CHAPTER 144

DEPARTMENT OF HEALTH

144.057 BACKGROUND STUDIES ON LICENSEES AND SUPPLEMENTAL NURSING SERVICES AGENCY PERSONNEL.

Subdivision 1. **Background studies required.** The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services which have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, and if the individual under study resides outside Minnesota, the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides;

(3) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. **Responsibilities of Department of Human Services.** The Department of Human Services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245C. For the purpose of this section, the

term "residential program" shall include all facilities described in subdivision 1. The Department of Human Services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245C. If an individual is disqualified, the Department of Human Services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the Department of Health.

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245C. The commissioner's decision shall be provided to the individual and to the Department of Human Services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action, except for the provisions under sections 245C.25, 245C.27, and 245C.28, subdivision 3.

Subd. 4. **Responsibilities of facilities and agencies.** Facilities and agencies described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapters 245A and 245C shall apply to these facilities and supplemental nursing services agencies. The provision of section 245C.09, shall apply to applicants, licensees, registrants, or an individual's refusal to cooperate with the completion of the background studies. Supplemental nursing services agencies subject to the registration requirements in section 144A.71 must maintain records verifying compliance with the background study requirements under this section.

History: *2003 c 15 art 1 s 33*

144.065 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS.

The state commissioner of health shall assist local health agencies and organizations throughout the state with the development and maintenance of services for the detection and treatment of sexually transmitted infections. These services shall provide for research, screening and diagnosis, treatment, case finding, investigation, and the dissemination of appropriate educational information. The state commissioner of health shall determine the composition of such services and shall establish a method of providing funds to boards of health as defined in section 145A.02, subdivision 2, state agencies, state councils, and nonprofit corporations, which offer such services. The state commissioner of health shall provide technical assistance to such agencies and organizations in accordance with the needs of the local area. Planning and implementation of services and technical assistance may be conducted in collaboration with boards of health; state agencies, including the University of Minnesota and the Department of Education; state councils; nonprofit organizations; and representatives of affected populations.

History: *2003 c 130 s 12*

144.09 COOPERATION WITH FEDERAL AUTHORITIES.

The state of Minnesota, through its legislative authority:

(1) accepts the provisions of any act of Congress providing for cooperation between the government of the United States and the several states in public protection of maternity and infancy;

(2) empowers and directs the commissioner to cooperate with the federal Children's Bureau to carry out the purposes of such acts; and

(3) appoints the commissioner of finance as custodian of all moneys given to the state by the United States under the authority of such acts and such money shall be paid out in the manner provided by such acts for the purposes therein specified.

History: *2003 c 112 art 2 s 50*

144.10 FEDERAL AID FOR MATERNAL AND CHILD WELFARE SERVICES; CUSTODIAN OF FUND; PLAN OF OPERATION; LOCAL APPROPRIATIONS.

The commissioner of finance is hereby appointed as the custodian of all moneys received, or which may hereafter be received, by the state by reason of any federal aid granted for maternal and child welfare service and for public health services, including the purposes as declared in Public Law 725 enacted by the 79th Congress of the United States, Chapter 958-2d Session and all amendments thereto, which moneys shall be expended in accordance with the purposes expressed in the acts of Congress granting such aid and solely in accordance with plans to be prepared by the state commissioner. The plans so to be prepared by the commissioner for maternal and child health service shall be approved by the United States Children's Bureau; and the plans of the commissioner for public health service shall be approved by the United States Public Health Service. Such plans shall include the training of personnel for both state and local health work and conform with all the requirements governing federal aid for these purposes. Such plans shall be designed to secure for the state the maximum amount of federal aid which is possible to be secured on the basis of the available state, county, and local appropriations for such purposes. The commissioner shall make reports, which shall be in such form and contain such information as may be required by the United States Children's Bureau or the United States Public Health Service, as the case may be; and comply with all the provisions, rules, and regulations which may be prescribed by these federal authorities in order to secure the correction and verification of such reports.

History: *2003 c 112 art 2 s 50*

144.1202 UNITED STATES NUCLEAR REGULATORY COMMISSION AGREEMENT.

[For text of subds 1 to 3, see M.S.2002]

Subd. 4. **Agreement; conditions of implementation.** (a) An agreement entered into before August 2, 2006, must remain in effect until terminated under the Atomic Energy Act of 1954, United States Code, title 42, section 2021, paragraph (j). The governor may not enter into an initial agreement with the Nuclear Regulatory Commission after August 1, 2006. If an agreement is not entered into by August 1, 2006, any rules adopted under this section are repealed effective August 1, 2006.

(b) An agreement authorized under subdivision 1 must be approved by law before it may be implemented.

History: *2003 c 111 s 1*

144.1222 PUBLIC POOLS; ENCLOSED SPORTS ARENAS.

[For text of subd 1, see M.S.2002]

Subd. 1a. **Fees.** All plans and specifications for public swimming pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each spa pool, $500;

(2) projects valued at $250,000 or less, a minimum of $800 per pool plus:

(i) for each slide, an additional $400; and

(ii) for each spa pool, an additional $500;

(3) projects valued at $250,000 or more, 0.5 percent of documented estimated project cost to a maximum fee of $10,000;

(4) alterations to an existing pool without changing the size or configuration of the pool, $400;

(5) removal or replacement of pool disinfection equipment only, $75; and

(6) request for variance from the public pool and spa rules, $500.

[For text of subds 2 to 3, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 25*

144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL DISORDERS.

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge laboratory service fees so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders. The laboratory service fee is $61 per specimen. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

Subd. 2. **Determination of tests to be administered.** The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of laboratory methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

Subd. 3. **Objection of parents to test.** Persons with a duty to perform testing under subdivision 1 shall advise parents of infants (1) that the blood or tissue samples used to perform testing thereunder as well as the results of such testing may be retained by the Department of Health, (2) the benefit of retaining the blood or tissue sample, and (3) that the following options are available to them with respect to the testing: (i) to decline to have the tests, or (ii) to elect to have the tests but to require that all blood samples and records of test results be destroyed within 24 months of the testing. If the parents of an infant object in writing to testing for heritable and congenital disorders or elect to require that blood samples and test results be destroyed, the objection or election shall be recorded on a form that is signed by a parent or legal guardian and made part of the infant's medical record. A written objection exempts an infant from the requirements of this section and section 144.128.

History: *1Sp2003 c 14 art 7 s 26*

144.1255 ADVISORY COMMITTEE ON HERITABLE AND CONGENITAL DISORDERS.

Subdivision 1. **Creation and membership.** (a) By July 1, 2003, the commissioner of health shall appoint an advisory committee to provide advice and recommendations to

the commissioner concerning tests and treatments for heritable and congenital disorders found in newborn children. Membership of the committee shall include, but not be limited to, at least one member from each of the following representative groups:

(1) parents and other consumers;

(2) primary care providers;

(3) clinicians and researchers specializing in newborn diseases and disorders;

(4) genetic counselors;

(5) birth hospital representatives;

(6) newborn screening laboratory professionals;

(7) nutritionists; and

(8) other experts as needed representing related fields such as emerging technologies and health insurance.

(b) The terms and removal of members are governed by section 15.059. Members shall not receive per diems but shall be compensated for expenses. Notwithstanding section 15.059, subdivision 5, the advisory committee does not expire.

Subd. 2. **Function and objectives.** The committee's activities include, but are not limited to:

(1) collection of information on the efficacy and reliability of various tests for heritable and congenital disorders;

(2) collection of information on the availability and efficacy of treatments for heritable and congenital disorders;

(3) collection of information on the severity of medical conditions caused by heritable and congenital disorders;

(4) discussion and assessment of the benefits of performing tests for heritable and congenital disorders as compared to the costs, treatment limitations, or other potential disadvantages of requiring the tests;

(5) discussion and assessment of ethical considerations surrounding the testing, treatment, and handling of data and specimens generated by the testing requirements of sections 144.125 to 144.128; and

(6) providing advice and recommendations to the commissioner concerning tests and treatments for heritable and congenital disorders found in newborn children.

History: *1Sp2003 c 14 art 7 s 27*

144.126 [Repealed, 1Sp2003 c 14 art 7 s 89]

144.128 COMMISSIONER'S DUTIES.

The commissioner shall:

(1) notify the physicians of newborns tested of the results of the tests performed;

(2) make referrals for the necessary treatment of diagnosed cases of heritable and congenital disorders when treatment is indicated;

(3) maintain a registry of the cases of heritable and congenital disorders detected by the screening program for the purpose of follow-up services; and

(4) adopt rules to carry out sections 144.125 to 144.128.

History: *1Sp2003 c 14 art 7 s 28*

144.1481 RURAL HEALTH ADVISORY COMMITTEE.

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a 15-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathy licensed under chapter 147;

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

(9) a licensed health care professional from an occupation not otherwise represented on the committee;

(10) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

(11) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation. Notwithstanding section 15.059, the advisory committee does not expire.

[For text of subds 2 and 3, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 29*

144.1483 RURAL HEALTH INITIATIVES.

The commissioner of health, through the Office of Rural Health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the Higher Education Services Office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;

(3) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(4) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

(5) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(6) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(7) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(8) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

(9) coordinate the development of a statewide plan for emergency medical services, in cooperation with the Emergency Medical Services Advisory Council;

(10) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota Department of Transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or health professional shortage area designation is subsequently withdrawn; and

(11) carry out other activities necessary to address rural health problems.

History: *1Sp2003 c 14 art 7 s 30*

144.1484 [Repealed, 1Sp2003 c 14 art 7 s 89]

144.1488 PROGRAM ADMINISTRATION AND ELIGIBILITY.

[For text of subds 1 and 3, see M.S.2002]

Subd. 4. **Eligible health professionals.** (a) To be eligible to apply to the commissioner for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, must have a current and unrestricted Minnesota license to practice, and must be ready to begin full-time clinical practice upon signing a contract for obligated service.

(b) Eligible providers are those specified by the federal Bureau of Health Professions in the policy information notice for the state's current federal grant application. A health professional selected for participation is not eligible for loan repayment until the health professional has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the commissioner.

History: *1Sp2003 c 14 art 7 s 31*

144.1491 FAILURE TO COMPLETE OBLIGATED SERVICE.

Subdivision 1. **Penalties for breach of contract.** A program participant who fails to complete the required years of obligated service shall repay the amount paid, as well as a financial penalty specified by the federal Bureau of Health Professions in the policy information notice for the state's current federal grant application. The commissioner shall report to the appropriate health-related licensing board a participant who fails to complete the service obligation and fails to repay the amount paid or fails to pay any financial penalty owed under this subdivision.

[For text of subd 2, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 32*

144.1494 [Repealed, 1Sp2003 c 14 art 7 s 89]

144.1495 [Repealed, 1Sp2003 c 14 art 7 s 89]

144.1496 [Repealed, 1Sp2003 c 14 art 7 s 89]

144.1497 [Repealed, 1Sp2003 c 14 art 7 s 89]

144.1501 HEALTH PROFESSIONAL EDUCATION LOAN FORGIVENESS PROGRAM.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(c) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(d) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(e) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(f) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(g) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(h) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(i) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(j) "Physician assistant" means a person registered under chapter 147A.

(k) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

(l) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 2. **Creation of account.** A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program for medical residents agreeing to practice in designated rural areas or underserved urban communities, for midlevel practitioners agreeing to practice in designated rural areas, and for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions. Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any

remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical resident or be enrolled in a midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area or facility type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

Subd. 6. **Rules.** The commissioner may adopt rules to implement this section.

History: *1Sp2003 c 14 art 7 s 33*

144.1502 DENTISTS LOAN FORGIVENESS.

[For text of subds 1 to 3, see M.S.2002]

Subd. 4. **Loan forgiveness.** The commissioner of health may accept applicants each year for participation in the loan forgiveness program, within the limits of available

funding. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for practice serving public program patients, as indicated by experience or training. The commissioner shall give preference to applicants who have attended a Minnesota dentistry educational institution and to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted dental school graduates in the year closest to the applicant's selection for which information is available or the balance of the qualifying educational loans, whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivision 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 3.

[For text of subds 5 and 6, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 34*

144.226 FEES.

[For text of subds 1 to 3, see M.S.2002]

Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $2 for each certified and noncertified birth or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth or death record is permitted under subdivision 1, paragraph (a).

History: *2003 c 112 art 2 s 50*

144.395 TOBACCO USE PREVENTION AND LOCAL PUBLIC HEALTH ENDOWMENT FUND.

Subdivision 1. **Creation.** (a) The tobacco use prevention and local public health endowment fund is created in the state treasury. The State Board of Investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate, except that the principal may be used to make expenditures from the fund for the purposes specified in this section when the market value of the fund falls below 105 percent of the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2. For purposes of this section, "principal" means an amount equal to the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2.

(b) If the commissioner of finance determines that probable receipts to the general fund will be sufficient to meet the need for expenditures from the general fund for a fiscal biennium, the commissioner may use cash reserves of the tobacco use prevention and local public health endowment fund, excluding an amount sufficient to meet the annual appropriations in subdivision 2, to pay expenses of the general fund. If cash reserves are transferred to the general fund to meet cash flow needs, the amount transferred, plus interest at a rate comparable to the rate earned by the state on invested commissioner of finance cash, as determined monthly by the commissioner, must be returned to the endowment fund as soon as sufficient cash balances are

available in the general fund, but in any event before the end of the fiscal biennium. An amount necessary to pay the interest is appropriated from the general fund. If cash reserves of the endowment fund are used to pay expenses for the general fund, the recipients of the grants shall be held harmless to the extent possible in the following order: (1) local public health; (2) local tobacco prevention; and (3) statewide tobacco prevention. When determining the fair market value of the fund, for the purposes described in subdivision 2, the value of the cash reserves transferred to the general fund must be included in the determination.

[For text of subds 2 and 3, see M.S.2002]

History: *2003 c 112 art 2 s 50*

144.396 TOBACCO USE PREVENTION.

Subdivision 1. **Purpose.** The legislature finds that it is important to reduce the prevalence of tobacco use among the youth of this state. It is a goal of the state to reduce tobacco use among youth by 25 percent by the year 2005, and to promote statewide and local tobacco use prevention activities to achieve this goal.

[For text of subd 2, see M.S.2002]

Subd. 3. **Statewide assessment.** The commissioner of health shall conduct a statewide assessment of tobacco-related behaviors and attitudes among youth to establish a baseline to measure the statewide effect of tobacco use prevention activities. The commissioner of education must provide any information requested by the commissioner of health as part of conducting the assessment. To the extent feasible, the commissioner of health should conduct the assessment so that the results may be compared to nationwide data.

[For text of subd 4, see M.S.2002]

Subd. 5. **Statewide tobacco prevention grants.** (a) To the extent funds are appropriated for the purposes of this subdivision, the commissioner of health shall award competitive grants to eligible applicants for projects and initiatives directed at the prevention of tobacco use. The project areas for grants include:

(1) statewide public education and information campaigns which include implementation at the local level; and

(2) coordinated special projects, including training and technical assistance, a resource clearinghouse, and contracts with ethnic and minority communities.

(b) Eligible applicants may include, but are not limited to, nonprofit organizations, colleges and universities, professional health associations, community health boards, and other health care organizations. Applicants must submit proposals to the commissioner. The proposals must specify the strategies to be implemented to target tobacco use among youth, and must take into account the need for a coordinated statewide tobacco prevention effort.

(c) The commissioner must give priority to applicants who demonstrate that the proposed project:

(1) is research based or based on proven effective strategies;

(2) is designed to coordinate with other activities and education messages related to other health initiatives;

(3) utilizes and enhances existing prevention activities and resources; or

(4) involves innovative approaches preventing tobacco use among youth.

[For text of subd 6, see M.S.2002]

Subd. 7. **Local public health promotion and protection.** The commissioner shall distribute funds appropriated for the purpose of local health promotion and protection activities to community health boards for local health initiatives other than tobacco prevention aimed at high risk health behaviors among youth. The commissioner shall

distribute these funds to the community health boards based on demographics and other need-based factors relating to health.

[For text of subds 8 and 9, see M.S.2002]

Subd. 10. **Report.** The commissioner of health shall submit a biennial report to the chairs and members of the house Health and Human Services Finance Committee and the senate Health and Family Security Budget Division on the statewide and local projects and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, and evaluation data and outcome measures, if available. These reports are due by January 15 of the odd-numbered years, beginning in 2001.

Subd. 11. **Audits.** The legislative auditor may audit tobacco use prevention and local public health expenditures to ensure that the money is spent for tobacco use prevention measures and public health initiatives.

Subd. 12. **Funds not to supplant existing funding.** Funds appropriated to the statewide tobacco prevention grants, local tobacco prevention grants, or the local public health promotion and prevention must not be used as a substitute for traditional sources of funding tobacco use prevention activities or public health initiatives. Any local unit of government receiving money under this section must ensure that existing local financial efforts remain in place.

History: *2003 c 130 s 12; 1Sp2003 c 14 art 7 s 35-40*

144.401 Subdivision 1.[Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 2. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5. [Repealed, 1Sp2003 c 9 art 8 s 8; 1Sp2003 c 14 art 8 s 32]

144.414 PROHIBITIONS.

[For text of subds 1 and 2, see M.S.2002]

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, or other health care-related facility, other than a nursing home, boarding care facility, or licensed residential facility, except as allowed in this subdivision.

(b) Smoking by participants in peer reviewed scientific studies related to the health effects of smoking may be allowed in a separated room ventilated at a rate of 60 cubic feet per minute per person pursuant to a policy that is approved by the commissioner and is established by the administrator of the program to minimize exposure of nonsmokers to smoke.

History: *1Sp2003 c 14 art 7 s 41*

144.5509 RADIATION THERAPY FACILITY CONSTRUCTION.

(a) A radiation therapy facility may be constructed only by an entity owned, operated, or controlled by a hospital licensed according to sections 144.50 to 144.56 either alone or in cooperation with another entity.

(b) This section expires August 1, 2008.

History: *1Sp2003 c 14 art 7 s 42*

144.551 HOSPITAL CONSTRUCTION MORATORIUM.

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex,

or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare; or

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services.

[For text of subds 2 to 4, see M.S.2002]

History: *1Sp2003 c 14 art 7 s 43*

144.6503 NURSING FACILITIES THAT SERVE PERSONS WITH ALZHEIMER'S DISEASE OR RELATED DISORDERS.

(a) If a nursing facility markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

History: *2003 c 37 s 1*

144.7022 ADMINISTRATIVE PENALTY ORDERS FOR REPORTING ORGANIZATIONS.

[For text of subds 1 to 3, see M.S.2002]

Subd. 4. **Penalty.** If the commissioner determines that the violation has been corrected or an acceptable corrective plan has been developed, the penalty may be forgiven, except where there are repeated or serious violations. The commissioner may issue an order with a penalty that will not be forgiven after corrective action is taken. Unless there is a request for review of the order under subdivision 6 before the penalty is due, the penalty is due and payable:

(1) on the 31st calendar day after the order was received, if the voluntary, nonprofit reporting organization fails to provide information to the commissioner showing that the violation has been corrected or that appropriate steps have been taken toward correcting the violation;

(2) on the 20th day after the voluntary, nonprofit reporting organization receives the commissioner's determination that the information provided is not sufficient to show that either the violation has been corrected or that appropriate steps have been taken toward correcting the violation; or

(3) on the 31st day after the order was received where the penalty is for repeated or serious violations and according to the order issued, the penalty will not be forgiven after corrective action is taken.

All penalties due under this section are payable to the commissioner of finance, state of Minnesota, and shall be deposited in the general fund.

[For text of subds 5 to 12, see M.S.2002]

History: *2003 c 112 art 2 s 50*

144.706 CITATION.

Sections 144.706 to 144.7069 may be cited as the Minnesota Adverse Health Care Events Reporting Act of 2003.

History: *2003 c 99 s 1*

144.7063 DEFINITIONS.

Subdivision 1. **Scope.** Unless the context clearly indicates otherwise, for the purposes of sections 144.706 to 144.7069, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Facility.** "Facility" means a hospital licensed under sections 144.50 to 144.58.

Subd. 4. **Serious disability.** "Serious disability" means (1) a physical or mental impairment that substantially limits one or more of the major life activities of an individual or a loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or (2) loss of a body part.

Subd. 5. **Surgery.** "Surgery" means the treatment of disease, injury, or deformity by manual or operative methods. Surgery includes endoscopies and other invasive procedures.

History: *2003 c 99 s 2; 1Sp2003 c 14 art 7 s 84*

144.7065 FACILITY REQUIREMENTS TO REPORT, ANALYZE, AND CORRECT.

Subdivision 1. **Reports of adverse health care events required.** Each facility shall report to the commissioner the occurrence of any of the adverse health care events described in subdivisions 2 to 7 as soon as is reasonably and practically possible, but no later than 15 working days after discovery of the event. The report shall be filed in a format specified by the commissioner and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. The commissioner may consult with experts and organizations familiar with patient safety when developing the format for reporting and in further defining events in order to be consistent with industry standards.

Subd. 2. **Surgical events.** Events reportable under this subdivision are:

(1) surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

(2) surgery performed on the wrong patient;

(3) the wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

(4) retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

(5) death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Subd. 3. **Product or device events.** Events reportable under this subdivision are:

(1) patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

(2) patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

(3) patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Subd. 4. **Patient protection events.** Events reportable under this subdivision are:

(1) an infant discharged to the wrong person;

(2) patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and

(3) patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Subd. 5. **Care management events.** Events reportable under this subdivision are:

(1) patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

(2) patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;

(3) maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

(4) patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;

(5) death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;

(6) stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission; and

(7) patient death or serious disability due to spinal manipulative therapy.

Subd. 6. **Environmental events.** Events reportable under this subdivision are:

(1) patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;

(2) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(3) patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;

(4) patient death associated with a fall while being cared for in a facility; and

(5) patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

Subd. 7. **Criminal events.** Events reportable under this subdivision are:

(1) any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(2) abduction of a patient of any age;

(3) sexual assault on a patient within or on the grounds of a facility; and

(4) death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

Subd. 8. **Root cause analysis; corrective action plan.** Following the occurrence of an adverse health care event, the facility must conduct a root cause analysis of the event. Following the analysis, the facility must: (1) implement a corrective action plan to implement the findings of the analysis or (2) report to the commissioner any reasons for not taking corrective action. If the root cause analysis and the implementation of a corrective action plan are complete at the time an event must be reported, the findings of the analysis and the corrective action plan must be included in the report of the event. The findings of the root cause analysis and a copy of the corrective action plan must otherwise be filed with the commissioner within 60 days of the event.

Subd. 9. **Electronic reporting.** The commissioner must design the reporting system so that a facility may file by electronic means the reports required under this section. The commissioner shall encourage a facility to use the electronic filing option when that option is feasible for the facility.

Subd. 10. **Relation to other law.** (a) Adverse health events described in subdivisions 2 to 6 do not constitute "maltreatment" or "a physical injury that is not reasonably explained" under section 626.557 and are excluded from the reporting requirements of section 626.557, provided the facility makes a determination within 24 hours of the discovery of the event that this section is applicable and the facility files the reports required under this section in a timely fashion.

(b) A facility that has determined that an event described in subdivisions 2 to 6 has occurred must inform persons who are mandated reporters under section 626.5572, subdivision 16, of that determination. A mandated reporter otherwise required to report under section 626.557, subdivision 3, paragraph (e), is relieved of the duty to report an event that the facility determines under paragraph (a) to be reportable under subdivisions 2 to 6.

(c) The protections and immunities applicable to voluntary reports under section 626.557 are not affected by this section.

(d) Notwithstanding section 626.557, a lead agency under section 626.5572, subdivision 13, is not required to conduct an investigation of an event described in subdivisions 2 to 6.

History: *2003 c 99 s 3; 1Sp2003 c 14 art 7 s 85*

144.7067 COMMISSIONER DUTIES AND RESPONSIBILITIES.

Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish an adverse health event reporting system designed to facilitate quality improvement in the health care system. The reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(b) The reporting system shall consist of:

(1) mandatory reporting by facilities of 27 adverse health care events;

(2) mandatory completion of a root cause analysis and a corrective action plan by the facility and reporting of the findings of the analysis and the plan to the commissioner or reporting of reasons for not taking corrective action;

(3) analysis of reported information by the commissioner to determine patterns of systemic failure in the health care system and successful methods to correct these failures;

(4) sanctions against facilities for failure to comply with reporting system requirements; and

(5) communication from the commissioner to facilities, health care purchasers, and the public to maximize the use of the reporting system to improve health care quality.

(c) The commissioner is not authorized to select from or between competing alternate acceptable medical practices.

Subd. 2. **Duty to analyze reports; communicate findings.** The commissioner shall:

(1) analyze adverse event reports, corrective action plans, and findings of the root cause analyses to determine patterns of systemic failure in the health care system and successful methods to correct these failures;

(2) communicate to individual facilities the commissioner's conclusions, if any, regarding an adverse event reported by the facility;

(3) communicate with relevant health care facilities any recommendations for corrective action resulting from the commissioner's analysis of submissions from facilities; and

(4) publish an annual report:

(i) describing, by institution, adverse events reported;

(ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses; and

(iii) making recommendations for modifications of state health care operations.

Subd. 3. **Sanctions.** (a) The commissioner shall take steps necessary to determine if adverse event reports, the findings of the root cause analyses, and corrective action plans are filed in a timely manner. The commissioner may sanction a facility for:

(1) failure to file a timely adverse event report under section 144.7065, subdivision 1; or

(2) failure to conduct a root cause analysis, to implement a corrective action plan, or to provide the findings of a root cause analysis or corrective action plan in a timely fashion under section 144.7065, subdivision 8.

(b) If a facility fails to develop and implement a corrective action plan or report to the commissioner why corrective action is not needed, the commissioner may suspend, revoke, fail to renew, or place conditions on the license under which the facility operates.

History: *2003 c 99 s 4*

144.7069 INTERSTATE COORDINATION; REPORTS.

The commissioner shall report the definitions and the list of reportable events adopted in this act to the National Quality Forum and, working in coordination with the National Quality Forum, to the other states. The commissioner shall monitor discussions by the National Quality Forum of amendments to the forum's list of reportable events and shall report to the legislature whenever the list is modified. The commissioner shall also monitor implementation efforts in other states to establish a list of reportable events and shall make recommendations to the legislature as necessary for modifications in the Minnesota list or in the other components of the Minnesota reporting system to keep the system as nearly uniform as possible with similar systems in other states.

History: *2003 c 99 s 5*