MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN JOHN COBB**, on January 17, 1995, at 8:00 a.m.

ROLL CALL

Members Present:
Rep. John Cobb, Chairman (R)
Sen. Charles "Chuck" Swysgood, Vice Chairman (R)
Rep. Beverly Barnhart (D)
Sen. James H. "Jim" Burnett (R)
Rep. Betty Lou Kasten (R)
Sen. John "J.D." Lynch (D)

Members Excused: None.

Members Absent: None.

Staff Present: Mark Lee, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
Ann Boden, Committee Secretary

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

Committee Business Summary:

Hearing:	DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES OVERVIEW: Family/Maternal Child Health Care; Preventative Health Bureau.
Executive Action:	DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES: Director's Office; Central Services Division; Health Services Division.

CHAIRMAN JOHN COBB read minutes from February 15, 1993 regarding the subcommittee's decision to work with the Department to allocate indirect costs after the committee does FTE's. He then asked the Director to help explain more about indirect costs.

Bob Robinson, Director, Department of Health and Environmental Sciences indicated that the Department no longer has members that can provide information from the past session. He referred the subcommittee to the attached report on carry-forward computation departmental costs. **EXHIBIT 1**

He mentioned that even though there is a fund balance in the indirect fund account, due to the formula required to recover indirect costs the Department has to request a 20.9 percent recovery this year.

CHAIRMAN COBB asked how Legislative Fiscal Analyst's (LFA) office got the Department down to ten percent. **Mr. Robinson** replied that the difference is that the amount does not consider those costs that are not cash outlays in any particular year, depreciation, accrued vacation, accrued sick leave. The ten percent equated to the cash costs of operating the Department. Other expenditures not accounted for in the calculation were other expenditures this subcommittee appropriated to indirect costs last session, largely being Legal Services.

CHAIRMAN COBB asked if the Department used this fund to continue funding programs, and if so, was that the reason it was down. **Mr. Robinson** pointed out that the Department of Health and Environmental Sciences (DHES) spent less than the amount of money appropriated by the subcommittee for Centralized Services and the Director's office. Basically, the Department has decreased the revenue into the fund balance account as a result of paying for the appropriation that was given by this subcommittee.

EXECUTIVE ACTION ON DIRECTOR'S OFFICE

BUDGET ITEM Personal Services; Inflation/Deflation; Fixed Costs; and all Other Present Law Adjustments proposed by the Executive :
Tape No. 1:A:9.2

Motion/Vote: **REP. BETTY LOU KASTEN MOVED TO ACCEPT $48,012 IN FY96 AND $50,196 IN FY97 FOR PERSONAL SERVICES; $249 IN FY96 AND $383 IN FY97 FOR INFLATION/DEFLATION; $8,921 IN FY96 AND $9,637 IN FY97 FOR FIXED COSTS; AND ($3,823) FOR EACH YEAR OF THE BIENNIUM FOR ALL OTHER PRESENT LAW ADJUSTMENTS PROPOSED BY THE EXECUTIVE. Motion FAILED 3-2 with REPS. KASTEN and BARNHART voting yes. (SEN. J.D. LYNCH) was not present for this vote.)**

BUDGET ITEM Environmental Impact Statements (EIS):
Tape No. 1:A:10.6

Discussion: **CHAIRMAN COBB** asked **Mr. Robinson** if the Director's Office is willing to accept a lower amount than what the executive proposes for Environmental Impact Statements (EIS). **Mr. Robinson** felt that the Director's Office could accept a reduction as long as the subcommittee would allow the Department to incorporate language to enable it to get a budget amendment without classifying it as an emergency if new applications came in that generated more than appropriated amount of EIS fees.

Motion/Vote: **CHAIRMAN COBB MOVED TO APPROVE $100,000 ANNUALLY IN STATE SPECIAL REVENUE TO INCLUDE LANGUAGE BY THE LFA AND THE DEPARTMENT TO BYPASS THE NEED FOR A BUDGET AMENDMENT IF A HIGHER ACTIVITY OF IMPACT STATEMENTS SHOULD ARISE. Motion CARRIED 4-1, with SEN. CHUCK SWYSGOOD voting no. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Equipment : **Tape No. 1:A:11.6**

No motion was made.

BUDGET ITEM Personal Services Reduction: **Tape No. 1:A:11.8**

Motion: **SEN. SWYSGOOD MOVED TO ACCEPT ($23,019) TOTAL FUNDS IN FY96 AND ($23,199) TOTAL FUNDS IN FY97 FOR PERSONAL SERVICES REDUCTION, BUT TO TAKE THE REDUCTION DIRECTLY OUT OF THE BASE AND NOT FROM VACANCY SAVINGS. (SEN. LYNCH was not present for this vote.)**

Discussion: **Mark Lee, LFA** noted that if the subcommittee decided to remove the aforementioned monies from the personal services base, it would be necessary to eliminate an FTE or a portion of an FTE.

Amended Motion: **SEN. SWYSGOOD AMENDED HIS MOTION TO ACCEPT ($23,019) TOTAL FUNDS IN FY96 AND ($23,199) TOTAL FUNDS IN FY97 BUT TO TAKE THE REDUCTIONS DIRECTLY FROM OPERATING EXPENSES, NOT VACANCY SAVINGS. (SEN. LYNCH was not present for this vote.)**

Discussion: **Mr. Robinson** said it would be difficult to take the 1994 base and reduce it by $23,199 in operating expenses. **SEN. SWYSGOOD** indicated that it "is less than being honest as a legislature" to allow vacancy savings to exist in order to fund the pay plan. **Mr. Robinson** said that if vacancy savings is removed, he would like the ability to manage within the Division to handle the removal of the proposed $23,199.

Vote: **Motion CARRIED 4-1 with REP. BARNHART voting no. (SEN. LYNCH was not present for this vote.)**

EXECUTIVE ACTION ON CENTRAL SERVICES DIVISION

BUDGET ITEM Personal Services; Inflation/Deflation' Fixed Costs: **Tape No. 25.6**

Motion: **REP. KASTEN MOVED TO ACCEPT 0.05 FTE IN EACH YEAR OF THE BIENNIUM, $122,541 IN FY96 AND $131,323 IN FY97 FOR PERSONAL SERVICES; $33,759 IN FY96 AND $55,228 IN FY97 FOR INFLATION/DEFLATION; AND $168,157 IN FY96 AND $101,766 IN FY97 FOR FIXED COSTS. Motion FAILED 2-3 with REPS. BARNHART AND KASTEN voting yes. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Computer Programming Services: **Tape No. 1:A:26.2**

Discussion: **SEN. SWYSGOOD** felt the base continued to grow and grow because rather than starting with a zero base under operating expenses, the Department justifies expenditures in items listed under other executive present law adjustments. **Mr. Robinson** then explained the Department's budget cycle process when submitting its budget.

SEN. SWYSGOOD said this budget item should be a one-time expenditure until the need arises again to upgrade the automated computer systems. He asked how much of the base will contain expenditures for upgrades next session. **Mr. Robinson** said that this would be zeroed out in the budget building process and would not be reflected in the next budget request.

Motion/Vote: **REP. BARNHART MOVED TO ACCEPT $52,174 IN EACH YEAR OF THE BIENNIUM FOR COMPUTER PROGRAMMING SERVICES. Motion FAILED 3-2 with REPS. BARNHART AND KASTEN voting yes. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Travel: **Tape No. 1:A:38.5**

Motion: **REP. BARNHART MOVED TO ACCEPT $11,066 IN EACH YEAR OF THE BIENNIUM FOR TRAVEL.**

Discussion: **REP. KASTEN** asked if the county negotiated indirect costs. **Mr. Robinson** said indirect costs were not negotiated at county level, but at the federal level.

Vote: **Motion FAILED 3-2 with REPS. BARNHART and KASTEN voting yes. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Indirect Costs: **Tape No. 1:A:40.5**

Discussion: **Mr. Robinson** explained that it is necessary to recover these funds this biennium or else the Department would be placed in a position to recover these funds at the 25% or 27% rate in future years.

Motion: **CHAIRMAN COBB MOVED TO ACCEPT $103,463 IN FY96 AND $104,360 IN FY97 FOR INDIRECT COSTS, ALLOWING THESE AMOUNTS TO BE ADJUSTED AFTER THE TOTAL BUDGET COSTS HAVE BEEN DETERMINED. Motion carried 5-0. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Equipment: **Tape No. 1:A:41.4**

No motion was made.

Discussion: **Mr. Robinson** commented that in order to continue to provide the necessary quality tests performed in the laboratory, it is essential to get this equipment. **Tripp Hammer, Chief, Information Bureau,** expressed his concern regarding an $8,000 loss in productivity. He said the current equipment is in danger of loosing its effective life.

Motion/Vote: **REP. KASTEN MOVED TO ACCEPT $162,577 IN FY96 AND $69,877 IN FY97 FOR EQUIPMENT. Motion FAILED 3-2, with REPS. KASTEN and BARNHART voting yes. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Other: **Tape No. 1:A:44.8**

Motion/Vote: **REP. KASTEN MOVED TO ACCEPT $39,247 IN EACH YEAR OF THE BIENNIUM FOR OTHER PRESENT LAW ADJUSTMENTS PROPOSED BY THE EXECUTIVE. Motion CARRIED 4-1 with REP. COBB voting no. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Information Service (DP) Staff: **Tape No. 1:A:45.9**

Discussion: **Mr. Robinson** said that regardless of increasing workload demands, the Department has been able to avoid adding staff because of the efficiencies developed by data processing. He urged the subcommittee to approve funding for this budget item as well as the upgrade for the local area networks (LAN).

No motion was made.

BUDGET ITEM Local Area Networks (LAN) Expansion & Upgrade: **Tape No. 1:A:47.5**

Motion/Vote: **REP. BARNHART MOVED TO ACCEPT 2.00 FTE IN EACH YEAR OF THE BIENNIUM AND $197,690 TOTAL FUNDS IN FY96 AND $146,490 TOTAL FUNDS IN FY97 FOR THE LAN EXPANSION & UPGRADE. Motion FAILED 4-1, with REP. BARNHART voting yes. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Dyed Fuel Program: **Tape No. 1:A:48.2**

Discussion: **Mr. Robinson** explained that these funds were actually the Department of Transportation (DOT) funds which were transferred to DHES to do the laboratory testing for the dyed fuel program for the DOT's enforcement effort to ensure the right tax has been paid.

SEN. SWYSGOOD asked how DHES would arrive at a figure it would charge to the DOT on a new set-up program like this. **John Hawthorne, Chief, Chemistry Laboratory Bureau,** replied that personnel costs to conduct the work and operating expenses such

as maintenance of the equipment, and supplies and materials are factors in determining the amount. He said tests are done on a daily basis, which result in approximately 8,000 analysis per year. He reported that the percentage of violations in the misuse of diesel fuels dropped from 14% to 11% since beginning lab analysis.

Motion/Vote: **REP. KASTEN MOVED TO ACCEPT 1.00 FTE AND $79,000 TOTAL FUNDS IN EACH YEAR OF THE BIENNIUM FOR THE DYED FUEL PROGRAM. Motion CARRIED 3-2, with REPS. COBB and BARNHART voting no. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Personal Services Reductions: **Tape No. 1:A:55.2**

Motion/Vote: **SEN. SWYSGOOD MOVED TO ACCEPT ($93,122) TOTAL FUNDS IN FY96 AND ($94,155) TOTAL FUNDS IN FY97 FOR PERSONAL SERVICES REDUCTIONS, BUT TO TAKE THE REDUCTIONS DIRECTLY FROM OPERATING EXPENSES, RATHER THAN FROM VACANCY SAVINGS. Motion CARRIED 4-1, with REP. BARNHART voting no. (SEN. LYNCH was not present for this vote.)**

EXECUTIVE ACTION ON HEALTH SERVICES DIVISION

Tape No. 1:A:56.3

BUDGET ITEM: Personal Services:

Discussion: **REP. KASTEN** questioned what would happen to the Certificate of Need (CON) program if the Health Care Authority (HCA) is not in existence after this legislature. **Mr. Lee** indicated that the LFA and Budget Office could receive directive to place the CON program back into this Division. He said any additional FTE needed could be excluded from the directive.

CHAIRMAN COBB asked about the 2.0 FTE. **Mr. Robinson** explained that 2.0 FTE would be transferred to the HCA, but currently funding is only available for 1.35 FTE, which are assigned directly to the CON program. **CHAIRMAN COBB** felt the subcommittee should hold off on any action regarding CON until the standing committee on Human Services is fully satisfied with relative issues. **SEN. SWYSGOOD** expressed his unacceptance of the rationale from another committee "telling us how to put together the budget". He spoke on behalf of the Senate by saying that if the House feels there are issues that need to be looked at, than he didn't have a problem with that, but he didn't feel it should interfere with the budgeting process.

Motion/Vote: **REP. KASTEN MOVED TO ACCEPT (1.00) FTE IN EACH YEAR OF THE BIENNIUM, $88,564, IN FY96 AND $94,078 IN FY97 FOR PERSONAL SERVICES; $15,176 IN FY96 AND $21,637 IN FY97 FOR INFLATION/DEFLATION; AND $10,996 IN FY96 AND $12,535 IN FY97 FOR FIXED COSTS. Motion FAILED 2-3 with REPS. KASTEN and BARNHART voting yes. (SEN. LYNCH was not present for this vote.)**

BUDGET ITEM Emergency Medical System (EMS) Consulting and Professional Services: **Tape No. 1:A:66.3**

Discussion: **SEN. SWYSGOOD** asked if the implementation of the statewide trauma system was a new program. **Mr. Robinson** said it was, and it would be a bill. **Drew Dawson, Chief, Emergency Medical Services Bureau,** said the trauma program has been a part of the on-going EMS operations. He said the Department plans to propose a bill that formalizes certain efforts of the EMS group who have worked on the statewide trauma plan over the past couple years.

SEN. SWYSGOOD asked if the fiscal note attached to the proposed legislation would use any of this budget money to fund the bill. **Mr. Robinson** indicated that there would be a fiscal note attached to the bill and there will be a proposed funding source for it which would suggest continuation of the trauma system after determination of federal funding is made by the legislature this session. **SEN. SWYSGOOD** questioned what would happen to this program if the bill did not make it through the legislative process. **Mr. Robinson** said the activities in this program could still be done.

SEN. LYNCH arrived to the meeting at 9:15 a.m.

Motion/Vote: **REP. BARNHART MOVED TO ACCEPT $336,933 IN FY96 AND $236,933 IN FY97 FOR EMS CONSULTING AND PROFESSIONAL SERVICES. Motion FAILED 3-3, with REPS. COBB and KASTEN, and SEN. BURNETT voting no.**

BUDGET ITEM EMS Contracts with Non-Profits: **Tape No. 1:A:73.9**

Discussion: **Mr. Robinson** mentioned that this budget item also includes the Poison Control Hotline used by all doctors and hospitals in the state.

Motion/Vote: **CHAIRMAN COBB MOVED TO ACCEPT $115,341 IN FY96 AND $115,232 IN FY97 FOR EMS CONTRACTS WITH NON-PROFITS. Motion CARRIED unanimously.**

BUDGET ITEM Rural Physicians Residency: **Tape No. 1:A:74.4**

Discussion: **REP. KASTEN** said after speaking with the Sidney Hospital, which is one of the hospitals working with Rural Physicians Residency, she didn't feel that this money should be put into the budget.

No motion was made.

OVERVIEW ON FAMILY/MATERNAL CHILD HEALTH CARE

Tape No. 1:B:0.3

SEN. SWYSGOOD acted as presiding chairman.

Dale Taliaferro, Administrator, Health Services Division, discussed the budget items listed Executive Present Law and New Proposals, and/or entertained questions from the subcommittee as follows:

Personal Services: This item was previously discussed.

Nutrition Program Consulting: The contract has been completed that developed an automated system linking all the local Women Infant and Children (WIC) programs to a central computer in the Helena office.

Montana Initiative for the Abatement of Morality in Infants (MIAMI): **REP. BARNHART** asked how the department's priorities have changed that now necessitate this level of expenditure, as indicated in the LFA issue. **Mr. Taliaferro** said there is no change in priority. He said that because the Division couldn't get the project started on July 1, since the expansion, the Division took the amount of reduction it couldn't spend anyway. **REP. BARNHART** asked how many places the MIAMI program existed in throughout Montana. **Maxine Ferguson, Bureau Chief, Family/Maternal & Child Health Bureau,** then distributed the annual report of the MIAMI project, which includes the first year of the Follow-Me project. **EXHIBIT 2** She referred the subcommittee to page 17 of the in response to **REP. BARNHART's** question, then gave a brief overview of the MIAMI program.

Indirect Costs: This item was previously discussed.

County Data Development: **Mr. Taliaferro** said this project is now completed. He said the project worked through county contracts to develop Maternal and Child Health (MCH) Care databases.

Family Planning: This funding is for contracted services to local family planning programs.

Child & Adult Food Program (CACFP) Grant: This is an estimated amount that would be spent in the biennium. These are direct payments to child care providers to pay for children's meals. This is 100% federally funded by the U.S. Department of Agriculture.

REP. BARNHART asked why no adults were served. **Mr. Taliaferro** said it was hard to determine at this time. He said because no adults participated in the program, extra outreach efforts were made by the Division, but only resulted in one applicant that was interested.

REP. KASTEN questioned if part of the reason could be that a lot of adult daycare is also taken through the nursing homes or other avenues. **Mr. Taliaferro** said it could be part of the reason.

SEN. SWYSGOOD asked how this program differs from WIC. **Mr. Taliaferro** explained that WIC provides food for the family to use at home for the child, and this program is solely for meals provided at daycare centers. **REP. BARNHART** asked if the daycare providers were required to be licensed. **Mr. Taliaferro** indicated that there are three categories enrolled in the program, Head Start, all child care centers, and non-profit daycares, receive grant monies.

Equipment: The majority of this funding request is for the WIC program. Since no paper records are made by WIC staff when dealing with clients, the whole system is dependent on the availability of computers for input of information.

WIC Food Benefits to Individuals: The subcommittee was referred to pages 7-15 through 7-21 of **EXHIBIT 4, January 16, 1995**, to answer questions such as what foods and how much are provided, how is eligibility determined, what are the age groups served, etc.

CHAIRMAN COBB reassumed the chair.

Follow Me Expansion: **Ms. Ferguson** provided the supplemental report on the Follow Me Expansion. **EXHIBIT 3** She then gave a brief background on the program and described the services available. She explained that the overall goal of the Follow Me program is to enhance child development, promote parenting and to ensure early intervention services for followed children as needed, so all Montana children will enter school healthy and ready to learn.

SEN. SWYSGOOD asked how long the program follows the children. **Ms. Ferguson** indicated that the ideal is to follow children to school entry or until they are well established within another system. **SEN. SWYSGOOD** asked her to address the issue brought up by the LFA. **Ms. Ferguson** discussed the changes needed to comply with federal mandates, and conveyed that the changes made did not alter the focus of the program, but explained it better.

REP. BARNHART expressed her support of the MIAMI and Follow Me programs. She asked if any evaluations have been done to determine how effective the programs are. **Ms. Ferguson** said both programs have developed a data system which receives information from individual counties. The information shows that there are more calls for services that can actually be provided and that referrals are being made in great numbers to local health departments from physicians and other agencies within the county.

CHAIRMAN COBB asked why the counties couldn't screen the children without this program since it is already being done on a

voluntary basis from local hospitals. **Ms. Ferguson** said the communities could benefit by this program because it could hire extra staff which would "give them a boost." **CHAIRMAN COBB** expressed that he didn't feel the requested funding would hire many staff for the 20 counties served, neither would it be enough to fund this program correctly. He asked what the best way would be to operate this program if only so much money was appropriated for it. **Ms. Ferguson** replied that this program has already encouraged counties to move further into home visiting and to collaborate services in rural areas. **CHAIRMAN COBB** indicated that he wanted to go after the most at risk in the hardest categories, serve them first, before expanding programs elsewhere. He suggested that no maternal and child grants should be provided to counties until they collaborate efforts to ensure target groups are being properly cared for.

REP. KASTEN asked how much of the approximate $51 million total funds actually get into the hand of the person who is in need compared to how much goes to the provider network or administration. **Mr. Taliaferro** said 15% is administrative costs, and that he would provide the subcommittee with a list of the money spent broken down by county and criteria used for dispensing funds.

Karen Sloan, Family Planning Nurse Practitioner, Havre, then requested the subcommittee's support of funding for the Family Planning Health Educator. She felt that if more education could be provided to more people, then less babies would fall into state aided programs.

Medical Outreach: **Ms. Ferguson** explained that the request for this funding would be used for the addition of 2.0 FTE. She said the Department proposes to use general fund expenditures in the MIAMI program to secure federal Medicaid match to fund these positions.

CHAIRMAN COBB asked if general fund was used to match other federal dollars for other purposes in the MIAMI program. **Ms. Ferguson** said not at this point in time; the general fund is being used as a required match on a condition of receiving federal MCH block grants.

Lead Abatement Expansion: This item was previously discussed.

CHAIRMAN COBB asked if the Department had any results from this before the expansion. **Mr. Robinson** reported that 4,000 blood test have been conducted and 10% of the results show levels of blood lead. As soon as the lead is discovered, the children receive care to reduce that blood level. **Lisa Cain, Program Manager, Child & Blood Program** told members of the subcommittee that a detailed follow-up is conducted on children with an elevated blood level. She said equipment is used in the home to detect the source of lead in the child's environment. She

emphasized that this is the single most important tool to remove the source of lead, thus limiting the risk.

Child Nutrition Administrative Support: **Mr. Taliaferro** said this request was to keep up with the growth of the Child Nutrition program.

Family Planning Health Educator: This was item previously discussed. **REP. BARNHART** questioned what the hiring practice was, and if staff would be located primarily in Helena. **Mr. Taliaferro** said Helena would be the ideal location because most of the communication regarding the programs comes from Helena.

Personal Services Reduction: There was no discussion on this item because it is self-explanatory.

Tape No. 2:A:02

BA468 Communications System Development: These will be grants to counties to do the assessment of maternal & child health needs to determine the use their block grant funding.

OVERVIEW OF PREVENTIVE HEALTH BUREAU

Tape No. 2:A:3.9

HIV Lab Testing & Evaluation: This request in the expansion due to the demand of HIV tests. These are all federal funds specifically for conducting HIV tests.

Contracts With Counties: These increased expenditures are to pass on federal funds for immunization and HIV counseling and testing.

Eliminate Rabies Vaccine: The manufacturer of the rabies vaccine will no longer allow the Department to order supplies that it can keep on hand. The manufacturer will now deliver the supplies directly to physicians. There is no longer a need for this program.

Indirect Costs: This item is self explanatory.

Equipment: This request is primarily for replacement computers.

Other: **Mr. Taliaferro** provided the subcommittee with a breakdown of these expenditures. **EXHIBIT 4**

Public Health Nutritionist: **Mr. Taliaferro** distributed the statute (50-49-107) outlining the appointment of this position by the Director of the Department. **EXHIBIT 5** This position has been funded with an increase in the preventative health block grant and has existed since 1991. **Mr. Taliaferro** then distributed a response for this budget item. **EXHIBIT 6**

Communicable Disease Emergency Fund: This was created during the 1993 special session when the need arose for a hotline to address protective measures for the Hanta virus. This is a restricted fund that can only be used for the control of communicable disease outbreaks that cannot be covered by some other funding source.

Diabetes Control: This funding request is based on not having adequate services for diabetics in Montana. The American Diabetes Association (ADA) has ranked Montana 38th in 50 states in terms of resources to serve diabetic people. This funding would be used for assessment, education and implementation of techniques to reduce the costs of diabetes.

CHAIRMAN COBB asked what would be done differently if the money is not allocated. **Mr. Taliaferro** said that if the ADA assessment is correct, then Montana will continue to have a higher burden of treatment for diabetes that is out of control than is necessary.

State Immunization Information System: The 1.0 FTE and $1 million is for four activities; the immunization information system, distribution of children's vaccines, carry-over funds for hepatitis B and to upgrade local systems to better coordinate with physicians.

Breast & Cervical Cancer: This project is working with physicians and community groups to promote testing and awareness of breast & cervical cancer and conduct an assessment of state resources. Once this project is complete, federal funds will be available to pay for actual screening.

Expand Tobacco Control: This is to provide additional tobacco prevention efforts throughout Montana.

CHAIRMAN COBB asked what this program would do to stop people from smoking. **Mr. Taliaferro** said it would provide education through schools, community groups and advertising campaigns. **CHAIRMAN COBB** said education is currently being provided, and asked if this program would really make any difference or if the money could be used elsewhere to do something different. **Mr. Robinson** explained that it is the job of public health to educate people to either quit or not start smoking, and this is where the real prevention occurs.

SEN. LYNCH said he would support this program, although there is more than plenty of information and education already available. He said if the funding would help one kid to stop smoking it would be worth it.

ADJOURNMENT

Adjournment: 11:25 a.m.

REPRESENTATIVE JOHN COBB, Chairman

ANN BODEN, Secretary

JC/ab

HUMAN SERVICES AND AGING

Joint Appropriations Subcommittee

ROLL CALL DATE 1-17-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. John Cobb, Chairman	X		
Rep. Beverly Barnhart	X		
Rep. Betty Lou Kasten	X		
Sen. Chuck Swysgood, Vice Chairman	X		
* Sen. J.D. Lynch	X		
Sen. Jim Burnett	X		

* in @ 9:00

EXHIBIT #1 1-17-95
DATE 1-17-95 #1
HB Human Svcs. Sub committee

CARRY-FORWARD COMPUTATION
DEPARTMENTAL COSTS

		FY92		FY94
(A) FIXED RATE PER NEGOTIATION AGREEMENT (A/B) COMPUTED AS FOLLOWS:		15.42%		10.18%
		$7,273,851 (B)		$11,182,295 (B)
DIRECT S & W BASE				
INDIRECT COST POOL:				
DEPARTMENT COSTS	1,044,201		1,271,665	
DEPT. SHARE STATEWIDE	53,180		147,509	
CARRY-FORWARD	24,362		(280,774)	
TOTAL POOL		1,121,743 (A)		1,138,400 (A)
(B) ACTUAL COSTS NEGOTIATED COMPUTED AS FOLLOWS:				
ACTUAL DIRECT S & W BASE		$11,182,295 (1)		
ACTUAL INDIRECT COST POOL:				
DEPARTMENTAL COSTS	1,271,665 (2)			
DEPT SHARE STATEWIDE	147,509 (3)			
CARRY-FORWARD	24,362			
TOTAL POOL		1,443,536		
(C) CARRY-FORWARD COMPUTATION:				
RECOVERED: FIXED RATE X ACTUAL DIRECT S & W BASE 15.42% X 11,182,295		1,724,310		
SHOULD HAVE RECOVERED: ACTUAL INDIRECTS COSTS FOR:				
EST ADJUSTMENT 93	0			
FY92	1,443,536	1,443,536		
UNDERRECOVERY (F-E) CARRY-FORWARD TO SUBSEQUENT YEAR		0		
OVERRECOVER (E-F) CARRY-FORWARD TO SUBSEQUENT YEAR		280,774		

FOOTNOTES

(1) INDIRECT COST PROPOSAL (TOTAL DIRECT SALARY & BENEFITS MINUS DEPT. INDIRECT SALARY & BENEFITS)
(2) INDIRECT COST PROPOSAL - DEPARTMENT INDIRECT COST TOTAL
(3) STATEWIDE COST ALLOCATION PLAN

CARRY-FORWARD COMPUTATION
DEPARTMENTAL COSTS

		FY92		FY94
(A) FIXED RATE PER NEGOTIATION AGREEMENT (A/B) COMPUTED AS FOLLOWS:		15.42%		15.90%
		$7,273,851 (B)		$11,182,295 (B)
DIRECT S & W BASE				
INDIRECT COST POOL:				
DEPARTMENT COSTS	1,044,201		1,468,965	
DEPT. SHARE STATEWIDE	53,180		147,509	
CARRY-FORWARD	24,362		161,432	
TOTAL POOL		1,121,743 (A)		1,777,906 (A)
(B) ACTUAL COSTS NEGOTIATED COMPUTED AS FOLLOWS:				
ACTUAL DIRECT S & W BASE		$11,182,295 (1)		
ACTUAL INDIRECT COST POOL:				
DEPARTMENTAL COSTS	1,271,665 (2)			
DEPT SHARE STATEWIDE	147,509 (3)			
CARRY-FORWARD	24,362			
TOTAL POOL		1,443,536		
(C) CARRY-FORWARD COMPUTATION:				
RECOVERED: FIXED RATE X ACTUAL DIRECT S & W BASE 15.42% X 11,182,295		1,724,310		
SHOULD HAVE RECOVERED: ACTUAL INDIRECTS COSTS FOR:				
EST ADJUSTMENT 94 (AA)	442,206			
FY92	1,443,536	1,885,742		
UNDERRECOVERY (F-E) CARRY-FORWARD TO SUBSEQUENT YEAR		161,432		
OVERRECOVER (E-F) CARRY-FORWARD TO SUBSEQUENT YEAR		0		

FOOTNOTES

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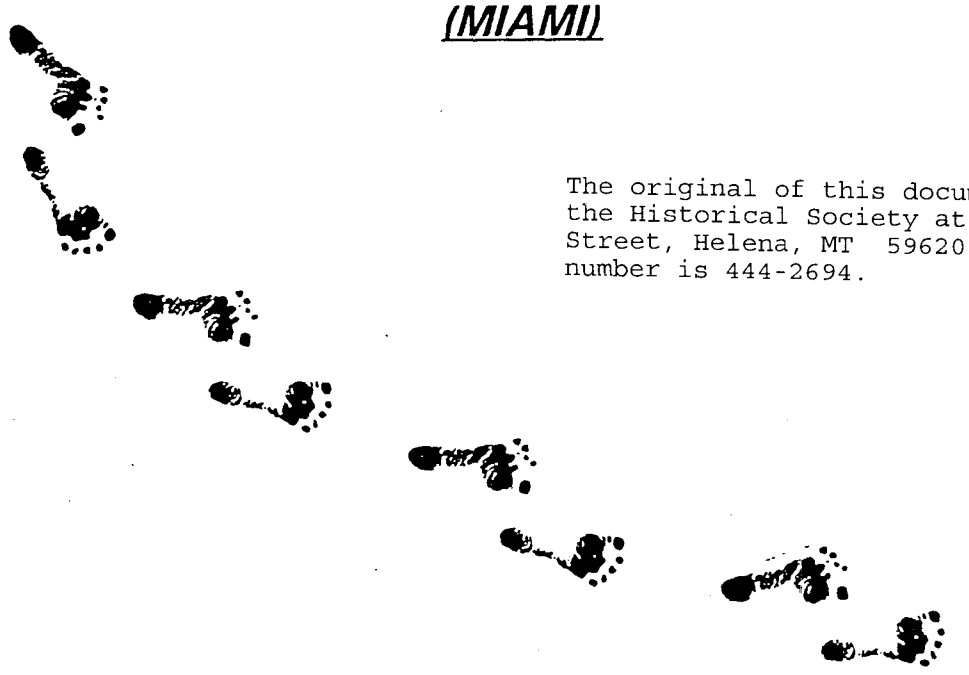
EXHIBIT 2
DATE 1-17-95
HB

Public Health Services for At-Risk Pregnant Women and Children in Montana

Montana's Initiative for the Abatement of Mortality in Infants (MIAMI)



Follow Me

Montana Perinatal Program -- Children's Special Health Services
Family/Maternal and Child Health Bureau

****

Health Services Division
Montana Department of Health and Environmental Sciences

January 1995

EXHIBIT 3
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HB

FOLLOW ME EXPANSION

. . . . . *Please see the attached MIAMI\FOLLOW ME report.*

The Follow Me program is explained in the MIAMI/FOLLOW ME report. This information supplements the report and includes several references which are attachments to this narrative.

Follow Me is an integral part of the overall planning for comprehensive maternal and child health services in Montana.

> PLEASE SEE THE ATTACHED INFORMATION FROM THE CARNEGIE FOUNDATION, "STARTING POINTS" FOR A LISTING OF SERVICES DEEMED NECESSARY FOR THE PROMOTION OF CHILD HEALTH.

Follow Me has been built on existing programs and capabilities of local public health agencies. This has kept administrative costs to a minimum, has enabled training to be targeted to specific skill-building areas because local staff already have basic skills in home visiting. These key areas assisted in expediting program development.

Follow Me and MIAMI are seen as the *foundations* for other programs which support families. These programs complement Follow Me services but do not duplicate the Follow Me services. DFS Partnership to Strengthen Families Projects are building on the capabilities of local Follow Me and MIAMI projects as well as local public health.

> PLEASE SEE ATTACHED CHARTS -- "FAMILY CONNECTION" AND "SERVICES FOR FAMILIES WITH YOUNG CHILDREN" *draft.*

Follow Me fills a gap in services, as evidenced by the high number of referrals experienced in local health departments which have Follow Me projects. Follow Me is unique in its services and duplicates no services provided by other agencies. No other project or program is positioned to provide the unique assessment activities and coordination that Follow Me provides. Home visiting is a traditional public health service provided by registered professional nurses and has been ongoing in Montana since the 1920s.

The assessment function of public health (one of the three primary or "core" functions), requires that in order to do adequate planning, there be knowledge of the health status of individuals. The most efficient way to do this for families with young children is through the assessment process used by professional public health nurses.

Role of Hospitals

As indicated in the MIAMI/Follow Me report, hospitals are providing referrals to local health departments. Hospital stays after delivery are shorter and shorter (12-24 hours) meaning hospital personnel have less time to spend assessing families and teaching new parents.

Hospitals which have tried doing followup after delivery are limiting that followup to a phone call or perhaps one (reimbursed) home visit. Time to truly assess the longterm ongoing needs of families is best accomplished in the home setting where the family is more comfortable; this is not the focus of the acute-care-centered hospital.

The success of a home visiting program is dependent upon nurses who visit frequently, starting during pregnancy and continuing at least two years, according to David Olds, who has conducted and is currently conducting extensive research in this area.

PLEASE SEE THE ATTACHED ARTICLE BY DAVID L. OLDS, PhD.

The Follow Me screening process lets families chose whether or not they want to fill out the questionnaire. It also gives them the chance to say what they want or feel they need. Hospitals in the pilot sites have been very cooperative and supportive of the screening process.

Funding and Use of Expansion Funds:

General funds are requested; federal Medicaid match will be sought for all eligible costs. Most of the money will be used for direct services at the local level. The new 1.0 FTE will be used for support services for the counties.

The base salary for a nurse consultant is $28,885. Other costs necessary to support this FTE include rent, desk, phone, file and other office supplies, computer and funds to support travel. Administrative costs will include that portion of the nurse consultant's salary not eligible for Medicaid match and indirect costs as charged against personnel services per department policy.

Follow Me projects are currently in both rural and urban areas of the state, and will be expanded on a per capita basis in response to Requests for Proposals (RFPs). It seems most efficient and effective to target areas

1) currently involved in DFS Partnership Projects;
2) currently using the Follow Me/MCH data system, which would reduce

EXHIBIT 3
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training costs;
3) currently providing Follow Me-like services where professional support and guidance could bring them closer to the Follow Me model.

In September, 1993, the DHES Follow Me Project was able to showcase local maternal and child health services during the first federal program review of maternal and child health in Montana since 1980. The comprehensive 5 day review involved about 400 people, including 2 days of visits to local health departments, hospitals, Indian health facilities, schools, and other agencies. The federal recommendations were to expand MIAMI and Follow Me Projects to all counties in the state as soon as possible.

Supporting healthy families is a big issue. Prevention and health promotion services are costly in terms of immediate gain. Follow Me outcomes are long-term. Although we are not asking for a great deal of money for expansion, general fund dollars will enable us to leverage Federal Medicaid dollars for services provided directly to Medicaid eligible clients and or on behalf of Medicaid clients to support administrative costs at the county level.

Priority Families

Follow Me targeted families and children who have "established", "biological", and "environmental" risk factors. Most of the children currently receiving Follow Me services are in the category of environmental risks, i.e., parental behaviors and lifestyles and poverty.

PLEASE SEE ATTACHED CHART, "WHAT IT TAKES FOR FAMILIES TO SUCCEED"

Other programs serve as an important adjunct to the Follow Me program. These programs tend to have a single focus, e.g., reduction of child abuse or services for a disabled child, thus not realizing as much in economic savings as multifocused programs.

Historically, public health nurses have been recognized for the ability to coordinate service delivery to families as well as see that mothers and children receive needed medical care (e.g., well child checks, immunizations and prenatal care) and provide parents with the information they need to be good parents and self-sufficient individuals.

Follow Me has recognized the need to have a multifocused model if it is to effect a decrease in unintended subsequent pregnancies, and a reduction in the continued long term reliance on AFDC and other social programs to attain the goal of cost effectiveness. The efficacy of multifocused approaches using paraprofessionals in

conjunction with public health has been demonstrated in Montana.

Also, according to David Olds (article attached) the full potential of home visiting will not be reached without ". . . nurses who visit frequently, beginning to follow the family during pregnancy and continuing at least through the first two years of life."

Knowing the community and its resources is an important part of public health nursing. Therefore, part of Follow Me service is to make referrals to other agencies who can provide additional services when needed. Public health nurses work hard to build self-sufficiency in families. Working with these children/families includes: providing info about basic child care or "how to" issues like feeding, bathing, sleep issues, dealing with crying, dealing with the other kids when there is a new baby in the family, discipline, immunizations, well child checkups, when to call the doctor, dealing with being a parent.

Every child should have the right to home visiting. The U.S. General Accounting Office (GAO), numerous experts, and many commission reports have suggested that ". . . home visiting can help all newborns have a good start in life, can foster child development and school readiness, can encourage parents to take advantage of preventive health services, and can decrease the incidence of infant mortality, low birth weight, and child abuse." [Source: Home Visiting: A Promising Early Intervention Strategy for At-Risk Families, GAO, July 1990.

With expansion, Follow Me would be able to screen more children. More importantly, Follow Me would be able to provide the followup services those identified need. On a practical level, it does little good to identify problems if one is unable to do anything about them. As screening is voluntary, there will always be some parents who will not chose to participate.

Role of Nurse Consultant

As stated above, the additional nurse consultant would provide additional support services to the county public health nurses and staff. Focus would be the MCH Block Grant guidelines which require states to provide family centered, culturally competent care in order for overburdened families to be able to make independent and informed choices about their children's care and development.

Nurse consultants provide technical assistance, education, professional public health nursing input for local county nurses, especially for those who did not graduate from a nursing education program which included a public health nursing component, i.e., associate degree or diploma education. Public health nurses are "models" for parents and as an example, can ofttimes interact with children in ways that give parents new ideas about their own interaction and discipline.

Although every effort has been made to make it easy to duplicate Follow Me in other counties, local staff need assistance to look at the needs in their community (community assessment), to focus on outcomes, and upgrade current skills or attain new skills which expedite their working with families. Forms have been developed to insure client\family confidentiality and to maintain continuity of services when families move into another Montana community.

Providing information to local personnel regarding referral to additional resources and development of those resources, for instance is another responsibility of the support services provided. Additionally, the current nurse consultant to CSHS now has responsibility for providing nursing services to the CSHS program, case management services for children identified in sponsored clinics, for development of the DHES\Follow Me data system, and the Follow Me program.

STARTING POINTS

MEETING THE NEEDS OF OUR YOUNGEST CHILDREN

THE REPORT OF THE CARNEGIE TASK FORCE ON
MEETING THE NEEDS OF YOUNG CHILDREN

CARNEGIE CORPORATION OF NEW YORK

APRIL 1994

Appendix: Comprehensive Services Recommended for the Promotion of Child Health

In 1981, the Select Panel for the Promotion of Child Health, after a two-year study, identified the services necessary to ensure the health of America's children. The task force endorses the panel's recommendations and has updated them to reflect new medical developments.

Women of Reproductive Age

Services for nonpregnant women

Diagnosis and treatment of general health problems that can adversely affect future pregnancy, fetal development, and maternal health

- Sexually transmitted diseases
- Immune status (rubella, HIV)
- Gynecological anatomic and functional disorders
- Organic medical problems
- Nutritional status, including both over- and underweight
- Fertility and genetic problems
- Significant dental problems
- Occupational exposures
- Genetic risk

Diagnosis and treatment of mental health and behavioral problems

- Substance abuse, including alcohol
- Smoking cessation
- Significant mental disorders

Comprehensive family planning services

- Education and counseling
- Physical exam and lab tests
- Provision of family planning methods and instruction regarding their use
- Pregnancy testing, counseling and referrals as appropriate
- Infertility services and genetic testing
- Sterilization services

Home health and homemaker services

Prenatal services

Early diagnosis of pregnancy

Counseling for pregnancy continuation

- Referral to prenatal care
- Childbirth preparation classes
- Adoption
- Termination of pregnancy

Prenatal care

History

- General physical exam
- Appropriate laboratory tests
- Diagnosis and treatment of general health problems
- Diagnosis and treatment of mental health problems
- Nutritional assessment and services
- Dental services
- Screening for infectious diseases
- Genetic screening, diagnosis, and counseling
- Identification and management of high-risk pregnancies

Counseling and anticipatory guidance regarding

- Physical activity and exercise
- Nutrition and adequate but not excessive weight gain during pregnancy
- Avoidance of substance abuse and environmental hazards
- Fetal growth and development and physiological changes in pregnancy
- Signs of abnormal pregnancy and of the onset of labor
- Preparation for labor (including partner, where appropriate)
- Use of medications during pregnancy
- Infant nutritional needs and feeding practices, including breastfeeding
- Child care arrangements
- Parenting skills, including risk of child abuse or neglect
- Linkage to continuous and comprehensive pediatric care
- Emotional and social changes brought on by the birth of a child

Perinatal and postpartum care

Monitoring labor

Medical services during labor and delivery

Delivery by qualified professional in a facility with adequate services

Diagnosis and treatment of general health problems

Diagnosis and treatment of mental health and behavior problems (postpartum depression)

Counseling and anticipatory guidance regarding

- Infant development and behavior
- Infant nutrition and feeding, including breastfeeding
- Home and automobile accident prevention
- Infant stimulation and parenting skills, including risk of abuse or neglect
- Immunization
- Health-damaging behavior by parents, including substance abuse and smoking
- Continuous and comprehensive health care
- Recognition and management of illness in the newborn
- Hygiene and first aid
- Child care arrangements

Other relevant topics of patient concern

Health education

Counseling and anticipatory guidance, as listed above

Developing positive health habits

Using health services appropriately

Accessing community health and social services

Access-related services

Transportation as appropriate

- Emergency transport
- Transportation services associated with a regionalized perinatal or tertiary care network
- Transportation services that facilitate obtaining needed health services

Outreach services

Hotline, translator, and 24-hour emergency telephone services

Child care services to facilitate obtaining needed health services

Infants under One Year

Services in the neonatal period

Evaluation and support immediately after delivery

Complete physical exam

Laboratory tests to screen for genetic disease and thyroid function

Diagnosis and treatment of general health problems, both acute and chronic

Preventive procedures, including

- Gonococcal eye infection prophylaxis
- Administration of vitamin K

Services of a neonatal intensive care unit, as appropriate

Nutritional assessment and supplementation, as needed

Bonding, attachment support, and extended contact with parents, including rooming-in, if desired

Linkage to continuous and comprehensive pediatric care after discharge

Home health services

Be alert for signs of abuse and neglect

Services for children

Periodic health assessment, including

- History and systems review
  - Medical history
  - Social setting
  - Family background
  - Genetic assessment
  - Age and development stage
  - Potential problems
- Complete physical examination, including
  - Height and weight
  - Head circumference
  - Developmental/behavioral assessment
  - Vision and hearing evaluation
- Screening and laboratory tests as indicated, including
  - Hemoglobin/hematocrit
  - Tuberculin skin test
  - Lead poisoning
  - Parasites
  - Screening for sickle cell and other disorders of hemoglobin
- Nutritional assessment and supplementation, as needed, including
  - Iron
  - Vitamin D
  - Fluoride

Immunizations

continued on page

Appendix: Comprehensive Services Recommended for the Promotion of Child Health, continued

Diagnosis and treatment of general health problems, both acute and chronic

Home health services

Services for families during infant's first year

Counseling and anticipatory guidance regarding
- Infant development and behavior
- Maternal nutritional needs, especially if breastfeeding
- Infant nutritional needs and feeding practices
- Home and automobile accident prevention
- Infant stimulation and parenting skills, including risk of abuse or neglect
- Immunizations
- Health-damaging behavior by parents, including substance abuse and smoking
- Continuous and comprehensive health care
- Recognition and management of illness
- Hygiene and first aid
- Child care arrangements
- Other relevant issues in response to parental concern

Counseling and appropriate treatment or referral as needed for parents
- Who have chronic health problems that affect their capacity to care for the infant, including
  - Handicapping conditions
  - Substance-abuse problems
  - Mental health problems (including maternal depression)
- Whose infant in seriously ill
- Whose infant has a chronic illness or a handicapping condition
- Whose infant is or is about to be hospitalized

Health education

Counseling and anticipatory guidance, as listed above

Developing positive health habits

Using health services appropriately

Accessing community health and social services

Access-related services

Transportation as appropriate
- Emergency transport
- Transportation services associated with a regionalized perinatal or tertiary care network
- Transportation services that facilitate obtaining needed health services

Outreach services

Hotline, translator, and 24-hour emergency telephone services

Child care services to facilitate obtaining needed health services

Children from One Year to Three Years

Services for children

Periodic health assessment, including
- History and systems review
  - Medical history
  - Social setting
  - Family background
  - Genetic assessment
  - Age and developmental stage
  - Potential problems
- Psychosocial history
  - Peer and family relationships
  - Child care progress and problems
- Complete physical examination
  - Height and weight
  - Developmental and behavioral assessment
  - Vision, hearing, and speech evaluation
  - Signs of abuse and neglect
- Screening and laboratory tests as indicated, including
  - Hemoglobin/hematocrit
  - Tuberculin skin test
  - Lead poisoning
  - Parasites
  - Screening for sickle cell and other hemoglobin disorders
- Nutritional assessment and supplementation, as needed, including iron, vitamin D, and fluoride

Immunizations

Diagnosis and treatment of general health problems, both acute and chronic

Diagnosis and treatment of mental health disorders, both acute and chronic
- Emotional disorders
- Learning disorders
- Behavioral disorders
- Substance abuse
- Problems with family and peer group

Counseling and support services for children with chronic or handicapping conditions

Dental services, preventive and therapeutic

Home health services

Services for children and their families

Counseling and anticipatory guidance regarding
- Nutritional needs
- Home and automobile injury prevention
- Parenting skills, including risk of abuse or neglect
- Immunizations
- Health-damaging behavior by parents, including substance abuse and smoking
- Continuous and comprehensive health care
- Child care arrangements
- Physical activity and exercise
- Hygiene and first aid
- Dental health
- Childhood antecedents of adult illness
- Child development
- Environmental hazards
- Other relevant issues in response to child and parental concern

Counseling and appropriate treatment or referral, as needed, for parents
- Who have chronic health problems that affect their capacity to care for the child, including
  - Handicapping conditions
  - Substance-abuse problems
  - Mental health problems (including maternal depression)
- Whose child is seriously ill
- Whose child has a chronic illness or a handicapping condition
- Whose child is or is about to be hospitalized

Health education

Counseling and anticipatory guidance, as listed above

Developing positive health habits

Using health services appropriately

Accessing social services and entitlements

Access-related services

Transportation as appropriate
- Emergency transport
- Transportation services associated with a regionalized or tertiary care network
- Transportation services that facilitate obtaining needed health services

Outreach services

Hotline, translator, and 24-hour emergency telephone services

Child care services to facilitate obtaining needed health services

SERVICES FOR FAMILIES WITH YOUNG CHILDREN

MONTANA

COMPREHENSIVE POLICY AND PLANNING BOARDS

- Interagency Coordinating Council for Prevention (ICC)
- Joint Oversight Committee on Children and Families
- State Family Services Advisory Council (DFS)
- Local Family Services Advisory Councils (DFS)
- MIAMI Advisory Council (DHES)
- Preventive Health Services Advisory Council (DHES)
- Family Support Services Advisory Council (SRS)
- Developmental Disabilities Planning/Advisory Council (DDPAC/SRS)

FAMILY SUPPORT	HEALTH-ORIENTED	EARLY INTERVENTION/PRESCHOOL
Department of Family Services ○ Partnership to Strengthen Families ○ Children's Services Reform and Refinancing Project ○ Family Support/Family Preservation Initiatives ○ Montana Child Day Care (lead agency) ○ Adoption Services	*Department of Health and Environmental Sciences* ○ Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) ○ FOLLOW ME ○ Family Planning ○ Children's Special Health Services (CSHS) ○ WIC ○ Child & Adult Care Food Program (CACFP) ○ Immunizations *Department of Social & Rehabilitation Services* ○ Medicaid Kids Count (EPSDT) Passport	*Head Start* *Office of the Superintendent of Public Instruction* ○ Special Education Division IDEA-B Child Find Deaf/Blind *Department of Social & Rehabilitation Services* ○ Developmental Disabilities Division Early Intervention, Part H

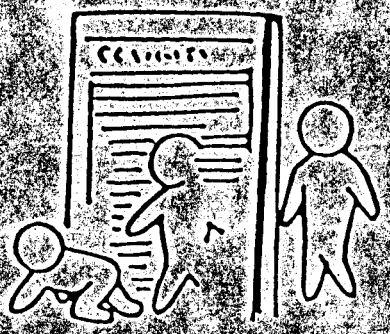
the FAMILY CONNECTION

A Partnership of Montana's Communities and the State of Montana to Focus on At Risk Children and Families

PURPOSE - Improve the lives of Montana's children and families.

PARTNERSHIP - Families, local communities and Montana Departments of Health & Environmental Sciences, Family Services, and Social & Rehabilitation Services

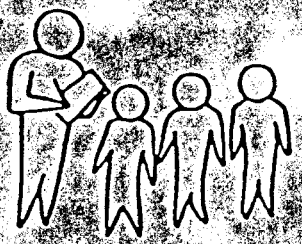
- MIAMI
- Follow Me
- Communities



Children are screened early to find those children and families who need help to develop the child's intellectual, physical, emotional and social potential.

FOLLOW ME

- Follow Me
- Local Public Health
- Partnership to Strengthen Families



High-risk children and families are linked with appropriate services so that every child enters school ready to develop his or her potential.

dfs

Service providers in partnership with families and communities make sure that the child and family receive support needed for success at school.

- Family strengths
- Self-sufficiency
- Day care
- Financial support
- Job skills
- Parenting skills
- Physical health services
- Mental health services (including counseling)
- Substance abuse services
- Homemaking and budget skill-building

- Child enters school ready to learn.

EXHIBIT 3
DATE 1-17-95

Home Visitation for Pregnant Women and Parents of Young Children

David L. Olds, PhD

• Many of the most pervasive, intractable, and costly problems faced by high-risk women and young children in our society today are a consequence of adverse maternal health-related behaviors (such as cigarette smoking, drinking, and drug use during pregnancy), dysfunctional infant care giving, and stressful environmental conditions that interfere with individual and family functioning. These problems include low birth weight, child abuse and neglect, childhood injuries, unintended and closely spaced pregnancy, and reduced economic self-sufficiency on the part of parents. Evidence is accumulating that these problems can be reduced with comprehensive programs of prenatal and infancy home visitation by nurses. While we are witnessing a renaissance of interest in home visitation as a means of addressing these problems, the recommendations of various health and human service advisory groups about the structure of proposed home-visitation initiatives are uncoordinated and frequently inconsistent with the empirical evidence. Home visitation is a promising strategy, but only when the program meets certain standards. The more successful programs contain the following: (1) a focus on families at greater need for the service, (2) the use of nurses who begin during pregnancy and follow the family at least through the second year of the child's life, (3) the promotion of positive health-related behaviors and qualities of infant care giving, and (4) provisions to reduce family stress by improving the social and physical environments in which families live.

(*AJDC*. 1992;146:704-708)

Prior to the 1970s community health nursing was an integral part of the US public health strategy to address the needs of at-risk children and their families. In the last 2 decades, such services have been reduced severely. Where home-visitation services have been provided, they have focused almost exclusively on pregnant women and children with identified health problems. Few home-visitation services have been devoted to prevention and health promotion.[1] In part, this is because third-party payers have been willing to reimburse for tangible services, such as long-term care of the elderly and disabled children, while they have shied away from disease prevention and health promotion. It did not help that early evaluations of home-visitation services were not promising.[2] Many of the early studies were difficult to interpret because the programs tested were not designed to address the full range of adverse circumstances that interfere with maternal health and care-giving behaviors. Where the programs were designed well, the evaluations fell short of the highest standards for field experimentation. In spite of the reticence of third-party payers to support preventive services and the equivocal results of early research, home visitation is once again being promoted as a means of preventing the death and damage of our most vulnerable children.[3-9]

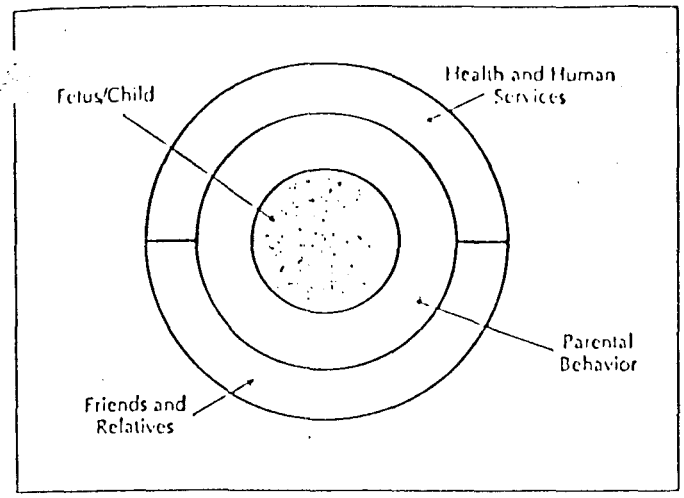
The US Advisory Board on Child Abuse and Neglect[3,4] has declared child maltreatment a national emergency, has identified home visitation as the most promising method of addressing this problem, and has called for the development of a national home visitation program for all new parents. The National Commission to Prevent Infant Mortality[5,6] has included home-visitation as a central part of its strategy to improve the outcomes of pregnancy and reduce infant mortality and morbidity. The Public Health Service Expert Panel on the Content of Prenatal Care has recommended that home visitation be included as part of an augmented set of services for low-income, at-risk women.[7,8] The General Accounting Office[9] issued a report in 1990 encouraging Congress to increase their level of support for home-visitation services through expansion of Title XIX of the Social Security Act. At least five legislative initiatives currently before Congress include provisions for expanding federal support for home-visitation services. In the meantime, at least 24 states have recently begun to increase their support of home-visitation services through a variety of Medicaid service categories.[9]

This renewed interest in home visitation derives from an increased appreciation for prevention in all aspects of health as well as from a recent accumulation of scientifically credible evidence that home visitation can be an effective preventive intervention for women and children.[10] This report synthesizes the evidence on home visitation for pregnant women and parents of young children and examines the current legislative initiatives in light of that evidence. The findings from a randomized trial of prena-

Accepted for publication March 16, 1992.

From the Department of Pediatrics, University of Rochester (NY) School of Medicine and Dentistry.

Reprint requests to the Department of Pediatrics, Box HWH, University of Rochester Medical Center, 601 Elmwood Ave, Rochester, NY 14642 (Dr Olds).



Intervention model for high-risk families.

The Evaluation

The evaluation was designed to assess improvements in child health and development, parental health-related behaviors, qualities of infant care giving, social support, and use of community services from pregnancy through the child's fourth year of life, 2 years after the end of the program. Data were derived from interviews with parents, observations of parental behavior and conditions in the home, and reviews of medical and social service records. Except in a few cases in which families inadvertently disclosed that they were visited by nurses, all data-gathering staff were unaware of the families' treatment assignments.[11-13]

Improvement of Pregnancy Outcomes

In contrast to women in the comparison groups (treatments 1 and 2), women who received visits by a nurse during pregnancy (treatments 3 and 4) reduced the number of cigarettes smoked, improved the quality of their diets, had fewer kidney infections, experienced greater support from family members and friends, and made better use of the Special Supplemental Food Program for Women, Infants, and Children. The positive effects of the program on birth weight and length of gestation concentrated on two groups at risk for these problems: smokers visited by a nurse bore 75% fewer preterm infants, and young adolescents visited by a nurse bore infants who were 395 g heavier at birth than infants of their counterparts in the comparison group. While the effect of the program on the birth weight of infants born to very young adolescents was greater (given known determinants of birth weight) than predicted, the effect is consistent with the behavioral changes produced by the program and was particularly strong for those young adolescents who registered in the study before midgestation.[11]

Improvement of Care Giving

Among poor, unmarried teenagers, the incidence of state-verified cases of child abuse and neglect during the first 2 years after delivery was 19% in the comparison group (treatments 1 and 2) and 4% in the group that received both prenatal and infancy nurse visitation (treatment 4), an 80% reduction. These findings were corroborated by observations of the women's treatment of their children and conditions in the home. The homes of poor, unmarried teenagers visited by a nurse were filled with more educationally stimulating play materials, and the mothers used less punishment and restriction in interacting with their children. Moreover, during the second year of life (when childhood injuries increase), children visted by a nurse (irrespective of risk status) were seen in the emergency department 32% fewer times for any reason and 56% fewer times for injuries and ingestions than children not receiving visits by a nurse.[12]

Improvement of Maternal Personal Development

During the first 4 years after delivery, low-income, unmarried women in treatment 4 showed an 82% increase in the number of months they were employed, had 43% fewer subsequent pregnancies, and postponed the birth of a second child a mean of 12 months longer than did their counterparts in treatments 1 and 2.[13] The impact of the program on maternal care giving cannot be interpreted fully without acknowledging that high-risk women visited by nurses had fewer children for whom they were responsible.

Effect on Government Spending

An investment in this type of home-visitation program for low-income women and children can pay for itself (from the standpoint of government spending) by the time the children are aged 4 years. On average, the prenatal and postpartum program (treatment 4) costs about $3200 for 2½ years of home visitation. Low-income women (those most likely to use government services) used $3300 less in other government services during the first 4 years after delivery of their first child than did their low-income counterparts in the comparison group. About a third of the cost savings for low-income families came from the reduction in unintended subsequent pregnancies, and about 80% of the cost savings were concentrated in reduction in Aid to Families with Dependent Children and Food Stamp payments.[26] The cost savings may very well continue as the children grow older, but the families have not yet been followed up beyond the children's fourth year of life.

Generalizability of Findings

In interpreting the findings from the Elmira trial, it is important to keep in mind that the results were derived from one study carried out in a small, semirural community with a white sample in the late 1970s and early 1980s. We do not yet know whether these findings apply to minorities living in major urban areas in the 1990s. The Elmira trial is being replicated in Memphis, Tenn, with a sample of 1100 low-income black families to determine the generalizability of the findings. The report of program effects on the outcomes of pregnancy for the Memphis trial will be produced in the spring of 1993. Another way to determine the generalizability of the findings is to examine other randomized trials of home visitation for pregnant women and parents of young children and see whether the general pattern of results is the same.

Other Trials of Home Visitation

A recent review of all of the randomized trials of pregnancy and infancy home-visitation programs aimed at preventing health and developmental problems in pregnant women and young children showed that programs vary tremendously in terms of their objectives, target

EXHIBIT 3
DATE 1-17-95

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References

1. Chavigny K, Korske M. Public health nursing in crisis. *Nurs Outlook.* 1983;31:312-316.

2. Combs-Orme T, Reis J, Ward LD. Effectiveness of home visits by public health nurses in maternal and child health: an empirical review. *Public Health Rep.* 1985;100:490-499.

3. US Advisory Board on Child Abuse and Neglect. *Child Abuse and Neglect: Critical First Steps in Response to a National Emergency.* Washington, DC: US Government Printing Office; August 1990. No. 017-092-00104-5.

4. US Advisory Board on Child Abuse and Neglect. *Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect.* Washington, DC: US Government Printing Office; September 1991:141-146.

5. National Commission to Prevent Infant Mortality. *Home Visiting: Opening Doors for America's Pregnant Women and Children.* Washington, DC: 1989.

6. National Commission to Prevent Infant Mortality. *Death Before Life: The Tragedy of Infant Mortality.* Washington, DC: National Commission to Prevent Infant Mortality; 1988:21.

7. Expert Panel on the Content of Prenatal Care. *Caring for Our Future: The Content of Prenatal Care.* Washington, DC: Public Health Service; 1989:80-89.

8. Merkatz IR, Thompson JE, Mullen PD, Goldenberg RL, eds. *New Perspectives on Prenatal Care.* New York, NY: Elsevier Science Publishing Co Inc; 1990:593-602.

9. US General Accounting Office. *Home Visiting: A Promising Early Intervention Strategy for At-Risk Families.* Washington, DC: US Government Printing Office; 1990. HRD 90-83.

10. Olds DL, Kitzman H. Can home-visitation improve the health of women and children at environmental risk? *Pediatrics.* 1990;86:108-116.

11. Olds DL, Henderson CR, Tatelbaum R, Chamberlin R. Improving the delivery of prenatal care and outcomes of pregnancy: a randomized trial of nurse home visitation. *Pediatrics.* 1986;77:16-28.

12. Olds DL, Henderson CR, Chamberlin R, Tatelbaum R. Preventing child abuse and neglect: a randomized trial of nurse home visitation. *Pediatrics.* 1986;78:65-78.

13. Olds DL, Henderson CR, Tatelbaum R, Chamberlin R. Improving the life-course development of socially disadvantaged mothers: a randomized trial of nurse home visitation. *Am J Public Health.* 1988;78:1436-1445.

14. Olds DL. Improving formal services for mothers and children. In: Garbarino J, Stocking SH, eds. *Protecting Children from Abuse and Neglect: Developing and Maintaining Effective Support System for Families.* San Francisco, Calif: Jossey-Bass Publishers; 1980:173-197.

15. Olds DL. The prenatal/early infancy project: an ecological approach to prevention of developmental disabilities. In: Belsky J, ed. *In the Beginning: Readings on Infancy.* New York, NY: Columbia University Press; 1982:270-285.

16. Olds DL. The prenatal/early infancy project. In: Price RH, Cowen EL, Lorion RP, Ramos-McKay J, eds. *14 Ounces of Prevention: A Casebook for Practitioners.* Washington, DC: American Psychological Association; 1985:9-23.

17. Committee to Study the Prevention of Low Birthweight, Institute of Medicine. *Preventing Low Birthweight.* Washington, DC: National Academy Press; 1985:24-31.

18. National Center for Health Statistics. Annual summary of births, marriages, divorces, and deaths: United States, 1990. *Monthly Vital Statistics Reports.* Hyattsville, Md: Public Health Service; 1991;39:18-19.

19. McCormick MC, Shapiro S, Starfield B. High-risk young mothers: infant mortality and morbidity in four areas in the United States, 1973-78. *Am J Public Health.* 1984;74:18-23.

20. Hofferth SL, Moore KA. Early childbearing and later economic well-being. *Am Sociol Rev.* 1979;44:784-815.

21. Furstenberg FF Jr, Brooks-Gunn J. *Adolescent Mothers in Later Life.* New York, NY: Cambridge University Press; 1987:48-76.

22. Boyer R, Savageau D. *Places Rated Almanac.* New York, NY: Rand McNally; 1981:336-337.

23. New York State Department of Social Services. *Annual Report of Child Protective Services in New York State.* Albany, NY: New York State Department of Social Services; 1973-1982.

24. Miller H, Merritt A. *Fetal Growth in Humans.* St Louis, Mo: Mosby-Year Book; 1979.

25. Beckwith L, Cohen S, Kopp C, Parmelee A, Manci T. Caregiver-infant interaction and early cognitive development in preterm infants. *Child Develop.* 1976;47:579-587.

26. Olds DL, Henderson CR, Phelps C, Kitzman H, Hanks C. Impact of prenatal and infancy nurse home visitation on government spending. Presented at the 1990 Annual Meeting of the American Pediatric Society and Society for Pediatric Research; May 8, 1990; Anaheim, Calif.

27. Bergman E. Nursing shortage seen receding; staffing snags now worst in west. *Am J Nurs.* 1991;91:86.

28. Hardy JB, Streett R. Family support and parenting education in the home: an effective extension of clinic-based preventive health care services for poor children. *J Pediatr.* 1989;115:927-931.

29. Hon J. P. Kennedy. Healthy Beginnings Act of 1991. *Congressional Record.* March 6, 1991;1244:E782-E783.

WHAT IT TAKES FOR FAMILIES TO SUCCEED

The eight categories listed across the top of this table are risk factors--elements of life which can be measured to tell how well a family is functioning. Attention is focused on those families whose lives are described in the bottom tier of the chart. The concept of "risk factors" as a way of talking about the problems and barriers which stand in the way of children and families achieving success was developed by a team of Iowa state agency and community based organization representatives participating in the Iowa Policy Academy on Children and Families At Risk.

	SHELTER	NUTRITION	PHYSICAL & MENTAL HEALTH	ALCOHOL, DRUG USE	NEGLECT, ABUSE, VIOLENCE	EDUCATION	EMPLOYMENT	EARNED INCOME
Family is **THRIVING** All members are continually growing and contributing to the well-being of the family unit and their community.	○ Chosen to suit preferences ○ Modified to suit taste	○ Variety ○ High quality ○ Low sugar, sodium, fat	○ Primary and specialist providers available locally ○ Comprehensive insurance ○ Preventive practices ○ Wellness behaviors	○ High self-esteem ○ Absence of substance abuse, addiction; active recovery strategies ○ Ability to identify and meet one's emotional and psychological needs ○ Problem-solving initiative	○ Strong family identity ○ Active nurturing, guidance of members' growth ○ Network of friends social relationships	○ Active ongoing learning (formal, informal) ○ Ability to evaluate, synthesize new information easily, quickly ○ Capacity to set and pursue long range career and personal goals ○ Extensive social/cultural/civic awareness	○ Constant new skill development ○ Transferable skills ○ Steady career advancement	○ Sufficient to provide choices in all goods and services
Family is **SAFE** The family is secure and has the potential to move forward.	○ Not hazardous, unhealthy ○ Requires less than 30% of income ○ Options limited by income ○ Unable to modify, improve: ○ lack of income ○ rental property	○ Recommended Daily Allowances met ○ Dietary requirements for special conditions (e.g., diabetes, pregnancy, etc.) met	○ Primary providers within half hour drive from home ○ Specialists within region ○ Insurance, adequate income ○ Sound basic health practices, hygiene ○ Timely treatment	○ Limited self-esteem ○ Substance abuse cessation ○ Ability to cope with unmet emotional and psychological needs ○ Reactive approach to problems	○ Physical safety ○ Emotional support ○ Psychological security ○ Sense of family unit ○ Extended family network ○ Feel a part of the community	○ Age, appropriate basic skills; diploma/GED ○ Ability to solve every-day problems ○ Some social/ cultural/civic awareness ○ Ability to set, pursue short term career and personal goals	○ Long term employment ○ Job-retention skills ○ Market-relevant skills	○ Sufficient to meet basic family needs; choices limited
DANGER Family is at risk!!! Growth potential of family members is limited because their safety needs are not met.	○ Unsafe, unhealthy ○ Options severely limited by income ○ Unable to modify improve ○ Shared, temporary ○ Homeless	○ Recommended Daily Allowances not met ○ Malnutrition ○ Eating disorders ○ Disability ○ Death	○ Providers not available ○ Inadequate income ○ Inadequate health practices ○ Lack of treatment ○ Disability ○ Death	○ Active substance abuse, addiction ○ Physical, psychological pathology ○ Inability to control oneself or situations ○ Inability to confront, solve problems	○ Physical abuse/neglect ○ Emotional intimidation ○ Psychological insecurity ○ Isolation, hostility ○ Family fragmentation ○ Injury, disability	○ Learning not valued or supported; school dropout ○ Basic skills inadequate for age, job ○ Little social/cultural/civic awareness ○ Inability to set, pursue systematic career and personal goals	○ No work experience ○ Minimum/entry level job skills ○ Underemployment ○ Sporadic, unsuccessful employment ○ Chronic/long-term unemployment	○ Inadequate to meet basic family needs ○ Reliance on public assistance

State of Montana

Follow Me (FM) Sites and FM Public Health Data Sites

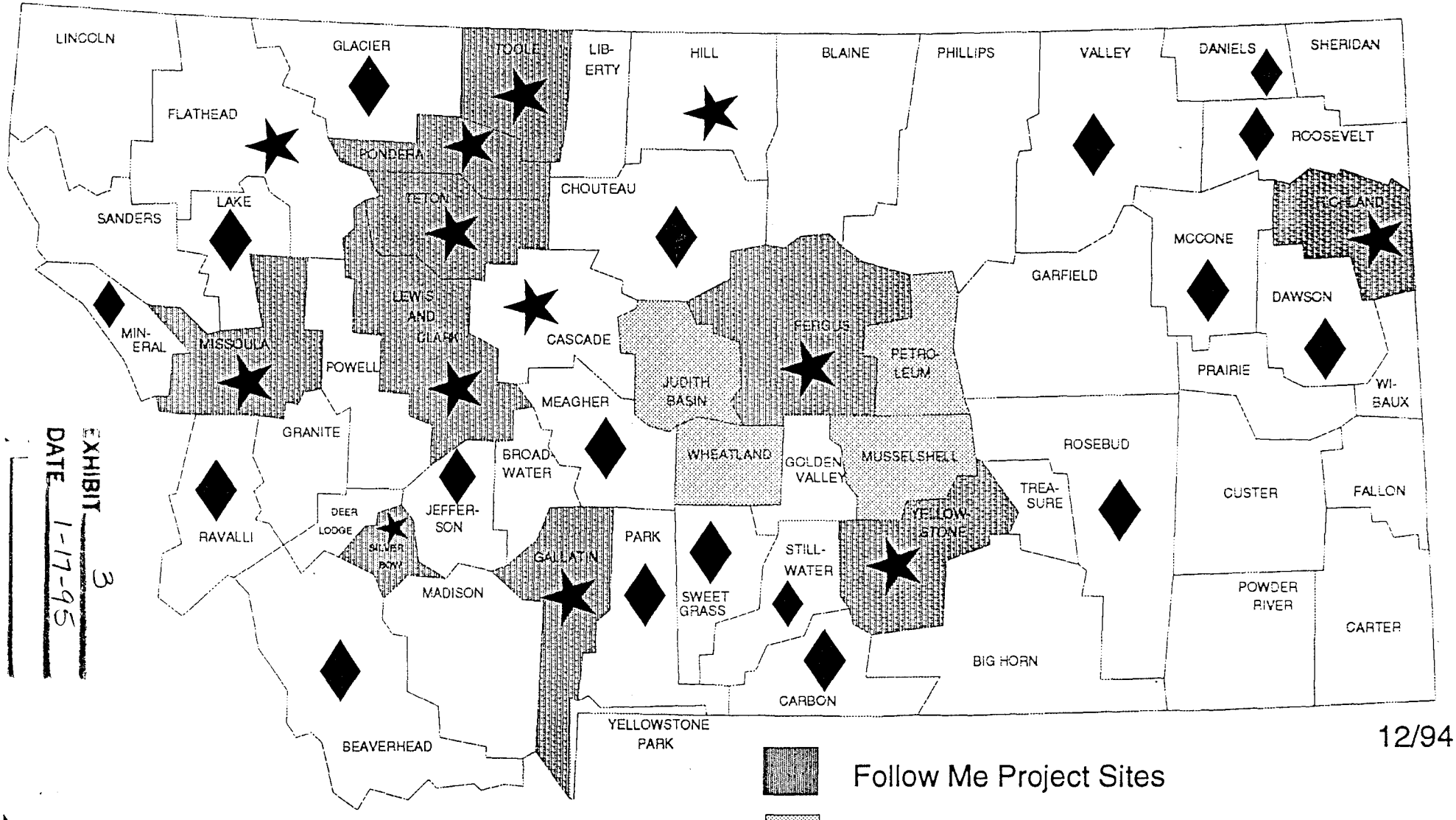

EXHIBIT 3
DATE 1-17-95

12/94

Follow Me Project Sites

Adjacent Counties Receiving FM Services

Current Data Users

Development Data User Sites (Target Date 6/95)

EXHIBIT 4
DATE 1-11-95
HB

OTHER in PHSB
Diff 94/96 by CV

	Rabies	Chronic	Communicable	Rape	BurAdm	Cty PH	EBSR99 Diff 94/96
2102 Consult		3,114	(21,969)		325		(18,530)
2106 Lab Testing			46,274		(100)		21,869
2165 Sec Serv			(21,806)				(21,806)
2169 Contracts			509,641	21,236	(8,762)	(40,184)	(33,588)
2170 Presc Ser			4,581				4,581
2190 Printing			20,501				20,501
2193 Photocopy			1,868				1,868
SubTotal							(25,105)
2208 Lab supp			8,834				8,834
2210 Minor Tools					(2,142)		(2,142)
2222 Drugs	(16,950)		1,055				1,185
2224 Pamphlets			1,362				1,362
2236 Supplies			9,253				9,253
2245 Data Process Supplies					(1,943)		(1,942)
SubTotal							16,550
2304 Postage	(24)		20,872				20,847
2385 Long Distance	0		3,567				3,564
SubTotal							24,411
2401 In Pers Car			1,099				1,100
2403 In Aircraft	(53)						(53)
2404 Motor Pool			698				698
2407 In Meals			881				881
2408 In Lodging			2,300				2,300
2410 In Ovr Meals			1,150				1,151
2412 Out Comm Tran			2,200				2,200
2418 Out Lodging			2,000				2,000
2430 Out Ovr Meals			800				861
SubTotal							11,138
2822 Freight	(53)						(53)
SubTotal							(53)
6205 Grants to Local				(16,759)			(16,759)
SubTotal							(16,759)
TOTAL							10,182

EXHIBIT 5
DATE 1-17-95
HB

50-49-101. Short title. This part may be cited as the "Montana Access to Food and Nutrition Act".

50-49-102. Purpose. It is the policy of the state of Montana that all citizens should have access to food programs and nutrition services to prevent any needy citizen from experiencing hunger and poor nutrition and their impact on physical and mental health.

50-49-103. Definitions. For purposes of this part, unless the context requires otherwise, the following definitions apply:

(1) "Council" means the state advisory council on food and nutrition established in 2-15-2210.

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

(3) "Food programs and nutrition services" means public or private programs to provide food and nutrition assistance to persons who have need. The term includes but is not limited to the food stamp program, food programs for the elderly, and supplemental food programs for women, infants, and children.

50-49-104. Terms -- vacancies. (1) Members of the council shall serve staggered terms of 3 years.

(2) A vacancy on the council must be filled in the same manner as the original appointment.

50-49-105. Powers and duties. The duties of the council are to:

(1) advise all state agencies on policies to coordinate the operation of public and private food assistance programs;

(2) annually report to the governor on the state of access to food and nutrition in Montana;

(3) provide a forum for review and discussion of state policies affecting hunger, food programs, and the status of nutrition for the population at risk;

(4) promote food assistance programs within the private and agricultural sectors of Montana's economy;

(5) recognize public and private acts and individuals who significantly contribute to the reduction of hunger in Montana; and

(6) educate the public as to problems and needs of hungry citizens.

50-49-106. Gifts and grants. The council may accept contributions, gifts, and grants to fund its activities.

50-49-107. Public health nutritionist -- appointment and duties. The director of the department shall appoint a registered dietitian as a public health nutritionist. The appointment of the public health nutritionist may not be required unless funding for the position is available. The public health nutritionist shall:

(1) establish a program of public education and technical assistance for programs that provide food assistance;

(2) provide staff assistance to the council;

(3) provide technical assistance to the governor's advisory council on aging; and

(4) provide technical assistance to health care and public health agencies.

50-49-108. Women, infants and children food supplement program to be available in all counties. The department shall provide the 1993 legislature with a plan to provide the services of the women, infants and children (WIC) food supplement program to counties that are currently not served by the program.

EXHIBIT 6
DATE 1-17-95
HB

Public Health Nutritionist: Response

1. **Since it is the department's mission to improve the public health of Montanans, show us how you are doing this and give us the data and results to show it.**

- the public health nutritionist is key to the coordination of nutrition education efforts in Montana
- formed the coalition, ***EAT RIGHT MONTANA***, to provide consistent, accurate nutrition information to all Montanans
- ***EAT RIGHT MONTANA*** partners represent a diverse cross section of Montana's population
- educational focus since May, 1992 has been the National Cancer Institute program ***5 A Day for Better Health*** - a large volume of materials have been developed and disseminated statewide - there have also been numerous media events to bring attention to the theme
- behavior change and the longer-term affect on chronic disease related to diet are difficult to measure
- 1994 - the first year that fruit and vegetable questions have been include in the Behavioral Risk Factor Surveillance System (BRFSS) - this will serve as a baseline with data from subsequent years allowing us to observe change
- key role for the public health nutritionist is to serve as staff person to the Montana State Advisory Council on Food and Nutrition
- the public health nutritionist uniquely situated to have knowledge of all the key players in food and nutrition issues across the states - this allows for matching of needs with resources

2. **Explain how this FTE is going to assure the access to adequate nutrition and ability to use food subsidy programs when necessary. Give us a list of all programs do this now or similar work.**

- 1991 legislature - **Montana Access to Food and Nutrition Act:** 50-49-101 to 50-49-108 MCA calls for the State Advisory Council on Food and Nutrition and public health nutritionist to ensure the policy of the state of Montana that says, "all citizens should have access to food programs and nutrition services to prevent any needy citizen experiencing hunger and poor nutrition and their impact on physical and mental health."
- the council provides an opportunity for representatives of state agencies with public food assistance programs to "sit at the same table" and discuss the issues - prior to the formation of the Council, this was not done - all programs functioned independently of each other and were not always aware of the rules and regulations of each others' programs - there is now a greater degree of collaboration and coordination
- each year, the Council prepares a report for the governor on the state of access to food and nutrition in Montana - the report includes significant recommendations for change - all legislators received a copy of the 1994 report
- there are currently no other "programs" attempting to do this - the Montana Hunger Coalition advocates for the issues, but does not have the legislative authority of the Council

3. **There is suppose to be a study at SRS showing how food subsidies may be affecting Native Americans. What is your comment on this report and what are you going to do about it?**

- looked at households participating in the Food Distribution Program on Indian Reservations (FDPIR) (copy of the report is available from Kathy Andersen)

- conducted by Dr. Paul Miller at the University of Montana
- showed 56 percent of households studied experienced hunger during the previous year by: a) running out of food; b) reducing the amount of food eaten by cutting the size of meals and/or skipping meals; or c) reducing the variety of nutritious foods
- the Food and Nutrition Council has supported this study since its start - a former Native American representative to the Council helped design the questionnaire
- the first public presentation of the results was during a forum in May, 1994 sponsored by the Council at Crow Agency - dietitians from all seven reservations were in attendance as were many representatives from Crow Agency
- a follow-up forum was sponsored by the Council in October, 1994 to discuss nutrition education as a component of the FDPIR - three or four reservations were represented at this meeting
- the Council continues to see this as a priority
- the Council, along with the Montana Hunger Coalition, is working with local communities, including reservations, to develop Community Nutrition Coalitions - the goal is to empower local groups to address food and nutrition problems at the local level

4. **If this FTE is not funded what is going to happen to most Montanans?**

- there will be a significant decrease in the extent of coordination among providers of nutrition education with a resulting decline in nutrition information being disseminated to the public
- there would be no staff person for the Food and Nutrition Council, making it very difficult for them to carry out their legislative mandate
- the long-term result of the above may include more diet-related chronic disease among Montanans and more inadequate nutrition as a result of the inavailability of sufficient, nutritious food for low-income Montanans

5. **This issue was not addressed by Representative Cobb, but could have significant implications for Montana - the legislature needs to be aware of it.**

- the Nutrition Block Grant as a component of the Personal Responsibility Act
- calls for all federal food and nutrition programs to be lumped together in a block grant - these include:

    - Food Stamp Program
    - Food Distribution Program on Indian Reservations (FDPIR)
    - School Breakfast Program
    - National School Lunch Program
    - Summer Food Service Program for Children
    - Child and Adult Care Food Program (CACFP)
    - Special Supplemental Food Program for Women, Infants and Children (WIC)
    - Elderly Nutrition Programs
    - Commodity Food Distribution
    - The Emergency Food Assistance Program (TEFAP)

- will result in significant cuts to all programs with some costs being shifted to the states
- will require an even greater degree of collaboration and coordination among food and nutrition programs - the Council will be key in affecting policy in the state if this federal legislation is passed

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging SUB-COMMITTEE DATE 1-17-95

~~BILL NO.~~ _____ ~~SPONSOR(S)~~ _____

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Marjorie Ferguson	DHES		
Karen Sloan 4 Cypress Drive Havre Mt	Mt Family Planning Council		
Audrey Hamm	DHES		
& Lizak			
Trish Hamm	DHES		
DENZEL C DAVIS	DHES.		
Judith Cleveland	DHES		
LISA CAIN	Montana Lead Program Butte-Silver Bow		
Karen Hoytomacy	Mt. Family Planning		

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

HR:1993
wp:vissbcom.man
CS-14