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Senate Language

ARTICLE 1

HEALTH POLICY

H2464-2 ARTICLE 1 SECTION 1 IS IDENTICAL TO H2435-3 ARTICLE 2 SECTION 6, WHICH MATCHES WITH UEH2435-1 ARTICLE 2 SECTION 35 ON PAGE R22A2 OF THE HHS ARTICLE 2 SIDE BY SIDE.

Section 1. **[144.6584] INFORMED CONSENT REQUIRED FOR SENSITIVE EXAMINATIONS.**

Subdivision 1. **Definition.** For purposes of this section, "sensitive examination" means a pelvic, breast, urogenital, or rectal examination.

Subd. 2. **Informed consent required; exceptions.** A health professional, or a student or resident participating in a course of instruction, clinical training, or a residency program for a health profession, must not perform a sensitive examination on an anesthetized or unconscious patient unless:

(1) the patient or the patient's legally authorized representative provided prior written, informed consent to the sensitive examination for preventive, diagnostic, or treatment purposes;

(2) the patient or the patient's legally authorized representative provided prior written, informed consent to the sensitive examination being performed solely for educational or training purposes;

(3) the patient or the patient's legally authorized representative provided prior written, informed consent to a surgical procedure or diagnostic examination and the sensitive examination is related to that surgical procedure or diagnostic examination and is medically necessary;

(4) the patient is unconscious and incapable of providing informed consent and the sensitive examination is medically necessary for diagnostic or treatment purposes; or

(5) the sensitive examination is performed by a health professional qualified to perform the examination and is performed for purposes of collecting evidence or documenting injuries.

Subd. 3. **Ground for disciplinary action.** A violation of this section is a ground for disciplinary action by the health-related licensing board regulating the individual who violated this section.

Sec. 2. Minnesota Statutes 2024, section 144.98, subdivision 8, is amended to read:

Subd. 8. **Exemption from national standards for quality control and personnel requirements.** ~~Effective January 1, 2012,~~ A laboratory that analyzes samples for compliance

with a permit issued under section 115.03, subdivision 5, may request exemption from the personnel requirements and specific quality control provisions for microbiology and chemistry stated in the national standards as incorporated by reference in subdivision 2a. The commissioner shall grant the exemption if the laboratory:

(1) complies with the methodology and quality control requirements, where available, in the most recent, approved edition of the Standard Methods for the Examination of Water and Wastewater as published by the Water Environment Federation; and

(2) supplies the name of the person meeting the requirements in section 115.73, or the personnel requirements in the national standard pursuant to subdivision 2a.

A laboratory applying for this exemption shall not apply for simultaneous accreditation under the national standard.

Sec. 3. Minnesota Statutes 2024, section 144.98, subdivision 9, is amended to read:

Subd. 9. **Exemption from national standards for proficiency testing frequency.** (a) ~~Effective January 1, 2012,~~ A laboratory applying for or requesting accreditation under the exemption in subdivision 8 must obtain an acceptable proficiency test result for each of the laboratory's accredited or requested fields of testing. The laboratory must analyze proficiency samples selected from one of two annual proficiency testing studies scheduled by the commissioner.

(b) If a laboratory fails to successfully complete the first scheduled proficiency study, the laboratory shall:

(1) obtain and analyze a supplemental test sample within 15 days of receiving the test report for the initial failed attempt; and

(2) participate in the second annual study as scheduled by the commissioner.

(c) If a laboratory does not submit results or fails two consecutive proficiency samples, the commissioner will revoke the laboratory's accreditation for the affected fields of testing.

(d) The commissioner may require a laboratory to analyze additional proficiency testing samples beyond what is required in this subdivision if information available to the commissioner indicates that the laboratory's analysis for the field of testing does not meet the requirements for accreditation.

(e) The commissioner may collect from laboratories accredited under the exemption in subdivision 8 any additional costs required to administer this subdivision and subdivision 8.

THE FOLLOWING SECTION IS FROM UEH2435-1 ARTICLE 2.

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Sec. 4. Minnesota Statutes 2024, section 144E.123, subdivision 3, is amended to read:

Subd. 3. **Review.** Prehospital care data may be reviewed by the director or its designees. The data shall be classified as private data on individuals under chapter 13, the Minnesota Government Data Practices Act. The director may share with the Washington/Baltimore High Intensity Drug Trafficking Area's Overdose Detection Mapping Application Program (ODMAP) data that identifies where and when an overdose incident happens, fatality status, suspected drug type, naloxone administration, and first responder type. ODMAP may:

(1) allow secure access to the system by authorized users to report information about an overdose incident;

(2) allow secure access to the system by authorized users to view, in near real-time, information about overdose incidents reported;

(3) produce a map in near real-time of the approximate locations of confirmed or suspected overdose incidents reported; and

(4) enable access to overdose incident information that assists in state and local decisions regarding the allocation of public health, public safety, and educational resources for the purposes of monitoring and reporting data related to suspected overdoses.

Sec. 5. Minnesota Statutes 2024, section 145.4718, is amended to read:

145.4718 PROGRAM EVALUATION.

(a) The director of child sex trafficking prevention established under section 145.4716 must conduct, or contract for, comprehensive evaluation of the statewide program for safe harbor for sexually exploited youth. The ~~first evaluation must be completed by June 30, 2015, and must be submitted~~ director must submit an updated evaluation to the commissioner of health and to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and public safety by September 1~~, 2015, and every two years thereafter~~ of each odd-numbered year. The evaluation must consider whether the program is reaching intended victims and whether support services are available, accessible, and adequate for sexually exploited youth, as defined in section 260C.007, subdivision 31.

(b) In conducting the evaluation, the director of child sex trafficking prevention must consider evaluation of outcomes, including whether the program increases identification of sexually exploited youth, coordination of investigations, access to services and housing available for sexually exploited youth, and improved effectiveness of services. The evaluation must also include examination of the ways in which penalties under section 609.3241 are assessed, collected, and distributed to ensure funding for investigation, prosecution, and victim services to combat sexual exploitation of youth.

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Sec. 34. Minnesota Statutes 2024, section 144E.123, subdivision 3, is amended to read:

Subd. 3. **Review.** Prehospital care data may be reviewed by the director or its designees. The data shall be classified as private data on individuals under chapter 13, the Minnesota Government Data Practices Act. The director may share with the Washington/Baltimore High Intensity Drug Trafficking Area's Overdose Detection Mapping Application Program (ODMAP) data that identifies where and when an overdose incident happens, fatality status, suspected drug type, naloxone administration, and first responder type. ODMAP may:

(1) allow secure access to the system by authorized users to report information about an overdose incident;

(2) allow secure access to the system by authorized users to view, in near real time, information about overdose incidents reported;

(3) produce a map in near real time of the approximate locations of confirmed or suspected overdose incidents reported; and

(4) enable access to overdose incident information that assists in state and local decisions regarding the allocation of public health, public safety, and educational resources for the purposes of monitoring and reporting data related to suspected overdoses.

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Sec. 6. Minnesota Statutes 2024, section 145.901, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** Within the limits of available funding, the commissioner of health ~~may~~ must conduct maternal death studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable maternal deaths in Minnesota.

Sec. 7. Minnesota Statutes 2024, section 145.902, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) For purposes of this section, a "safe place" means:

(1) a hospital licensed under sections 144.50 to 144.56~~.~~;

(2) a fire station that is staffed continuously, 24 hours per day, by firefighters or emergency medical services personnel, except when all staff are called out in an emergency and when the dual alarm system dispatches the nearest first responder to receive the infant as in any similar emergency;

(3) a health care provider who provides urgent care medical services~~, or~~;

(4) a newborn safety device installed by a fire station that meets the requirements in clause (2) and is participating in the program or by a licensed hospital that is staffed continuously, 24 hours per day; or

(5) an ambulance service licensed under chapter 144E dispatched in response to a 911 call from a mother or a person with the mother's permission to relinquish a newborn infant.

(b) A safe place shall receive a newborn left with an employee on the premises of the safe place during its hours of operation or in a newborn safety device, provided that:

(1) the newborn infant was born within seven days of being left at the safe place, as determined within a reasonable degree of medical certainty; ~~and~~

(2) the newborn infant is left in an unharmed condition~~.~~; and

(3) the newborn safety device:

(i) is designed to permit a parent to anonymously place a newborn infant in the device with the intent to leave the newborn infant;

(ii) allows fire station personnel or hospital personnel to remove the newborn infant from the device and take custody of the newborn infant;

(iii) is installed with an adequate dual alarm system connected to the physical location where the device is physically installed, and the dual alarm system is tested at least one time per month and visually checked at least two times per day to ensure the alarm system is in working order; and

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THE FOLLOWING SECTION IS FROM UEH2435-1 ARTICLE 2.

Sec. 37. Minnesota Statutes 2024, section 145.901, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** Within the limits of available funding, the commissioner of health ~~may~~ must conduct maternal death studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable maternal deaths in Minnesota.

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(iv) is physically located inside a participating fire station that is staffed continuously, 24 hours per day, by firefighters or emergency medical services personnel or inside a licensed hospital that is staffed continuously, 24 hours per day. The safety device must be located in an area that is conspicuous and visible to fire station personnel or hospital personnel.

(c) The safe place must not inquire as to the identity of the mother or the person leaving the newborn or call the police, provided the newborn is unharmed when presented to the hospital. The safe place may ask the mother or the person leaving the newborn about the medical history of the mother or newborn but the mother or the person leaving the newborn is not required to provide any information. The safe place may provide the mother or the person leaving the newborn with information about how to contact relevant social service agencies. This information must be available for the relinquishing parent in the newborn safety device.

(d) A safe place that is a health care provider who provides urgent care medical services shall dial 911, advise the dispatcher that the call is being made from a safe place for newborns, and ask the dispatcher to send an ambulance or take other appropriate action to transport the newborn to a hospital. An ambulance with whom a newborn is left or personnel at a fire station at which a newborn is left shall transport the newborn to a hospital for care. Hospitals must receive a newborn left with a safe place and make the report as required in subdivision 2.

Sec. 8. Minnesota Statutes 2024, section 145.902, subdivision 3, is amended to read:

Subd. 3. **Immunity.** (a) A safe place with responsibility for performing duties under this section, and any employee, doctor, ambulance personnel, or other medical professional working at the safe place, are immune from any criminal liability that otherwise might result from their actions, if they are acting in good faith in receiving a newborn, and are immune from any civil liability that otherwise might result from merely receiving a newborn.

(b) A safe place performing duties under this section, or an employee, doctor, ambulance personnel, or other medical professional working at the safe place who is a mandated reporter under chapter 260E, is immune from any criminal or civil liability that otherwise might result from the failure to make a report under that section if the person is acting in good faith in complying with this section.

(c) No person shall be prosecuted for any crime based solely on the act of leaving a newborn infant in compliance with this section.

Sec. 9. Minnesota Statutes 2024, section 147A.02, is amended to read:

147A.02 QUALIFICATIONS FOR LICENSURE.

(a) The board may grant a license as a physician assistant to an applicant who:

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THE FOLLOWING TWO SECTIONS ARE FROM UEH2435-1 ARTICLE 3.

Sec. 6. Minnesota Statutes 2024, section 147A.02, is amended to read:

147A.02 QUALIFICATIONS FOR LICENSURE.

(a) The board may grant a license as a physician assistant to an applicant who:

(1) submits an application on forms approved by the board;

(2) pays the appropriate fee as determined by the board;

(3) has current certification from the National Commission on Certification of Physician Assistants, or its successor agency as approved by the board;

(4) certifies that the applicant is mentally and physically able to engage safely in practice as a physician assistant;

(5) has no licensure, certification, or registration as a physician assistant under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a physician assistant, unless the board considers the condition and agrees to licensure;

(6) submits any other information the board deems necessary to evaluate the applicant's qualifications; and

(7) has been approved by the board.

(b) All persons registered as physician assistants as of June 30, 1995, are eligible for continuing license renewal. All persons applying for licensure after that date shall be licensed according to this chapter.

(c) A physician assistant who qualifies for licensure must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where physician assistants and physicians work together to provide patient care. The physician assistant shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this paragraph, a collaborative agreement is a mutually agreed upon plan for the overall working relationship ~~and collaborative arrangement~~ between a physician assistant~~,~~ and one or more physicians licensed under chapter 147~~,~~ or licensed in another state or United States territory that designates the scope of ~~services that can be provided~~ collaboration necessary to manage the care of patients. The physician assistant and one of the collaborative physicians must have experience in providing care to patients with the same or similar medical conditions. The collaborating physician is not required to be physically present so long as the collaborating physician and physician assistant are or can be easily in contact with each other by radio, telephone, or other telecommunication device.

Sec. 10. Minnesota Statutes 2024, section 148.56, subdivision 1, is amended to read:

Subdivision 1. **Optometry defined.** (a) Any person shall be deemed to be practicing optometry within the meaning of sections 148.52 to 148.62 who shall in any way:

(1) advertise as an optometrist;

(1) submits an application on forms approved by the board;

(2) pays the appropriate fee as determined by the board;

(3) has current certification from the National Commission on Certification of Physician Assistants, or its successor agency as approved by the board;

(4) certifies that the applicant is mentally and physically able to engage safely in practice as a physician assistant;

(5) has no licensure, certification, or registration as a physician assistant under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a physician assistant, unless the board considers the condition and agrees to licensure;

(6) submits any other information the board deems necessary to evaluate the applicant's qualifications; and

(7) has been approved by the board.

(b) All persons registered as physician assistants as of June 30, 1995, are eligible for continuing license renewal. All persons applying for licensure after that date shall be licensed according to this chapter.

(c) A physician assistant who qualifies for licensure must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where physician assistants and physicians work together to provide patient care. The physician assistant shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this paragraph, a collaborative agreement is a mutually agreed upon plan for the overall working relationship ~~and collaborative arrangement~~ between a physician assistant~~,~~ and one or more physicians licensed under chapter 147 or licensed in another state or United States territory, that designates the scope of ~~services that can be provided~~ collaboration necessary to manage the care of patients. The physician assistant and one of the collaborative physicians must have experience in providing care to patients with the same or similar medical conditions. The collaborating physician is not required to be physically present so long as the collaborating physician and physician assistant are or can be easily in contact with each other by radio, telephone, or other telecommunication device.

Sec. 21. Minnesota Statutes 2024, section 148.56, subdivision 1, is amended to read:

Subdivision 1. **Optometry defined.** (a) Any person shall be deemed to be practicing optometry within the meaning of sections 148.52 to 148.62 who shall in any way:

(1) advertise as an optometrist;

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(2) employ any means, including the use of autorefractors or other automated testing devices, for the measurement of the powers of vision or the adaptation of lenses or prisms for the aid thereof;

(3) possess testing appliances for the purpose of the measurement of the powers of vision;

(4) diagnose any disease, optical deficiency or deformity, or visual or muscular anomaly of the visual system consisting of the human eye and its accessory or subordinate anatomical parts;

(5) prescribe lenses, including plano or cosmetic contact lenses, or prisms for the correction or the relief of same;

(6) employ or prescribe ocular exercises, orthoptics, or habilitative and rehabilitative therapeutic vision care; or

(7) prescribe or administer legend drugs to aid in the diagnosis, cure, mitigation, prevention, treatment, or management of disease, deficiency, deformity, or abnormality of the human eye and adnexa included in the curricula of accredited schools or colleges of optometry, and as limited by Minnesota statute and adopted rules by the Board of Optometry, or who holds oneself out as being able to do so.

(b) In the course of treatment, nothing in this section shall allow:

(1) legend drugs to be administered intravenously~~, intramuscularly, or by injection, except for treatment of anaphylaxis~~; by intraocular or sub-Tenon injection; by injection posterior to the orbital septum; or by intramuscular injection, except as permitted under paragraph (d);

(2) invasive surgery including, but not limited to, surgery using lasers;

(3) Schedule II and III oral legend drugs ~~and oral steroids~~ to be administered or prescribed; or

(4) oral ~~antivirals to be prescribed or administered for more than ten days; or~~ steroids to be administered or prescribed for more than 14 days without consultation with a physician.

~~(5) oral carbonic anhydrase inhibitors to be prescribed or administered for more than seven days.~~

(c) Nothing in this section shall allow anesthetics to be administered by injection, except that an optometrist may administer local anesthesia by injection:

(1) for excision of chalazia, except that recurrent chalazia must be referred to a physician; and

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(2) employ any means, including the use of autorefractors or other automated testing devices, for the measurement of the powers of vision or the adaptation of lenses or prisms for the aid thereof;

(3) possess testing appliances for the purpose of the measurement of the powers of vision;

(4) diagnose any disease, optical deficiency or deformity, or visual or muscular anomaly of the visual system consisting of the human eye and its accessory or subordinate anatomical parts;

(5) prescribe lenses, including plano or cosmetic contact lenses, or prisms for the correction or the relief of same;

(6) employ or prescribe ocular exercises, orthoptics, or habilitative and rehabilitative therapeutic vision care; or

(7) prescribe or administer legend drugs to aid in the diagnosis, cure, mitigation, prevention, treatment, or management of disease, deficiency, deformity, or abnormality of the human eye and adnexa included in the curricula of accredited schools or colleges of optometry, and as limited by Minnesota statute and adopted rules by the Board of Optometry, or who holds oneself out as being able to do so.

(b) In the course of treatment, nothing in this section shall allow:

(1) legend drugs to be administered intravenously~~, intramuscularly, or by injection, except for treatment of anaphylaxis~~ or by sub-Tenon, retrobulbar, or intravitreal injection;

(2) invasive surgery including, but not limited to, surgery using lasers;

(3) Schedule II and III oral legend drugs ~~and oral steroids~~ to be administered or prescribed; or

(4) oral ~~antivirals to be prescribed or administered for more than ten days; or~~ steroids to be administered or prescribed for more than 14 days without consultation with a physician.

~~(5) oral carbonic anhydrase inhibitors to be prescribed or administered for more than seven days.~~

(2) for excision of a single epidermal lesion that: (i) is without characteristics of malignancy; (ii) is no larger than five millimeters in size; (iii) is no deeper than the dermal layer of the skin; and (iv) is not a lesion involving the eyelid margin.

(d) An optometrist may inject Botulinum toxin, limited to the periocular muscles of facial expression innervated by the first two branches of the facial nerve, including for cosmetic purposes.

Sec. 11. Minnesota Statutes 2024, section 148.56, is amended by adding a subdivision to read:

Subd. 1a. **Injections.** In order to perform injections permitted under subdivision 1, an optometrist must receive approval from the board after demonstrating to the board that the optometrist has sufficient educational or clinical training to perform injections. This subdivision does not apply to injections for treatment of anaphylaxis.