MONTANA ADMINISTRATIVE REGISTER

1998 ISSUE NO. 4
FEBRUARY 26, 1998
PAGES 515-598

MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 4

The Montana Administrative Register (MAR), a twice-monthly publication, has three sections. The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted. The rule section indicates that the proposed rule action is adopted and lists any changes made since the proposed stage. The interpretation section contains the attorney general's opinions and state declaratory rulings. Special notices and tables are found at the back of each register.

Inquiries regarding the rulemaking process, including material found in the Montana Administrative Register and the Administrative Rules of Montana, may be made by calling the Administrative Rules Bureau at (406) 444-2055.

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BEFORE THE BOARD OF ALTERNATIVE HEALTH CARE
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to out-of-state licensure	)))	NOTICE OF PROPOSED AMENDMENT OF 8.4.510 LICENSURE OF OUT-OF-STATE APPLICANTS

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On March 28, 1998, the Board of Alternative Health Care proposes to amend the above-stated rule.

2. The proposed amendment will read as follows: (new matter underlined, deleted matter interlined)

"8.4.510 LICENSURE OF OUT-OF-STATE APPLICANTS

(1) through (1)(c) will remain the same.

(d) Candidates who were licensed without sitting for the NARM examination shall supply proof of successful completion of a qualifications examination (acceptable to the board) administered by the licensing authority of the state or jurisdiction granting the license.

(d) and (e) will remain the same, but will be renumbered (e) and (f)."

Auth: Sec. 37-27-105, MCA; IMP, Sec. 37-1-304, MCA

REASON: The proposed amendment will allow candidates who were licensed under a qualifications examination other than NARM to be considered for licensure in Montana. The Board is aware that several other states have been licensing direct-entry midwives for a number of years, before the wide-spread availability of the NARM examination. The Board would like to be able to evaluate those other examinations for equivalency to the NARM examination to allow greater access to licensure in Montana.

3. Interested persons may submit their data, views or arguments concerning the proposed amendments in writing to the Board of Alternative Health Care, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., March 26, 1998.

4. If a person who is directly affected by the proposed amendments wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Alternative Health Care, 111 N. Jackson, P.O. Box 200513, Helena, Montana 59620-0513, or by facsimile to (406) 444-1667, to be received no later than 5:00 p.m., March 26, 1998.

5. If the Board receives requests for a public hearing on the proposed amendments from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 6 based on the 56 licensees in Montana.

6. Persons who wish to be informed of all Board of Alternative Health Care administrative rulemaking proceedings, or other administrative proceedings, may be placed on a list of interested persons by advising the Board, in writing, at 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513 or by phone at (406) 444-5436.

BOARD OF ALTERNATIVE HEALTH CARE
MICHAEL BERGKAMP, ND, CHAIRMAN

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 17, 1998.

BEFORE THE WEIGHTS AND MEASURES BUREAU
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment and adoption of rules pertaining to the Voluntary Registration of Serviceperson and Service Agencies and the Uniform Regulation for National Type Evaluation	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT AND ADOPTION OF RULES PERTAINING TO THE VOLUNTARY REGISTRATION OF SERVICEPERSON AND SERVICE AGENCIES AND THE UNIFORM REGULATION OF NATIONAL TYPE EVALUATION

TO: All Interested Persons:

1. On April 7, 1998, at 9:00 a.m., a public hearing will be held in the Downstairs Conference Room at the Department of Commerce, Weights and Measures Bureau, 1424 Ninth Avenue, Helena, Montana, to consider the proposed amendment and adoption of rules pertaining to the Voluntary Registration of Servicemen and Service Agencies and the Uniform Regulation for National Type Evaluation.

2. The proposed amendment to ARM 8.77.101, 8.77.102, 8.77.103, 8.77.104 and 8.77.201 will read as follows: (new matter interlined, deleted matter interlined)

"8.77.101 SCALE PIT CLEARANCE (1) On and after December 20, 1972, no new installations or replacements of vehicle or livestock scales shall be placed in a pit, where the clearance from the floor of the pit to the bottom of the i-beams is less than ~~forty-two (42)~~ inches.

(2) will remain the same.

(3) Electronic scales which do not require a pit for their installation, operation~~,~~ or maintenance shall be installed in strict compliance with the manufacturer's specification for each specific model and with the ~~U.S. Bureau of Standards~~ National Institute of Standards and Technology (NIST) Handbook 44.

(4) Scale pits must have concrete walls surrounding the entire pit, substantial in both durability and strength to prevent soil, snow and other materials from entering the pit area and preventing the scale from operating properly. The requirements of this ~~section~~ rule will apply only to those scales installed after its adoption."

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

REASON: The purpose for these changes to this rule is to correct punctuation and grammatical errors. The reason for taking out the "U.S. Bureau of Standards" is to reflect the correct name of the document. The "Bureau of Standards" name was changed to the "National Institute of Standards and Technology" in 1972. Since that time the correct name of the document has been NIST Handbook 44.

"8.77.102 FEES FOR TESTING AND CERTIFICATION

(1) Special inspection fees will be as follows:

(a) will remain the same.

(b) all other units $1.25 a mile; and

(c) will remain the same.

(2) Where fees are not paid within ~~thirty (30)~~ days after the special inspection, the equipment will be sealed and removed from service by the ~~inspector~~ bureau chief of weights and measures~~,~~ or his deputies, until such fees have been paid. The weights and measures bureau will coordinate the special inspections, whenever possible, with other inspection activities in an effort to keep charges as reasonable as possible."

Auth: Sec. 30-12-202, 37-1-134, MCA; IMP, Sec. 30-12-202, 30-12-203, MCA

REASON: The purpose for these changes to this rule is to correct punctuation and grammatical errors. The change from "inspector" to "Bureau Chief" reflects the correct terminology that should have been used in the original rule.

"8.77.103 ~~FOURTH EDITION~~ NIST HANDBOOK 44 - SPECIFICATION, TOLERANCE~~,~~ AND USER REQUIREMENT FOR WEIGHING DEVICES

(1) The bureau of weights and measures with the advice and counsel of ~~the national bureau of standards~~ NIST hereby adopts the specifications, tolerances and regulations for commercial weighing and measuring devices published in ~~National Bureau of Standards~~ NIST Handbook 44 - ~~Fourth Edition, 1971 and supplements thereto, or in any publication revising or superseding Handbook 44~~ 1998 Edition, as the specifications, tolerances~~,~~ and regulations for commercial weighing and measuring devices for the state of Montana~~, except as follows:~~

~~(2) Wheel load weighers.~~

~~(a) Tolerances. Section T.3.7., Handbook 44, Basic Tolerance Values for Wheel Load Weighers, does not apply in Montana. The basic maintenance tolerance for individual wheel load weighers used in this state shall be the same as the prescribed in Handbook 44 for axle load weighers.~~

~~(b) User Requirements. Section UR. 3.5.2., Handbook 44, Level Condition, does not apply in Montana. In this state, when either an axle load or a gross load determination is being made, utilizing wheel load weighers, the vehicle being weighed shall be in a reasonably level position with all wheels on the same plane as the load receiving element of the weighing device used in making the determination.~~

~~(3) Retail motor fuel dispensers.~~

~~(a) In the case of retail motor fuel dispensers currently pricing motor fuels on a half gallon method or some fraction of a gallon, such dispensers may be kept in service for retail sales if the total fuel sales of the retail station involved are less than 10,000 gallons per month or 120,000 gallons per year whichever is greater.~~

~~(b) In the case where the retail station involved qualifies in subsection (a) above, when any dispenser is~~

~~replaced due to wear or other reasons, all of the fuel dispensers at the retail outlet must be replaced with retail fuel dispensers that compute the total dollar amount per unit measure of fuel dispensed in unit amounts such as gallons, or in the case where metric measures are used, in liters.~~"

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

REASON: The purpose for these changes in this rule is to correct the grammatical errors. The reasons for the deletion of the text is that the rules addressed in (2) and (3) are outmoded and arachic. These issues have either been addressed in the current edition of Handbook 44 (2) or have over the years been rendered obsolete (3).

"8.77.104 VOLUNTARY REGISTRATION AND FEES OF SERVICEMEN PERSONS AND SERVICE AGENCIES (1) and (1)(a) will remain the same.

(b) an agency that provides acceptable evidence that ~~he or~~ it is:

(i) fully qualified by training or experience to install, service, repair~~,~~ or recondition a commercial weighing or measuring device;

(ii) has a thorough working knowledge of all appropriate weights and measure laws, orders, rules~~,~~ and regulations; and

(iii) has possession of~~,~~ or available for use~~,~~ and will use, calibrated weights and measures standards and testing equipment appropriate in design and adequate in amount.

(c) ~~(~~An employee of government shall not be eligible for registration.~~)~~;

(d) the bureau shall check the qualifications of each applicant. It will be necessary for an applicant to have available sufficient standards and equipment;

(e) the bureau shall issue a "certificate of registration" to approved qualified applicants. The certificate of registration authorizes weights and measures officials to remove rejection seals and tags previously placed on commercial and law enforcement weighing or measuring devices, and, in addition, are authorized to place in service repaired or newly installed devices;

(f) the bureau is not guaranteeing the work or fair dealing of a registered serviceperson or service agency. The bureau will, however, remove from the registration list any registered serviceperson or service agency that performs unsatisfactory work or takes unfair advantage of a device owner;

(g) registration with the bureau shall be on a voluntary basis. The bureau shall reserve the right to limit or reject the application of any serviceperson or service agency and to revoke his, her or its permit to remove rejection seals or tags for good cause; and

~~(c)~~(h) this ~~policy~~ rule shall in no way preclude or limit the right and privilege of any ~~qualified~~ individual or agency not registered with the bureau to install, service, repair~~,~~ or recondition a commercial weighing or measuring device. However, only a registered repair person or agency shall be

able to remove an official rejection tag or mark. Additionally, only a registered repair person or agency shall be able to place a new or used weighing or measuring device into commercial service.

~~(2) Definitions.~~

~~(a) The term "registered serviceman" means any individual who for hire, award, commission, or any other payment of any kind, installs, services, repairs, or reconditions a commercial weighing or measuring device, and who voluntarily registers himself as such with the bureau of weights and measures.~~

~~(b) "Registered service agency" means any agency, firm, company, or corporation which, for hire, award, commission, or any other payment of any kind, installs, services, repairs, or reconditions a commercial weighing or measuring device, and which voluntarily registers itself as such with the bureau of weights and measures. Under agency registration, identification of individual servicemen shall not be required.~~

~~(c) The term "commercial weighing and measuring device" includes any weight or measure of weighing or measuring device commercially used or employed in establishing the size, quantity, extent, area, or measurement of quantities, things, produce, or articles for distribution or consumption, purchased, offered, or submitted for sale, hire, or award, or in computing any basic charge or payment for services rendered on the basis of weight or measure, and shall also include any accessory attached to or used in connection with a commercial weighing or measuring device when such accessory is so designed or installed that its operation affects, or may affect, the accuracy of the device.~~

~~(3)~~(2) The bureau may enter into an informal reciprocal agreement with any other state(s) ~~or states~~ that ~~has or~~ have similar voluntary registration policies. Under such agreement, the registered service~~men~~person and the registered service agencies of the states party to the reciprocal agreement are granted full reciprocal authority, including reciprocal recognition of standards and testing equipment, in all states party to such agreement.

~~(4)~~(3) There will be an annual fee of $5~~.00~~ per registered service~~man~~person and $10~~.00~~ per registered service agency to cover costs ~~of administering the plan. Said fee shall be paid to the bureau~~ at the time application for registration is made, and annually, thereafter ~~during the month of January~~, to be paid to the bureau ~~thereafter~~.

~~(5)~~(4) An individual or agency qualified by training or experience may apply for voluntary registration to service weighing devices or measuring devices on an application form supplied by the bureau. Said form, duly signed and witnessed, shall include certification by the applicant that the individual or agency:

(a) is fully qualified to install, service, repair~~,~~ or recondition whatever devices for the service of which competence is being registered;

(b) has in possession~~,~~ or available for use, and will use, all necessary testing equipment and standards; and

(c) has full knowledge of all appropriate weights and measures laws~~,~~ orders, rules and regulations. ~~An applicant also shall submit appropriate evidence or reference as to qualifications.~~

(5) Each applicant shall complete and pass a written test to determine the applicant's knowledge of the appropriate weights and measures laws, orders, rules and regulations prior to the issuance of the initial certificate of registration. Subsequent testing may be necessary due to changes in weights and measures laws and rules and shall be given when deemed necessary by the bureau. An applicant also shall submit appropriate evidence or reference as to qualifications. Application for registration shall be voluntary, but the bureau is authorized to reject or limit any application.

(6) Applicants must have available sufficient standards and equipment to adequately test devices as set forth in the notes section of each applicable code in NIST Handbook 44, "Specifications, Tolerances, and Other Technical Requirements for Weighing and Measuring Devices." When applicable, this equipment will meet the specifications of:

(a) National Institute of Standards and Technology Handbook 105-1, "Specifications and Tolerances for Reference Standards and Field Standard Weights and Measures, Specifications and Tolerances for Field Standard Weights (NIST Class F)";

(b) National Institute of Standards and Technology Handbook 105-2, "Specifications and Tolerances for Reference Standards and Field Standard Weights and Measures, Specifications and Tolerances for Field Standard Measuring Flask"; or

(c) National Institute of Standards and Technology Handbook 105-3, "Specifications and Tolerances for Reference Standards and Field Standard Weights and Measures, Specifications and Tolerances for Graduated Neck Type Volumetric Field Standards."

~~(6)~~(7) The bureau will review and check the qualifications of each applicant. ~~Upon receipt and acceptance of a properly executed application form,~~ ~~t~~The bureau shall issue to the applicant a "certificate of registration", including an assigned registration number~~, which shall remain effective until December 31 each year unless revoked under subsection (10) below~~, if it is determined that the applicant is qualified. The "certificate of registration" will expire one year from the date of issuance.

~~(7)~~(8) A bearer of a "certificate of registration" shall:

(a) have the authority to remove an official rejection tag or mark placed on a weighing or measuring device by the authority of the bureau;

(b) place in service, until such time as an official examination can be made, a weighing or measuring device that has been officially rejected; and

(c) place in service, until such time as an official examination can be made, a new or used weighing or measuring device. The registered serviceperson or service agency is

responsible for installing, repairing and adjusting devices such that the devices are adjusted as closely as practicable to zero error.

~~(8)~~(9) The bureau shall furnish each registered service~~man~~person and registered service agency with a supply of report forms to be known as "placed in service reports." Such a form~~s~~ shall be executed in triplicate, ~~shall~~ include the assigned registration number~~,~~ and ~~shall~~ be signed by a registered service~~man~~person or ~~by a~~ service~~man~~person representing a registered agency for each rejected device ~~placed in~~ restored to service, and for each newly installed device placed in service. Within 24 hours after a device is restored to service, or placed in service, the original of the properly executed placed in service report, together with any official rejection tag removed from the device, shall be mailed to the bureau at ~~1520 East 6th Avenue, Room 50,~~ Department of Commerce, Weights and Measures Bureau, 1424 9th Avenue, P.O. Box 200512, Helena, Montana 59620-0512. The duplicate copy of the report shall be ~~left with the device~~ handed to the owner or operator of the device, and the triplicate copy of the report shall be retained by the registered service~~man~~person or agency.

~~(9)~~(10) A registered service~~man~~person and a registered service agency shall submit, at least biennially, to the bureau~~,~~ for examination and certification, any standards and testing equipment that are used, or are to be used, in the performance of the service and testing functions with respect to weighing and measuring devices for which competence is registered. A registered service~~man~~person or agency shall not use, in servicing commercial weighing or measuring devices, any standards or testing equipment that have not been certified by the bureau. Equipment calibrated by another state weights and measures laboratory that can show traceability to the national institute of standards and technology will also be recognized as equipment suitable for use by registered servicepersons or service agencies in this state.

~~(10)~~(11) The bureau ~~may,~~ is authorized to suspend or revoke a "certificate of registration" for good cause~~, after careful investigation and consideration, suspend or revoke a certificate of registration~~ which shall include, but not be limited to:

(a) taking unfair advantage of an owner of a device;

(b) failure to have test equipment or standards certified;

(c) failure to use adequate testing equipment; and

(d) failure to adjust commercial or law-enforcement devices to comply with NIST Handbook 44 subsequent to service or repair.

~~(11)~~(12) The bureau shall publish, from time to time as it deem~~ed~~s appropriate, and may supply upon request, lists of registered service~~men~~persons and registered service agencies."

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

REASON: The current rule is somewhat vague as it relates to how much authority an individual who is not a registered

serviceperson has in regard to placing in service and removing rejection tags. By adding additional language in (1), the rule should clarify both the verbiage and the intent of this rule. The addition of the authority of the Bureau to require the completion of a written test is to provide a necessary tool to be used in the screening of applicants. Presently anyone can apply for and receive a license regardless of qualifications or adequate standards. By implementing a testing procedure we will at least be able to insure that the applicant is cognizant of the basic rules and regulations concerned with Weights and Measures.

"8.77.201 NIST HANDBOOK 130 - UNIFORM LAWS AND REGULATIONS (1) The bureau of weights and measures with the advice and counsel of the national institute of standards and technology hereby adopts the regulations to provide accurate and adequate information on packages as to the identity and quantity of contents so that purchasers can make price and quantity comparison. The regulations are published in the National Institute of Standards and Technology Handbook 130, Part IV, A. Uniform Packaging and Labeling Regulation, B. Uniform Regulation for the Method of Sale of Commodities, C. Uniform Unit Pricing Regulation, 1998 Edition. A copy of NIST Handbook 130 can be obtained from the United States Department of Commerce, National Institute of Standards and Technology, National Conference of Weights and Measures, Gaithersburg, Maryland 20899-0001.

(2) will remain the same."

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

REASON: The bureau is updating the new edition to 1998 and deleting the 1995 Edition.

3. The proposed new rules will read as follows:

"I DEFINITIONS As used in 8.77.104 and this rule, the following words and phrases will be construed to have the following meanings:

(1) "Registered serviceperson" shall be construed to mean any individual who for hire, award, commission or any other payment of any kind installs, services, repairs or reconditions a commercial weighing or measuring device, and who voluntarily applies for registration with the bureau of weights and measures.

(2) "Registered service agency" shall be construed to mean any agency, firm, company or corporation that for hire, award, commission or any other payment of any kind installs, services, repairs or reconditions a commercial weighing or measuring device, and that voluntarily registers itself as such with the bureau of weights and measures. Under agency registration, identification of individual servicepersons shall be required.

(3) "Commercial weighing and measuring device" shall be construed to include any weight or measure or weighing or

measuring devices commercially used or employed in establishing the size, quantity, extent, area or measurement of quantities, things, produce or articles for distribution or consumption, purchased, offered or submitted for sale, hire or award, or in computing any basic charge of payment for services rendered on the basis of weight or measure. It shall also include any accessory attached to or used in connection with a commercial weighing or measuring device when such accessory is so designed or installed that its operation affects, or may affect, the accuracy of the device."

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

REASON: The bureau is deleting the definitions from 8.77.104 and adopting a new definition rule to provide clarity.

"II UNIFORM REGULATION FOR NATIONAL TYPE EVALUATION

(1) The weights and measures bureau of the department of commerce adopts and incorporates by reference herein the Uniform Regulation for National Type Evaluation, as found in the NIST Handbook 130. A copy of NIST Handbook 130 can be obtained from the United States Department of Commerce, National Institute of Standards and Technology, National Conference of Weights and Measures, Gaithersburg, Maryland 20899-0001. Uniform Laws and Regulations 1998 Edition has been published in the National Conference on Weights and Measures, Publication 14 on page 127, "National Type Evaluation Program, Administrative Procedures, Technical Policy, Checklists, and Test Procedures" and is adopted in its entirety with the following exceptions:

(a) Section 2.3 means the bureau chief of the bureau of weights and measures and not the director of the bureau of weights and measures;

(b) Section 4, subsections 3 through 7, insert in all blank spaces the date of January 1, 1999; and

(c) Section 8, insert in the blank space January 1, 1999, for the effective date for this regulation."

Auth: Sec. 30-12-201, MCA; IMP, Sec. 30-12-202, MCA

REASON: The addition of the National Type Evaluation Program (NTEP) to Montana's Weights and Measure's laws, by implementing this rule Montana would join the majority of the other states in requiring that all weighing and measuring devices sold in Montana meet a nationally recognized performance standard. This rule would benefit consumers in Montana by requiring that weighing and measuring equipment offered for sale has been exposed to a rigorous testing and evaluation procedure. Additionally, this rule adoption will also benefit the weighing and measuring manufacturers by allowing them to produce products that will be technically accepted in all NTEP jurisdictions rather than having to produce a separate design for individual jurisdictions.

4. Interested person may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the

Weights and Measures Bureau, of the Department of Commerce, 1424 9th Avenue, P.O. Box 200512, Helena, Montana 59620, no later than 5:00 p.m., April 7, 1998.

5. The Bureau will make reasonable accommodations for persons with disabilities who wish to participate in the public hearing. If you wish to request an accommodation, contact the Department no later than 5:00 p.m., March 31, 1998, to advise us of the nature of the accommodation that you need. Please contact Jack Kane, Weights and Measures Bureau, Department of Commerce, 1424 9th Avenue, P.O. Box 200512, Helena, Montana 59620; telephone (406) 444-3164; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-4305. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Jack Kane at the above-stated address.

6. Persons who wish to be informed of all Weights and Measures administrative rulemaking hearings or other administrative hearings may be placed on a list of interested persons by advising the Bureau at the rulemaking hearing or in writing to the Weights and Measures Bureau, Department of Commerce, 1424 9th Avenue, P.O. Box 200512, Helena, Montana 59620.

7. Jack Kane, Bureau Chief, will preside over and conduct the hearing.

WEIGHTS AND MEASURES BUREAU
JACK KANE, BUREAU CHIEF

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 17, 1998.

BEFORE THE TRAVEL PROMOTION AND DEVELOPMENT DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of a rule pertaining to the Tourism Advisory Council	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF A RULE PERTAINING TO THE TOURISM ADVISORY COUNCIL

TO: All Interested Persons:

1. On March 30, 1998, at 1:00 p.m., a public hearing will be held in the Upstairs Conference Room at the Department of Commerce, 1424 Ninth Avenue, Helena, Montana, to consider the proposed amendment of a rule pertaining to the Tourism Advisory Council.

2. The proposed amendment to ARM 8.119.101 will read as follows: (new matter underlined, deleted matter interlined)

"8.119.101 TOURISM ADVISORY COUNCIL (1) will remain the same.

(2) The tourism advisory council hereby incorporates by reference the guide entitled "Regulations and Procedures for Regional/CVB Tourism Organizations, February 1997~~8~~," setting forth the regulations and procedures pertaining to the distribution of accommodation tax revenue. The guide is available for public inspection during normal business hours at the Montana ~~Tourism Development~~ Travel Promotion and ~~Promotion~~ Development Division, Department of Commerce, 1424 Ninth Avenue, Helena, Montana 59620. Copies of the guide are available on request.

(3) Distribution of funds to regional nonprofit tourism corporations and to nonprofit convention and visitors bureaus is contingent upon compliance with the "Regulations and Procedures for Regional/CVB Tourism Organizations, February 1997~~8~~."

Auth: Sec. 2-15-1816, MCA; IMP, Sec. 2-15-1816, MCA

REASON: The reason the Regulations and Procedures for Regional/CVB Tourism Organizations were changed was that several items were changed to clarify their meaning. Additionally, several new sections on internet page/site development were added. The internet had not been previously addressed within these regulations. The amendment also corrects the division name.

3. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Travel Promotion and Development Division, Department of Commerce, 1424 Ninth Avenue, Helena, Montana 59620, no later than 5:00 p.m., March 30, 1998.

4. The Division will make reasonable accommodations for persons with disabilities who wish to participate in the public hearing. If you wish to request an accommodation, contact the Department no later 5:00 p.m., March 23, 1998, to advise us of the nature of the accommodation that you need. Please contact Anna Marie Moe, Travel Promotion and Development Division, Department of Commerce, 1424 Ninth Avenue, Helena, Montana 59620; telephone (406) 444-2669; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 444-1800. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Anna Marie Moe at the above-stated address.

5. Persons who wish to be informed of all Travel Promotion and Development Division administrative rulemaking hearings or other administrative hearings may be placed on a list of interested persons by advising the Division at the rulemaking hearing or in writing to the Travel Promotion and Development Division, Department of Commerce, 1424 Ninth Avenue, Helena, Montana 59620.

6. Greg Overturf, Legal Counsel, will preside over and conduct the hearing.

TRAVEL PROMOTION AND DEVELOPMENT DIVISION

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 17, 1998.

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

In the matter of the amendment of Rule 6.6.4001 pertaining to the valuation of securities other than those specifically referred to in statutes.	))))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On January 15, 1998, the state auditor and commissioner of insurance of the state of Montana published notice of proposed amendment of Rule 6.6.4001 pertaining to the valuation of securities other than those specifically referred to in statutes. The notice was published at page 47 of the 1998 Montana Administrative Register, issue number 1.

2. The agency has amended Rule 6.6.4001 exactly as proposed.

3. No comments or testimony were received.

MARK O'KEEFE
STATE AUDITOR AND
COMMISSIONER OF INSURANCE

By: _____
David L. Hunter
Deputy State Auditor

By: _____
Russell B. Hill
Rules Reviewer

Certified to the Secretary of State on this 17th day of February, 1998.

BEFORE THE BOARD OF ALTERNATIVE HEALTH CARE
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to continuing education requirements, licensing by examination, midwives continuing education requirements, and the adoption of a new rule pertaining to the natural substances formulary list	NOTICE OF AMENDMENT OF 8.4.405 NATUROPATHIC PHYSICIAN CONTINUING EDUCATION REQUIREMENTS, 8.4.501 LICENSING BY EXAMINATION AND 8.4.508 MIDWIVES CONTINUING EDUCATION REQUIREMENTS AND THE ADOPTION OF NEW RULE I (8.4.406) NATUROPATHIC PHYSICIAN NATURAL SUBSTANCE FORMULARY LIST

TO: All Interested Persons:

1. On December 1, 1997, the Board of Alternative Health Care published a notice of public hearing to consider the proposed amendment and adoption of the above-stated rules at page 2134, 1997 Montana Administrative Register, issue number 23. The hearing was held on January 8, 1998 in Helena, Montana.

2. The Board has amended ARM 8.4.405, 8.4.501 and 8.4.508 exactly as proposed. The Board has adopted new rule I (8.4.406) as proposed, but with the following changes:

"8.4.406 NATUROPATHIC PHYSICIAN NATURAL SUBSTANCE FORMULARY LIST (1) through (3)(a) will remain the same as proposed.

(b) ~~cephalosporins,~~ cephalexan, cefaclor -- ~~all~~ derived from penicillium species;

(c) through (e) will remain the same as proposed.

(4) through (5)(e) will remain the same as proposed.

~~(f) digitalis glycosides;~~

(g) through (w) will remain the same as proposed, but will be renumbered (f) through (v).

(6) through (10)(d)(iii) will remain the same as proposed.

~~(e) insulin preparations;~~

(f) through (h) will remain the same as proposed, but will be renumbered (e) through (g).

(11) through (15) will remain the same as proposed.

~~(a) laminaria;~~

(b) and (c) will remain the same as proposed, but will be renumbered (a) and (b).

~~(d) prostaglandin E2;~~

(e) and (f) will remain the same as proposed, but will be renumbered (c) and (d).

(16) through (17) will remain the same as proposed."

3. The Board has thoroughly considered all comments and testimony received. Those comments, and the Board's responses thereto, are as follows:

NEW RULE I

COMMENT NO. 1: One comment was received stating naturopaths should not ethically be allowed to prescribe pharmaceuticals until they are able to demonstrate that their education and training meet the same standards required for licensure of MDs and DOs.

RESPONSE: The Board noted it was the Montana Legislature who granted authority to naturopathic physicians to be licensed, and to prescribe natural substances on a formulary list. Naturopathic physicians do receive significant training in use of the pharmaceuticals on the formulary, which is sufficient to meet the commentor's demand. The formulary will make the parameters of naturopathic physician prescribing authority much clearer for all licensees, and the public as well. Naturopathic physician education does include both pharmacology and pharmacognecy. The Board further noted that many other groups, besides MDs and ODs, have been granted prescriptive authority by the Legislature, including nurse practitioners, dentists, optometrists, podiatrists and veterinarians, and their education is apparently considered sufficient by the Legislature also. Finally, the Board pointed out that the formulary committee which recommended the list to the Board was composed of one licensed pharmacist, two licensed naturopathic physicians, one medical doctor, and one public member, all as required by 37-26-301, MCA.

COMMENT NO. 2: Seven comments were received in support of the proposed New Rule I establishing the formulary list.

RESPONSE: The Board acknowledged receipt of the comments in support.

COMMENT NO. 3: One comment was received stating the commentor was a licensed naturopathic physician in Oregon, and had held a federal DEA number for many years. In his experience under the Oregon formulary, there were no difficulties with others in the healing arts, since the naturopathic physicians are not a threat to MDs, and do not want to be MDs, despite having some prescriptive authority. The comment stated that allowing naturopathic physicians to write the appropriate prescription at the right time is good for the people of Montana. Finally, use of the formulary will bring the standards of Montana up to the current national standards with the rest of the U.S.

RESPONSE: The Board acknowledged receipt of this comment in support. The Board further noted that learning of the commentor's experiences in using the Oregon formulary was helpful, and provided valuable information to the Board.

COMMENT NO. 4: One comment was received stating very serious concerns regarding granting the privileges of legend drug prescriptive authority to naturopathic physicians in the state of Montana. The comment stated that even in view of the intensive and extensive training that a medical doctor has to

undergo before they are licensed to practice medicine, major medical problems continue to be encountered with the prescribing of legend drugs in the U.S. The comment noted the recent emergence of germs that are resistant to all known antibiotics, which may be attributed to the inappropriate prescribing practices of licensed, trained physicians. Finally, the comment concluded that if these problems can occur when legend drug prescribing authority is limited and placed in the hands of well-trained individuals, serious concerns arise over allowing legend drug prescriptive authority to lesser-trained individuals.

RESPONSE: See response to Comment No. 1, above. Also, the Board noted the information presented in the comment was not accurate on statistics regarding the states which license naturopathic physicians, and allow prescriptive authority to naturopathic physicians through the use of a formulary. Most of these states allow naturopathic physicians to prescribe legend drugs. Additionally, all the legend drugs included in Montana's proposed formulary are, in fact, covered in a naturopathic physician's education. The proposed formulary did limit the drugs to those for which a naturopathic physician is trained, as mandated by the Legislature in granting the formulary authority in 37-26-301, MCA. Finally, the Board is in place to discipline or revoke naturopathic physician licenses for abuse of the prescriptive authority. The Board is also in place to review the formulary each year and amend the list to delete inappropriate drugs or abused drugs.

COMMENT NO. 5: One comment was received stating the proposed formulary list contains many substances that have a great potential for harm if misused. Examples include: antibiotics and anti-fungals that have a potential to cause serious allergic reactions; psychoactive agents that have a potential for severe reactions including seizures and delirium; narcotic analgesic medications that have a potential for harm and abuse; vasoactive agents that may be harmful for patients with hypertension and heart disease; and hormones that are potentially dangerous and pose a significant threat to public health if misused.

RESPONSE: See response to Comment No. 1 and Comment No. 4 above.

COMMENT NO. 6: One comment was received stating digitalis should not be included on the formulary, as it is a cardiac glycoside, and requires very careful monitoring. It is an extremely dangerous drug if not prescribed appropriately, and can result in untold harm or even death.

RESPONSE: The Board agreed with the comment, and will amend the rule to delete digitalis from the formulary as shown above. The Board agreed with the expressed concern that it is not being used botanically. The Board noted digitalis is not usually used as a botanical extract. Therefore, it is inappropriately on the formulary list.

COMMENT NO. 7: One comment was received stating insulin preparations should not be included on the formulary, as insulin is used to manage patients with insulin dependent diabetes mellitus. Progression of diabetes mellitus can be slowed with very careful monitoring, however, this takes extensive testing by trained professionals that specialize in this subspecialty of medicine.

RESPONSE: The Board agreed with the comment and will amend the rule to remove insulin preparations from the formulary, as shown above. The Board noted that it was not clear whether naturopathic physician training covers the initial diagnosis and prescribing of insulin, as opposed to the management of diabetes. Since the Board is following the Legislative mandate to only list those drugs which are within the scope of substances covered by approved naturopathic college curricula or continuing education, it will delete this drug from the list. Finally, the Board noted that insulin remains a non-legend drug which does not require a prescription.

COMMENT NO. 8: One comment was received stating childbirth preparations such as laminaria, pitocin by IM injection and prostaglandin should not be included on the formulary list. Laminaria is used for the induction of labor, that requires a trained obstetrician. Pitocin by IM injection has been announced as an inappropriate means to administer that medicine. Finally, prostaglandin E2 alpha is primarily used to induce abortion, and should therefore be handled by individuals trained in obstetrics and gynecology.

RESPONSE: The Board noted it has a childbirth specialty license available for those naturopathic physicians who wish to perform childbirth and delivery. Only those licensees with this training would appropriately use the childbirth preparations. However, lamanaria and prostaglandin E2 will be deleted from the proposed formulary list, as the Board recognizes their somewhat inappropriate inclusion. Pitocin is definitely within the scope of practice of childbirth specialty trained naturopathic physicians, as covered by statute.

COMMENT NO. 9: One comment was received stating the actual bill passed by the 1997 Montana Legislature rejected an attempt to allow naturopathic physicians to prescribe legend drugs, but instead kept statutory language which prohibited naturopathic physicians from prescribing legend drugs. The Legislative bill did contain authority to create a natural substance formulary list, but this was limited by the language which lists topical drugs and nonprescription drugs. The Legislature intended to allow a "natural substances" formulary list only.

RESPONSE: The Board noted it had brought the bill to the Legislature to create a formulary which included legend drugs. The Legislature's intent, as put in the bill, includes the term "drugs" (which would include legend drugs) that are within the scope of authority of a naturopathic physician school

curricula, and continuing education training. The Legislature did not prohibit, nor does the bill language prohibit the prescription of legend drugs. Instead, the bill was brought with the express explanation that it was an attempt to better communicate with pharmacists, as the naturopathic physician's authority was unclear.

COMMENT NO. 10: The Board noted, on its own, that the formulary should not use the term "cephalosporins," as this is too broad of a usage. Only cephalexan and cefaclor are appropriate and necessary for naturopathic practice.

RESPONSE: The Board will amend the rule to delete "cephalosporins," as shown above.

8.4.405 NATUROPATHIC PHYSICIAN CONTINUING EDUCATION

COMMENT NO. 11: One comment was received stating ARM 8.4.405 on Naturopathic Physician Continuing Education Requirements fall short of the goal of ensuring that naturopathic physicians adhere to a doctrine of professionalism and a lifetime of learning and adapting to new developments in their field. The comment stated the educational activity of listening to audio cassettes is not equivalent to learning. The amendment should set a standard for the accrediting organization, and require a self-assessment examination.

RESPONSE: The Board noted this proposed amendment was to an existing Continuing Education rule, which already outlines the total number of credits required (15 per year), and limits reading and audiotape listening to 2 of those credits per year. The commentor would need to review the entire Continuing Education rule, which was not re-printed in this proposed amendment notice, to understand the context of the proposed continuing education amendment.

BOARD OF ALTERNATIVE HEALTH CARE
MICHAEL BERGKAMP, ND, CHAIRMAN

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 17, 1998.

BEFORE THE BOARD OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to classification of experience	NOTICE OF AMENDMENT OF A RULE PERTAINING TO CLASSIFICATION OF EXPERIENCE

TO: All Interested Persons:

1. On September 8, 1997, the Montana Board of Professional Engineers and Land Surveyors published a notice of public hearing on the proposed amendment of a rule pertaining to classification of experience at page 1504, 1997 Montana Administrative Register, issue number 17. The public hearing was held on October 3, 1997, in Helena, Montana.

2. The Board has amended ARM 8.48.507 as proposed, but with the following changes: (authority and implementing sections remain the same as proposed)

"8.48.507 CLASSIFICATION OF EXPERIENCE (1) through (3) will remain the same as proposed.

~~(4) Obtaining a Ph.D. in engineering from an approved program is considered equivalent to passing the fundamentals of the engineering exam. Four years experience in addition is required to qualify to take the professional engineers examination.~~

(5) through (7)(b) will remain the same as proposed but will be renumbered (4) through (6)(b)."

3. The Board has thoroughly considered all comments and testimony received. Those comments and the Board's responses are as follows:

COMMENT NO. 1: One commentor made a general comment that the rule requires further revision to provide greater clarity and, for purposes of determining content, a complete review of the surrounding states' experience requirements. Commentor directs the Board's attention to terms such as "should" and "credible."

RESPONSE: Although the Board recognizes that there may be some confusion with the use of words such as "should" and "credible," the Board rejects the comment as it is impossible to create a rule that makes any type of sense without the use of such modifiers. The Board would simply remind all licensees that the rules are intended to be interpreted as a reasonable person would interpret the rule using the commonly understood meaning associated with such words.

COMMENT NO. 2: One commentor stated that the Board should consider whether there is any reason to allow sub-professional experience and, if so, add a definition which clarifies the nature of sub-professional experience.

RESPONSE: The Board rejects the comment as it has been the Board's experience that sub-professional experience is

legitimate experience for purposes of licensure. Moreover, the rule is more than clear in a description of what types of experience qualify as sub-professional rendering further definition unnecessary.

COMMENT NO. 3: One commentor suggested revising the entire rule to provide that the education component of an applicants experience must be obtained from an ABET accredited program.

RESPONSE: The Board rejects this comment as it is clear in the statute that programs must simply be "board approved." Because the Board only accepts ABET accredited programs, the further clarification is unnecessary.

COMMENT NO. 4: One commentor suggested defining the term "graduation" as used in 8.48.507(1)(a).

RESPONSE: The Board rejects the comment as the term has a specific meaning in the English language and, therefore, does not require further definition.

COMMENT NO. 5: One commentor states that it is unclear from the language whether the phrase "one half the period of experience" means that the Board will credit an applicant with six months of experience for one year of sub-professional work or, in the alternative, that two years of the four year experience requirement may be gained through sub-professional work.

RESPONSE: The Board rejects the comment. It is clear from the use of the language in the implementing statute as well as the rule that up to two years experience may be gained in sub-professional work. Therefore, it is unnecessary to further define the amount of experience which is available through sub-professional work.

COMMENT NO. 6: One commentor states that 8.48.507(1)(b), subsections (i), (ii), (v), (vi), and (vii) are types of experience whereas (iii) and (iv) are general experience qualifiers appropriately placed elsewhere in the rule.

RESPONSE: The Board rejects the comment as the rule is clear regarding the types of experience the Board will accept for pre-professional licensing experience. Therefore, although general in nature, subsections (iii) and (iv) are clear enough to provide licensees with guidance regarding the type of experience which the Board will accept.

COMMENT NO. 7: Three commentors refer to the redundant language in the rule suggesting that the redundancy be removed.

RESPONSE: Although the Board agrees that some language is redundant, the Board rejects the comment based on the Board's belief that the redundancy actually results in further clarity. Rather than relying on awkward prefatory language, each subsection is self-standing and easier to interpret.

COMMENT NO. 8: One commentor states that subsections (v) and (vi) unnecessarily repeat language found in Mont. Code Ann. § 37-67-306(4) (1997).

RESPONSE: The Board rejects the comment. Although some of the language is repeated, the majority of the language is necessary to further elaborate on the Board's explanation of the statute which the Board is responsible for implementing.

COMMENT NO. 9: One commentor suggested that the term "Ph.D." be joined with the term "D.Sc." throughout.

RESPONSE: The Board accepts the comment. The difficulty presented, however, in amending the current rule is that many programs have not abandoned the use of the philosophy designation for doctoral degrees. By simply removing the "Ph.D." language, the unintended result will be that some candidates may have difficulty in obtaining their licensure when the degree conferred is different from that contained in the rules. The Board will reserve discussion regarding this change for a future rulemaking process.

COMMENT NO. 10: Four individuals provided comments on subsection 8.48.507(4). Two commentors state that the waiver of the fundamentals examination is redundant to the provisions of Mont. Code Ann. § 37-67-306(5) (1997). Accordingly, the subsection should be repealed.

RESPONSE: The Board agrees with the comment and will delete the subsection.

COMMENT NO. 11: Two commentors suggest that the rule be clarified to remove the ambiguity pertaining to the number of additional years of experience required for Ph.D. to be allowed to sit for the P.E. exam. One subsection seems to suggest that only two years is required while this subsection seems to require four years.

RESPONSE: See response to Comment No. 10 above.

COMMENT NO. 12: One commentor suggested keeping the F.E. exam requirement for Ph.D.s for purposes of reciprocity with other states. Commentor makes reference to at least one neighboring state which requires even Ph.D.s to sit for the F.E. exam.

RESPONSE: The Board agrees with the comment, however, will reserve discussion on this issue for a future Board meeting and rulemaking process.

COMMENT NO. 13: Commentor questions the phrase "in charge" as it is used in subsection 8.48.507(6).

RESPONSE: The Board rejects the comment as it is clear that the experience must be obtained while the license applicant is serving in a supervisory capacity. It is further clear that something less than "responsible charge" is required as that term is defined in the statutes. Therefore, while the phrase may be somewhat ambiguous, it is sufficiently clear for

licensees to understand what experience the Board will accept for purposes of licensure.

COMMENT NO. 14: Commentor suggests adding a definition of "field aspects" as that phrase is used in 8.48.507(7). Commentor suggests clarifying the relationship between subsections (7)(a) and (7)(b) to that prefatory language found at the beginning of subsection (7).

RESPONSE: The Board rejects the comment as the phrase "field aspects" has a well-defined meaning in the profession and is readily interpreted by those individuals who regularly practice within the profession. Regarding the further clarification, the subsections are further discussion of two field aspects in which the Board has a particular interest for licensure purposes and, therefore, are appropriately placed within that section without further reference to the prefatory language.

COMMENT NO. 15: One commentor provided his suggestions for a continuing education requirement instituted by the Board.

RESPONSE: Because the comments are not directed to the substance of this rulemaking procedure, they are not addressed in this adoption notice.

BOARD OF PROFESSIONAL ENGINEERS
AND LAND SURVEYORS

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, February 17, 1998.

BEFORE THE DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION OF THE STATE OF MONTANA

In the matter of the amendment of 36.24.104 concerning Types of Bonds; Financial and Other Requirements in the Wastewater Revolving Fund Act	NOTICE OF AMENDMENT

TO: All Interested Persons.

1. On January 15, 1998, the Department of Natural Resources and Conservation published notice of the proposed amendment of ARM 36.24.104 pertaining to types of bonds; financial and other requirements in the wastewater revolving fund act, at page 102 of the 1998 Montana Administrative Register, Issue No. 1.

2. The department has amended the rule as proposed.
AUTH: 75-5-1105, MCA
IMP: 75-5-1113, MCA

3. No comments were received.

DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION

ARTHUR R. CLINCH, DIRECTOR

DONALD D. MACINTYRE, RULE REVIEWER

Certified to the Secretary of State February 17, 1998.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of rules I through XXI and the repeal of 16.32.346 pertaining to minimum standards for mental health centers	)))))	NOTICE OF ADOPTION AND REPEAL

TO: All Interested Persons

1. On September 8, 1997, the Department of Public Health and Human Services published notice of the proposed adoption of rules I through XXI and the repeal of 16.32.346 pertaining to minimum standards for mental health centers at page 1556 of the 1997 Montana Administrative Register, issue number 17.

2. The Department has repealed rule 16.32.346 as proposed.

3. The Department has adopted the rules I (16.32.601), III (16.32.607), IV (16.32.608), VI (16.32.610), IX (16.32.617), X (16.32.621), XI (16.32.622), XIII (16.32.624), XIV (16.32.627), and XV (16.32.630) as proposed.

4. The Department has adopted the following rule(s) as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

RULE II [16.32.602] MENTAL HEALTH CENTER: DEFINITIONS In addition to the definitions in 50-5-101, MCA, the following definitions apply to this subchapter:

(1) through (11) remain as proposed.

(12) "Licensed mental health professional" means:

(a) a physician, clinical psychologist, social worker, professional counselor or registered nurse licensed to practice in Montana; or

(b) an occupational therapist licensed to practice in Montana working in a child and adolescent day treatment program or adult day treatment program.

(13) "Medical director" means a ~~psychiatrist~~ physician licensed by the Montana board of medical examiners ~~to practice psychiatry~~ who oversees the mental health center's clinical services and who has:

(a) at least a 3-year residency in psychiatry; or

(b) at least 3 years' post-graduate psychiatric training in a program approved by the counsel on medical evaluation of the American medical association; or

(c) at least 3 years of experience in a medical practice dedicated substantially to serving persons with mental illnesses.

(14) through (18) remain as proposed.

(19) "Seclusion" means staff initiating or escorting a child or adolescent ~~is separated involuntarily by staff from visible contact with the rest of the class~~ to a seclusion time-out room to calm down and appropriately manage their behavior.

(20) remains as proposed.

(21) "Time-out" means a staff, child or adolescent ~~requesting a voluntary time apart from the rest of the class or initiating a time-out generally away from the group~~ activity to enable the child or adolescent to calm down and appropriately manage their behavior.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE V [16.32.609] MENTAL HEALTH CENTER: CLINICAL SERVICES (1)(a) through (i) remain as proposed.

(j) conducting medication management services, if clinically indicated, for:

(i) self-administering of medications by clients;

~~(i)~~ (ii) administering and ~~dispensing~~ monitoring client medications, both prescriptive and over the counter medications, by appropriately licensed staff working within the scope of their practice;

(iii) assessing the need for medication adjustment or new medication prescriptions for clients;

(iv) addressing how the clients will be monitored when medication adjustments or new prescriptions are ordered;

(1)(j)(ii) through (vii) remain the same in text, but are renumbered (1)(j)(v) through (x).

(2) remains as proposed.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE VII [16.32.615] MENTAL HEALTH CENTER: CLIENT ASSESSMENTS (1) Each mental health center shall complete an ~~initial~~ intake assessment within 12 hours after admission for crisis intervention and stabilization facility services and within ~~72 hours after admission~~ 3 contacts, or 14 days from the first contact, whichever is later, for other services. ~~The initial~~ Intake assessments must include the following information:

(1)(a) through (e) remain as proposed.

~~(2) Each mental health center shall develop a complete intake assessment within 10 days after admission and include the following information if clinically indicated:~~

(2)(a) through (e) remain the same in text, but are renumbered (1)(f) through (j).

(3) and (4) remain the same in text, but are renumbered (2) and (3).

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE VIII [16.32.616] MENTAL HEALTH CENTER: INDIVIDUALIZED TREATMENT PLANS (1) Based upon the findings of the assessment(s), each mental health center shall establish an individualized treatment plan for each client within 24 hours after admission for crisis intervention and stabilization facility services and within ~~1 week after admission~~ 5 contacts, or 21 days from the first contact, whichever is later, for other services. The treatment plan must contain:

(1)(a) through (2) remain as proposed.

(3) The treatment plan review must be conducted by ~~a~~ at least one licensed mental health professional and include ~~person(s)~~ persons with primary responsibility for ~~each service received by the client~~ implementation of the plan. Other staff members ~~and outside service providers~~ must be involved in the review process as clinically ~~indicted~~ indicated. Outside service providers must be contacted and encouraged to participate in the treatment plan review, as clinically indicated. The review must be comprehensive with regard to the client's response to treatment and result in either an amended treatment plan or a statement of the continued appropriateness of the existing plan. The results must be entered into the client's clinical record. The documentation must include a description of the client's functioning and justification for each client goal.

(4) If the mental health center develops separate treatment plans for each service, a copy of each treatment plan must be kept in the client's record.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XII [16.32.623] MENTAL HEALTH CENTER: COMPLIANCE WITH BUILDING AND FIRE CODES, FIRE EXTINGUISHERS, SMOKE DETECTORS AND MAINTENANCE (1) Each mental health center shall ensure that its facilities, buildings, and homes:

(a) meet all applicable state and local building and fire codes;

(1)(b) and (c) remain as proposed.

(2) Each mental health center shall ~~maintain~~ ensure its facilities, buildings, homes, equipment, and grounds are clean and maintained in good repair at all times for the safety and well-being of its clients, staff, and visitors.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XVI [16.32.640] MENTAL HEALTH CENTER: CHILD AND ADOLESCENT AND ADULT INTENSIVE CASE MANAGEMENT (1) remains as proposed.

(2) Each mental health center providing intensive case management program services shall:

(a) employ or contract with a program supervisor, experienced in providing services to individuals with a mental illnesses~~, in each community where an intensive case management program exists~~. The program supervisor shall meet with each intensive case manager, ~~on an~~ either individually or in a group meeting ~~basis, no less than every other week for supervision and consultation purposes;~~ at least every 30 days. Individual supervision of case managers must be offered by the mental health center as needed and may be initiated by either the case manager or the supervisor;

(b) employ or contract with case managers who have the knowledge and skills needed to effectively perform case management duties. Minimum qualifications for a case manager are a bachelor's degree in a human services field ~~or RN licensure, and~~ with at least 1 year of full time experience serving people with mental illnesses. Individuals with other educational backgrounds who, as providers, consumers, or advocates of mental health services have developed the necessary skills, may also be employed as intensive case managers. The mental health center's case management position description must contain equivalency provisions;

(c) train the program supervisor and program staff in the therapeutic de-escalation of crisis situations to ensure the protection and safety of the clients and staff. The training must include the use of physical and non-physical methods of managing clients and must be updated, at least annually, to ensure the maintenance of necessary skills;

(2)(c) and (d) remain the same in text, but are renumbered (2)(d) and (e).

(3) and (4) remain as proposed.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XVII [16.32.644] MENTAL HEALTH CENTER: CHILD AND ADOLESCENT DAY TREATMENT PROGRAM (1) remains as proposed.

(2) The child and adolescent day treatment program must be site based, ~~and shall~~ Appropriate, supplemental day treatment services may be delivered off-site. The program shall:

(a) operate at least 5 days per week for at least 3 hours per day, unless school holidays preclude day treatment activities~~;~~. Preschool day treatment programs shall operate at least 3 days a week, 3 hours a day, unless school holidays preclude day treatment activities;

(2)(b) and (c) remain as proposed.

(d) provide mental health services according to the individualized treatment plan which may include ~~including~~ individual therapy, family and group therapy, social skills training, life skills training, pre-vocational training, therapeutic recreation services and ensure access to emergency

services;

(2)(e)(i) through (f) remain as proposed.

(g) establish policies and procedures regarding the use of time-out and seclusion. Time-out and seclusion may not be used with a locked door. Mechanical restraints may not be used. If time-out is used, intermittent to continuous staff observation is required, as clinically indicated. If seclusion is used, ~~there must be~~ continuous ~~direct~~ staff observation is required. Written permission from the parent or legal guardian must be obtained for the use of non-aversive and aversive interventions and must be placed in the client's clinical record. The clinical record must include signed orders by a licensed mental health professional for use of seclusion, a detailed description of the circumstances warranting such action, and the date, time and duration of the seclusion;

(2)(h) and (i) remain as proposed.

(3) The day treatment program staff: ~~(a)~~ shall attend all child study team (CST) meetings and individual education planning meetings when clinically indicated and permission has been granted by the parent or legal guardian or child, when age appropriate. If the client requires an individualized education program (IEP), a copy of the ~~program~~ IEP must be included in the client's treatment plan unless the parent or legal guardian or child, when age appropriate, fails to authorize release to the mental health center.

~~(b)~~ (4) The program supervisor and day treatment program staff must be trained in the therapeutic de-escalation of crisis situations to ensure the protection and safety of the clients and staff. The training must include the use of physical and non-physical methods of ~~controlling~~ managing children and adolescents and must be updated, at least annually, to ensure that necessary skills are maintained.

~~(4)~~ (5) Each licensed mental health professional shall carry an active caseload not to exceed 12 day treatment clients. The 1 to 12 ratio applies only to clients attending the program at least 3 to 5 days a week; the ratio does not apply to clients attending the program 1 to 2 days a week.

(6) There must be at least one full-time equivalent (FTE) clinical or support~~ive~~ staff member for every 6 8 clients in the program. Support staff means an adult, under the supervision of the program supervisor or therapist, with experience in working with children and adolescents with severe emotional disturbances. For the purpose of this ratio, the number of participants in the program must be based on the average daily attendance.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XVIII [16.32.645] MENTAL HEALTH CENTER: ADULT DAY TREATMENT PROGRAM (1) and (2)(a) remain as proposed.

(b) employ or contract with a ~~site based~~ program supervisor who

is knowledgeable about the service and support needs of individuals with a mental illness, day treatment programming and psychosocial rehabilitation. The program supervisor or program therapist must be site based;

(2)(c) through (g) remain as proposed.

(3) The program supervisor and day treatment program staff must be trained in the therapeutic de-escalation of crisis situations to ensure the protection and safety of the clients and staff. The training must include the use of physical and non-physical methods of managing clients, and must be updated, at least annually, to ensure that necessary skills are maintained.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XIX [16.32.646] MENTAL HEALTH CENTER: MENTAL HEALTH GROUP HOME (1) through (8) remain as proposed.

(9) The program supervisor and group home program staff must be trained in the therapeutic de-escalation of crisis situations to ensure the protection and safety of the residents and staff. The training must include the use of physical and non-physical methods of managing residents, and must be updated, at least annually, to ensure that necessary skills are maintained.

(9) and (10) remain the same in text, but are renumbered (10) and (11).

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XX [16.32.650] MENTAL HEALTH CENTER: CRISIS *TELEPHONE SERVICES* (1) remains as proposed.

(2) The mental health center providing crisis telephone services shall:

(a) ensure that crisis telephone services are available 24 hours a day, seven days a week. Answering services and receptionists may be used to transfer calls to individuals who have been trained to respond to crisis calls;

(b) employ or contract with ~~only licensed mental health professionals to answer crisis calls. Local law enforcement officers trained to answer and refer mental health crisis calls may be used. Calls must be answered promptly and in person. Answering services may not be used~~ appropriately trained individuals, under the supervision of a licensed mental health professional, to respond to crisis calls. An appropriately trained individual is one who has received training and instruction regarding:

(i) the policies and procedures of the mental health center for crisis intervention services;

(ii) crisis intervention techniques;

(iii) the process for voluntary and involuntary

hospitalization:

(iv) the signs and symptoms of mental illness; and

(v) the appropriate utilization of community resources.

(c) ensure that a licensed mental health professional provides consultation and backup, as indicated, for unlicensed individuals responding to crisis calls;

(d) establish written policies and procedures governing in-person contacts between crisis responders and crisis callers. The policies and procedures must address the circumstances under which the contacts may or may not occur and safety issues associated with in-person contacts;

(2)(c) remains the same in text, but is renumbered (2)(e).

~~(d)~~ (f) maintain ~~progress notes~~ documentation for each crisis call. The ~~progress notes~~ documentation must reflect:

(2)(d)(i) through (iii) remain the same in text, but are renumbered (2)(f)(i) through (iii).

(iv) ~~a description of the crisis~~ the nature of the emergency, including an assessment of dangerousness/lethality, medical concerns, and social supports; and

(v) ~~an assessment of any danger posed by caller to self or others;~~ the result of the intervention.

~~(vi) an assessment of mental illness; and~~

~~(vii) action taken and outcome.~~

(3) No individual may respond to crisis calls until the mental health center documents in writing in the individual's personnel file that the individual has received the training and instruction required in (2)(b) above. Additional training and instruction must be provided to crisis responders based upon an ongoing assessment of presenting problems and responder needs and to ensure that necessary crisis intervention skills are maintained.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

RULE XXI [16.32.651] MENTAL HEALTH CENTER: CRISIS INTERVENTION AND STABILIZATION FACILITY (1) through (3)(a) remain as proposed.

(b) require staff working in the crisis intervention and stabilization facility:

(i) be 18 years of age;

(ii) possess a high school diploma or GED; and

(iii) be capable of implementing each resident's treatment plan;

(3)(b) remains the same in text, but is renumbered (3)(c).

~~(c)~~ (d) orient staff prior to assuming the duties of the position. ~~The orientation must include specific information on the following subjects~~ on:

(i) the types of mental illness and treatment approaches;

(ii) suicide risk assessment and prevention procedures; and

(iii) ~~crisis prevention and de-escalation procedures;~~

program policies and procedures, including emergency procedures.

(e) orient staff within 8 weeks from assuming the duties of the position on:

~~(iv)~~ (i) therapeutic communications;

~~(v)~~ (ii) the legal responsibilities of mental health service providers;

~~(vi)~~ (iii) mental health laws of Montana regarding the rights of consumers;

~~(vii)~~ (iv) other services provided by the mental health center; and

~~(viii)~~ (v) infection control and prevention of transmission of blood borne pathogens~~;~~.

(f) maintain written program policies and procedures at the facility:

(3)(d) and (e) remain the same in text, but are renumbered (3)(g) and (h).

(i) maintain a staff-to-patient ratio dictated by resident need. A procedure must be established to increase or decrease staff coverage as indicated by resident need:

(3)(f) through (3)(f)(ii) remain the same in text, but are renumbered (3)(j) through (3)(j)(ii).

(iii) be drug and alcohol free ~~(with the exception of prescribed medications, caffeine and nicotine)~~ to the extent it does not significantly impair the individual's ability to meet the other admission criteria;

(iv) be willing to enter the program, follow program rules, and accept recommended treatment;

(3)(f)(v) through (f)(vii) remain the same in text, but are renumbered (3)(j)(v) through (j)(vii).

(k) establish written policies and procedures:

(i) for completing a medical screening and establishing medical stabilization, prior to admission;

~~(g) establish policies and procedures~~ (iii) for the secure storage of toxic household chemicals and sharp household items such as utensils and tools~~;~~.

~~(h) develop written procedures~~ (ii) to be followed should residents, considered to be at risk for harming themselves or others, attempt to leave the facility without discharge authorization from the licensed mental health professional responsible for their treatment; and

(l) when clinically appropriate, provide each resident upon admission, or as soon as possible thereafter:

(i) a written statement of resident rights which, at a minimum, include the applicable patient rights in 53-21-142, MCA;

(ii) a copy of the mental health center grievance procedure; and

(iii) the written rules of conduct including the consequences for violating the rules.

(m) ensure inpatient psychiatric hospital care is available through a transfer agreement for residents in need of hospitalization:

(3)(i) remains the same in text, but is renumbered (3)(n).

(o) make referrals for services that would help prevent or diminish future crises at the time of the resident's discharge. Referrals may be made for the resident to receive additional treatment or training or assistance such as securing housing.

(4) The program supervisor and program staff must be trained in the therapeutic de-escalation of crisis situations to ensure the protection and safety of the residents and staff. The training must include the use of physical and non-physical methods of managing residents and must be updated, at least annually, to ensure that necessary skills are maintained.

AUTH: Sec. 50-5-103, MCA
IMP: Sec. 50-5-103 and 50-5-204, MCA

5. The Department has thoroughly considered all commentary received. The comments received and the department's response to each follow:

GENERAL COMMENTS

COMMENT #1: One commentor supported the adoption of the new rules because the rules would provide more choice to consumers and competition in the provision of services.

RESPONSE: The department believes that the rules will provide much needed specificity by clarifying the minimum standards that govern the operation of mental health centers.

COMMENT #2: One commentor questioned the effect of these rules on agencies with multiple sites asking whether each site or the agency as a whole should apply for licensure.

RESPONSE: The agency itself would apply for a single license to operate multiple sites.

COMMENT #3: Several commentors proposed accepting appropriate accreditation such as Commission on Accreditation of Rehabilitative Facilities (CARF) accreditation in lieu of regular licensing visits or mental health center designation.

RESPONSE: Pursuant to 50-5-103(5) and (6), MCA, the department may consider as eligible for licensure both Joint Commission on Accreditation of Health Care Organizations (JCAHO) and CARF accredited mental health center programs. Mental health center programs accredited by JCAHO or CARF may be inspected by the department to ensure compliance with state licensure standards. Accreditation accepted by the department, in lieu of licensure for one or more programs, does not confer licensure on those programs of a mental health center that are not accredited by JCAHO or CARF.

COMMENT #4: One commentor recommended a grandfather clause or time period to allow clinically privileged staff to obtain licensure.

RESPONSE: The question of grandfathering clinically privileged staff working in community mental health centers has been addressed in 37-23-208, MCA, "Opportunity for examination allowed for certain counselors". Persons meeting certain requirements were given the opportunity to take the national board of certified counselors examination to determine fitness for licensure under Title 37, chapter 23, MCA, if they applied to the board of social work examiners and professional counselors before April 30, 1997. A license issued to an individual under 37-23-208, MCA, authorizes the individual to practice as a licensed professional counselor exclusively in a community mental health center.

COMMENT #5: One commentor recommended the state develop a plan for compliance with the adoption of new rules. The commentor recommended the plan allow for up to 12 months for complete compliance.

RESPONSE: The department is required by 50-5-103(3), MCA, to extend a reasonable time for compliance with administrative rules upon adoption. A reasonable time period for compliance will depend upon the type and severity of the deficiency or deficiencies noted at the time of inspection.

RULE II (16.32.602) DEFINITIONS

COMMENT #6: One commentor objected to the narrow view being taken of the disciplines required of mental health professionals. Another commentor stated that the definition of a "qualified mental health professional" fails to recognize other disciplines used in mental health center programs. An example would be a licensed occupational therapist with mental health training in psychosocial rehabilitation programs/adult day treatment programs.

RESPONSE: In review of the licensure requirements of an occupational therapist, the department has broadened the definition of a "licensed mental health professional" to include an occupational therapist working in an adult, child and adolescent day treatment program. Part of the education of an occupational therapist is psychiatric rehabilitation.

COMMENT #7: One commentor does not believe all registered nurses should be included in the definition of "licensed mental health professional," without knowing what education and experience they have in the mental health field.

RESPONSE: Part of the education of a registered nurse is

training and study in psychiatric and mental health nursing. The department feels that such training qualifies a registered nurse to work as a licensed mental health professional in a mental health center.

COMMENT #8: Several commentors disagreed with the definition of a "medical director" questioning the requirement that a medical director be a psychiatrist. One commentor noted that its medical director was a medical doctor, who has been affiliated with the mental health center for a long time and maintains an intense clinical interest in mental illness. Several commentors discussed the difficulties in obtaining psychiatric services in rural areas of the state. One commentor recommended the term "psychiatrist" be changed to "medical doctor". Another commentor recommended changing "medical director" to "clinical director" and opening up the options to include a Ph.D. or master level psychologist, master level registered nurse, master level social worker or comparable human service degree with experience in working with severely mentally ill.

RESPONSE: The Montana Board of Medical Examiners licenses physicians and not the speciality field of psychiatry (in contrast to the proposed rule which defined a medical director as a psychiatrist licensed to practice psychiatry). The board recommended that the definition of "medical director", in part, be revised to require a physician who has completed a 3 or more year residency in psychiatry (or at least 3 years post graduate psychiatric training in a program approved by the Counsel on Medical Evaluation of the American Medical Association). The department has amended the rule accordingly. Further, the department has amended the definition to allow a physician to act as the medical director if the physician has at least 3 years of experience in a medical practice dedicated substantially to serving persons with mental illnesses. Given the psychiatric and diverse mental health needs of clients served by a mental health center, the department feels that a doctor with specific psychiatric training is required to oversee a center's clinical services. A mental health center may elect to satisfy this requirement by employing or contracting with psychiatrists from urban areas in Montana and out-of-state psychiatrists licensed to practice in Montana. Along with regularly scheduled face-to-face visits, other methods of communication and oversight by the medical director are acceptable.

COMMENT #9: Several commentors recommended the definitions of "program supervisor" and "program therapist" be revised to include, "a mental health professional in the process of obtaining licensure". For example, there is a period of time between the hire date and obtaining licensure through the state process when out-of-state candidates are hired.

RESPONSE: The department disagrees with the commentors' recommendations to expand the definitions of "program supervisor" and "program therapist". The program supervisor provides daily overall responsibility for the operation of the program, which includes clinical oversight. The primary program therapist provides individual and group therapy. An established level of clinical competency, as demonstrated by the licensure status of the supervisor or therapist, is required of both positions. Additional therapists may be used; however, their scope of practice must be consistent with the requirements of their professional licensing board.

COMMENT #10: One commentor disagreed with the definition of "program supervisor" claiming that it made sense to require licensed staff to provide supervision and deliver certain specific services. However, requiring a licensed mental health professional to administer a program or programs did not make sense.

RESPONSE: The program supervisor provides clinical supervision to unlicensed staff working in the program. In the administration of a program, the program supervisor is required to deal with a variety of clinical issues; for example, development of clinical policies and procedures. The department feels that it is appropriate, therefore, to require that the program supervisor be licensed as a mental health professional.

COMMENT #11: One commentor requested that clinically privileged staff be included in the definition of "program supervisor" and "program therapist". Both the Mental Health Access Plan and the department's request for proposal for managed care, via section 343.1, allow the managed care organization to utilize as providers "unlicensed clinical staff of community mental health centers who have been clinically privileged".

RESPONSE: The department disagrees with the commentor's request and has declined to add clinically privileged staff to the definitions of "program supervisor" and "program therapist". Please refer to the department's responses to comment numbers 4 and 9.

COMMENT #12: Several commentors recommended that appropriately trained individuals who need clinical experience to complete their graduate education be included in the definitions of "program supervisor" and "program therapist". Both the Mental Health Access Plan and the managed care request for proposal encourage the managed care organization "to support the use of supervised internships and practice and to allow mental health centers to utilize supervised and appropriately trained individuals who need clinical experience to complete their graduate education or attain licensure".

RESPONSE: Please refer to department's responses to comment numbers 4 and 9. Please note that Rule IV(1)(d)(i) (16.32.608) requires the mental health center to define the responsibilities, limitations, and supervision of students, interns and volunteers working for the mental health center.

COMMENT #13: One commentor said the definitions of "seclusion" and "time-out" will drastically increase documentation requirements by program staff. In day treatment programs staff must document interventions utilized prior to seclusion, a description of the behavior to be modified, expected and actual behavioral outcome, and time in seclusion consistent with the Office of Public Instruction's regulations. Staff initiating a time-out with a youth by directing them to a hallway or location outside the hearing of other youth in order to assist the youth in regaining control of their behavior is a much less restrictive intervention than staff initiating a time-out in a seclusion time-out room. Documenting in detail, as proposed in the draft rules, each instance of staff initiated time-out or seclusion will significantly increase staff time spent doing paperwork as opposed to providing direct services to the youth. The commentor recommended seclusion be defined "as staff initiating or escorting a youth to a seclusion time-out room, and time-out be defined as a staff or youth initiated time-out generally away from the group activity".

RESPONSE: The department agrees with the recommended changes to the definitions of "seclusion" and "time-out" and has amended those definitions accordingly.

COMMENT #14: One commentor recommended that the rules include the requirement that parents fully participate in treatment planning and that parents give written permission for use of non-aversive and aversive interventions.

RESPONSE: Rule VIII(1)(d) (16.32.616) has always required the parent/guardian's signature indicating participation in the development of the treatment plan if possible or appropriate. The department does agree with the commentor's recommendation that the day treatment program have the parent/guardian's written permission for the use of non-aversive and aversive interventions and has amended Rule XVII(2)(g) (16.32.644) accordingly.

COMMENT #15: One commentor recommended the term "illness" be changed to "disorder" in the definition of "severe emotional distress". Youth as young as 3 are diagnosed with conditions that significantly impact their functioning. Youth as young as 3 do not have several years with this extended impact yet do have significant impairment in functioning. Conditions which significantly impact functioning in a youth may not be those typically diagnosed as mental illness as an adult.

RESPONSE: The statutory definition of "mental health center" in 50-5-101(31), MCA, uses the term "mental illness" and not "mental disorder". The proposed rules thereafter define the term "mental illness". The department feels that the rules should reflect the statutory terminology and has therefore elected to retain the term "mental illness" wherever that term appears in the proposed rules.

RULE III (16.32.607) SERVICES

COMMENT #16: One commentor, whose agency is not a community mental health center, and was awarded a contract prior to the implementation of managed care to provide case management services, suggested a grandfather clause which would not require them to become a mental health center. The commentor also asked the department to provide time lines for compliance with the rule and/or to change the rule to allow agencies to provide case management services without becoming a mental health center.

RESPONSE: The department disagrees with the commentor's requests to implement a grandfather clause or alternatively, to revise the rules so that an agency can provide case management services without becoming a mental health center. Section 50-5-101(31), MCA, defines a mental health center as "a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients, the rehabilitation of mentally ill individuals, or any combination of these services". The department believes case management services fall within the definition of a "mental health center" and as a result, will continue to require that any entity providing such services be licensed as a mental health center. Please see the department's response to comment number 5 regarding time lines for compliance.

COMMENT #17: One commentor's agency provides case management services under contract for the managed care organization to clients in intensive therapeutic youth group homes and therapeutic foster care services throughout the state. The commentor questioned how this rule would pertain to these services and believes this situation highlights the difficulty in mandating case management as a "mental health center only" service. It clearly demonstrates the applicability of the accreditation process as an alternate or adjunct designation. For those agencies that provide case management through channels other than the mental health center designation should be accredited by a nationally recognized "case management specific" accreditation process.

RESPONSE: If case management services provided for clients in therapeutic youth group homes and therapeutic foster care services fit the definition of "intensive case management services" in the proposed rule, the provider would require

licensure as a mental health center, with a child and adolescent intensive case management area of endorsement. This does not include professionals providing case management services within the scope of their practice. Please refer to the department's response to comment number 3 with respect to accreditation by CARF or JCAHO.

COMMENT #18: One commentor's agency provides case management services under contract with the developmentally disabled program in the Disabilities Service Division of the department. As a result, the agency has a specific division of case management within their organization. The commentor believes that case managers must act independently of the service provider in providing quality case management and the requisite advocacy that goes hand-in-hand with this service. The commentor recommends the rule specify that case management must remain separate from direct service provisions except in specifically identified situations. The ability of the case manager to advocate for services is lost once a case manager becomes the provider of services. All agencies providing case management should have to specifically delineate the separation of responsibilities in this area.

RESPONSE: The department disagrees with mandating the case manager's degree of independence regarding advocacy and providing services. Rule XVI(2)(d) (16.32.640) requires each mental health center to develop policies and procedures addressing the independence of intensive case managers.

COMMENT #19: Several commentors disagreed with Rule III (16.32.607), Services, and Rule XV (16.32.630), License Endorsement, claiming the rules would fragment the continuum of services presently provided by community mental health centers. The proposed rules distort the common nationwide meaning of a mental health center as being an entity that provides a continuum of services. Another commentor recommended the State license organizations that provide 1 or 2 mental health services specific to services provided, without requiring them to meet all the standards for a mental health center. In this way, these agencies would not be equated with the term "mental health center", which still has a specific meaning nationwide. One commentor recommended that the preamble in paragraph 2 of Rule III (16.32.607) be changed to: "(2) A mental health center shall provide either directly or through contract all of the following services:"

RESPONSE: The definition of a "community mental health center" in 53-21-201, MCA, differs from the definition of a "mental health center". Section 50-5-101(31), MCA, defines a "mental health center" as a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients, the rehabilitation of

mentally ill individuals, or any combination of these services. Clearly, that definition contemplates that a facility may provide a single service, a combination of services or all of the named services. The department believes Rule III (16.32.607) and Rule XV (16.32.630) are consistent with the definition of a "mental health center" in requiring a center to offer at least one of the services listed therein. The department declines to make the recommended change to paragraph 2 of Rule III (16.32.607) as that would mandate a mental health center, either directly or through contract, to offer all of the services versus one service or a combination of services. The department believes such a change would conflict with the statutory definition of a "mental health center" as discussed above.

RULE IV (16.32.608) ORGANIZATION STRUCTURE

COMMENT #20: One commentor questioned to what extent a medical director was needed if the only service provided was case management. The commentor discusses the difficulty in finding a psychiatrist in many parts of the state. The commentor believes contingencies need to be made for single service providers or for the lack of available psychiatric coverage. The commentor questioned if out-of-state psychiatrists could be used if they visited the agency on a regular schedule, or if other forms of communication could be used. The commentor recommended the rule clarify the amount and type of psychiatric coverage required for single service providers and the use of telecommunications.

RESPONSE: Requirements of the medical director would be minimal if the only service provided was case management. Rule IV (16.32.608), Organizational Structure, and V (16.32.609), Clinical Services, outline the primary responsibilities of a medical director. Mental health centers may employ or contract with psychiatrists from urban areas in Montana or from out-of-state psychiatrists licensed to practice in Montana. Along with regularly scheduled face-to-face visits, other methods of communication and oversight by the medical director would be acceptable.

COMMENT #21: One commentor expressed a concern that the licensing rule dictates the organizational structure of the service delivery system in the requirements of qualifications and lines of authority for management personnel.

RESPONSE: The standards require certain qualifications for key personnel (the medical director, a program supervisor and program therapist) within the organization. The department believes an established level of clinical competency is required of certain personnel positions.

COMMENT #22: Several commentors disagreed with the requirement that the medical director review the clinical services policy and procedure manual. When policies do not relate to medical and rehabilitative procedures, the requirement is inefficient and cost prohibitive. One commentor recommended the rule be changed to "the manual must be reviewed and updated at least annually by the Center administration". One commentor recommended "best practice calls for such review by the governing body of an organization in conjunction with the administrator".

RESPONSE: The department disagrees with the commentors' request that the medical director not be required to review the clinical services policy and procedure manual. Per Rule IV(2) (16.32.608), Organizational Structure, the medical director is part of the mental health center's administration. A "medical director" is defined under Rule II (16.32.602), Definitions, as one who "oversees the mental health center's clinical services". The department believes the medical director's required oversight, given the director's medical and clinical background, reasonably includes reviewing clinical services' policies and procedures.

RULE VII (16.32.615) CLIENT ASSESSMENTS

COMMENT #23: Several commentors disagreed with the time frames established "for other services" assessments in paragraphs (1) and (2) in Rule VII (16.32.615) claiming that it would generate unnecessary paperwork. The 10-day completion date does not allow adequate time for the managed care company to process and authorize assessments. Complete assessments usually take 2 sessions. The second session may be scheduled beyond the 10-day limit when taking into account weekends, holidays or parent schedules. One commentor disagreed with the 10-day time frame because the individual's disease may interfere with the assessment process; more than 10 days may be needed to complete the assessment. One commentor recommended deleting the standard for the initial intake assessment. Two commentors recommended the standard be changed to read "shall develop a complete intake assessment within 3 contacts". One commentor recommended a time frame be included within the 3 contacts.

RESPONSE: The department agrees with the commentors' recommendations to delete the initial intake assessment so as to require a single intake assessment and has amended the rule accordingly. The department acknowledges that certain clinical conditions may interfere with the assessment process thereby requiring more than 10 days to complete an assessment. Therefore, with respect to "other services", the department has amended the rule to require the completion of the intake assessment within 3 contacts, or 14 days from the first contact, whichever is later.

RULE VIII (16.32.616) INDIVIDUALIZED TREATMENT PLANS

COMMENT #24: Several commentors noted that requiring the treatment plan to be completed in one week under Rule VIII(1) (16.32.616) while requiring the intake assessment to be completed in 10 days under Rule VII(2) (16.32.615) did not follow best clinical practices. One commentor recommended the standard be changed to "prior to the 5th contact or within 2 weeks".

RESPONSE: The department agrees that the completion date of the treatment plan should be revised and has amended the rule to require the completion of the treatment plan within 5 contacts, or 21 days from the first contact, whichever is later, for other services.

COMMENT #25: One commentor disagreed with the requirement that the treatment plan be reviewed at intervals of no less than 90 days believing it to be excessively restrictive and costly. The commentor compares the time frame of the standard to the managed care organization's interim reauthorization reports. Under managed care, clinicians are required to submit interim reports for reauthorization of services which outlines the patient's current condition and changes in the treatment plan. Sometimes this is more often than 90 days and sometimes not. Some clients are seen on an as needed basis for treatment and their treatment plans are not reviewed every 90 days. The commentor recommended the standard say something like " . . . treatment plans must be reviewed at clinically appropriate intervals . . ." with documentation of the review in the chart.

RESPONSE: The department disagrees with the commentor's recommendation to change the requirement for treatment plan reviews to "clinically appropriate intervals". The interpretation of clinically appropriate intervals would be inconsistent among mental health centers. If the client is seen on an as needed basis, treatment interventions and treatment plan reviews would presumably be brief.

COMMENT #26: One commentor disagreed with the wording and intent of paragraph (3) in Rule VIII (16.32.616). The wording indicates the entire treatment team needs to meet every 90 days to review the client's treatment plan. Given the number of clients each team member has on their case load, this would not be feasible. The commentor recommended the primary therapist be required to review their own treatment plan every six months.

RESPONSE: The intent of the rule is that at least one licensed mental health professional be involved in developing and reviewing the treatment plan. In this way, the treatment interventions of unlicensed staff members are reviewed by a licensed mental health professional. The language ". . .

person(s) with primary responsibility for implementation of the plan" means one staff person from each program is required to participate in development and review of the treatment plan. The rule has been amended to clearly specify the persons required to review the treatment plan. In clarification, if mental health center clients are receiving more than one service from the center, their treatment plans may be combined or separate. The rule has been further amended to require that the mental health center keep a copy of each treatment plan in the client's file.

COMMENT #27: A commentor voiced concerns about the requirement for outside service providers to participate in treatment planning in paragraph (3) of Rule VIII (16.32.616), and what implications that would have on a center's license.

RESPONSE: The department, in requiring the involvement of outside service providers, recognized that the best interests of clients are served when all providers of services to a client participate in the review process. The department acknowledges that outside service providers (those providers who are not under contract with the mental health center to provide a service the mental health center cannot directly provide) may be unwilling or unable to participate in the review process. The department has amended the rule to clarify that the mental health center should contact and encourage outside service providers to participate in the review process, where clinically indicated. Such amendment acknowledges the center's responsibility to contact outside providers, but does not mandate an outside provider's involvement if the provider cannot or will not participate (assuming again that the provider has not contracted with the mental health center to provide the services).

COMMENT #28: One commentor questioned whether the word "indicted" in paragraph (3) of Rule VIII (16.32.616) should be "indicated".

RESPONSE: The correct word is "indicated" and the rule has been amended accordingly.

RULE XI (16.32.622) QUALITY ASSESSMENT

COMMENT #29: One commentor objected to the requirement in paragraph (1) of Rule XI (16.32.622) that requires the quality assessment program to include procedures for reviewing emergency or unusual occurrences stating that such information may be sensitive, potentially privileged and proprietary.

RESPONSE: The department believes that the requirement to include procedures for reviewing emergency or unusual occurrences is a critical component of an effective quality

assessment program. If certain information, however sensitive or confidential, is necessary to determine compliance with these rules, the department, pursuant to 50-5-204(6), MCA, must be granted access to those records. The Government Health Care Information Act, Title 50, chapter 16, part 6, MCA, governs the responsibilities and obligations of the department to maintain health care information in the possession of the department.

COMMENT #30: One commentor questioned if a single service provider could contract with a mental health center.

RESPONSE: Yes, a single service provider may contract with a mental health center to provide certain services. The mental health center is responsible for the provider's compliance with these rules.

RULE XVI (16.32.640) CHILD AND ADOLESCENT AND ADULT INTENSIVE CASE MANAGEMENT

COMMENT #31: Several commentors disagreed with the requirements in paragraph (2)(a) in Rule XVI (16.32.640), specifically the requirement to have a program supervisor in each community where an intensive case management program exists and the requirement that the supervisor meet with every case manager on an individual basis every other week for supervision. One commentor, with experience in offering case management services in many communities, recommended one supervisor be required for adult services and one for child and adolescent services per mental health center. Several commentors thought the face-to-face, no less than every other week supervision, was excessive. Several commentors recommended other methods of supervision be allowed, such as telemedicine, fax, e-mail, and computer conferencing. One commentor recommended regular face-to-face visits along with other methods of communication. One commentor does not believe it is the State's responsibility to define how many face-to-face supervisory visits are required. One commentor disagreed with the requirement that the program supervisor meet with each intensive case manager, on an individual basis, citing that it was neither clinically indicated or cost effective. Group supervision has been found to be as effective. The commentor recommended "on an individual basis" be dropped.

RESPONSE: The department has amended Rule XVI (16.32.640) to delete the requirement for a case management supervisor in every community where case management services are offered. In addition, the department has amended the rule to require that a supervisor meet with each case manager, either individually or in a group meeting, at least every 30 days (as opposed to every 2 weeks). Given the different levels of case manager education and experience, the department has further amended the rule to state that individual supervision of case managers must be

offered as needed and may be initiated by either the case manager or supervisor. The department disagrees with the recommendation that the department not require a specific number of face-to-face supervisory visits. The department believes in-person meetings are more effective than other methods of communication.

COMMENT #32: One commentor questioned the need to include RN licensure in the minimum qualifications for case managers if an RN is considered a licensed mental health professional.

RESPONSE: The department agrees and has deleted the term "RN licensure". A registered nurse is a licensed mental health professional which qualifies the nurse to be a case manager.

COMMENT #33: One commentor recommended that de-escalation training be required of mental health centers providing a crisis intervention stabilization facility, case management and adult day treatment services. The commentor noted that this training was beneficial for staff working with clients who experience crises or have behavior problems that may escalate. Another commentor recommended the training be obtained from Mandt or a similar type program.

RESPONSE: The department agrees with the first commentor that program supervisors and program staff working in crisis facilities or providing case management or adult day treatment services should be trained in de-escalation techniques. The department further believes that program supervisors and program staff providing child and adolescent day treatment services or working in group homes should also be trained in de-escalation techniques. The department has therefore amended Rule XVI (16.32.640), Child and Adolescent and Adult Intensive Case Management, Rule XVII (16.32.644), Child and Adolescent Day Treatment Program, Rule XVIII (16.32.645), Adult Day Treatment Program, Rule XIX (16.32.646), Mental Health Group Home, and Rule XXI (16.32.651), Crisis Intervention and Stabilization Facility, to require the de-escalation training. The department believes that each mental health center should be able to make its own determination as to how and where to obtain the required training and has elected not to require or reference a specific training program.

COMMENT #34: Several commentors recommended eliminating the word "intensive" as it appears in the definition (Rule II (16.32.602)) and description of "Child and Adolescent and Adult Intensive Case Management" (Rule XVI (16.32.640)) claiming that the new designation would not allow for different service levels based on individual client need. The term "intensive" designates a form of case management that should be tracked and monitored separately from the provision of basic case management services. All case management is not intensive. Some of it is

merely a coordination of services. Some of it can be as minimal as checking in with a client once every 3 to 4 months for an update. One commentor recommended eliminating "intensive" because it designates a service currently provided by an existing mental health center. The commentor recommended the term "therapeutic" or "clinical" be used as part of the description and definition of this service.

RESPONSE: The department disagrees with eliminating the word "intensive". The definition and description of "intensive case management" services allows for different service levels to be provided to clients, based on their individual need. The word "intensive" is used to differentiate between case management services provided by individuals whose sole function is to provide case management to individuals with a mental illness, versus professionals providing case management services within the scope of their practice.

COMMENT #35: One commentor disagreed with the requirement in paragraph (2)(c) of Rule XVI (16.32.640) that progress notes be entered into the client's record at least every 30 days noting that the clinical files of centers with multiple services would be huge. The commentor recommended the primary therapist write a single progress note based on input from the service providers as opposed to each service provider generating its own progress note.

RESPONSE: The department believes the requirement for progress notes every 30 days is a reasonable requirement. In comparison, the contracts between the department and community mental health centers (before the implementation of managed care) required that progress notes be entered for each client contact. The department has actually reduced the documentation requirements when compared to the prior contractual standard. The department does note, however, the requirement to enter a progress note upon the occurrence of any significant change in the client's condition which may well require that a progress note be written more frequently than every 30 days. The department feels that it is appropriate to require each service provider to enter its own progress note based upon the service provider's familiarity with and monitoring of the client's condition.

COMMENT #36: One commentor, whose agency is not a community mental health center, provides child and adolescent intensive case management services, and has CARF accreditation. The commentor recommended CARF accreditation be added to the rule as a requirement. If CARF accreditation is not included as a requirement in the rule, the commentor recommended that this accreditation be accepted in lieu of mental health center designation.

RESPONSE: The department disagrees with the recommendation that

CARF accreditation be added to the rule as a requirement. Please refer to the department's response to comment number 3.

RULE XVII (16.32.644) CHILD AND ADOLESCENT DAY TREATMENT PROGRAM

COMMENT #37: One commentor disagreed with the requirement in paragraph (2) of Rule XVII (16.32.644) that the program be site based stating that services such as life skills training, social skills training, and pre-vocational training are often appropriately offered off-site. The commentor recommended making a reference to allow for off-site services in the rule or add "although services may be delivered off-site as specified in the individualized treatment plan".

Response: The department generally agrees with the comment, but not the recommended wording. The recommended wording does not indicate the day treatment program is primarily site based. The department has amended the rule to allow for appropriate supplemental day treatment services to be delivered off-site.

COMMENT #38: Several commentors disagreed with the requirement in paragraph (2)(a) of Rule XVII (16.32.644) that the child and adolescent day treatment program operate at least 5 days a week. Five days a week would exclude Head Start programs that operate between 3 and 4 days a week for 3 hours a day. Another commentor objected to the number of days and hours requirement because the clinical justification was unclear citing that rural and summer programs cannot support daily operation. The commentor recommended the standard be dropped, or at the least changed to "operate at least 3 days per week".

RESPONSE: The department believes that a child and adolescent day treatment program should operate through the year to ensure continuity of services, without interruption. However, the department agrees with the commentors' recommendation to reduce the required number of weekly days from 5 to 3 and has amended the rule accordingly. The client's clinical needs rather than the program's financial viability will dictate the program's schedule for rural and summer programs.

COMMENT #39: One commentor disagreed with the requirements in paragraph (2) of Rule XVII (16.32.644) that the program be site based and that the program employ a program supervisor. The commentor stated that such requirements would jeopardize or eliminate the itinerate day treatment program in rural areas. The itinerate day treatment program has been used successfully in working with seriously emotionally disturbed youth, such as the Bitterroot Valley Special Education Co-op in Ravalli County. The loss of the itinerate day treatment program would be a detriment to their special education system, the schools and the children served.

RESPONSE: Services provided in site based child and adolescent day treatment programs are different than itinerate services. Itinerate services do not meet the standards of a day treatment program. However, nothing in these rules prohibit a mental health center from providing itinerate services.

COMMENT #40: One commentor disagreed with the requirement in paragraph (2)(b) of Rule XVII (16.32.644) that the program be site based. Some services are offered off-site as clinically indicated and in some rural programs, therapists provide services to youth at several different schools. The commentor recommended site based be dropped or defined to mean site based only during hours of operation with therapists and supervisors otherwise available as needed by each program site.

RESPONSE: The department disagrees with the commentor and has elected to retain the site based requirement. The standards in Rule XVII (16.32.644) are for site based child and adolescent day treatment programs. Itinerate services do not meet the standards of a day treatment program. However, nothing in these rules prohibits a mental health center from providing itinerate services.

COMMENT #41: One commentor asked whether Rule XVII (16.32.644) applied to separate schools in a school district. For example the Helena school district has 2 programs, one at Front School and the other at Smith School. The commentor recommended one supervisor be allowed per school district; if not, it would be costly and the programs over staffed.

RESPONSE: Rule XVII (16.32.644) requires either the program supervisor or program therapist to be site based. If each school referred to in comment number 41 has a program therapist on site, one program supervisor could supervise the programs offered at the two schools.

COMMENT #42: One commentor disagreed with the wording of paragraph (2)(d) in Rule XVII (16.32.644) stating that the mix of services provided to any one client should be based on client need and as specified in the individualized treatment plan. Program therapists provide crisis intervention and assessment services during the program day. After hours, crisis intervention and assessment services are routed through the mental health professional on call. The commentor recommended the rule be changed to "provide mental health services according to the individualized treatment plan which may include individual therapy, family and group therapy, social skills training, life skills training, pre-vocational training, therapeutic recreation services and ensure access to emergency services".

RESPONSE: The department agrees with the recommendation that

services be provided to each client based on need and has amended the rule accordingly.

COMMENT #43: One commentor recommended paragraphs (2)(e)(i) and (2)(e)(iii) in Rule XVII (16.32.644) be changed to include Head Start Programs, as they are not school districts. If Head Start is not included, it may be implied that we cannot do day treatment with Head Start Programs.

RESPONSE: The department believes that the wording "interagency agreements with educational agencies" in Rule XVII (16.32.644) clearly encompasses a Head Start Program and does not feel that it is necessary to amend either of the referenced paragraphs.

COMMENT #44: One commentor recommended that paragraph (2)(g) in Rule XVII (16.32.644) require staff observation of youth in time-out. The difference between time-out and seclusion is that a youth voluntarily requests to leave the class. The commentor believes the reason for leaving the class is the same as seclusion, to get their behavior, anger, etc. under control or prevent it from escalating. The commentor also recommended that the clinical record include a signed statement indicating the circumstances under which time-out may be allowed for the youth.

RESPONSE: In clarification, the department defines time-out and seclusion differently than that of the commentor. Please refer to the department's response to comment number 13. The department acknowledges time-out is used to gain control or prevent the youth's anger or behavior from escalating and agrees with staff observation of youth in time-out. The rule has been amended to require staff observation. The department does not believe that it should require that the clinical record include a signed statement indicating circumstances under which time-out may be allowed. The department believes that each child and adolescent day treatment program should be able to make its own determination as to the necessity of such a requirement.

COMMENT #45: One commentor recommended that paragraph (2)(h) of Rule XVII (16.32.644) requires 8 hours of training, 2 hours of which should relate to refresher training for appropriate physical restraint procedures, obtained from a certified program such as MANDT. The commentor believes this is essential for the safety of youth and staff.

RESPONSE: The department agrees that de-escalation training is needed and has amended Rule XVII (16.32.644). See the department's response to comment number 33. The department does not agree in dictating the number of hours required for annual updates, which may vary according to the training program, or mandating the source from which to obtain training.

COMMENT #46: One commentor recommended paragraph (3)(a) in Rule

XVII (16.32.644) be changed to require attendance by the staff at child study team (CST) meetings subject to, however, permission being granted by the school and/or parent or child when age appropriate. The commentor agreed that a copy of the individualized education program (IEP) should be included in the client's treatment plan subject, however, to the parent or legal guardian authorizing release of the IEP to the mental health program. If the school does not notify the mental health program of the CST or the IEP, mental health staff attendance will not occur. Although the intent is appropriate and participation is critical to good day treatment services, mental health staff do not control the CST, the school and parents do.

RESPONSE: The department agrees with the comments concerning parent or guardian consent and has amended Rule XVII (16.32.644) accordingly. However, the department does not agree that attendance at CST meetings by day treatment program staff should be contingent upon permission by the school. Rule XVII (16.32.644) also requires the day treatment program to provide appropriate educational services to clients including special education, if necessary, through full collaboration with a school district, employment of educational staff or interagency agreements with educational agencies. It is the responsibility of the day treatment program to ensure through agreement with the school district that permission will be granted to the staff to attend CST meetings and that notice will be provided to the day treatment staff of scheduled CST meetings. If the day treatment program is not able to reach such an agreement with the school district, the program should seriously reconsider its involvement as a day treatment program with that school district. Given the importance of CST meetings and the IEP for special education students, it is doubtful that the program could meet the needs of the client as required by Rule XVII (16.32.644) if educational and mental health staff are not able to work together.

COMMENT #47: One commentor recommended that the word "controlling" be changed to "managing" in paragraph (3)(b) of Rule XVII (16.32.644) so the locus of control remains with the child.

RESPONSE: The department agrees and has amended Rule XVII (16.32.644) accordingly.

COMMENT #48: One commentor asked for clarification of paragraph (4) of Rule XVII (16.32.644) regarding the program's staff to client ratio. The commentor recommended that a definition of support staff be included which would read "an adult with severe emotional disturbance (SED) experience under the supervision of the Head Start Director and/or the on-site Mental Health Licensed Professional".

RESPONSE: The department agrees that Rule XVII (16.32.644) should include a definition of "support staff" but disagrees with the commentor's recommended definition. Paragraph (2)(b) of Rule XVII (16.32.644) requires the program supervisor or program therapist to be site based. Support staff need to be under the supervision of the program supervisor or therapist to help implement the child's treatment plan. The department has amended Rule XVII (16.32.644) to define "support staff" as a person with experience in working with children and adolescents with severe emotional disturbances under the supervision of the program supervisor or program therapist.

COMMENT #49: One commentor disagreed with the department's requirement in paragraph (4) of Rule XVII (16.32.644) that an active case load for a licensed mental health professional not exceed 12 day treatment clients. The commentor recommended the standard be changed to "Each licensed mental health professional shall carry an active caseload which allows for the delivery of clinical services as defined in the individualized treatment plan". The 1 to 12 ratio does not allow for providing adequate transition of youth returning to a less restrictive environment. Transition services are a vital component of the program, and the program therapist the most logical service provider. Since transition services are provided less frequently, usually from 4 to 5 days per week to 1 day per week, the program therapist can carry an active caseload larger than 12.

RESPONSE: The department agrees that the 1 to 12 ratio in Rule XVII (16.32.644) may not allow for providing adequate transition of youth returning to a less restrictive environment. Upon consideration, Rule XVII (16.32.644) will be amended to reflect that the 1 to 12 ratio applies only to clients attending the program at least 3 to 5 days a week and that the 1 to 12 ratio does not apply to clients attending the program 1 to 2 days a week.

COMMENT #50: The author of comment number 49 also recommended that the requirement in paragraph (4) of Rule XVII (16.32.644) that there be at least one full-time equivalent (FTE) clinical or supportive staff member for every six clients in the program be deleted for the same reasons delineated in comment number 49. In the alternative, the commentor recommended that the standard be made consistent with Adult Day Treatment programs which require a client-to-staff ratio of 1:10, allowing the master's level clinician to work with up to 20 clients.

RESPONSE: The department acknowledges that the staff to client ratio should increase to accommodate those youth transitioning from 4 to 5 days to a less restrictive environment. However, the department disagrees with the commentor's recommended client to staff ratio of 1:10. Instead, the department believes the appropriate client to staff ratio should be 1:8, to allow for

transitional clients in the program that require less staff intervention. The department has amended Rule XVII (16.32.644) accordingly.

RULE XVIII (16.32.645) ADULT DAY TREATMENT PROGRAM

COMMENT #51: One commentor disagreed with the requirement in paragraph (2)(a) of Rule XVIII (16.32.645) that the adult day treatment program operate at least 2 days a week. The standard does not encourage expansion of adult day treatment programs into rural areas. The commentor recommended eliminating the standard or allowing urban day treatment programs to dispatch day treatment personnel to satellite locations under the urban day treatment license to encourage more rural programs.

RESPONSE: The department disagrees with changing the weekly time requirement based upon its belief that an adult day treatment program requires a minimal level of structure, stability, continuity and consistency. However, these rules do not prohibit a mental health center from providing group therapy or group activities in rural areas.

COMMENT #52: One commentor disagreed with the requirement in paragraph (2)(b) of Rule XVIII (16.32.645) for a site based program supervisor. The model is unworkable and cost prohibitive for smaller rural programs, given the difficulty of recruiting licensed therapists to rural areas and the limited income generating work of the position. The adult day treatment program on the Blackfeet Indian reservation is supervised out of Cut Bank by an unlicensed social worker and out of Great Falls by the Community Support Program (CSP) director. The commentor recommended small rural programs be able to operate without site based licensed supervision.

RESPONSE: The department has amended Rule XVIII (16.32.645) to require either the program therapist or program supervisor to be site based. The department believes, however, that an established level of clinical competency, as demonstrated by the licensure status of the supervisor or therapist, is required of these positions. Please refer to the department's response to comment number 9.

RULE XIX (16.32.646) MENTAL HEALTH GROUP HOME

COMMENT #53: One commentor questioned if mental health group homes have to be licensed. A.W.A.R.E., Inc. operates many group homes that have to be licensed by the State.

RESPONSE: Mental health group homes for adults were previously operated by community mental health centers under contract with the department. At that time, such homes required a public accommodation license. When these rules are adopted, mental

health group homes for adults will only require a mental health center license.

COMMENT #54: One commentor disagreed with the requirement in Rule XIX(5)(a) (16.32.646) that a mental health group home employ a program supervisor (defined as a licensed mental health professional). This requirement would preclude the use of an existing unlicensed program supervisor with extensive experience in transitional living. The program supervisor was clinically privileged under the contract with the department. The commentor recommended years of experience be allowed for licensure, or allow the CSP director act as a co-supervisor. The CSP director is a licensed mental health professional who directs the activities of each of the program supervisors.

RESPONSE: With the implementation of managed care, the department no longer clinically privileges staff working in community mental health centers. The question of grandfathering clinically privileged staff working in community mental health centers has been addressed in 37-23-208, MCA. Please refer to the department's response to comment number 4. The qualifications of a licensed mental health professional have been addressed in the department's response to comment number 9.

COMMENT #55: One commentor disagreed with the requirement in paragraph (5)(g) of Rule XIX (16.32.646) that the mental health group home enter progress notes into the client's record at least every 30 days noting that such requirement would make the client file enormous. The commentor recommended the primary therapist write a progress note based on input received from the group home versus individual notes from each service.

RESPONSE: The department believes the frequency requirement for progress notes is reasonable. The contracts between the department and community mental health centers (before the implementation of managed care) also required that progress notes be entered into the client record on a monthly basis. Treatment goals and objectives are required of all services received by the client. Progress notes are required to assess the resident's progress or lack of progress toward identified goals. The department does note, however, the requirement to enter a progress note upon the occurrence of any significant change in the client's condition which may well require that a progress note be written more frequently than every 30 days.

RULE XX (16.32.650) CRISIS TELEPHONE SERVICES

COMMENT #56: One commentor recommended paragraph (2)(a) of Rule XX (16.32.650) be amended to add the clarifying language, "7 days a week."

RESPONSE: The department agrees with the commentor and has

amended the rule accordingly.

COMMENT #57: Many commentors disagreed with the requirement in paragraph (2)(b) of Rule XX (16.32.650) that only licensed mental health professionals and trained law enforcement officers be allowed to answer crisis calls and that answering services could not be used.

One commentor recommended appropriately trained individuals who need clinical experience to attain licensure should be allowed to answer crisis calls and answering services should be allowed. The commentor pointed out that doctors in Helena and Great Falls use answering services to screen out non-emergency calls during evenings and weekends.

One commentor agreed that answering service personnel should not be conducting crisis intervention services, but recommended they be allowed to transfer calls to health care providers. An answering service in Billings provides call transfers to all health care providers in the community. Due to the volume of calls and numbers of mental health professionals rotating emergency call, a phone answering service is the most reasonable method to provide emergency care.

One commentor said using trained individuals with access to licensed personnel for consultation is effective and a national standard. Using law enforcement deters use of a crisis line until the crisis becomes life threatening. The intent of a crisis line is to help mitigate the crisis before it reaches the point of life threatening behavior. The commentor recommended paragraph (2)(b) of Rule XX (16.32.650) be revised to read "employ or contract with only trained personnel under the supervision of licensed mental health professionals to answer crisis calls". The commentor also recommended a standard be added to require access to licensed personnel for consultation and a mechanism to ensure face-to-face contact when and where appropriate.

One commentor disagreed with the rule that receptionists and answering services are not allowed to pick up calls and forward them to designated crisis responders. The rule change would eliminate mobile crisis teams if designated crisis responders had to stay close to the center's phone, dealing with wrong numbers, hang-ups, and calls intended for other Center programs. The commentor recommended changing the wording in paragraph (2)(b) of Rule XX (16.32.650) to read "The mental heath center providing crisis telephone services shall employ or contract with only licensed mental health professionals to respond to crisis calls" and "answering services may not be used for any other purpose other than to intercept after-hour phone calls and relay urgent calls and messages to the designated crisis responder".

The rule eliminates crisis support lines or suicide prevention centers staffed by trained volunteers or paraprofessionals as an effective component of the continuum of services. These services screen calls for true emergencies or potential emergencies, which are referred to professional crisis responders or police. The commentor points out the advantages to this type of system.

One commentor points out that their center's clinical staff, licensed or unlicensed, take turns rotating crisis calls. Backup is provided by a licensed mental health professional. They have not had a problem with this system in 25 years. The commentor utilizes an answering service in the Miles City area and disagrees with the proposal that they not be allowed. The center has a number of clinicians sharing crisis line rotation and they do not see any other way of deploying crisis calls. The answering service is efficient in contacting the clinician on the rotation schedule on the cell phone or their home phone number. In different areas of the region, hospitals, law enforcement or answering services are used as first responders.

RESPONSE: The department agrees with the commentors' recommendations (but not with the recommended wording) to allow appropriately trained individuals (who may or may not be licensed mental health professionals) to respond to crisis calls, to require that a licensed mental health professional provide consultation and/or backup for unlicensed individuals responding to crisis calls, and to allow answering services and receptionists to transfer crisis calls. The department has further specified what training is required of individuals before they can respond to crisis calls and has required the mental health center to establish policies and procedures on in-person contacts. The department has amended Rule XX (16.32.650) accordingly.

COMMENT #58: One commentor recommended the wording of the documentation requirements for crisis calls in attachment G of the contract between the department and community mental health centers, prior to managed care, be used in place of the proposed wording in paragraph (2)(d) of Rule XX (16.32.650). The commentor noted the contract requirements were clearer.

RESPONSE: The department agrees and has amended Rule XX (16.32.650) accordingly.

COMMENT #59: One commentor thought that Rule XX (16.32.650) required a duplication of crisis services, as the managed care organization operates a 24 hour crisis line staffed by mental health professionals.

RESPONSE: The department disagrees that Rule XX (16.32.650) requires a duplication of crisis services. Crisis telephone

services are only required to be offered by a mental health center if it has elected to be licensed as a provider of crisis telephone services pursuant to Rule XV (16.32.630), License Endorsement.

COMMENT #60: One commentor disagreed with the rule being limited to licensed mental health professionals when the state certifies individuals, licensed or otherwise, based on more relevant criteria as crisis responders. It makes no sense to liberalize the criteria for responding to crisis calls and at the same time force mental health centers to hire licensed but unqualified professionals to respond to crisis calls and at the same time lay off clinicians who are better qualified to provide the service. The commentor recommended, at a minimum, the rule be changed to "employ or contract with only licensed mental health professionals or state-certified mental health professional persons to answer crisis calls".

RESPONSE: The department in its response to comment number 57 amended Rule XX (16.32.650) to clarify that appropriately trained individuals can respond to crisis calls. Nothing in the amended language would preclude the use of state certified mental health professionals in responding to crisis calls. Please refer to the department's response to comment number 57 for more detail.

RULE XXI (16.32.651) CRISIS INTERVENTION AND STABILIZATION FACILITY

COMMENT #61: One commentor said the standards in Rule XXI (16.32.651) are all new, and therefore should be adopted with great care. There have been no prior licensure standards for crisis facilities from which to learn. The commentor believes the currently proposed standards are too minimal and could result in a danger to the public.

RESPONSE: Prior to the implementation of managed care (April 1, 1997), the contracts between the department and community mental health centers contained standards for crisis intervention and stabilization facility services. Crisis intervention and stabilization facilities have long been operated as part of community mental health centers. The department reviewed the terms and conditions that had been included in the above-mentioned contracts applicable to crisis intervention and stabilization services. Inspections and observations of the existing crisis intervention and stabilization facilities also provided further information as to desired standards for inclusion in the rule. The department feels strongly that the standards reflected in Rule XXI (16.32.651) will protect public health and safety and, in particular, the health and safety of the clients who will receive services from a crisis intervention and stabilization facility.

COMMENT #62: One commentor was appalled to learn that the proposed rules do not require a crisis intervention facility to meet group home standards.

RESPONSE: In review of the mental health group home and crisis intervention and stabilization facility standards, the department agrees that conceptually, some of the group home standards should also apply to crisis intervention and stabilization facilities. Mental health group homes are required to provide a different level of treatment and training to residents not required in crisis intervention and stabilization facilities, unless similar issues precipitate the resident's crisis. With that in mind, the department has amended Rule XXI (16.32.651) to include requirements pertaining to transfer agreements, staff qualifications and orientation, resident rights, the facility's grievance procedure and rules of conduct and the need to follow rules. The department has further amended the rule to reflect the requirement that the facility make referrals, upon the resident's discharge, for services that may prevent or diminish future crises.

COMMENT #63: One commentor believed the standards requiring the crisis intervention and stabilization facility to be clean, in good repair and meet local building codes had been dropped since the June 11, 1997, MetNet conference in which the proposed rules were discussed.

RESPONSE: The department continues to require in Rule XII (16.32.623), Compliance with Building and Fire Codes, Fire Extinguishers, Smoke Detectors and Maintenance, that mental health centers (to include a crisis intervention stabilization facility) meet minimum building and fire codes and that the facilities, buildings, homes, equipment and grounds be maintained in good repair at all times. The department acknowledges that state rather than local building and fire codes may apply to some mental health centers since some centers may be located outside of local building and fire code jurisdictions. The department has therefore amended Rule XII (16.32.623) to clarify that each mental health center is required to meet applicable State or local building and fire codes. The department has further amended Rule XII (16.32.623) to clarify the center's responsibility to ensure that its facilities, buildings, homes, equipment and grounds are clean.

COMMENT #64: One commentor questioned why Rule XXI (16.32.651) does not address requirements on space per patient.

RESPONSE: As a reminder, the department notes that Rule I (16.32.601) through Rule XV (16.32.630) are generally applicable to a mental health center, unless a specific type of service is exempted in the text of those rules. Therefore, a crisis intervention and stabilization facility is required to meet the

general requirements in those rules and the specific requirements in Rule XXI (16.32.651). Rule XIII (16.32.624), Physical Environment, requires each mental health center providing a crisis intervention stabilization facility to ensure that no more than 4 residents reside in a single bedroom and further clarifies the minimum size of the bedroom, per bed.

COMMENT #65: One commentor questioned why Rule XXI (16.32.651) does not address requirements on staff to patient ratio.

RESPONSE: The department has amended Rule XXI (16.32.651) to require that a crisis intervention and stabilization facility maintain a staff to patient ratio dictated by resident need.

COMMENT #66: One commentor questioned why the standards did not address meals.

RESPONSE: The department refers the commentor to Rule I (16.32.601), Application of Other Rules, which refers to other licensure rules in ARM Title 16, chapter 32, subchapter 3, which are applicable, in general, to health care facilities (which definition includes a mental health center). ARM 16.32.305 clarifies that a health care facility which serves food or beverage to patients or residents must comply with the Food Service Establishment Act, Title 50, chapter 50, MCA, and implementing food service establishment rules.

COMMENT #67: One commentor asked who develops the treatment plan in Rule XXI (16.32.651) and in what time frame.

RESPONSE: Rule VIII (16.32.616), Individualized Treatment Plans, applies to each mental health center (which definition includes a crisis intervention and stabilization facility). Rule VIII (1) (16.32.616) addresses the required time frame for development of the treatment plan following admission to a crisis intervention and stabilization facility. Rule VIII(1)(e) (16.32.616) addresses the development and ongoing review of the treatment plan. Rule VIII(1)(e) and (3) (16.32.616) address who develops and reviews the client's treatment plan. Rule VIII(2) (16.32.616) addresses the intervals with which the treatment plan is reviewed.

COMMENT #68: One commentor questioned why the standards did not address medication. Admission criteria allow a person on prescribed medication to enter the facility. Presumably, those medications are self-administered. What provision is made for someone in crisis who should not have access to their prescribed medications? How will medication be stored? How are medications administered? What provision is made for someone who needs medications adjusted due to their current crisis? What about someone who needs new medication as a result of the crisis?

RESPONSE: Rule V (16.32.609) requires each mental health center to establish policies and procedures for the conduct of medication management services, if clinically indicated. Medication management services would be clinically indicated for crisis intervention and stabilization facilities given the unstable conditions of the residents. The rule clarifies that medication management services would include policies and procedures for administering client medications, maintaining a medical administration record, addressing medication errors, adverse and non-adverse drug reactions, providing medication management education to clients, securing the safe storage of medication and refrigerating medication.

However, in addition to those requirements already established in Rule V (16.32.609), the department agrees with the commentor that the rule should be amended to require each mental health center to establish policies and procedures on resident self-administration of medication, assessing and addressing the need for new medical prescriptions, medication adjustment and medication monitoring. Rule V (16.32.609) has been amended accordingly.

The required policies and procedures in Rule V (16.32.609) coupled with the requirement to establish admission criteria in Rule XXI (16.32.651), including assessing whether the individual will follow the recommended treatment, ensures that a crisis intervention and stabilization facility will have adequate provisions in place to meet the needs of an individual in crisis who should not have access to their prescribed medications. If an individual referred to the program or a resident in the program is considered to be a danger to self or others and refuses to cooperate with self or professional administration of his or her medication, the individual should not be treated in a crisis intervention and stabilization facility. In such event, the facility should transfer the individual to an inpatient facility. The department has therefore amended Rule XXI (16.32.651) to require the facility to establish policies and procedures pertaining to transfer agreements for inpatient hospital care.

COMMENT #69: One commentor questioned that if the admission criteria require the individual to be medically stable, with the exception of their mental illness, who assesses the individual's medical stability? Is that person specifically trained to assess medical stability? What provisions are made for individuals who are not medically stable?

RESPONSE: Rule XXI (16.32.651) has been amended to require a facility to develop a policy and procedure which outlines how a medical screening and/or medical stabilization will be completed prior to admission.

COMMENT #70: One commentor questioned when would someone's need for medication adjustment and monitoring make them inappropriate for admission to a crisis intervention and stabilization facility?

RESPONSE: Medication adjustment and monitoring would not make an individual inappropriate for admission to a crisis intervention and stabilization facility unless the facility could not monitor the client's physical signs as indicated by the physician in adjusting the resident's medication, or if the individual was determined to be medically unstable.

COMMENT #71: One commentor asked what level of responsibility does the crisis and stabilization facility assume for the client's safety?

RESPONSE: Rule XXI (16.32.651) requires the facility to assess, prior to admission of an individual, the individual's needs and the appropriateness of the services to meet those needs, including assessing whether the individual is medically stable and willing to sign a no-harm contract, if clinically indicated. The facility is required to develop written procedures to be followed should residents, considered to be at risk for harming themselves or others, attempt to leave the facility without appropriate discharge authorization. The facility is required to establish policies and procedures for the secure storage of toxic household chemicals and sharp household items. Of note, Rule V (16.32.609), Clinical Services, requires each mental health center to provide safe and secure storage of medication.

COMMENT #72: One commentor interpreted paragraph (3)(a) in Rule XXI (16.32.651) to require the facility to provide up to 2 office spaces - one office for the program supervisor, who may very well for reasons of efficiency, be expected to provide administrative oversight for the facility and supervision for other programs as well and one office for any unlicensed clinician working under the direction of the program supervisor to provide day-to-day treatment on site. The commentor claimed this was an untenable expense burden for crisis stabilization facilities and would moreover run afoul of local zoning regulations that allow them to operate in areas zoned as residential as long as only one room is used as an office. The commentor recommended the "on site" requirement be eliminated. Other unlicensed disciplines, such as a post-doctoral fellow, have the experience to provide on site supervision under the direction of off-site licensed staff.

RESPONSE: Rule XXI (16.32.651) does not require the facility to provide 2 office spaces. Of note, the program supervisor is expressly required to provide daily overall responsibility for the operation of the crisis intervention and stabilization facility; such requirement is not discretionary on the part of

the program supervisor as implied by the commentor. An established level of clinical competency is required of the program supervisor. The crisis nature of the client requires the supervisor be site based.

COMMENT #73: One commentor disagreed with the requirement in paragraph (3)(c) in Rule XXI (16.32.651) that staff be oriented prior to assuming the duties of the position. The commentor recommended some of the training be allowed to be provided after hire in the form of in service training. The commentor pointed out the proposed training standards were originally developed by its crisis intervention and stabilization facility and have since been modified through program need. The commentor recommended supplementing the language in paragraph (3)(c) to include, "The orientation may be tailored by the program supervisor to the background of the new staff member. The program supervisor must certify that within eight weeks of assuming the duties of the position each staff person has demonstrated an acceptable level of knowledge with regard to the following subjects."

RESPONSE: In reviewing the training requirements for staff, the department believes training on mental illness and treatment, suicide risk and prevention procedures and program policies and procedures should be completed prior to assuming the duties of the position. The rest of the training requirements must be completed within eight weeks of the staff member assuming the duties of the position. Rule XXI (16.32.651) has been amended accordingly.

COMMENT #74: One commentor recommended the requirement in paragraph (3)(f)(iii) in Rule XXI (16.32.651) that clients be alcohol and drug free be changed to "below state legal intoxication level" as staff can not always tell if someone has been drinking or using drugs. The commentor expressed concern they will not be able to serve clients in need of service with this requirement.

RESPONSE: While the department declines to revise Rule XXI (16.32.651) as recommended by the commentor, the department has amended the rule to require that the individual be drug and alcohol free to the extent it does not significantly impair the individual's ability to meet the other admission criteria. The purpose of a crisis intervention and stabilization facility is to provide crisis intervention and stabilization services rather than detoxification services.

Rule Reviewer

Director, Public Health and Human Services

Certified to the Secretary of State February 17, 1998.

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules, amendment or repeal of existing rules filed with the Secretary of State, except rules proposed by the Department of Revenue. Proposals of the Department of Revenue are reviewed by the Revenue Oversight Committee.

The Administrative Code Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition, the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt or amend a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with the existing or proposed rules. The address is Room 138, Montana State Capitol, Helena, Montana 59620.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions: Administrative Rules of Montana (ARM) is a looseleaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statutes and rules by the attorney general (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1. Consult ARM topical index. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.
Statute Number and Department	2. Go to cross reference table at end of each title which lists MCA section numbers and corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through December 31, 1997. This table includes those rules adopted during the period January 1, 1998 through March 31, 1998 and any proposed rule action that was pending during the past 6-month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through December 31, 1997, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1996, 1997 and 1998 Montana Administrative Registers.

To aid the user, the Accumulative Table includes rulemaking actions of such entities as boards and commissions listed separately under their appropriate title number. These will fall alphabetically after department rulemaking actions.

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BOARD APPOINTEES AND VACANCIES

Section 2-15-108, MCA, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of 2-15-108, MCA, is that the Secretary of State publish monthly in the ***Montana Administrative Register*** a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments effective in January 1998, appear. Vacancies scheduled to appear from March 1, 1998, through May 31, 1998, are listed, as are current vacancies due to resignations or other reasons. Individuals interested in serving on a board should refer to the bill that created the board for details about the number of members to be appointed and necessary qualifications.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of February 2, 1998.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES FROM JANUARY, 1998

Appointee	Appointed by	Succeeds	Appointment/End Date
Appellate Defender Commission (Administration)			
Ms. Beverly Kolar	Governor	reappointed	1/1/1998
Geyser			1/1/2001
Qualifications (if required): public member			
Board of Chiropractors (Commerce)			
Dr. Gregory Hoell	Governor	Harris	1/13/1998
Bozeman			1/1/2001
Qualifications (if required): licensed and practicing chiropractor			
Board of Horseracing (Commerce)			
Ms. Lou Wojciechowski	Governor	reappointed	1/20/1998
Billings			1/20/2001
Qualifications (if required): representing District 2			
Mr. Joe Erickson	Governor	reappointed	1/20/1998
Cascade			1/20/2001
Qualifications (if required): representing the horseracing industry			
Mr. Bill Brown	Governor	reappointed	1/20/1998
Butte			1/20/2001
Qualifications (if required): representing the horseracing industry			
Ms. Susan Austin	Governor	Fisher	1/20/1998
Kalispell			1/20/2001
Qualifications (if required): representing District 5			
Developmental Disabilities Planning and Advisory Council (Public Health and Human Services)			
Sen. Sharon Estrada	Governor	not listed	1/1/1998
Billings			1/1/1999
Qualifications (if required): member of the State Senate			

BOARD AND COUNCIL APPOINTEES FROM JANUARY, 1998

Appointee	Appointed by	Succeeds	Appointment/End Date
Developmental Disabilities Planning and Advisory Council (Public Health and Human Services) cont.			
Rep. Bob Lawson Whitefish Qualifications (if required): member of the State House of Representatives	Governor	not listed	1/1/1998 1/1/1999
Mr. Bernadette Franks-Ongoy Helena Qualifications (if required): representing the Montana Advocacy Program	Governor	Smith	1/7/1998 1/1/2001
Judicial Nomination Commission (Justice)			
Judge Diana Barz Billings Qualifications (if required): none specified	Chief Justice	not listed	1/1/1998 1/1/2002
Ms. Pam Rein Big Timber Qualifications (if required): public member	Governor	reappointed	1/1/1998 1/1/2002
Martin Luther King Holiday Commemorative Commission (Commerce)			
Mr. Gary Conti Bozeman Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Ms. Angelina Vallejo Cormier Billings Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Mr. Robert Fourstar Wolf Point Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000

BOARD AND COUNCIL APPOINTEES FROM JANUARY, 1998

Appointee	Appointed by	Succeeds	Appointment/End Date
Martin Luther King Holiday Commemorative Commission (Commerce) cont.			
Ms. Kay Maloney Great Falls Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Ms. Cristina Medina Helena Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Mr. Brian Schnitzer Billings Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Ms. Michelle Wilkerson Great Falls Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Ms. Donna Ruff Fairview Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Dr. Frederick Gilliard Great Falls Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Ms. Carol Murray Browning Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000
Mrs. Pat Ojo Missoula Qualifications (if required): public member	Governor	not listed	1/20/1998 1/20/2000

BOARD AND COUNCIL APPOINTEES FROM JANUARY, 1998

Appointee	Appointed by	Succeeds	Appointment/End Date
Martin Luther King Holiday Commemorative Commission (Commerce) cont.			
Mr. Benjamin Pease, Jr. Billings	Governor	not listed	1/20/1998 1/20/2000
Qualifications (if required): public member			
Mr. Anthony Caldwell Great Falls	Governor	not listed	1/20/1998 1/20/2000
Qualifications (if required): public member			
Mr. William Jones Great Falls	Governor	not listed	1/20/1998 1/20/2000
Qualifications (if required): public member			
Mr. Wyman McDonald Helena	Governor	not listed	1/20/1998 1/20/2000
Qualifications (if required): Director of the Office of Indian Affairs			
Ms. Betty McCoy Bozeman	Governor	not listed	1/20/1998 1/20/2000
Qualifications (if required): public member			
Mr. Alan Thompson Helena	Governor	not listed	1/20/1998 1/20/2000
Qualifications (if required): public member			
Microbusiness Advisory Council (Commerce)			
Ms. Andrea Main Billings	Governor	Pierre	1/7/1998 6/30/2000
Qualifications (if required): representing minorities			

BOARD AND COUNCIL APPOINTEES FROM JANUARY, 1998

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Children's Trust Fund Board (Public Health and Human Services)			
Ms. Judy Birch	Governor	reappointed	1/13/1998
Helena			1/1/2001
Qualifications (if required): public member			
Ms. Barbara Campbell	Governor	reappointed	1/13/1998
Deer Lodge			1/1/2001
Qualifications (if required): public member			
Ms. Judy Garrity	Governor	reappointed	1/13/1998
Helena			1/1/2001
Qualifications (if required): public member			
Mr. Kirk Astroth	Governor	reappointed	1/13/1998
Bozeman			1/1/2001
Qualifications (if required): public member			
Mr. Mark A. Bryan	Governor	Acevedo	1/13/1998
Bozeman			1/1/2001
Qualifications (if required): public member			
Montana High School Association Board (not listed)			
Rep. Jeanette S. McKee	Governor	Lind	1/14/1998
Hamilton			1/1/2002
Qualifications (if required): public member			
Montana Higher Education Student Assistance Corporation (Education)			
Mr. Richard Bartos	Governor	reappointed	1/12/1998
Helena			1/1/2001
Qualifications (if required): public member			

BOARD AND COUNCIL APPOINTEES FROM JANUARY, 1998

Appointee	Appointed by	Succeeds	Appointment/End Date
State Lottery Commission (Commerce)			
Ms. Carol Thomas	Governor	reappointed	1/14/1998
Great Falls			1/1/2002
Qualifications (if required): public member			
Mr. Donald Murray	Governor	O'Toole	1/14/1998
Kalispell			1/1/2002
Qualifications (if required): attorney			
Vocational Rehabilitation Advisory Council (Public Health and Human Services)			
Ms. Sue Nielson	Director	Kelly	1/9/1998
Miles City			1/1/2000
Qualifications (if required): none specified			
Yellowstone River Task Force (Fish, Wildlife and Parks)			
Mr. Jim Woodhull	Governor	Kastelitz	1/14/1998
Livingston			1/1/2002
Qualifications (if required): City of Livingston representative			

VACANCIES ON BOARDS AND COUNCILS -- MARCH 1, 1998 through MAY 31, 1998

Board/current position holder	Appointed by	Term end
Board of Architects (Commerce)		
Ms. Pamela J. Hill, Bozeman	Governor	3/27/1998
Qualifications (if required): architect on staff at a state university of architecture		
Mr. Thomas Geelan, Havre	Governor	3/27/1998
Qualifications (if required): public member		
Board of Athletics (Commerce)		
Mr. Gary Langley, Helena	Governor	4/25/1998
Qualifications (if required): public member		
Board of Dentistry (Commerce)		
Dr. Donald O. Nordstrom, Missoula	Governor	3/29/1998
Qualifications (if required): dentist		
Board of Hail Insurance (Agriculture)		
Mr. Keith Arntzen, Hilger	Governor	4/18/1998
Qualifications (if required): public member		
Board of Nursing Home Administrators (Commerce)		
Mr. Douglas Faus, Chester	Governor	5/28/1998
Qualifications (if required): nursing home administrator		
Board of Plumbers (Commerce)		
Mr. Duane Steinmetz, Billings	Governor	5/4/1998
Qualifications (if required): journeyman plumber		
Mr. Richard Grover, Missoula	Governor	5/4/1998
Qualifications (if required): master plumber		

VACANCIES ON BOARDS AND COUNCILS -- MARCH 1, 1998 through MAY 31, 1998

Board/current position holder	Appointed by	Term end
Board of Real Estate Appraisers (Commerce)		
Ms. Cheryl Van Every, Sidney Qualifications (if required): public member	Governor	5/1/1998
Mr. William Northcutt, Joliet Qualifications (if required): real estate appraiser	Governor	5/1/1998
Board of Realty Regulation (Commerce)		
Mr. Jack K. Moore, Great Falls Qualifications (if required): public member and a Republican	Governor	5/9/1998
Board of Veteran's Affairs (Military Affairs)		
Ms. Karen Furu, Bozeman Qualifications (if required): veteran	Governor	5/18/1998
Executive Board of Montana State University (Education)		
Mr. Richard Roehm, Bozeman Qualifications (if required): public member	Governor	4/15/1998
Ms. Carol Willis, Billings Qualifications (if required): public member	Governor	4/15/1998
Executive Board of Montana Tech College Advisory Council (Education)		
Mr. Truxton Fisher, Butte Qualifications (if required): public member	Governor	4/15/1998
Executive Board of Northern Montana College (Education)		
Mr. Doug Ross, Havre Qualifications (if required): public member	Governor	4/15/1998

VACANCIES ON BOARDS AND COUNCILS -- MARCH 1, 1998 through MAY 31, 1998

Board/current position holder	Appointed by	Term end
Executive Board of University of Montana (Education)		
Ms. Arlene Breum, Missoula Qualifications (if required): public member	Governor	4/15/1998
Executive Board of Western Montana College (Education)		
Ms. Patricia J. Blade, Dillon Qualifications (if required): public member	Governor	4/15/1998
Multistate Tax Commission Advisory Council (Revenue)		
Mr. David W. Woodgerd, Helena Qualifications (if required): none specified	Director	3/1/1998
Ms. Judy Paynter, Helena Qualifications (if required): none specified	Director	3/1/1998
Ms. Lynn Chenoweth, Helena Qualifications (if required): none specified	Director	3/1/1998
Public Employees' Retirement Board (Administration)		
Mr. Troy W. McGee, Sr., Helena Qualifications (if required): retired public employee	Governor	4/1/1998
Mr. Fred J. Flanders, Helena Qualifications (if required): member at large	Governor	4/1/1998
State Library Commission (Education)		
Ms. Mary Doggett, White Sulphur Springs Qualifications (if required): public member	Governor	5/22/1998