consent of:

(a) the subject of the test;

(b) the subject's legal guardian;

(c) the subject's next of kin or significant other if:

(i) the subject is unconscious or otherwise mentally incapacitated;

(ii) there is no legal guardian;

(iii) there are medical indications of an HIV-related condition; and

(iv) the test is advisable in order to determine the proper course of treatment of the subject; or

(d) the subject's next of kin or significant other or the person, if any, designated by the subject in hospital records to act on the subject's behalf if:

(i) the subject is in a hospital; and

(ii) the circumstances in subsections (1)(c)(i) through (1)(c)(iv) exist.

(2) When a health care provider orders an HIV-related test, the provider also certifies that informed consent has been received prior to ordering an HIV-related test.

(3) Before the subject of the test executes an informed consent agreement, the health care provider ordering the test or the provider's designee must give pretest counseling to:

(a) the subject;

(b) the subject's legal guardian;

(c) the subject's next of kin or significant other if:

(i) the subject is unconscious or otherwise mentally incapacitated; and

(ii) there is no guardian; or

(d) the subject's next of kin or significant other or the person, if any, designated by the subject in hospital records to act on the subject's behalf if:

(i) the subject is in the hospital; and

(ii) the circumstances in subsections (1)(c)(i) and (1)(c)(ii) exist.

(4) A health care provider who does not provide HIV-related tests on an anonymous basis shall inform each person who wishes to be tested that anonymous testing is available at one of the counseling-testing sites established by the department, or elsewhere.

(5) The subject of an HIV-related test or any of the subject's representatives authorized by subsection (1) to act in the subject's stead shall designate, as part of his written informed consent, a health care provider to receive the results of an HIV-related test. The designated health care provider shall inform the subject or the subject's representative of the results in person.

(6) At the time the subject of a test or the subject's representative is given the test results, the health care provider or the provider's designee shall give the subject or the subject's representative posttest counseling.

(7) If a test is performed as part of an application for insurance, the insurance company must ensure that:

(a) negative results can be obtained by the subject or the subject's representative upon request; and

(b) positive results are returned to the health care provider designated by the subject or the subject's representative.

(8) A minor may consent or refuse to consent to be the subject of an HIV-related test, pursuant to 41-1-402.

(9) Subsections (1) through (6) do not apply to:

(a) the performance of an HIV-related test by a health care provider or health care facility that procures, processes, distributes, or uses a human body part donated for a purpose specified under Title 72, chapter 17, if the test is necessary to assure medical acceptability of the gift for the purposes intended;

(b) the performance of an HIV-related test for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher;

(c) the performance of an HIV-related test when:

(i) the subject of the test is unconscious or otherwise mentally incapacitated;

(ii) there are medical indications of an HIV-related condition;

(iii) the test is advisable in order to determine the proper course of treatment of the subject; and

(iv) none of the individuals listed in subsection (1)(b), (1)(c), or (1)(d) exists or is available within a reasonable time after the test is determined to be advisable; or

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(d) the performance of an HIV-related test conducted pursuant to 50-18-107 or 50-18-108, with the exception that the pretest and posttest counseling must still be given.

(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 person providing emergency services who is described in 50-16-702(1) 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 centers 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 centers 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 posttest 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.

(11) A knowing or purposeful violation of this section is a misdemeanor punishable by a fine of $1,000 or imprisonment for up to 6 months, or both.

NEW SECTION. **Section 7. Health care facility and emergency services organization responsibilities for tracking exposure to infectious disease.** (1)The health care facility and the emergency services organization shall develop internal procedures for implementing the provisions of this chapter and department rules.

(2) The health care facility shall designate an infectious disease control officer, and alternate, who will be responsible for maintaining the required records and notifying designated officers in accordance with the provisions of this chapter and the rules promulgated under this chapter.

(3) The emergency services organization shall name a designated officer and alternate.

SENATE HEALTH & WELFARE
EXHIBIT NO. 12
DATE 3-26-93
BILL NO. HJR 15

Amendments to House Joint Resolution No. 15
Third Reading Copy

For the Senate Public Health, Welfare, and Safety Committee

Prepared by Tom Gomez
March 23, 1993

1. Title, line 5.
Strike: "URGING"
Insert: "COMPLIMENTING"

2. Title, line 6.
Strike: "AND CONGRESS TO GRANT THE"
Insert: "FOR ITS DECISION GRANTING A"
Following: "FEDERAL"
Insert: "MEDICAID"

3. Title, line 7.
Strike: "REGARDING MEDICAID IN ORDER"

4. Title, line 8.
Following: "PLAN"
Strike: "TO TAKE EFFECT"
Insert: "; AND URGING FLEXIBILITY FOR OTHER STATES SEEKING WAIVERS UNDER THE MEDICAID PROGRAM"

5. Page 1, line 11.
Following: "federal"
Insert: "Medicaid"

6. Page 1, line 16.
Strike: "discourages"
Insert: "was discouraging to"
Strike: "from"

7. Page 1, lines 19 through 22.
Strike: lines 19 through 22 in their entirety

8. Page 1, line 25.
Strike: "shows"
Insert: "showed"

9. Page 2, lines 4 through 7.
Following: "1992,"
Strike: remainder of line 4 through "1990" on line 7
Insert: "seeking reconsideration of its waiver request; and WHEREAS, on March 19, 1993, the Clinton administration granted Oregon's waiver request, allowing the state to implement the Oregon Health Plan"

10. Page 2, line 11.
Following: line 10
Insert: "(1)"

11. Page 2, line 12
Following: "States"
Strike: "Congress grant"
Insert: "Secretary of Health and Human Services be commended for their decision granting"

12. Page 2, line 15.
Following: line 14
Insert: "(2) That the Clinton administration grant other states seeking waivers the flexibility needed to enable these states to try new or different approaches to the delivery of health care services or to reform the health care system."

13. Page 2, lines 17 through 19.
Following: "Delegation," on line 17
Strike: remainder of line 17 through "Representatives" on line 19
Insert: "the United States Secretary of Health and Human Services"

SENATE HEALTH & WELFARE
EXHIBIT NO. 13
DATE HB 274
BILL NO. 3-26-93

Amendments to House Bill No. 274
Third Reading Copy

Requested by Representative Brown
For the Committee on Public Health

Prepared by Greg Petesch
March 24, 1993

1. Page 2, lines 8 through 13.
Strike: subsection (1) in its entirety
Renumber: subsequent subsections

2. Page 2, lines 16 through 22.
Strike: subsection (3) in its entirety
Renumber: subsequent subsections

3. Page 3, line 15.
Strike: "(1)"

4. Page 3, lines 18 through 24.
Strike: subsections (a) and (b) in their entirety

5. Page 3, line 25.
Strike: "(c)"
Insert: "(1)"

6. Page 4, lines 1 and 2.
Following: "dependency counselor" on line 1
Strike: remainder of line 1 through "worker" on line 2
Following: "and"
Insert: "has"

7. Page 4, lines 4 through 7.
Strike: subsection (d) in its entirety

8. Page 4, lines 8 through 13.
Following: "(2)" on line 8
Strike: remainder of line 8 through "professionals" on line 13
Insert: "a license as a professional counselor, social worker, or psychologist"

9. Page 5, line 25.
Strike: "ACT AS"
Insert: "represent to the public that the person is"

10. Page 6, line 3.
Strike: "ACTING AS"
Insert: "representing to the public that the person is"

DATE 3-26-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: HB 225, HB 315

Name (please print)	Representing	Bill No.	Check One: Support	Oppose
K.W. McBride O.D.	MOA	315	✓	
J.W. Reeves, O.D	MOA	315	✓	
LAWRENCE KENT HARRINGTON O.D	MOA	315	✓	
Kim CAINAN	MOA / Student Optometric Assoc.	315	✓	
Bob Sherer O.D.	MOA	315	✓	
Patrick J. Stotler O.D	Self	315	✓	
Craig McBride O.D.	MOA., Self.	315	✓	
P.L. Kathleen O.D	Bd of Optometry	315	—	
Mindy E. Stoner, O.D.	MT optometric Assn.		✓	
Larry LaRock.	MT. Optometric Assn	315	✓	
Joe Benjamin	MT Opt Assn	315	✓	
DARRYL BRUCE	DCHS / ADHD	225	✓	
Norma Jean Boles	DCHS / ADHD	225	✓	
Roland M. Mena	DCHS / ADHD	225	✓	
William Simons OD	MOA	315	✓	
Mike Simons OD	MOA	315	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

DATE 3-26-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: HB 225 - HB 315

Name	Representing	Bill No.	Check One Support	Oppose
Tom Ferguson MD	MOA	315	✓	
Gloria Hermanson	MT Academy of Opthalmology	315		✓
Jerry Loendorf	MT. Med. Assn	315		✓
Dan Shea	Private Citizen	225		✓
~~Peter~~				
Roger Furlong	MAO	315		✓
Jim Ronalds	MAO	315		✓
Loren S. McKerrow MD	MAO	315		✓
Mike Ruppert	CDPM	225	X	
Dan Shea	Private	315	X	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10