CHAPTER 144

DEPARTMENT OF HEALTH

144.0535 ENTRY FOR INSPECTION.

For the purposes of performing their official duties, all officers and employees of the state department of health shall have the right to enter any building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected.

History: *1989 c 282 art 2 s 7*

144.0723 CLIENT REIMBURSEMENT CLASSIFICATIONS; PROCEDURES FOR RECONSIDERATION.

Subdivision 1. **Client reimbursement classifications.** The commissioner of health shall establish reimbursement classifications based upon the assessment of each client in intermediate care facilities for the mentally retarded conducted after December 31, 1988, under section 256B.501, subdivision 3g, or under rules established by the commissioner of human services under section 256B.501, subdivision 3j. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services to set payment rates for intermediate care facilities for the mentally retarded beginning on or after October 1, 1990.

Subd. 2. **Notice of client reimbursement classification.** The commissioner of health shall notify each client and intermediate care facility for the mentally retarded in which the client resides of the reimbursement classification established under subdivision 1. The notice must inform the client of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of classification must be sent by first-class mail. The individual client notices may be sent to the client's intermediate care facility for the mentally retarded for distribution to the client. The facility must distribute the notice to the client's case manager and to the client or to the client's representative. This notice must be distributed within three working days after the facility receives the notices from the department. For the purposes of this section, "representative" includes the client's legal representative as defined in Minnesota Rules, part 9525.0015, subpart 18, the person authorized to pay the client's facility expenses, or any other individual designated by the client.

Subd. 3. **Request for reconsideration.** The client, client's representative, or the intermediate care facility for the mentally retarded may request that the commissioner reconsider the assigned classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days after the receipt of the notice of client classification. The request for reconsideration must include the name of the client, the name and address of the facility in which the client resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the client at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 4. **Access to information.** Upon written request, the intermediate care facility for the mentally retarded must give the client's case manager, the client, or the client's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The facility shall also provide access to and a copy of other information from the client's record that has been requested by or on behalf of the client to support a client's reconsideration request. A copy of any requested material must be provided within three working days after the facility receives a written request for the information. If the facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment. Notwithstanding this section, any order issued by the commissioner under this subdivision must require that the facility immediately comply with the request for information and that as of the date the order is issued, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

Subd. 5. **Facility's request for reconsideration.** (a) In addition to the information required in subdivision 3, a reconsideration request from an intermediate care facility for the mentally retarded must contain the following information:

(1) the date the reimbursement classification notices were received by the facility;

(2) the date the classification notices were distributed to the client's case manager and to the client or to the client's representative; and

(3) a copy of a notice sent to the client's case manager, and to the client or client's representative that tells the client or the client's representative (i) that a reconsideration of the client's reimbursement classification is being requested; (ii) the reason for the request; (iii) that the client's rate may change if the request is approved by the department; (iv) that copies of the facility's request and supporting documentation are available for review; and (v) that the client also has the right to request a reconsideration.

(b) If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

Subd. 6. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivisions 3 and 5. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. At the commissioner's discretion, the commissioner may review the reimbursement classifications assigned to all clients in the facility. Within 15 working days after receiving the request for reconsideration, the commissioner shall affirm or modify the original client classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The client and the intermediate care facility for the mentally retarded shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 7. **Audit authority.** The department of health may audit assessments of clients in intermediate care facilities for the mentally retarded. The audits may be

conducted at the facility, and the department may conduct the audits on an unannounced basis.

Subd. 8. **Rulemaking.** The commissioner of health shall adopt rules necessary to implement these provisions.

History: *1989 c 282 art 3 s 3*

144.122 LICENSE AND PERMIT FEES.

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the department of finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the general fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

History: *1989 c 209 art 1 s 14; 1989 c 282 art 1 s 16*

144.335 ACCESS TO HEALTH RECORDS.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient designates in writing as a representative. Except for minors who have received health care services pursuant to sections 144.341 to 144.347, in the case of a minor, "patient" includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is licensed to furnish the services pursuant to chapter 147, 148, 148B, 150A, 151, or 153; (2) a home care provider licensed under section 144A.46; and (3) a health care facility licensed pursuant to this chapter or chapter 144A.

Subd. 2. **Patient access.** (a) Upon request, a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

(b) Upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient (1) copies of the patient's health record, including

but not limited to laboratory reports, X-rays, prescriptions, and other technical information used in assessing the patient's health condition, or (2) the pertinent portion of the record relating to a condition specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

(c) If a provider, as defined in subdivision 1, clause (b)(1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in subdivision 1, clause (b)(1). The other provider or third party may release the information to the patient.

(d) A provider as defined in subdivision 1, clause (b)(3), shall release information upon written request unless, prior to the request, a provider as defined in subdivision 1, clause (b)(1), has designated and described a specific basis for withholding the information as authorized by paragraph (c).

Subd. 3. **Provider transfers and loans.** A patient's health record, including but not limited to, laboratory reports, X-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

[For text of subd 4, see M.S.1988]

History: *1989 c 64 s 1,2; 1989 c 175 s 3; 1989 c 209 art 1 s 15*

144.50 HOSPITALS, LICENSES; DEFINITIONS.

[For text of subds 1 to 5, see M.S.1988]

Subd. 6. **Supervised living facility licenses.** (a) The commissioner may license as a supervised living facility a facility seeking medical assistance certification as an intermediate care facility for persons with mental retardation or related conditions for four or more persons as authorized under section 252.291.

(b) Class B supervised living facilities for six or less persons seeking medical assistance certification as an intermediate care facility for persons with mental retardation or related conditions shall meet Group R, Division 3, occupancy requirements of the state building code, the fire protection provisions of chapter 21 of the 1985 life safety code, NFPA 101, for facilities housing persons with impractical evacuation capabilities, and shall provide the necessary physical plant accommodations to meet the needs and functional disabilities of the residents.

Subd. 7. **Residents with aids or hepatitis.** Boarding care homes and supervised living facilities licensed by the commissioner of health must accept as a resident a person who is infected with the human immunodeficiency virus or the hepatitis B virus unless the facility cannot meet the needs of the person under Minnesota Rules, part 4665.0200, subpart 5, or 4655.1500, subpart 2, or the person is otherwise not eligible for admission to the facility under state laws or rules.

History: *1989 c 282 art 2 s 8; art 3 s 4*

144.562 SWING BED APPROVAL; ISSUANCE OF LICENSE CONDITIONS; VIOLATIONS.

[For text of subd 1, see M.S.1988]

Subd. 2. **Eligibility for license condition.** A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and, as of the effective date, the available nursing homes within 50 miles have had occupancy rates of 96 percent or higher in the past two years; (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66; and (3) it agrees to utilize no more than four hospital beds as swing beds at any one time, except that the commissioner may approve the utilization of up to three additional beds at the request of a hospital if no Medicare certified skilled nursing facility beds are available within 25 miles of that hospital.

Subd. 3. **Approval of license condition.** The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision:

(a) The hospital must meet the eligibility criteria in subdivision 2.

(b) The hospital must be in compliance with the Medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 482.66.

(c) The hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of Medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(d) The hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

(e) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(f) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, Medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

[For text of subds 4 to 7, see M.S.1988]

History: *1989 c 282 art 2 s 9,10*

144.581 HOSPITAL AUTHORITIES.

[For text of subds 1 to 4, see M.S.1988]

Subd. 5. **Closed meetings; recording.** (a) Notwithstanding subdivision 4 or section 471.705, a public hospital or an organization established under this section may hold a closed meeting to discuss specific marketing activity and contracts that might be entered into pursuant to the marketing activity in cases where the hospital or organization is in competition with health care providers that offer similar goods or services, and where disclosure of information pertaining to those matters would cause harm to the competitive position of the hospital or organization, provided that the goods or services do not require a tax levy. No contracts referred to in this paragraph may be entered into earlier than 15 days after the proposed contract has been described at a public meeting and the description entered in the minutes, except for contracts for consulting services or with individuals for personal services.

(b) A meeting may not be closed under paragraph (a) except by a majority vote of the board of directors in a public meeting. The time and place of the closed meeting must be announced at the public meeting. A written roll of members present at the closed meeting must be available to the public after the closed meeting. The proceedings of a closed meeting must be tape-recorded and preserved by the board of directors for two years. The data on the tape are nonpublic data under section 13.02, subdivision 9. However, the data become public data under section 13.02, subdivision 14, two years after the meeting, or when the hospital or organization takes action on matters referred to in paragraph (a), except for contracts for consulting services. In the case of personal service contracts, the data become public when the contract is signed. For entities subject to section 471.345, a contract entered into by the board is subject to the requirements of section 471.345.

(c) The board of directors may not discuss a tax levy at a closed meeting.

History: *1989 c 351 s 15*

144.6501 NURSING HOME ADMISSION CONTRACTS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Facility" means a nursing home licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.58.

(b) "Contract of admission," "admission contract," or "admission agreement," includes, but is not limited to, all documents that a resident or resident's representative must sign at the time of, or as a condition of, admission to the facility. Oral representations and statements between the facility and the resident or resident's representative are not part of the contract of admission unless expressly contained in writing in those documents.

(c) "Legal representative" means an attorney-in-fact under a valid power of attorney executed by the prospective resident, or a conservator or guardian of the person or of the estate, or a representative payee appointed for the prospective resident, or other agent of limited powers.

Subd. 2. **Waivers of liability prohibited.** An admission contract must not include a waiver of facility liability for the health and safety or personal property of a resident while the resident is under the facility's supervision. An admission contract must not include a provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor any provision that requires or implies a lesser standard of care or responsibility than is required by law.

Subd. 3. **Contracts of admission.** (a) A facility shall make complete unsigned copies of its admission contract available to potential applicants and to the state or local long-term care ombudsman immediately upon request.

(b) A facility shall post conspicuously within the facility, in a location accessible to public view, either a complete copy of its admission contract or notice of its availability from the facility.

(c) An admission contract must be printed in black type of at least ten-point type size. The facility shall give a complete copy of the admission contract to the resident

or the resident's legal representative promptly after it has been signed by the resident or legal representative.

(d) An admission contract is a consumer contract under sections 325G.29 to 325G.37.

(e) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT. ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

Subd. 4. **Residents' signatures.** (a) Before or at the time of admission, the facility shall make reasonable efforts to communicate the content of the admission contract to, and obtain on the admission contract the signature of, the person who is to be admitted to the facility. The admission contract must be signed by the prospective resident unless the resident is legally incompetent or cannot understand or sign the admission contract because of the resident's medical condition.

(b) If the resident cannot sign the admission contract, the reason must be documented in the resident's medical record by the admitting physician.

(c) If the determination under paragraph (b) has been made, the facility may request the signature of another person on behalf of the applicant, subject to the provisions of paragraph (d). The facility must not require the person to disclose any information regarding the person's personal financial assets, liabilities, or income, unless the person voluntarily chooses to become financially responsible for the resident's care.

(d) A person other than the resident or a spouse who is financially responsible for the resident who signs an admission contract must not be required by the facility to assume financial responsibility for the resident's care. A person who desires to assume financial responsibility for the resident's care may contract with the facility to do so.

(e) The admission contract must include written notice, in bold capital letters, that a person other than the resident or financially responsible spouse may not be required by the facility to assume financial responsibility for the resident's care.

(f) This subdivision does not preclude the facility from obtaining the signature of a legal representative, if applicable.

Subd. 5. **Public benefits eligibility.** An admission contract must clearly and explicitly state whether the facility participates in the Medicare, medical assistance, or Veterans Administration programs. If the facility's participation in any of those programs is limited for any reason, the admission contract must clearly state the limitation and whether the facility is eligible to receive payment from the program for the person who is considering admission or who has been admitted to the facility.

Subd. 6. **Medical assistance payment.** (a) An admission contract for a facility that is certified for participation in the medical assistance program must state that neither the prospective resident, nor anyone on the resident's behalf, is required to pay privately any amount for which the resident's care at the facility has been approved for payment by medical assistance or to make any kind of donation, voluntary or otherwise. An admission contract must state that the facility does not require as a condition of admission, either in its admission contract or by oral promise before signing the admission contract, that residents remain in private pay status for any period of time.

(b) The admission contract must state that upon presentation of proof of eligibility, the facility will submit a medical assistance claim for reimbursement and will return any and all payments made by the resident, or by any person on the resident's behalf, for services covered by medical assistance, upon receipt of medical assistance payment.

(c) A facility that participates in the medical assistance program shall not charge for the day of the resident's discharge from the facility or subsequent days.

(d) If a facility's charges incurred by the resident are delinquent for 30 days, and

no person has agreed to apply for medical assistance for the resident, the facility may petition the court under chapter 525 to appoint a representative for the resident in order to apply for medical assistance for the resident.

(e) The remedy provided in this subdivision does not preclude a facility from seeking any other remedy available under other laws of this state.

Subd. 7. **Consent to treatment.** An admission contract must not include a clause requiring a resident to sign a consent to all treatment ordered by any physician. An admission contract may require consent only for routine nursing care or emergency care. An admission contract must contain a clause that informs the resident of the right to refuse treatment.

Subd. 8. **Written acknowledgment.** An admission contract must contain a written acknowledgment that the resident has been informed of the patient's bill of rights, as required in section 144.652.

Subd. 9. **Violations; penalties.** (a) Violation of this section is grounds for issuance of a correction order, and if uncorrected, a penalty assessment issued by the commissioner of health, under section 144A.10. The civil fine for noncompliance with a correction order issued under this section is $250 per day.

(b) Unless otherwise expressly provided, the remedies or penalties provided by this subdivision do not preclude a resident from seeking any other remedy and penalty available under other laws of this state.

Subd. 10. **Applicability.** This section applies to new admissions to facilities on and after October 1, 1989. This section does not require the execution of a new admission contract for a resident who was residing in a facility before August 1, 1989. However, provisions of the admission contract that are inconsistent with or in conflict with this section are voidable at the sole option of the resident. Residents must be given notice of the changes in admission contracts according to this section and must be given the opportunity to execute a new admission contract that conforms to this section.

History: *1989 c 285 s 2*

144.651 PATIENTS AND RESIDENTS OF HEALTH CARE FACILITIES; BILL OF RIGHTS.

[For text of subd 1, see M.S.1988]

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age.

[For text of subds 3 to 9, see M.S.1988]

Subd. 10. **Participation in planning treatment; notification of family members.** (a) Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative. In the event that the patient or resident cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences.

(b) If a patient or resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under

paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient or resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient or resident has an effective advance directive to the contrary or knows the patient or resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient or resident has executed an advance directive relative to the patient or resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the patient or resident;

(2) examining the medical records of the patient or resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the patient or resident has executed an advance directive and whether the patient or resident has a physician to whom the patient or resident normally goes for care; and

(4) inquiring of the physician to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the patient or resident and the medical records of the patient or resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the patient or resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

[For text of subds 11 to 32, see M.S.1988]

History: *1989 c 186 s 1; 1989 c 282 art 3 s 5*

144.698 REPORTING REQUIREMENTS.

Subdivision 1. **Yearly reports.** Each hospital and each outpatient surgical center, which has not filed the financial information required by this section with a voluntary, nonprofit reporting organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:

(1) a balance sheet detailing the assets, liabilities, and net worth of the hospital;

(2) a detailed statement of income and expenses;

(3) a copy of its most recent cost report, if any, filed pursuant to requirements of Title XVIII of the United States Social Security Act;

(4) a copy of all changes to articles of incorporation or bylaws;

(5) information on services provided to benefit the community, including services

provided at no cost or for a reduced fee to patients unable to pay, teaching and research activities, or other community or charitable activities;

(6) information required on the revenue and expense report form set in effect on July 1, 1989; and

(7) other information required by the commissioner in rule.

[For text of subds 2 to 5, see M.S.1988]

History: *1989 c 282 art 2 s 11*

144.701 RATE DISCLOSURE.

Subdivision 1. **Consumer information.** The commissioner of health shall ensure that the total costs, total revenues, and total services of each hospital and each outpatient surgical center are reported to the public in a form understandable to consumers.

Subd. 2. **Data for policy making.** The commissioner of health shall compile relevant financial and accounting data concerning hospitals and outpatient surgical centers in order to have statistical information available for legislative policy making.

Subd. 3. **Rate schedule.** The commissioner of health shall obtain from each hospital and outpatient surgical center a current rate schedule. Any subsequent amendments or modifications of that schedule shall be filed with the commissioner of health on or before their effective date.

Subd. 4. **Filing fees.** Each report which is required to be submitted to the commissioner of health under sections 144.695 to 144.703 and which is not submitted to a voluntary, nonprofit reporting organization in accordance with section 144.702 shall be accompanied by a filing fee in an amount prescribed by rule of the commissioner of health. Fees received pursuant to this subdivision shall be deposited in the general fund of the state treasury. Upon the withdrawal of approval of a reporting organization, or the decision of the commissioner to not renew a reporting organization, fees collected under section 144.702 shall be submitted to the commissioner and deposited in the general fund. The commissioner shall report the termination or nonrenewal of the voluntary reporting organization to the chair of the health and human services subdivision of the appropriations committee of the house of representatives, to the chair of the health and human services division of the finance committee of the senate, and the commissioner of finance.

History: *1989 c 282 art 2 s 12*

144.702 VOLUNTARY REPORTING OF HOSPITAL AND OUTPATIENT SURGICAL CENTER COSTS.

[For text of subd 1, see M.S.1988]

Subd. 2. **Approval of organization's reporting procedures.** The commissioner of health may approve voluntary reporting procedures consistent with written operating requirements for the voluntary, nonprofit reporting organization which shall be established annually by the commissioner. These written operating requirements shall specify reports, analyses, and other deliverables to be produced by the voluntary, nonprofit reporting organization, and the dates on which those deliverables must be submitted to the commissioner. The commissioner of health shall, by rule, prescribe standards for submission of data by hospitals and outpatient surgical centers to the voluntary, nonprofit reporting organization or to the commissioner. These standards shall provide for:

(a) The filing of appropriate financial information with the reporting organization;

(b) Adequate analysis and verification of that financial information; and

(c) Timely publication of the costs, revenues, and rates of individual hospitals and outpatient surgical centers prior to the effective date of any proposed rate increase. The commissioner of health shall annually review the procedures approved pursuant to this subdivision.

[For text of subds 3 to 6, see M.S.1988]

Subd. 7. **Staff support.** The commissioner may require as part of the written operating requirements for the voluntary, nonprofit reporting organization that the organization provide sufficient funds to cover the costs of one professional staff position who will directly administer the health care cost information system.

Subd. 8. **Termination or nonrenewal of reporting organization.** The commissioner may withdraw approval of any voluntary, nonprofit reporting organization for failure on the part of the voluntary, nonprofit reporting organization to comply with the written operating requirements under subdivision 2. Upon the effective date of the withdrawal, all funds collected by the voluntary, nonprofit reporting organization under section 144.701, subdivision 4, but not expended shall be deposited in the general fund.

The commissioner may choose not to renew approval of a voluntary, nonprofit reporting organization if the organization has failed to perform its obligations satisfactorily under the written operating requirements under subdivision 2.

History: *1989 c 282 art 2 s 13-15*

144.761 DEFINITIONS.

Subdivision 1. **Scope of definitions.** For purposes of this chapter, the following terms have the meanings given them.

Subd. 2. **HIV.** "HIV" means the human immunodeficiency virus, the causative agent of AIDS.

Subd. 3. **Hepatitis B.** "Hepatitis B" means the hepatitis B virus.

Subd. 4. **Emergency medical services agency.** "Emergency medical services agency" means an agency, entity, or organization that employs or uses emergency medical services personnel as employees or volunteers licensed or certified under sections 144.801 to 144.8091.

Subd. 5. **Emergency medical services personnel.** "Emergency medical services personnel" means:

(1) individuals employed to provide prehospital emergency medical services;

(2) persons employed as licensed police officers under section 626.84, subdivision 1, who experience a significant exposure in the performance of their duties;

(3) firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as employees or volunteers of an ambulance service as defined by sections 144.801 to 144.8092, who provide prehospital emergency medical services;

(4) crime lab personnel receiving a significant exposure while involved in a criminal investigation; and

(5) correctional guards, including security guards at the Minnesota security hospital, employed by the state or a local unit of government who experience a significant exposure to an inmate who is transported to a facility for emergency medical care.

Subd. 6. **Patient.** "Patient" means an individual who is received by a facility and who receives the services of emergency medical services personnel. Patient includes, but is not limited to, victims of accident or injury, or deceased persons.

Subd. 7. **Significant exposure.** "Significant exposure" means:

(1) contact of broken skin or mucous membrane of emergency medical services personnel with a patient's blood, amniotic fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, cerebrospinal fluid, semen, vaginal secretions, or bodily fluids grossly contaminated with blood;

(2) a needle stick, scalpel or instrument wound, or other wound inflicted by an object that is contaminated with blood, and that is capable of cutting or puncturing the skin of emergency medical services personnel; or

(3) an exposure that occurs by any other method of transmission recognized by contemporary epidemiological standards as a significant exposure.

Subd. 8. **Facility.** "Facility" means a licensed hospital and freestanding emergency medical care facility licensed under sections 144.50 to 144.56 that receives a patient cared for by emergency medical services personnel.

History: *1989 c 154 s 1*

144.762 NOTIFICATION PROTOCOL FOR EXPOSURE TO HIV AND HEPATITIS B.

Subdivision 1. **Notification protocol required.** Every facility that receives a patient shall adopt a postexposure notification protocol for emergency medical services personnel who have experienced a significant exposure.

Subd. 2. **Requirements for protocol.** The postexposure notification protocol must include the following:

(1) a method for emergency medical services personnel to notify the facility that they may have experienced a significant exposure from a patient that was transported to the facility. The facility shall provide to the emergency medical services personnel a significant exposure report form to be completed by the emergency medical services personnel in a timely fashion;

(2) a process to investigate whether a significant exposure has occurred. This investigation must be completed within 72 hours of receipt of the exposure report;

(3) if there has been a significant exposure, a process to determine whether the patient has hepatitis B or HIV infection;

(4) if the patient has an infectious disease that could be transmitted by the type of exposure that occurred, or, if it is not possible to determine what disease the patient may have, a process for making recommendations for appropriate counseling and testing to the emergency medical services personnel;

(5) compliance with applicable state and federal laws relating to data practices, confidentiality, informed consent, and the patient bill of rights; and

(6) a process for providing counseling for the patient to be tested and for the emergency medical services personnel filing the exposure report.

Subd. 3. **Immunity.** A facility is not civilly or criminally liable for actions relating to the notification of emergency medical services personnel if the facility has made a good faith effort to adopt and follow a notification protocol.

History: *1989 c 154 s 2*

144.763 COUNSELING REQUIREMENTS.

With regard to testing for HIV infection, facilities shall ensure that pretest counseling, notification of test results, and posttest counseling are provided to all patients tested and to emergency medical services personnel requesting notification.

History: *1989 c 154 s 3*

144.764 RESPONSIBILITY FOR TESTING; COSTS.

The facility that receives a patient shall ensure that tests under sections 144.761 to 144.7691 are performed. The emergency medical services agency that employs the emergency medical services personnel who request testing under sections 144.761 to 144.7691 must pay for the cost of counseling, testing, and costs associated with the testing of the patient and of the emergency medical services personnel.

History: *1989 c 154 s 4*

144.765 PATIENT'S RIGHT TO REFUSE TESTING.

Upon notification of a significant exposure, the facility shall ask the patient to consent to blood testing to determine the presence of the HIV virus or the hepatitis B virus. The patient shall be informed that the test results without personally identifying information will be reported to the emergency medical services personnel. The patient

shall be informed of the right to refuse to be tested. If the patient refuses to be tested, the patient's refusal will be forwarded to the emergency medical services agency and to the emergency medical services personnel. The right to refuse a blood test under the circumstances described in this section does not apply to a prisoner who is in the custody or under the jurisdiction of the commissioner of corrections.

History: *1989 c 154 s 5*

144.766 DEATH OF PATIENT.

If a patient who is the subject of a reported significant exposure dies before an opportunity to consent to blood testing under sections 144.761 to 144.7691, the facility shall conduct a test of the deceased person for hepatitis B and HIV infection. Consent of the deceased person's representative is not necessary for purposes of this section.

History: *1989 c 154 s 6*

144.767 TEST RESULTS; REPORTS.

Subdivision 1. **Report to employer.** Results of tests conducted under this section shall be reported by the facility to a designated agent of the emergency medical services agency that employs or uses the emergency medical services personnel and to the emergency medical services personnel who report the significant exposure. The test results shall be reported without personally identifying information.

Subd. 2. **Report to patient.** The facility that receives the patient shall inform the patient or, if the patient is deceased, the representatives of the deceased person, of test results for all tests conducted under this chapter.

History: *1989 c 154 s 7*

144.768 TEST INFORMATION CONFIDENTIALITY.

Subdivision 1. **Private data.** Information concerning test results obtained under this chapter is, with respect to patients and employees of persons in the private sector, private and confidential information and, with respect to patients and employees of state agencies, statewide systems, or political subdivisions, private data.

Subd. 2. **Consent to release information.** A facility shall not disclose to emergency medical services personnel personally identifying information about a patient without a written release signed by the patient or a personal representative of the decedent.

History: *1989 c 154 s 8*

144.769 PENALTY FOR UNAUTHORIZED RELEASE OF PATIENT INFORMATION.

Any unauthorized release, by an individual or agency described in section 144.761, subdivision 4 or 5, of personally identifying information under sections 144.761 to 144.7691 is a misdemeanor. This section does not preclude the patient from pursuing remedies and penalties under sections 13.08 and 13.09 or other private causes of action against an individual, state agency, statewide system, political subdivision, or person responsible for releasing private data, or confidential or private information on the patient or employee.

History: *1989 c 154 s 9*

144.7691 DUTIES OF THE COMMISSIONER.

Subdivision 1. **Technical consultation.** The commissioner shall provide technical consultation for:

(1) development of an exposure report form to be used by the facility;

(2) development of a postexposure notification protocol to be adopted by the facility;

(3) training and education of emergency medical services personnel on infectious disease guidelines and protocols for emergency medical services personnel to use to prevent transmission of infectious disease;

(4) development of recommendations for counseling and testing the patient and emergency medical services personnel; and

(5) a mechanism for the facility to notify the patient of the results of the test.

Subd. 2. **Rulemaking authority.** The commissioner may adopt rules to carry out sections 144.761 to 144.7691. The commissioner may by rule add other infectious diseases to section 144.762, subdivision 2, clause (3).

History: *1989 c 154 s 10*

144.801 DEFINITIONS.

[For text of subds 1 to 6, see M.S.1988]

Subd. 7. **Base of operations.** "Base of operations" means the address at which the physical plant housing ambulances, related equipment and personnel is located.

[For text of subds 9 and 10, see M.S.1988]

History: *1989 c 134 s 1*

144.802 LICENSING.

[For text of subds 1 and 2, see M.S.1988]

Subd. 3. **Applications; notice of application; recommendations.** (a) Each prospective licensee and each present licensee wishing to offer a new type or types of ambulance service, to establish a new base of operation, or to expand a primary service area, shall make written application for a license to the commissioner on a form provided by the commissioner.

(b) For applications for the provision of ambulance services in a service area located within a county, the commissioner shall promptly send notice of the completed application to the county board and to each community health service board, regional emergency medical services system designated under section 144.8093, ambulance service, and municipality in the area in which ambulance service would be provided by the applicant. The commissioner shall publish the notice, at the applicant's expense, in the State Register and in a newspaper in the municipality in which the base of operation will be located, or if no newspaper is published in the municipality or if the service would be provided in more than one municipality, in a newspaper published at the county seat of the county in which the service would be provided.

(c) For applications for the provision of ambulance services in a service area larger than a county, the commissioner shall promptly send notice of the completed application to the municipality in which the service's base of operation will be located and to each community health board, county board, regional emergency medical services system designated under section 144.8093, and ambulance service located within the counties in which any part of the service area described by the applicant is located, and any contiguous counties. The commissioner shall publish this notice, at the applicant's expense, in the State Register.

(d) The commissioner shall request that the chief administrative law judge appoint an administrative law judge to hold a public hearing in the municipality in which the service's base of operation will be located. The public hearing shall be conducted as contested case hearing under chapter 14.

(e) Each municipality, county, community health service, regional emergency medical services system, ambulance service, and other person wishing to make recommendations concerning the disposition of the application shall make written recommendations to the administrative law judge within 30 days of the publication of notice of the application in the State Register.

(f) The administrative law judge shall:

(1) hold a public hearing in the municipality in which the service's base of operations is or will be located;

(2) provide notice of the public hearing in the newspaper or newspapers in which notice was published under paragraph (b) for two successive weeks at least ten days before the date of the hearing;

(3) allow any interested person the opportunity to be heard, to be represented by counsel, and to present oral and written evidence at the public hearing;

(4) provide a transcript of the hearing at the expense of any individual requesting it.

(g) The administrative law judge shall review and comment upon the application and shall make written recommendations as to its disposition to the commissioner within 90 days of receiving notice of the application. In making the recommendations, the administrative law judge shall consider and make written comments as to whether the proposed service, change in base of operations, or expansion in primary service area is needed, based on consideration of the following factors:

(1) the relationship of the proposed service, change in base of operations or expansion in primary service area to the current community health plan as approved by the commissioner under section 145.918;

(2) the recommendations or comments of the governing bodies of the counties and municipalities in which the service would be provided;

(3) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;

(4) the estimated effect of the proposed service, change in base of operation or expansion in primary service area on the public health;

(5) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service, change in base of operations, or expansion in primary service area.

The administrative law judge shall recommend that the commissioner either grant or deny a license or recommend that a modified license be granted. The reasons for the recommendation shall be set forth in detail. The administrative law judge shall make the recommendations and reasons available to any individual requesting them.

Subd. 3a. **Licensure of air ambulance services.** Except for submission of a written application to the commissioner on a form provided by the commissioner, an application to provide air ambulance service shall be exempt from the provisions of subdivisions 3 and 4.

A license issued pursuant to this subdivision need not designate a primary service area.

No license shall be issued under this subdivision unless the commissioner of health determines that the applicant complies with the requirements of applicable federal and state statutes and rules governing aviation operations within the state.

Subd. 4. **Commissioner's decision.** Within 30 days after receiving the administrative law judge's report, the commissioner shall grant or deny a license to the applicant. In granting or denying a license, the commissioner shall consider the administrative law judge's report, the evidence contained in the application, and any hearing record and other applicable evidence. The commissioner's decision shall be based on a consideration of the factors contained in subdivision 3, clause (g). If the commissioner's decision is different from the administrative law judge's recommendations, the commissioner shall set forth in detail the reasons for differing from the recommendations.

[For text of subd 5, see M.S.1988]

Subd. 6. **Temporary license.** Notwithstanding other provisions herein, the commissioner may issue a temporary license for instances in which a primary service area would be deprived of ambulance service. The temporary license shall expire when an applicant has been issued a regular license under this section. The temporary license shall be valid no more than six months from date of issuance. A temporary licensee must provide evidence that the licensee will meet the requirements of section 144.804 and the rules adopted under this section.

History: *1989 c 134 s 2-5*

144.804 STANDARDS.

Subdivision 1. **Drivers and attendants.** No publicly or privately owned basic ambulance service shall be operated in the state unless its drivers and attendants possess a current emergency medical care certificate authorized by rules adopted by the commissioner of health according to chapter 14. Until August 1, 1994, a licensee may substitute a person currently certified by the American Red Cross in advanced first aid and emergency care or a person who has successfully completed the United States Department of Transportation first responder curriculum, and who has also been trained to use all of the equipment carried in the ambulance, for one of the persons on a basic ambulance, provided that person will function as the driver while transporting a patient. The commissioner may grant a variance to allow a licensed ambulance service to use attendants certified by the American Red Cross in advanced first aid and emergency care in order to ensure 24-hour emergency ambulance coverage. The variance must expire no later than August 1, 1990. The commissioner shall study the roles and responsibilities of first responder units and report the findings by January 1, 1991. This study shall address at a minimum: (1) education and training; (2) appropriate equipment and its use; (3) medical direction and supervision; and (4) supervisory and regulatory requirements.

Subd. 2. **Equipment and staff.** (a) Every ambulance offering ambulance service shall be equipped as required by the commissioner and carry at least the minimal equipment necessary for the type of service to be provided as determined by standards adopted by the commissioner pursuant to subdivision 3.

(b) Each ambulance service shall offer service 24 hours per day every day of the year, unless otherwise authorized by the commissioner.

(c) Each ambulance while transporting a patient shall be staffed by at least a driver and an attendant, according to subdivision 1. An ambulance service may substitute for the attendant a physician, osteopath, registered nurse, or physician's assistant who is qualified by training to use appropriate equipment in the ambulance. Advanced life support procedures including, but not limited to, intravenous fluid administration, drug administration, endotracheal intubation, cardioversion, defibrillation, and intravenous access may be performed by the physician, osteopath, registered nurse, or physician's assistant who has appropriate training and authorization, and who provides all of the equipment and supplies not normally carried on basic ambulances.

(d) An ambulance service shall not deny emergency ambulance service to any person needing emergency ambulance service because of inability to pay or due to source of payment for services if this need develops within the licensee's primary service area. Transport for such a patient may be limited to the closest appropriate emergency medical facility.

Subd. 3. **Types of services to be regulated.** The commissioner may adopt rules needed to carry out sections 144.801 to 144.8091, including the following types of ambulance service:

(a) basic ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to rules adopted by the commissioner according to chapter 14, and that provides a level of care so as to ensure that life-threatening situations and potentially serious injuries can be recognized, patients will be protected from additional hazards, basic treatment to reduce the seriousness of emergency situations will be administered and patients transported to an appropriate medical facility for treatment;

(b) intermediate ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the commissioner adopts according to chapter 14, and that provides basic ambulance service and intravenous infusions or defibrillation or both. Standards adopted by the commissioner shall include, but not be limited to, equipment, training, procedures, and medical control;

(c) advanced ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the commissioner adopts accord-

ing to chapter 14, and that provides basic ambulance service, and in addition, advanced airway management, defibrillation, and administration of intravenous fluids and pharmaceuticals. Vehicles of advanced ambulance service licensees not equipped or staffed at the advanced ambulance service level shall not be identified to the public as capable of providing advanced ambulance service.

(d) specialized ambulance service that provides basic, intermediate, or advanced service as designated by the commissioner, and is restricted by the commissioner to (1) less than 24 hours of every day, (2) designated segments of the population, or (3) certain types of medical conditions; and

(e) air ambulance service, that includes fixed-wing and helicopter, and is specialized ambulance service.

Until standards have been developed under clauses (b), (d), and (e), the current provisions of Minnesota Rules shall govern these services.

Subd. 4. [Repealed, 1989 c 134 s 12]

Subd. 5. **Local government's powers.** Local units of government may, with the approval of the commissioner, establish standards for ambulance services which impose additional requirements upon such services. Local units of government intending to impose additional requirements shall consider whether any benefit accruing to the public health would outweigh the costs associated with the additional requirements. Local units of government which desire to impose such additional requirements shall, prior to promulgation of relevant ordinances, rules or regulations, furnish the commissioner with a copy of such proposed ordinances, rules or regulations, along with information which affirmatively substantiates that the proposed ordinances, rules or regulations: will in no way conflict with the relevant rules of the department of health; will establish additional requirements tending to protect the public health; will not diminish public access to ambulance services of acceptable quality; and will not interfere with the orderly development of regional systems of emergency medical care. The commissioner shall base any decision to approve or disapprove such standards upon whether or not the local unit of government in question has affirmatively substantiated that the proposed ordinances, rules or regulations meet these criteria.

Subd. 6. **Rules on primary service areas.** The commissioner shall promulgate rules defining primary service areas under section 144.801, subdivision 8, under which the commissioner shall designate each licensed ambulance service as serving a primary service area or areas.

Subd. 7. **Drivers of ambulance service vehicles.** An ambulance service vehicle shall be staffed by a driver possessing a current Minnesota driver's license or equivalent and whose driving privileges are not under suspension or revocation by any state. If red lights and siren are used, the driver must also have completed training approved by the commissioner in emergency driving techniques. An ambulance transporting patients must be staffed by at least two persons who are trained according to this section, one of whom may be the driver.

History: *1989 c 134 s 6*

144.805 [Repealed, 1989 c 134 s 12]

144.806 PENALTIES.

Any person who violates a provision of sections 144.801 to 144.806 is guilty of a misdemeanor. The commissioner may issue fines to assure compliance with sections 144.801 to 144.806 and rules adopted under those sections. The commissioner shall adopt rules to implement a schedule of fines by January 1, 1991.

History: *1989 c 134 s 7*

144.807 REPORTS.

Subdivision 1. **Reporting of information.** Operators of ambulance services licensed pursuant to sections 144.801 to 144.806 shall report information about ambulance

service to the commissioner as the commissioner may require. The reports shall be classified as "private data on individuals" under the Minnesota government data practices act, chapter 13.

[For text of subd 2, see M.S.1988]

Subd. 3. [Repealed, 1989 c 134 s 12]

History: *1989 c 134 s 8*

144.808 INSPECTIONS.

The commissioner may inspect ambulance services as frequently as deemed necessary. These inspections shall be for the purpose of determining whether the ambulance and equipment is clean and in proper working order and whether the operator is in compliance with sections 144.801 to 144.804 and any rules that the commissioner adopts related to sections 144.801 to 144.804.

History: *1989 c 134 s 9*

144.809 RENEWAL OF EMERGENCY MEDICAL TECHNICIAN'S CERTIFICATE, FEE.

No fee set by the commissioner for biennial renewal of an emergency medical technician's certificate by a volunteer member of an ambulance service, fire department, or police department shall exceed $2.

History: *1989 c 134 s 10*

144.8091 REIMBURSEMENT TO NONPROFIT AMBULANCE SERVICES.

Subdivision 1. **Repayment for volunteer training.** Any political subdivision, or nonprofit hospital or nonprofit corporation operating a licensed ambulance service shall be reimbursed by the commissioner for the necessary expense of the initial training of a volunteer ambulance attendant upon successful completion by the attendant of a basic emergency medical care course, or a continuing education course for basic emergency medical care, or both, which has been approved by the commissioner, pursuant to section 144.804. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the training course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than $210 for successful completion of a basic course, and $70 for successful completion of a continuing education course.

Subd. 2. **Volunteer attendant defined.** For purposes of this section, "volunteer ambulance attendant" means a person who provides emergency medical services for a Minnesota licensed ambulance service without the expectation of remuneration and who does not depend in any way upon the provision of these services for the person's livelihood. An individual may be considered a volunteer ambulance attendant even though that individual receives an hourly stipend for each hour of actual service provided, except for hours on standby alert, even though this hourly stipend is regarded as taxable income for purposes of state or federal law, provided that this hourly stipend does not exceed $500 within one year of the final certification examination. Reimbursement will be paid under provisions of this section when documentation is provided the department of health that the individual has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

Subd. 3. [Repealed by amendment, 1989 c 134 s 11]

History: *1989 c 134 s 11*

144.8092 [Repealed, 1989 c 134 s 12]

144.851 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.851 to 144.862.

Subd. 2. **Abatement.** "Abatement" means the use of the best available technology to remove or encapsulate deteriorating or intact lead paint or to reduce the availability of lead in soil and house dust, medicine, water, and any other sources considered a lead hazard by the commissioner.

Subd. 3. **Board of health.** "Board of health" means an administrative authority established under section 145A.03 or 145A.07.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 5. **Elevated blood lead level.** "Elevated blood lead level" means at least 25 micrograms per deciliter.

Subd. 6. **Encapsulation.** "Encapsulation" refers to the covering or containment of a lead source in soil or paint to prevent harmful exposure to lead. Encapsulation includes, but is not limited to, covering of bare soil that contains more than acceptable levels of lead under rules adopted under section 144.862 with sod or soil that contains acceptable parts per million lead under rules adopted under section 144.862, seeding, and treatment for walkways and parking areas.

Subd. 7. **Lead abatement contractor.** "Lead abatement contractor" means an employer or other person or entity who, for financial gain, directly performs or causes to be performed, through subcontracting or similar delegation, work related to lead hazard abatement or immediate hazard removal.

History: *1989 c 282 art 2 s 16*

144.852 PROACTIVE LEAD EDUCATION STRATEGY.

The commissioner shall contract with boards of health in communities at high risk for toxic lead exposure to children, lead advocacy organizations, and businesses to design and implement a uniform, proactive educational program to introduce sections 144.851 to 144.861 and promote the prevention of exposure to all sources of lead to target populations. Priority shall be given to provide ongoing education to health care and social service providers, registered lead abatement contractors, building trades professionals and nonprofessionals, property owners, and parents. Educational materials shall be multilingual and multicultural to meet the needs of diverse populations.

History: *1989 c 282 art 2 s 17*

144.853 LEAD SCREENING FOR CHILDREN.

Within limits of available appropriations, the commissioner shall contract with the boards of health in Minneapolis, St. Paul, and Duluth to promote and subsidize a baseline blood lead test of all children at risk who live in the high risk areas served by these boards of health and who are under six years of age. The lead screening shall be advocated on a statewide basis through the proactive education efforts of boards of health. The lead screening shall be promoted to be carried out in conjunction with routine blood tests.

Medical laboratories performing blood lead analyses must provide copies of the laboratory report form for all blood levels of at least ten micrograms per deciliter to the commissioner and to the board of health of the city or county in which the patient resides.

The information obtained from the screenings shall be reported by census tract and made available for research and to the public.

The commissioner shall work through the statewide WIC program to ensure that erythrocyte protoporphyrin testing of children for lead toxicity is integrated as a state reimbursed screening component of WIC services. The commissioner shall also evaluate the accessibility and affordability of lead screening for children throughout the state as provided by other health care providers and report the findings to the legislature by January 1990.

History: *1989 c 282 art 2 s 18*

144.854 ASSESSMENT AND ABATEMENT.

Subdivision 1. **Residence assessment.** If a child or pregnant woman is identified as having a blood lead level that exceeds 25 micrograms per deciliter or the Center for Disease Control recommendation for elevated blood level, the board of health must do a timely assessment of the child's or pregnant woman's residence to determine the sources of lead contamination and must provide education to the residents and the owner on the best means of reducing the danger of the lead sources.

Subd. 2. **Abatement orders.** If the level of lead in paint, soil, or dust found during the assessment conducted under subdivision 1 exceeds the toxic level of lead standards established in rules adopted under section 144.862, the board of health must order the property owner to abate the lead sources.

Subd. 3. **Provision of equipment.** State matching funds shall be made available for a grant program to community-based organizations to purchase and provide paint removal equipment. Equipment shall include: drop cloth, secure containers, power water sprayers, scrapers, and any other equipment required by local health department or state health department rules. Equipment shall be made available to low-income households on a priority basis.

Subd. 4. **Protection of resident and yard.** No person shall be required to scrape loose paint or remove intact paint in response to a housing code violation order or environmental health or abatement order unless the municipality provides:

(1) specific information regarding personal safety precautions, and proper removal, containment, and cleanup of lead paint and debris;

(2) a referral to an organization with proper removal equipment; and

(3) a lead paint removal hot-line phone number for information and technical assistance.

Subd. 5. **Warning notice.** A warning notice must be posted on all entrances to properties for which an order to abate a lead source has been issued by a board of health. This notice must remain posted until the abatement has been completed in accordance with the order, or until the board of health removes it. This warning must be at least 8-1/2 by 11 inches in size, and must include the following provisions, or provisions using substantially similar language:

(a) "This property contains dangerous amounts of lead to which children under age six and pregnant women should not be exposed."

(b) "It is unlawful to remove or deface this warning. This warning may be removed only upon the direction of the board of health."

Subd. 6. **Relocation of residents.** Relocation of residents is required from rooms or dwellings for removal of intact paint and the removal or disruption of lead painted surfaces and plaster walls during construction or remodeling projects. The commissioner shall contract with boards of health for safe housing for relocation requirements. Efforts must be made to minimize disruption and ensure that a family may return to their place of residence if they desire, after abatement is completed.

Subd. 7. **Retesting required.** After completion of the abatement as ordered, the board of health must retest the paint, soil, and dust previously in violation to assure the violations no longer exist.

History: *1989 c 282 art 2 s 19*

144.856 REGISTRATION OF ABATEMENT CONTRACTORS.

After July 1, 1989, abatement contractors who contract for the removal of leaded soil, dust, or deteriorating paint must register by phone, mail, or in person with the commissioner and notify the board of health of all abatement projects undertaken in response to an abatement order. All abatement contractors shall be given instructional materials on safe abatement methods and the requirements of relocation from rooms or dwellings by residents. By July 1, 1990, the commissioner shall develop a training program for abatement contractors and adopt rules specifying the abatement methods

that must be used by contractors to provide for the safe collection, handling, storage, encapsulation, removal, transportation, and disposal of lead containing material. The commissioner shall adopt emergency rules for abatement methods and standards for paint, bare soil, dust, and drinking water from public fountains for cities of the first class. By January 1, 1991, the commissioner shall report to the legislature concerning the need for licensure or certification of lead abatement contractors.

History: *1989 c 282 art 2 s 20*

144.860 LEAD ABATEMENT ADVOCATE.

The commissioner shall create and administer a program to fund locally based advocates who, following the issuance of an abatement order, will visit the family in their residence to instruct them about safety measures, materials, and methods to be followed before, during, and after the abatement process.

History: *1989 c 282 art 2 s 21*

144.861 STUDY ON ABATEMENT COSTS.

The commissioner of state planning shall convene a task force of representatives of the Minnesota housing finance agency, the pollution control agency, the department of health, the state planning agency, abatement contractors, realtors, community residents including both tenants and landowners, lead advocacy organizations, and cultural groups at high risk of lead poisoning to evaluate the costs of providing assistance to property owners and local communities required to do abatement under this law and of providing subsidized programs to assist them. The task force shall also present recommendations for a statewide subsidized abatement service program. The agency shall report its findings and recommendations to the legislature by January 1990.

History: *1989 c 282 art 2 s 22*

144.862 RULES.

By June 30, 1990, the commissioner of the pollution control agency and the commissioner of health shall jointly adopt rules to set toxic lead levels for paint, bare soil, dust, and drinking water from public fountains.

History: *1989 c 282 art 2 s 23*