

## CHAPTER 144

### DEPARTMENT OF HEALTH

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#### 144.0525 DATA FROM LABOR AND INDUSTRY AND ECONOMIC SECURITY DEPARTMENTS; EPIDEMIOLOGIC STUDIES.

All data collected by the commissioner of health under sections 176.234, 268.19, and 270B.14, subdivision 11, shall be used only for the purposes of epidemiologic investigations, notification of persons exposed to health hazards as a result of employment, and surveillance of occupational health and safety.

**History:** 1997 c 66 s 79

#### 144.056 PLAIN LANGUAGE IN WRITTEN MATERIALS.

(a) To the extent reasonable and consistent with the goals of providing easily understandable and readable materials and complying with federal and state laws governing the program, all written materials relating to determinations of eligibility for or amounts of benefits that will be given to applicants for or recipients of assistance under a program administered or supervised by the commissioner of health must be understandable to a person who reads at the seventh-grade level, using the Flesch scale analysis readability score as determined under section 72C.09.

(b) All written materials relating to services and determinations of eligibility for or amounts of benefits that will be given to applicants for or recipients of assistance under programs administered or supervised by the commissioner of health must be developed to satisfy the plain language requirements of the Plain Language Contract Act under sections 325G.29 to 325G.36. Materials may be submitted to the attorney general for review and certification.

tification. Notwithstanding section 325G.35, subdivision 1, the attorney general shall review submitted materials to determine whether they comply with the requirements of section 325G.31. The remedies available pursuant to sections 8.31 and 325G.33 to 325G.36 do not apply to these materials. Failure to comply with this section does not provide a basis for suspending the implementation or operation of other laws governing programs administered by the commissioner.

(c) The requirements of this section apply to all materials modified or developed by the commissioner on or after July 1, 1988. The requirements of this section do not apply to materials that must be submitted to a federal agency for approval to the extent that application of the requirements prevents federal approval.

(d) Nothing in this section may be construed to prohibit a lawsuit brought to require the commissioner to comply with this section or to affect individual appeal rights under the special supplemental food program for women, infants, and children granted pursuant to federal regulations under the Code of Federal Regulations, chapter 7, section 246.

**History:** 1997 c 7 art 2 s 13

#### **144.057 BACKGROUND STUDIES ON LICENSEES.**

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

(1) individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; and

(2) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services.

If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

*[For text of subs 2 to 4, see M.S.1996]*

**History:** 1997 c 248 s 1

#### **144.062 VACCINE COST REDUCTION PROGRAM.**

The commissioner of administration, after consulting with the commissioner of health, shall negotiate discounts or rebates on vaccine or may purchase vaccine at reduced prices. Vaccines may be offered for sale to medical care providers at the department's cost plus a fee for administrative costs. As a condition of receiving the vaccine at reduced cost, a medical care provider must agree to pass on the savings to patients. The commissioner of health may transfer money appropriated for other department of health programs to the commissioner of administration for the initial cost of purchasing vaccine, provided the money is repaid by the end of each state fiscal year and the commissioner of finance approves the transfer. Proceeds from the sale of vaccines to medical care providers, including fees collected for administrative costs, are appropriated to the commissioner of administration. If the commissioner of administration, in consultation with the commissioner of health, determines that a vaccine cost reduction program is not economically feasible or cost-effective, the commissioner may elect not to implement the program.

**History:** 1997 c 7 art 2 s 14

#### **144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.**

*[For text of subs 1 and 2, see M.S.1996]*

**Subd. 3. Level of care criteria; modifications.** The commissioner shall seek appropriate federal waivers to implement this subdivision. Notwithstanding any laws or rules to the contrary, effective July 1, 1998, Minnesota's level of care criteria for admission of any person to a nursing facility licensed under chapter 144A, or a boarding care home licensed under sections 144.50 to 144.56, are modified as follows:

(1) the resident reimbursement classifications and terminology established by rule under sections 256B.41 to 256B.48 are the basis for applying the level of care criteria changes;

(2) an applicant to a certified nursing facility or certified boarding care home who is dependent in zero, one, or two case mix activities of daily living, is classified as a case mix A, and is independent in orientation and self-preservation, is reclassified as a high function class A person and is not eligible for admission to Minnesota certified nursing facilities or certified boarding care homes;

(3) applicants in clause (2) who are dependent in one or two case mix activities of daily living, who are eligible for assistance as determined under sections 256B.055 and 256B.056 or meet eligibility criteria for section 256B.0913 are eligible for a service allowance under section 256B.0913, subdivision 15, and are not eligible for services under sections 256B.0913, subdivisions 1 to 14, and 256B.0915. Applicants in clause (2) shall have the option of residing in community settings under sections 256I.01 to 256I.06, if otherwise eligible, or receiving the services allowance option under section 256B.0913, subdivision 15, but not both;

(4) residents of a certified nursing facility or certified boarding care home who were admitted before July 1, 1998, or individuals receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915, before July 1, 1998, are not subject to the new level of care criteria unless the resident is discharged home or to another service setting other than a certified nursing facility or certified boarding care home and applies for admission to a certified nursing facility or certified boarding care home after June 30, 1998;

(5) the local screening teams under section 256B.0911 may determine the existence of extraordinary circumstances which render nonadmission to a certified nursing or certified boarding care home a serious threat to the health and safety of applicants in clause (2) and may authorize admission to a certified nursing facility or certified boarding care home in accordance with a treatment and discharge plan; and

(6) an individual deemed ineligible for admission to Minnesota certified nursing facilities is entitled to an appeal under section 256.045, subdivision 3.

If the commissioner determines upon appeal that an applicant in clause (2) presents extraordinary circumstances including but not limited to the absence or inaccessibility of suitable alternatives, contravening family circumstances, or protective service issues, the applicant may be eligible for admission to Minnesota certified nursing facilities or certified boarding care homes.

*[For text of subd 3a, see M.S.1996]*

**History:** 1997 c 203 art 4 s 3

#### **144.092 COORDINATED NUTRITION DATA COLLECTION.**

The commissioner of health may develop and coordinate a reporting system to improve the state's ability to document inadequate nutrient and food intake of Minnesota's children and adults and to identify problems and determine the most appropriate strategies for improving inadequate nutritional status. The board on aging may develop a method to evaluate the nutritional status and requirements of the elderly in Minnesota.

**History:** 1997 c 7 art 2 s 15

#### **144.121 X-RAY MACHINES AND FACILITIES USING OTHER SOURCES OF IONIZING RADIATION.**

**Subdivision 1. Registration; fees.** The fee for the registration for x-ray machines and other sources of ionizing radiation required to be registered under rules adopted by the state commissioner of health pursuant to section 144.12, shall be in an amount as described in sub-

division 1a pursuant to section 144.122. The registration shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122.

**Subd. 1a. Fees for x-ray machines and other sources of ionizing radiation.** A facility with x-ray machines or other sources of ionizing radiation must biennially pay an initial or biennial renewal registration fee consisting of a base facility fee of \$132 and an additional fee for each x-ray machine or other source of ionizing radiation as follows:

(1) medical or veterinary equipment	\$106
(2) dental x-ray equipment	\$ 66
(3) accelerator	\$132
(4) radiation therapy equipment	\$132
(5) x-ray equipment not used on humans or animals	\$106
(6) devices with sources of ionizing radiation not used on humans or animals	\$106
(7) sources of radium	\$198

**Subd. 1b. Penalty fee for late registration.** Applications for initial or renewal registrations submitted to the commissioner after the time specified by the commissioner shall be accompanied by a penalty fee of \$20 in addition to the fees prescribed in subdivision 1a.

**Subd. 1c. Fee for x-ray machines and other sources of ionizing radiation registered during last 12 months of a biennial registration period.** The initial registration fee of x-ray machines or other sources of radiation required to be registered during the last 12 months of a biennial registration period will be 50 percent of the applicable registration fee prescribed in subdivision 1a.

*[For text of subs 2 to 7, see M.S.1996]*

**History:** 1997 c 203 art 2 s 7-10

#### **144.125 TESTS OF INFANTS FOR INBORN METABOLIC ERRORS.**

It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for inborn errors of metabolism in accordance with rules prescribed by the state commissioner of health. In determining which tests must be administered, the commissioner shall take into consideration the adequacy of laboratory methods to detect the inborn metabolic error, the ability to treat or prevent medical conditions caused by the inborn metabolic error, and the severity of the medical conditions caused by the inborn metabolic error. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge laboratory service fees so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with inborn metabolic errors. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

**History:** 1997 c 203 art 2 s 11; 1997 c 205 s 19

#### **144.147 RURAL HOSPITAL PLANNING AND TRANSITION GRANT PROGRAM.**

**Subdivision 1. Definition.** "Eligible rural hospital" means any nonfederal, general acute care hospital that:

- (1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 5,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;
- (2) has 50 or fewer beds; and
- (3) is not for profit.

**Subd. 2. Grants authorized.** The commissioner shall establish a program of grants to assist eligible rural hospitals. The commissioner shall award grants to hospitals and communities for the purposes set forth in paragraphs (a) and (b).

(a) Grants may be used by hospitals and their communities to develop strategic plans for preserving or enhancing access to health services. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what health services are needed and desired by the community. The assessment must include interviews with or surveys of area health professionals, local community leaders, and public hearings;

(2) an assessment of the feasibility of providing needed health services that identifies priorities and timeliness for potential changes; and

(3) an implementation plan.

The strategic plan must be developed by a committee that includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community.

(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan. Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, or a rural health care system. Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals.

**Subd. 3. Consideration of grants.** In determining which hospitals will receive grants under this section, the commissioner shall take into account:

(1) improving community access to hospital or health services;

(2) changes in service populations;

(3) demand for ambulatory and emergency services;

(4) the extent that the health needs of the community are not currently being met by other providers in the service area;

(5) the need to recruit and retain health professionals;

(6) the extent of community support;

(7) the coordination with local community organizations, such as community development and public health agencies; and

(8) the financial condition of the hospital.

**Subd. 4. Allocation of grants.** (a) Eligible hospitals must apply to the commissioner no later than September 1 of each fiscal year for grants awarded for that fiscal year. A grant may be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

(c) Each relevant community health board has 30 days in which to review and comment to the commissioner on grant applications from hospitals in their community health service area.

(d) In determining which hospitals will receive grants under this section, the commissioner shall consider the following factors:

(1) Description of the problem, description of the project, and the likelihood of successful outcome of the project. The applicant must explain clearly the nature of the health service problems in their service area, how the grant funds will be used, what will be accomplished, and the results expected. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations.

(2) The extent of community support for the hospital and this proposed project. The applicant should demonstrate support for the hospital and for the proposed project from other local health service providers and from local community and government leaders. Evidence of such support may include past commitments of financial support from local individuals, organizations, or government entities; and commitment of financial support, in-kind services or cash, for this project.

(3) The comments, if any, resulting from a review of the application by the community health board in whose community health service area the hospital is located.

(e) In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning the maximum of 70 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; and a maximum of 30 points for the extent of community support for the hospital and this project. The commissioner may also take into account other relevant factors.

(f) A grant to a hospital, including hospitals that submit applications as consortia, may not exceed \$50,000 a year and may not exceed a term of two years. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-half of the amount, which may include in-kind services, is available for the same purposes from nonstate sources. A hospital receiving a grant under this section may use the grant for any expenses incurred in the development of strategic plans or the implementation of transition projects with respect to which the grant is made. Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

(g) The commissioner may adopt rules to implement this section.

*[For text of subd 5, see M.S.1996]*

**History:** 1997 c 225 art 2 s 48-51

## RURAL HOSPITAL DEMONSTRATION PROJECT

### 144.1475 RURAL HOSPITAL DEMONSTRATION PROJECT.

Subdivision 1. **Establishment.** The commissioner of health, for the biennium ending June 30, 1999, shall establish at least three demonstration projects per fiscal year to assist rural hospitals in the planning and implementation process to either consolidate or cooperate with another existing hospital in its service area to provide better quality health care to its community. A demonstration project must include at least two eligible hospitals. For purposes of this section, an "eligible hospital" means a hospital that:

- (1) is located outside the seven-county metropolitan area;
- (2) has 50 or fewer licensed beds; and
- (3) is located within a 25-mile radius of another hospital.

At least one of the eligible hospitals in a demonstration project must have had a negative operating margin during one of the two years prior to application.

Subd. 2. **Application.** (a) An eligible hospital seeking to be a participant in a demonstration project must submit an application to the commissioner of health detailing the hospital's efforts to consolidate health care delivery in its service area, cooperate with another hospital in the delivery of health care, or both consolidate and cooperate. Applications must be submitted by October 15 of each fiscal year for grants awarded for that fiscal year.

(b) Applications must:

- (1) describe the problem that the proposed consolidation or cooperation will address, the consolidation or cooperation project, how the grant funds will be used, what will be accomplished, and the results expected;
- (2) describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals and organizations;
- (3) include written commitments from the applicant hospital and at least one other hospital that will participate in the consolidation or cooperation demonstration project, that specify the activities the organization will undertake during the project; the resources the organization will contribute to the demonstration project, and the expected role and nature of the organization's involvement in proposed consolidation or cooperation activities; and
- (4) provide evidence of support for the proposed project from other local health service providers and from local community and government leaders.

Subd. 3. **Grants.** The commissioner of health shall allocate a grant of up to \$100,000 to the highest scoring applicants each year until available funding is expended. Grants may be used by eligible hospitals to:

- (1) conduct consolidation or cooperation negotiations;
- (2) develop consolidation or cooperation plans, including financial plans and architectural designs;
- (3) seek community input and conduct community education on proposed or planned consolidations or cooperative activities; and
- (4) implement consolidation or cooperation plans.

Subd. 4. **Consideration of grants.** In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning: a maximum of 40 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; a maximum of 30 points for explicit and unequivocal written commitments from organizations participating in the project; a maximum of 20 points for matching funds or in-kind services committed by the applicant or others to the project; and a maximum of ten points for the extent of community support for the project. The commissioner shall consider the comments, if any, resulting from a review of the application by the community health board in whose community health service area the applicant is located. The commissioner may also take into account other relevant factors.

Subd. 5. **Evaluation.** The commissioner of health shall evaluate the overall effectiveness of the demonstration projects and report to the legislature by September 1, 2000. The commissioner may collect, from the hospitals receiving grants, any information necessary to evaluate the demonstration project.

**History:** 1997 c 225 art 2 s 52

## RURAL HOSPITAL GRANT PROGRAM

### 144.148 RURAL HOSPITAL CAPITAL IMPROVEMENT GRANT AND LOAN PROGRAM.

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

- (b) "Eligible rural hospital" means a hospital that:
  - (1) is located outside the seven-county metropolitan area;
  - (2) has 50 or fewer licensed hospital beds with a net hospital operating margin not greater than two percent in the two fiscal years prior to application; and
  - (3) is 25 miles or more from another hospital.
- (c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital.

Subd. 2. **Program.** The commissioner of health shall award rural hospital capital improvement grants or loans to eligible rural hospitals. A grant or loan shall not exceed \$1,500,000 per hospital. Grants or loans shall be interest free. An eligible rural hospital may apply the funds retroactively to capital improvements made during the two fiscal years preceding the fiscal year in which the grant or loan was received, provided the hospital met the eligibility criteria during that time period.

Subd. 3. **Applications.** Eligible hospitals seeking a grant or loan shall apply to the commissioner. Applications must include a description of the problem that the proposed project will address, a description of the project including construction and remodeling drawings or specifications, sources of funds for the project, uses of funds for the project, the results expected, and a plan to maintain or operate any facility or equipment included in the project. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organization. Applicants must submit to the commissioner evidence that competitive bidding was used to select contractors for the project.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the hospital's application is complete and whether the hospital and the project are eligible for a grant or loan. In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning: a maximum of 40 points for an applicant's clarity and thoroughness in describing the problem and the project; a maximum

of 40 points for the extent to which the applicant has demonstrated that it has made adequate provisions to assure proper and efficient operation of the facility once the project is completed; and a maximum of 20 points for the extent to which the proposed project is consistent with the hospital's capital improvement plan or strategic plan. The commissioner may also take into account other relevant factors. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies a loan applicant.

**Subd. 5. Program oversight.** The commissioner of health shall review audited financial information of the hospital to assess eligibility. The commissioner shall determine the amount of a grant or loan to be given to an eligible rural hospital based on the relative score of each eligible hospital's application and the funds available to the commissioner. The grant or loan shall be used to update, remodel, or replace aging facilities and equipment necessary to maintain the operations of the hospital.

**Subd. 6. Loan payment.** Loans shall be repaid as provided in this subdivision over a period of 15 years. In those years when an eligible rural hospital experiences a positive net operating margin in excess of two percent, the eligible rural hospital shall pay to the state one-half of the excess above two percent, up to the yearly payment amount based upon a loan period of 15 years. If the amount paid back in any year is less than the yearly payment amount, or if no payment is required because the eligible rural hospital does not experience a positive net operating margin in excess of two percent, the amount unpaid for that year shall be forgiven by the state without any financial penalty. As a condition of receiving an award through this program, eligible hospitals must agree to any and all collection activities the commissioner finds necessary to collect loan payments in those years a payment is due.

**Subd. 7. Accounting treatment.** The commissioner of finance shall record as grants in the state accounting system funds obligated by this section. Loan payments received under this section shall be deposited in the health care access fund.

**Subd. 8. Expiration.** This section expires June 30, 1999.

**History:** 1997 c 225 art 2 s 53

#### **144.1484 RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.**

**Subdivision 1. Sole community hospital financial assistance grants.** The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services; (2) have experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of 40 or fewer licensed beds; and (4) demonstrate to the commissioner that it has obtained local support for the hospital and that any state support awarded under this program will not be used to supplant local support for the hospital. The commissioner shall review audited financial statements of the hospital to assess the extent of local support. Evidence of local support may include bonds issued by a local government entity such as a city, county, or hospital district for the purpose of financing hospital projects; and loans, grants, or donations to the hospital from local government entities, private organizations, or individuals. The commissioner shall determine the amount of the award to be given to each eligible hospital based on the hospital's operating loss margin (total operating losses as a percentage of total operating revenue) for two of the previous three most recent consecutive fiscal years for which audited financial information is available and the total amount of funding available. For purposes of calculating a hospital's operating loss margin, total operating revenue does not include grant funding provided under this subdivision. One hundred percent of the available funds will be disbursed proportionately based on the operating loss margins of the eligible hospitals.

*[For text of subd 2, see M.S.1996]*

**History:** 1997 c 225 art 2 s 54

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**144.1494 RURAL PHYSICIANS.**

**Subdivision 1. Creation of account.** A rural physician education account is established in the health care access fund. The commissioner shall use money from the account to establish a loan forgiveness program for medical residents agreeing to practice in designated rural areas, as defined by the commissioner.

**Subd. 2. Eligibility.** To be eligible to participate in the program, a prospective physician must submit a letter of interest to the commissioner. A resident who is accepted must sign a contract to agree to serve at least three of the first five years following residency in a designated rural area.

**Subd. 3. Loan forgiveness.** For each fiscal year after 1995, the commissioner may accept up to 12 applicants who are medical residents, including four applicants who are pediatric residents, six applicants who are family practice residents, and two applicants who are internal medicine residents, for participation in the loan forgiveness program. If the commissioner does not receive enough applicants per fiscal year to fill the number of residents in the specific areas of practice, the resident applicants may be from any area of practice. The 12 resident applicants may be in any year of training; however, priority must be given to the following categories of residents in descending order: third year residents, second year residents, and first year residents. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed \$10,000, as a qualified loan. For each year that a participant serves as a physician in a designated rural area, up to a maximum of four years, the commissioner shall annually pay an amount equal to one year of qualified loans. Participants who move their practice from one designated rural area to another remain eligible for loan repayment. In addition, in any year that a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional \$2,000, above the \$10,000 yearly maximum.

**Subd. 4. Penalty for nonfulfillment.** If a participant does not fulfill the required three-year minimum commitment of service in a designated rural area, the commissioner shall collect from the participant the amount paid under the loan forgiveness program. The commissioner shall deposit the money collected in the rural physician education account established in subdivision 1. The commissioner shall allow waivers of all or part of the money owed the commissioner if emergency circumstances prevented fulfillment of the three-year service commitment.

**Subd. 5. Loan forgiveness; underserved urban communities.** For each fiscal year beginning on and after 1995, the commissioner may accept up to four applicants who are residents in family practice, pediatrics, or internal medicine per fiscal year for participation in the urban primary care physician loan forgiveness program. The resident applicants may be in any year of residency training; however, priority will be given to the following categories of residents in descending order: third year residents, second year residents, and first year residents. If the commissioner does not receive enough qualified applicants per fiscal year to fill the number of slots for urban underserved communities, the slots may be allocated to residents who have applied for the rural physician loan forgiveness program in subdivision 1. Applicants are responsible for securing their own loans. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed \$10,000, as a qualified loan. For each year that a participant serves as a physician in a designated underserved urban area, up to a maximum of four years, the commissioner shall annually pay an amount equal to one

year of qualified loans. Participants who move their practice from one designated underserved urban community to another remain eligible for loan repayment.

**History:** 1990 c 591 art 4 s 5,9; 1991 c 356 art 8 s 20; 1992 c 549 art 6 s 1,2; 1993 c 345 art 11 s 2-5; 1995 c 212 art 3 s 57,59; 1995 c 234 art 8 s 23,24,48; 1997 c 183 art 2 s 7,20; 1997 c 225 art 2 s 47

#### 144.1495 MIDLEVEL PRACTITIONERS.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

- (a) "Designated rural area" has the definition developed in rule by the commissioner.
- (b) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.
- (c) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advance practice as nurse-midwives.
- (d) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advance practice as nurse practitioners.
- (e) "Physician assistant" means a person registered under chapter 147A.

Subd. 2. **Creation of account.** A midlevel practitioner education account is established in the health care access fund. The commissioner shall use money from the account to establish a loan forgiveness program for midlevel practitioners agreeing to practice in designated rural areas.

Subd. 3. **Eligibility.** To be eligible to participate in the program, a prospective midlevel practitioner must submit a letter of interest to the commissioner prior to or while attending a program of study designed to prepare the individual for service as a midlevel practitioner. A midlevel practitioner student who is accepted into this program must sign a contract to agree to serve at least two of the first four years following graduation from the program in a designated rural area.

Subd. 4. **Loan forgiveness.** The commissioner may accept up to eight applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of midlevel practitioner study, up to a maximum of two years, an agreed amount, not to exceed \$7,000, as a qualified loan. For purposes of this provision, "qualifying educational loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional. For each year that a participant serves as a midlevel practitioner in a designated rural area, up to a maximum of four years, the commissioner shall annually repay an amount equal to one-half a qualified loan. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the service commitment required under subdivision 4 for full repayment of all qualified loans, the commissioner shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the midlevel practitioner education account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner if emergency circumstances prevented fulfillment of the required service commitment.

**History:** 1992 c 549 art 6 s 3; 1993 c 345 art 11 s 6,7; 1995 c 205 art 2 s 2; 1995 c 212 art 3 s 57,59; 1995 c 234 art 8 s 25,26

#### 144.1496 NURSES IN NURSING HOMES OR ICF/MRS.

Subdivision 1. **Creation of the account.** An education account in the health care access fund is established for a loan forgiveness program for nurses who agree to practice nursing in a nursing home or intermediate care facility for persons with mental retardation or related conditions. The account consists of money appropriated by the legislature and repayments

and penalties collected under subdivision 4. Money from the account must be used for a loan forgiveness program.

**Subd. 2. Eligibility.** To be eligible to participate in the loan forgiveness program, a person planning to enroll or enrolled in a program of study designed to prepare the person to become a registered nurse or licensed practical nurse must submit a letter of interest to the commissioner before completion of a nursing education program. Before completion of the program, the applicant must sign a contract in which the applicant agrees to practice nursing for at least one of the first two years following completion of the nursing education program providing nursing services in a licensed nursing home or intermediate care facility for persons with mental retardation or related conditions.

**Subd. 3. Loan forgiveness.** The commissioner may accept up to ten applicants a year. Applicants are responsible for securing their own loans. For each year of nursing education, for up to two years, applicants accepted into the loan forgiveness program may designate an agreed amount, not to exceed \$3,000, as a qualified loan. For each year that a participant practices nursing in a nursing home or intermediate care facility for persons with mental retardation or related conditions, up to a maximum of two years, the commissioner shall annually repay an amount equal to one year of qualified loans. Participants who move from one nursing home or intermediate care facility for persons with mental retardation or related conditions to another remain eligible for loan repayment.

**Subd. 4. Penalty for nonfulfillment.** If a participant does not fulfill the service commitment required under subdivision 3 for full repayment of all qualified loans, the commissioner shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The commissioner shall deposit the collections in the health care access fund to be credited to the account established in subdivision 1. The commissioner may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

**Subd. 5. Rules.** The commissioner shall adopt rules to implement this section.

**History:** 1992 c 549 art 6 s 7; 1993 c 345 art 11 s 8; 1995 c 212 art 3 s 57,59

#### 144.1497 RURAL CLINICAL SITES FOR NURSE PRACTITIONER EDUCATION.

**Subdivision 1. Definition.** For purposes of this section, "rural" means any area of the state outside of the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

**Subd. 2. Establishment.** A grant program is established under the authority of the commissioner to provide grants to colleges or schools of nursing located in Minnesota that operate programs of study designed to prepare registered nurses for advanced practice as nurse practitioners.

**Subd. 3. Program goals.** Colleges and schools of nursing shall use grants received to provide rural students with increased access to programs of study for nurse practitioners, by:

- (1) developing rural clinical sites;
- (2) allowing students to remain in their rural communities for clinical rotations; and
- (3) providing faculty to supervise students at rural clinical sites.

The overall goal of the grant program is to increase the number of graduates of nurse practitioner programs who work in rural areas of the state.

**Subd. 4. Responsibility of nursing programs.** (a) Colleges or schools of nursing interested in participating in the grant program must apply to the commissioner, according to the policies established by the commissioner. Applications submitted by colleges or schools of nursing must include a detailed proposal for achieving the goals listed in subdivision 3, a plan for encouraging sufficient applications from rural applicants to meet the requirements of paragraph (b), and any additional information required by the commissioner.

(b) Each college or school of nursing, as a condition of accepting a grant, shall make at least 25 percent of the openings in each nurse practitioner entering class available to applicants who live in rural areas and desire to practice as a nurse practitioner in rural areas. This requirement is effective beginning with the fall 1994 entering class and remains in effect for

each biennium thereafter for which a college or school of nursing is awarded a grant renewal. The commissioner may exempt colleges or schools of nursing from this requirement if the college or school can demonstrate, to the satisfaction of the commissioner, that the nurse practitioner program did not receive enough applications or acceptance letters from qualified rural applicants to meet the requirement.

(c) Colleges or schools of nursing participating in the grant program shall report to the commissioner on their program activity as requested by the commissioner.

**Subd. 5. Responsibilities of the commissioner.** (a) The commissioner shall establish an application process for interested colleges and schools of nursing, and shall require colleges and schools of nursing to submit grant applications to the commissioner by November 1, 1993. The commissioner may award up to two grants for the biennium ending June 30, 1995.

(b) In selecting grant recipients, the commissioner shall consider:

(1) the likelihood that an applicant's grant proposal will be successful in achieving the program goals listed in subdivision 3;

(2) the potential effectiveness of the college's or school's plan to encourage applications from rural applicants; and

(3) the academic quality of the college's or school's program of education for nurse practitioners.

(c) The commissioner shall notify grant recipients of an award by December 1, 1993, and shall disburse the grants by January 1, 1994. The commissioner may renew grants if a college or school of nursing demonstrates that satisfactory progress has been made during the past biennium toward achieving the goals listed in subdivision 3.

**History:** 1993 c 345 art 11 s 9; 1995 c 212 art 3 s 57,59

#### 144.212 DEFINITIONS.

*[For text of subd 1, see M.S.1996]*

**Subd. 1a. Amendment.** "Amendment" means completion or correction of a vital record.

*[For text of subd 2, see M.S.1996]*

**Subd. 2a. Delayed registration.** "Delayed registration" means registration of a certificate of birth or death filed one or more years after the date established by law for filing a certificate of birth or death.

*[For text of subds 3 and 4, see M.S.1996]*

**Subd. 4a. Institution.** "Institution" means a public or private establishment that:

(1) provides inpatient or outpatient medical, surgical, or diagnostic care or treatment; or  
 (2) provides nursing, custodial, or domiciliary care, or to which persons are committed by law.

*[For text of subds 5 to 11, see M.S.1996]*

**History:** 1997 c 228 s 3-5.

#### 144.215 BIRTH REGISTRATION.

**Subdivision 1. When and where to file.** A certificate of birth for each live birth which occurs in this state shall be filed with the state registrar or the local registrar of the district in which the birth occurred, within five days after the birth.

*[For text of subds 2 to 4, see M.S.1996]*

**Subd. 5. Births occurring in an institution.** When a birth occurs in an institution or en route to an institution, the person in charge of the institution or that person's authorized de-

signee shall obtain the personal data required under this section and shall prepare the certificate of birth. For purposes of this section, "institution" means a hospital or other facility that provides childbirth services.

**Subd. 6. Births occurring outside an institution.** When a birth occurs outside of an institution as defined in subdivision 5, the certificate of birth shall be prepared and filed by one of the following persons, in the indicated order of preference:

- (1) the physician present at the time of the birth or immediately thereafter;
- (2) in the absence of a physician, a person present at the time of the birth or immediately thereafter;
- (3) the father or mother of the child; or
- (4) in the absence of the father and if the mother is unable, the person with primary responsibility for the premises where the child was born.

**Subd. 7. Evidence required to register a noninstitution birth within the first year of birth.** When a birth occurs in this state outside of an institution, as defined in subdivision 5, and the birth certificate is filed before the first birthday, evidence in support of the facts of birth shall be required when neither the state nor local registrar has personal knowledge regarding the facts of birth. Evidence shall be presented by the individual responsible for filing the certificate under subdivision 6. Evidence shall consist of proof that the child was born alive, proof of pregnancy, or evidence of the mother's presence in this state on the date of the birth. If the evidence is not acceptable, the state registrar shall advise the applicant of the reason for not filing a birth certificate and shall further advise the applicant of the right of appeal to a court of competent jurisdiction.

**History:** 1997 c 205 s 20; 1997 c 228 s 6-8

**NOTE:** Subdivisions 6 and 7, as added by Laws 1997, chapter 228, sections 7 and 8, respectively, are effective August 1, 1998. Laws 1997, chapter 228, section 14.

#### 144.218 REPLACEMENT CERTIFICATES OF BIRTH.

**Subdivision 1. Adoption.** Upon receipt of a certified copy of an order, decree, or certificate of adoption, the state registrar shall register a replacement certificate in the new name of the adopted person. The original certificate of birth and the certified copy are confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.1761. A certified copy of the original birth certificate from which the registration number has been deleted and which has been marked "Not for Official Use," or the information contained on the original birth certificate, except for the registration number, shall be provided on request to a parent who is named on the original birth certificate. Upon the receipt of a certified copy of a court order of annulment of adoption the state registrar shall restore the original certificate to its original place in the file.

**Subd. 2. Adoption of foreign persons.** In proceedings for the adoption of a person who was born in a foreign country, the court, upon evidence presented by the commissioner of human services from information secured at the port of entry, or upon evidence from other reliable sources, may make findings of fact as to the date and place of birth and parentage. Upon receipt of certified copies of the court findings and the order or decree of adoption, the state registrar shall register a birth certificate in the new name of the adopted person. The certified copies of the court findings and the order or decree of adoption are confidential, pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.1761. The birth certificate shall state the place of birth as specifically as possible, and that the certificate is not evidence of United States citizenship.

**Subd. 3. Subsequent marriage of birth parents.** If, in cases in which a certificate of birth has been registered pursuant to section 144.215 and the birth parents of the child marry after the birth of the child, a replacement certificate of birth shall be registered upon presentation of a certified copy of the marriage certificate of the birth parents, and either a recognition of parentage or court adjudication of paternity. The information presented and the original certificate of birth are confidential, pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

**Subd. 4. Incomplete, incorrect, and modified certificates.** If a court finds that a birth certificate is incomplete, inaccurate or false, or if it is being issued pursuant to section

259.10, subdivision 2, it may order the registration of a replacement certificate, and, if necessary, set forth the correct information in the order. Upon receipt of the order the state registrar shall register a replacement certificate containing the findings of the court, and the prior certificate shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

**History:** 1997 c 205 s 21

#### **144.223 REPORT OF MARRIAGE.**

Data relating to certificates of marriage registered shall be reported to the state registrar by the local registrars pursuant to the rules of the commissioner. The information necessary to compile the report shall be furnished by the applicant prior to the issuance of the marriage license. The report shall contain the following information:

**A. Personal information on bride and groom:**

1. Name;
2. Residence;
3. Date and place of birth;
4. Race;
5. If previously married, how terminated;
6. Signature of applicant and date signed, and social security number.

**B. Information concerning the marriage:**

1. Date of marriage;
2. Place of marriage;
3. Civil or religious ceremony.

**History:** 1997 c 203 art 6 s 4

#### **144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.**

*[For text of subd 1, see M.S.1996]*

**Subd. 2. Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original certificate of birth and the certified copy, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate on the birth registration form whether data pertaining to the birth will be public data. Notwithstanding the designation of the data as confidential, it may be disclosed:

- (1) to a parent or guardian of the child;
- (2) to the child when the child is 18 years of age or older;
- (3) under paragraph (b); or
- (4) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.1761; 144.218, subdivision 1; and 259.89. The birth and death records of the commissioner of health shall be open to inspection by the commissioner of human services and it shall not be necessary for the commissioner of human services to obtain an order of the court in order to inspect records or to secure certified copies of them.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services or public health member of a family services collaborative for purposes of providing services under section 121.8355.

[For text of subs 2a to 6, see M.S.1996]

**Subd. 7. Certified copy of birth or death certificate.** The state or local registrar shall issue a certified copy of a birth or death certificate to an individual upon the individual's proper completion of an affidavit provided by the commissioner:

(1) to a person who has a tangible interest in the requested certificate. A person who has a tangible interest is:

- (i) the subject of the certificate;
- (ii) a child of the subject;
- (iii) the spouse of the subject;
- (iv) a parent of the subject, unless the parent is a birth parent whose parental rights have been terminated;
- (v) the legal custodian or guardian of the subject;
- (vi) a personal representative of the estate of the subject or a successor of the subject, as defined in section 524.1-201, if the subject is deceased;
- (vii) a representative authorized by a person under clauses (1) to (3); or
- (viii) a person who demonstrates that a certified copy of the certificate is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner;

(2) to any local, state, or federal governmental agency upon request if the certified certificate is necessary for the governmental agency to perform its authorized duties. An authorized governmental agency includes the department of human services, the department of revenue, and the United States Immigration and Naturalization Service; or

(3) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order.

**Subd. 8. Standardized format for certified birth and death certificates.** No later than July 1, 2000, the commissioner shall develop a standardized format for certified birth certificates and death certificates issued by state and local registrars. The format shall incorporate security features in accordance with this section. The standardized format must be implemented on a statewide basis by July 1, 2001.

**History:** 1997 c 228 s 9-11

**NOTE:** Subdivision 7, as added by Laws 1997, chapter 228, section 10, is effective August 1, 2000. Laws 1997, chapter 228, section 14.

## 144.226 FEES.

**Subdivision 1. Which services are for fee.** The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(a) The fee for the issuance of a certified copy or certification of a vital record, or a certification that the record cannot be found is \$8. No fee shall be charged for a certified birth or death record that is reissued within one year of the original issue, if the previously issued record is surrendered.

(b) The fee for the replacement of a birth record for all events except adoption is \$20.

(c) The fee for the filing of a delayed registration of birth or death is \$20.

(d) The fee for the amendment of any vital record when requested more than one year after the filing of the record is \$20. No fee shall be charged for an amendment requested within one year after the filing of the certificate.

(e) The fee for the verification of information from vital records is \$8 when the applicant furnishes the specific information to locate the record. When the applicant does not furnish specific information, the fee is \$20 per hour for staff time expended. Specific information shall include the correct date of the event and the correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the records. The fee shall be payable at time of application.

(f) The fee for issuance of a certified or noncertified copy of any document on file pertaining to a vital record or a certification that the record cannot be found is \$8.

[For text of subs 2 and 3, see M.S.1996]

Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of \$3 for each certified and noncertified birth or death record. The local or state registrar shall forward this amount to the state treasurer to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth or death record is permitted under subdivision 1, paragraph (a). This surcharge requirement expires June 30, 2002.

**History:** 1997 c 203 art 2 s 12,13

#### 144.29 HEALTH RECORDS; CHILDREN OF SCHOOL AGE.

It shall be the duty of every school nurse, school physician, school attendance officer, superintendent of schools, principal, teacher, and of the persons charged with the duty of compiling and keeping the school census records, to cause a health record to be kept for each child of school age. Such record shall be kept in such form that it may be transferred with the child to any school which the child shall attend within the state. It shall contain a record of such student health data as defined in section 13.32, subdivision 2, paragraph (a), and shall be classified as private data as defined in section 13.32, subdivision 3. Nothing in sections 144.29 to 144.32 shall be construed to require any child whose parent or guardian objects in writing thereto to undergo a physical or medical examination or treatment. A copy shall be forwarded to the proper department of any state to which the child shall remove. Each district shall assign a teacher, school nurse, or other professional person to review, at the beginning of each school year, the health record of all pupils under the assignee's direction. Growth, results of vision and hearing screening, and findings obtained from health assessments must be entered periodically on the pupil's health record.

**History:** 1Sp1997 c 3 s 23; 1Sp1997 c 4 art 6 s 16

#### 144.335 ACCESS TO HEALTH RECORDS.

[For text of subs 1 to 3, see M.S.1996]

Subd. 3a. **Patient consent to release of records; liability.** (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law. Except as provided in paragraph (c) or (d), a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

(b) This subdivision does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency; or

(2) to other providers within related health care entities when necessary for the current treatment of the patient.

(c) Notwithstanding paragraph (a), if a patient explicitly gives informed consent to the release of health records for the purposes and pursuant to the restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.



(d) Notwithstanding paragraph (a), health records may be released to an external researcher solely for purposes of medical or scientific research only as follows:

(1) health records generated before January 1, 1997, may be released if the patient has not objected or does not elect to object after that date;

(2) for health records generated on or after January 1, 1997, the provider must:

(i) disclose in writing to patients currently being treated by the provider that health records, regardless of when generated, may be released and that the patient may object, in which case the records will not be released; and

(ii) use reasonable efforts to obtain the patient's written general authorization that describes the release of records in item (i), which does not expire but may be revoked or limited in writing at any time by the patient or the patient's authorized representative;

(3) authorization may be established if an authorization is mailed at least two times to the patient's last known address with a postage prepaid return envelope and a conspicuous notice that the patient's medical records may be released if the patient does not object, and at least 60 days have expired since the second notice was sent; and the provider must advise the patient of the rights specified in clause (4); and

(4) the provider must, at the request of the patient, provide information on how the patient may contact an external researcher to whom the health record was released and the date it was released.

In making a release for research purposes the provider shall make a reasonable effort to determine that:

(i) the use or disclosure does not violate any limitations under which the record was collected;

(ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

(e) A person who negligently or intentionally releases a health record in violation of this subdivision, or who forges a signature on a consent form, or who obtains under false pretenses the consent form or health records of another person, or who, without the person's consent, alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

(f) Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Paragraph (a) applies to consents given under this paragraph.

(g) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record.

*[For text of subs 3b to 6, see M.S.1996]*

**History:** *1Sp1997 c 3 s 24*

#### **144.394 HEALTH PROMOTION AND EDUCATION.**

The commissioner may sell at market value all health promotion and health education materials. Proceeds from the sale of the materials are appropriated to the department of health for the program that developed the material.

**History:** *1997 c 203 art 2 s 14*

**144.445 TUBERCULOSIS SCREENING IN CORRECTIONAL INSTITUTIONS AND FACILITIES.**

**Subdivision 1. Screening of inmates.** All persons detained or confined for 14 consecutive days or more in facilities operated, licensed, or inspected by the department of corrections shall be screened for tuberculosis with either a Mantoux test or a chest roentgenogram (x-ray) as consistent with screening and follow-up practices recommended by the United States Public Health Service or the department of health, as determined by the commissioner of health. Administration of the Mantoux test or chest roentgenogram (x-ray) must take place on or before the 14th day of detention or confinement.

*[For text of subd 2, see M.S.1996]*

**Subd. 3. Exceptions.** Subdivisions 1 and 2 do not apply to:

(1) a person who is detained or confined in a juvenile temporary holdover facility, provided that the person has no symptoms suggestive of tuberculosis, evidence of a new exposure to active tuberculosis, or other health condition that may require a chest roentgenogram (x-ray) be performed to rule out active tuberculosis;

(2) a person who is detained or confined in a facility operated, licensed, or inspected by the department of corrections where the facility holds a written record of a negative Mantoux test performed on the person (i) within three months prior to intake into the facility; or (ii) within 12 months prior to intake into the facility if the person has remained under the continuing jurisdiction of a correctional facility since the negative Mantoux test, provided that the person has no symptoms suggestive of tuberculosis, evidence of a new exposure to active tuberculosis, or other health condition that may require a chest roentgenogram (x-ray) be performed to rule out active tuberculosis;

(3) a person who is detained or confined in a facility operated, licensed, or inspected by the department of corrections where the facility has a written record of (i) a history of adequately treated active tuberculosis; (ii) compliance with currently prescribed tuberculosis therapy or preventive therapy; or (iii) completion of a course of preventive therapy, provided the person has no symptoms suggestive of tuberculosis, evidence of a new exposure to active tuberculosis, or other health condition that may require a chest roentgenogram (x-ray) to rule out active tuberculosis;

(4) a person who is detained or confined in a facility operated, licensed, or inspected by the department of corrections where the facility holds a written record of a negative chest roentgenogram (x-ray) (i) within six months; or (ii) within 12 months prior to intake in the facility if the person has remained under the continuing jurisdiction of a correctional facility since the negative chest roentgenogram (x-ray), provided that the person has no symptoms suggestive of tuberculosis, evidence of a new exposure to active tuberculosis, or other health condition that may require a new chest roentgenogram (x-ray) to rule out active tuberculosis;

(5) an employee with a record of either a past positive Mantoux test reaction or active tuberculosis who is currently completing or has a documented history of completing a course of tuberculosis therapy or preventive therapy, provided the employee has no symptoms suggestive of tuberculosis, evidence of a new exposure to active tuberculosis, or other health condition that may require a chest roentgenogram (x-ray) be performed to rule out active tuberculosis;

(6) an employee with either a record of a past positive Mantoux test reaction or a positive or significant Mantoux test reaction in preemployment screening who does not complete a course of preventive therapy may be exempt from annual Mantoux testing or other screening if the employee has a documented negative chest roentgenogram (x-ray) performed at any time since the initial positive Mantoux test, provided the employee has no symptoms suggestive of tuberculosis, evidence of a new exposure to active tuberculosis, or other health condition that may require a chest roentgenogram (x-ray) be performed to rule out active tuberculosis; and

(7) the commissioner may exempt additional employees or persons detained or confined in facilities operated, licensed, or inspected by the department of corrections based on currently accepted public health standards or the person's health status.

[For text of subs 4 and 5, see M.S.1996]

**History:** 1997 c 164 s 1,2

## TUBERCULOSIS HEALTH THREAT

### 144.4801 TITLE.

Sections 144.4801 to 144.4813 may be cited as the "Tuberculosis Health Threat Act."

**History:** 1997 c 164 s 3

### 144.4802 AUTHORITY.

**Subdivision 1. Authority to commit.** Under the powers and duties assigned to the commissioner in this chapter and chapter 145, the commissioner may proceed under sections 144.4801 to 144.4813 whenever the commissioner has probable cause to believe that a person who has active tuberculosis or is clinically suspected of having active tuberculosis is an endangerment to the public health.

**Subd. 2. Preemption.** Sections 144.4801 to 144.4813 preempt and supersede sections 144.4171 to 144.4186, 144.443, and 144.444 with regard to a tuberculosis health threat. Nothing in sections 144.4801 to 144.4813 restricts the commissioner's authority to seek injunctive relief pursuant to section 145.075, or any other relief under other statutes or at common law.

**Subd. 3. Reliance on spiritual means in lieu of medical treatment.** Nothing in sections 144.4801 to 144.4813 shall be construed to abridge the right of a carrier to refuse medical treatment for tuberculosis if the carrier opposes medical treatment on the basis of sincere religious beliefs and complies with a monitoring plan developed by the commissioner for the isolation of the carrier as defined in section 144.4803, subdivision 14. A carrier who meets the requirements of this subdivision is not considered an endangerment under section 144.4803, subdivision 10, clauses (2) to (6) and (8). Nothing in this subdivision shall be construed to limit the authority of the commissioner to take necessary actions to protect the public health according to sections 144.4801 to 144.4813.

**History:** 1997 c 164 s 4

### 144.4803 DEFINITIONS.

**Subdivision 1. Active tuberculosis.** "Active tuberculosis" includes infectious and non-infectious tuberculosis and means:

- (1) a condition evidenced by a positive culture for mycobacterium tuberculosis taken from a pulmonary or laryngeal source;
- (2) a condition evidenced by a positive culture for mycobacterium tuberculosis taken from an extrapulmonary source when there is clinical evidence such as a positive skin test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with pulmonary tuberculosis; or
- (3) a condition in which clinical specimens are not available for culture, but there is radiographic evidence of tuberculosis such as an abnormal chest x-ray, and clinical evidence such as a positive skin test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with pulmonary tuberculosis, that lead a physician to reasonably diagnose active tuberculosis according to currently accepted standards of medical practice and to initiate treatment for tuberculosis.

**Subd. 2. Board of health.** "Board of health" means an administrative authority established under section 145A.03.

**Subd. 3. Carrier.** "Carrier" means a person who has active tuberculosis or is clinically suspected of having active tuberculosis.

**Subd. 4. Clinically suspected of having active tuberculosis.** "Clinically suspected of having active tuberculosis" means presenting a reasonable possibility of having active tuberculosis based upon epidemiologic, clinical, or radiographic evidence, laboratory test results,

or other reliable evidence as determined by a physician using currently accepted standards of medical practice.

**Subd. 5. Commissioner.** "Commissioner" means the commissioner of health.

**Subd. 6. Contagion precautions for tuberculosis.** "Contagion precautions for tuberculosis" means those measures under currently accepted standards of medical practice that prevent a carrier from exposing others to tuberculosis.

**Subd. 7. Department.** "Department" means the department of health.

**Subd. 8. Directly observed therapy.** "Directly observed therapy" means a method for ensuring compliance with medication directions in which a licensed health professional or designee observes a person ingesting prescribed medications or administers the prescribed medication to the person.

**Subd. 9. Disease prevention officer.** "Disease prevention officer" means a designated agent of the commissioner, or a designated agent of a board of health that has express delegated authority from the commissioner to proceed under sections 144.4801 to 144.4813.

**Subd. 10. Endangerment to the public health.** "Endangerment to the public health" means a carrier who may transmit tuberculosis to another person or persons because the carrier has engaged or is engaging in any of the following conduct:

(1) refuses or fails to submit to a diagnostic tuberculosis examination that is ordered by a physician and is reasonable according to currently accepted standards of medical practice;

(2) refuses or fails to initiate or complete treatment for tuberculosis that is prescribed by a physician and is reasonable according to currently accepted standards of medical practice;

(3) refuses or fails to keep appointments for treatment of tuberculosis;

(4) refuses or fails to provide the commissioner, upon request, with evidence showing the completion of a course of treatment for tuberculosis that is prescribed by a physician and is reasonable according to currently accepted standards of medical practice;

(5) refuses or fails to initiate or complete a course of directly observed therapy that is prescribed by a physician and is reasonable according to currently accepted standards of medical practice;

(6) misses at least 20 percent of scheduled appointments for directly observed therapy, or misses at least two consecutive appointments for directly observed therapy;

(7) refuses or fails to follow contagion precautions for tuberculosis after being instructed on the precautions by a licensed health professional or by the commissioner;

(8) based on evidence of the carrier's past or present behavior, may not complete a course of treatment for tuberculosis that is reasonable according to currently accepted standards of medical practice; or

(9) may expose other persons to tuberculosis based on epidemiological, medical, or other reliable evidence.

**Subd. 11. Epidemiological data or epidemiological evidence.** "Epidemiological data" or "epidemiological evidence" means data or evidence relating to the occurrence, distribution, clinical characteristics, and control of disease within a group of people or within a specified population.

**Subd. 12. Health order.** "Health order" means an order issued by the commissioner or a board of health with express delegated authority from the commissioner.

**Subd. 13. Infectious tuberculosis.** "Infectious tuberculosis" means the stage of tuberculosis where mycobacterial organisms are capable of being expelled into the air by a person, as determined by laboratory, epidemiological, or clinical findings.

**Subd. 14. Isolation.** "Isolation" means placing a carrier who has infectious tuberculosis in:

(1) a hospital or other treatment facility;

(2) the carrier's residence or current location; or

(3) any other place approved by the commissioner, provided that the place of isolation prevents or limits the transmission of the infectious tuberculosis agent to others during the period of infectiousness.

**Subd. 15. Licensed health professional.** "Licensed health professional" means a person licensed by one of the health-related licensing boards listed in section 214.01, subdivision 2.

**Subd. 16. Peace officer.** "Peace officer" means an employee or an elected or appointed official of a political subdivision or law enforcement agency who is licensed by the board of peace officer standards and training, is charged with the prevention and detection of crime and the enforcement of the general criminal laws of the state, and has the full power of arrest. "Peace officer" includes an officer of the Minnesota state patrol.

**Subd. 17. Physician.** "Physician" means a person who is licensed by the board of medical practice under chapter 147 to practice medicine.

**Subd. 18. Respondent.** "Respondent" means a person or group of persons to whom the commissioner has issued a health order, excluding the carrier.

**Subd. 19. Treatment facility.** "Treatment facility" means a hospital or other treatment provider that is qualified to provide care, treatment, and appropriate contagion precautions for tuberculosis.

**History:** 1997 c 164 s 5

#### 144.4804 REPORTING RELATING TO TUBERCULOSIS.

**Subdivision 1. Mandatory reporting.** A licensed health professional must report to the commissioner or a disease prevention officer within 24 hours of obtaining knowledge of a reportable person as specified in subdivision 3, unless the licensed health professional is aware that the facts causing the person to be a reportable person have previously been reported. Within 72 hours of making a report, excluding Saturdays, Sundays, and legal holidays, the licensed health professional shall submit to the commissioner or to the disease prevention officer a certified copy of the reportable person's medical records relating to the carrier's tuberculosis and status as an endangerment to the public health if the person is reportable under subdivision 3, clause (3), (4), or (5). A reporting facility may designate an infection control practitioner to make reports and to send certified medical records relating to the carrier's tuberculosis and status as an endangerment to the public health under this subdivision.

**Subd. 2. Voluntary reporting.** A person other than a licensed health professional may report to the commissioner or a disease prevention officer if the person has knowledge of a reportable person as specified in subdivision 3, or has probable cause to believe that a person should be reported under subdivision 3.

**Subd. 3. Reportable persons.** A licensed health professional must report to the commissioner or a disease prevention officer if the licensed health professional has knowledge of:

- (1) a person who has been diagnosed with active tuberculosis;
- (2) a person who is clinically suspected of having active tuberculosis;
- (3) a person who refuses or fails to submit to a diagnostic tuberculosis examination when the person is clinically suspected of having tuberculosis;
- (4) a carrier who has refused or failed to initiate or complete treatment for tuberculosis, including refusal or failure to take medication for tuberculosis or keep appointments for directly observed therapy or other treatment of tuberculosis; or
- (5) a person who refuses or fails to follow contagion precautions for tuberculosis after being instructed on the precautions by a licensed health professional or by the commissioner.

**Subd. 4. Reporting information.** The report by a licensed health professional under subdivision 1 or by a person under subdivision 2 must contain the following information, to the extent known:

- (1) the reportable person's name, birth date, address or last known location, and telephone number;
- (2) the date and specific circumstances that cause the person to be a reportable person;
- (3) the reporting person's name, title, address, and telephone number; and
- (4) any other information relevant to the reportable person's case of tuberculosis.

**Subd. 5. Immunity for reporting.** A licensed health professional who is required to report under subdivision 1 or a person who voluntarily reports in good faith under subdivision 2 is immune from liability in a civil, administrative, disciplinary, or criminal action for reporting under this section.

**Subd. 6. Falsified reports.** A person who knowingly or recklessly makes a false report under this section is liable in a civil suit for actual damages suffered by the person or persons reported and for punitive damages.

**Subd. 7. Waiver of privilege.** A person who is the subject of a report under subdivision 1 is deemed to have waived any privilege created in section 595.02, subdivision 1, paragraphs (d), (e), (g), (i), (j), and (k), with respect to any information provided under this section.

**History:** 1997 c 164 s 6

#### **144.4805 ISSUANCE OF HEALTH ORDER; RIGHTS OF CARRIER AND RESPONDENT.**

**Subdivision 1. Authority.** Only the commissioner, or a board of health with express delegated authority from the commissioner, may issue a health order under this section.

**Subd. 2. Grounds for health order.** Whenever the commissioner has probable cause to believe that a carrier is an endangerment to the public health, the commissioner may issue a health order that the commissioner deems necessary to protect the public health. The commissioner may petition the court for enforcement of the health order. In a court proceeding for enforcement of the health order, the commissioner shall demonstrate the particularized circumstances constituting the necessity for the health order. The health order may be issued to any person, including a carrier, physician, licensed health professional, or treatment facility. The health order may be in the form of a subpoena by the commissioner for certified medical records relating to the carrier's tuberculosis and status as an endangerment to the public health.

**Subd. 3. Contents of health order.** A health order must include:

- (1) a citation to this section as the legal authority under which the order is issued;
- (2) a summary of evidence upon which the person is alleged to be a carrier;
- (3) a description of the alleged conduct of the carrier that makes the carrier an endangerment to the public health;
- (4) a description of less restrictive alternatives that the commissioner considered and rejected, together with the reasons for the rejection, or a description of less restrictive alternatives that the commissioner used and that were unsuccessful;
- (5) the preventive measure ordered; and
- (6) a notice advising the carrier or respondent that:
  - (i) a hearing will be held if the carrier or respondent petitions the court for a hearing or if the commissioner determines that the carrier has not complied with the health order;
  - (ii) the carrier or respondent has the right to appear at the hearing;
  - (iii) the carrier or respondent has the right to present and cross-examine witnesses at the hearing;
  - (iv) the carrier has the right to court-appointed counsel in a proceeding under sections 144.4801 to 144.4813; and
  - (v) the carrier or respondent has the right to the assistance of an interpreter in a proceeding under sections 144.4801 to 144.4813.

**Subd. 4. Right to counsel.** (a) The carrier or respondent has the right to counsel in any proceeding under sections 144.4801 to 144.4813. The court shall promptly appoint counsel for a carrier if the carrier does not have counsel:

- (1) at the time the court issues an order under section 144.4807, subdivision 7, authorizing the continued detention of the carrier;
- (2) at the time the court issues an order under section 144.4808, subdivision 2, authorizing the carrier to be apprehended and held; or
- (3) in all other cases, at the time either party files a notice for a preliminary hearing under section 144.4810, subdivision 2.

The court shall appoint counsel for the carrier. The cost of court-appointed counsel shall be paid by the court.

(b) Upon being notified of the name and address of counsel for the carrier, the commissioner shall promptly forward to the carrier and the carrier's counsel the following:

- (1) a copy of the health order;
- (2) a certified copy of relevant portions of the carrier's medical records; and
- (3) the name and address of the licensed health professional, including the carrier's attending physician or nurse, or the public health physician or nurse whom the commissioner intends to have testify at the preliminary hearing, and a summary of the witness' testimony, including a copy of the witness' affidavit, if any.

**Subd. 5. Duty to communicate.** The commissioner's counsel and the carrier's counsel shall make every effort to communicate prior to any hearing and to stipulate as to undisputed facts, witnesses, and exhibits.

**Subd. 6. Right to interpreter.** The carrier or respondent has the right to the assistance of an interpreter in a proceeding under sections 144.4801 to 144.4813.

**Subd. 7. Service of order.** A health order may be served by a disease prevention officer or peace officer.

**History:** 1997 c 164 s 7

#### **144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.**

A health order may include, but need not be limited to, an order:

(1) requiring the carrier's attending physician or treatment facility to isolate and detain the carrier for treatment or for a diagnostic examination for tuberculosis, pursuant to section 144.4807, subdivision 1, if the carrier is an endangerment to the public health and is in a treatment facility;

(2) requiring a carrier who is an endangerment to the public health to submit to diagnostic examination for tuberculosis and to remain in the treatment facility until the commissioner receives the results of the examination;

(3) requiring a carrier who is an endangerment to the public health to remain in or present at a treatment facility until the carrier has completed a course of treatment for tuberculosis that is prescribed by a physician and is reasonable according to currently accepted standards of medical practice;

(4) requiring a carrier who is an endangerment to the public health to complete a course of treatment for tuberculosis that is prescribed by a physician and is reasonable according to currently accepted standards of medical practice and, if necessary, to follow contagion precautions for tuberculosis;

(5) requiring a carrier who is an endangerment to the public health to follow a course of directly observed therapy that is prescribed by a physician and is reasonable according to currently accepted standards of medical practice;

(6) excluding a carrier who is an endangerment to the public health from the carrier's place of work or school, or from other premises if the commissioner determines that exclusion is necessary because contagion precautions for tuberculosis cannot be maintained in a manner adequate to protect others from being exposed to tuberculosis;

(7) requiring a licensed health professional or treatment facility to provide to the commissioner certified copies of all medical and epidemiological data relevant to the carrier's tuberculosis and status as an endangerment to the public health;

(8) requiring the diagnostic examination for tuberculosis of other persons in the carrier's household, workplace, or school, or other persons in close contact with the carrier if the commissioner has probable cause to believe that the persons may have active tuberculosis or may have been exposed to tuberculosis based on epidemiological, medical, or other reliable evidence; or

(9) requiring a carrier or other persons to follow contagion precautions for tuberculosis.

**History:** 1997 c 164 s 8

**144.4807 NOTICE OF OBLIGATION TO ISOLATE OR EXAMINE.**

**Subdivision 1. Obligation to isolate.** If the carrier is in a treatment facility, the commissioner or a carrier's attending physician, after obtaining approval from the commissioner, may issue a notice of obligation to isolate to a treatment facility if the commissioner or attending physician has probable cause to believe that a carrier is an endangerment to the public health.

**Subd. 2. Obligation to examine.** If the carrier is clinically suspected of having active tuberculosis, the commissioner may issue a notice of obligation to examine to the carrier's attending physician to conduct a diagnostic examination for tuberculosis on the carrier.

**Subd. 3. Precautions to avoid exposure.** Upon receiving a notice of obligation to isolate or notice of obligation to examine, a treatment facility shall immediately take all reasonable precautions to prevent the carrier from exposing other persons to tuberculosis, including the use of guards or locks, if appropriate.

**Subd. 4. Service of health order on carrier.** When issuing a notice of obligation to isolate or examine to the carrier's physician or a treatment facility, the commissioner shall simultaneously serve a health order on the carrier ordering the carrier to remain in the treatment facility for treatment or examination.

**Subd. 5. Duration of detention.** No carrier may be detained under subdivision 1 or 2 longer than 72 hours, excluding Saturdays, Sundays, and legal holidays, unless the court issues an order authorizing continued detention of the carrier pursuant to subdivision 7. A carrier may not be released prior to the expiration of the 72-hour hold without the express consent of the commissioner.

**Subd. 6. Application for extension of 72-hour hold.** The commissioner may seek an order extending the hold under subdivision 5 by filing an ex parte application with the probate division of the district court of the county in which the carrier resides. The application may be filed orally by telephone or by facsimile, provided that a written application is filed within 72 hours, excluding Saturdays, Sundays, and legal holidays.

**Subd. 7. Court order extending 72-hour hold.** The court may extend the hold under subdivision 5 by up to six days, excluding Saturdays, Sundays, and legal holidays, if the court finds that there is probable cause to believe that the carrier is an endangerment to the public health. The court may find probable cause to detain, examine, and isolate the carrier based upon a written statement by facsimile or upon an oral statement by telephone from the carrier's attending physician or nurse, a public health physician or nurse, other licensed health professional, or disease prevention officer, stating the grounds and facts that demonstrate that the carrier is an endangerment to the public health, provided that an affidavit from such witness is filed with the court within 72 hours, excluding Saturdays, Sundays, and legal holidays. The order may be issued orally by telephone, or by facsimile, provided that a written order is issued within 72 hours, excluding Saturdays, Sundays, and legal holidays. The oral and written order shall contain a notice of the carrier's rights contained in section 144.4805, subdivision 3, clause (6). A carrier may not be released prior to the hold extended under this subdivision without the express consent of the commissioner.

**Subd. 8. Appointment of counsel.** If the carrier does not have counsel at the time the court issues an order to extend the hold under subdivision 7, the court shall promptly appoint counsel for the carrier.

**Subd. 9. Immunity.** A disease prevention officer, peace officer, physician, licensed health professional, or treatment facility that acts in good faith under this section is immune from liability in any civil, administrative, disciplinary, or criminal action for acting under this section.

*History: 1997 c 164 s 9*

**144.4808 APPREHEND AND HOLD ORDER.**

**Subdivision 1. Application for apprehend and hold order.** The commissioner may make an ex parte application for an order to apprehend and hold a carrier who is not in a treatment facility if the commissioner has probable cause to believe that a carrier is:

(1) an endangerment to the public health; and



(2) either in imminent danger of exposing another person or persons to tuberculosis, or may flee or become unlocatable.

The commissioner shall file the application in the probate division of the district court of the county in which the carrier resides. The application may be filed orally by telephone or by facsimile, provided that a written application is filed within 72 hours, excluding Saturdays, Sundays, and legal holidays.

**Subd. 2. Court order to apprehend and hold.** The court may find probable cause to apprehend and hold the carrier based upon a written statement by facsimile or oral statement by telephone from the carrier's attending physician or nurse, a public health physician or nurse, other licensed health professional, or disease prevention officer, stating the grounds and facts that demonstrate that the carrier is an endangerment to the public health, provided that an affidavit from such witness is filed with the court within 72 hours, excluding Saturdays, Sundays, and legal holidays. The court may issue an order to a peace officer or to a disease prevention officer, or both to:

(1) apprehend and transport the carrier to a designated treatment facility, and detain the carrier until the carrier is admitted to the treatment facility; or

(2) apprehend and isolate the carrier.

The order may be issued orally by telephone, or by facsimile, provided that a written order is issued within 72 hours, excluding Saturdays, Sundays, and legal holidays. The oral and written order shall contain a notice of the carrier's rights contained in section 144.4805, subdivision 3, clause (6).

**Subd. 3. Duration of detention.** A carrier may be detained under this subdivision up to six days, excluding Saturdays, Sundays, and legal holidays. A carrier may not be released prior to the expiration of the hold authorized under this section without the express consent of the commissioner.

**Subd. 4. Apprehension of carrier.** If the carrier flees or forcibly resists the peace officer or disease prevention officer, the officer may use all necessary and lawful means to apprehend, hold, transport, or isolate the carrier. This subdivision is authority for the officer to carry out the duties specified in this section. The commissioner shall provide any information and equipment necessary to protect the officer from becoming exposed to tuberculosis.

**Subd. 5. Appointment of counsel.** If the carrier does not have counsel at the time the court issues an apprehend and hold order under subdivision 2, the court shall promptly appoint counsel for the carrier.

**Subd. 6. Immunity.** A disease prevention officer, peace officer, physician, licensed health professional, or treatment facility that acts in good faith under this section is immune from liability in any civil, administrative, disciplinary, or criminal action for acting under this section.

**History:** 1997 c 164 s 10

#### 144.4809 PRELIMINARY HEARING.

**Subdivision 1. Grounds for hearing.** A party may petition the court for an order for enforcement of or relief from a health order or judicial order.

**Subd. 2. Petition for preliminary hearing.** The petitioning party shall serve on the commissioner and file in the probate division of the district court of the county in which the carrier or respondent resides a petition and notice of preliminary hearing. The court shall hold a preliminary hearing no later than 15 days from the date of the filing and service of the petition for a preliminary hearing. If a carrier detained under section 144.4807 or 144.4808 files a petition for a preliminary hearing, the hearing must be held no later than five days from the date of the filing and service of the petition, excluding Saturdays, Sundays, and legal holidays.

**Subd. 3. Commissioner's notice of hearing.** If the commissioner petitions the court to enforce the health order, the notice of the preliminary hearing must contain the following information:

(1) the date, time, and place of the hearing;

(2) the right of the carrier to be represented by court-appointed counsel during any proceeding under sections 144.4801 to 144.4813;

(3) the right of the carrier or respondent to the assistance of an interpreter in any proceeding under sections 144.4801 to 144.4813;

(4) the right of the carrier or respondent to appear at the hearing;

(5) the right of the carrier or respondent to present and cross-examine witnesses;

(6) a statement of any disputed facts, or a statement of the nature of any other disputed matter; and

(7) the name and address of any witness that the petitioning party intends to call to testify at the hearing, and a brief summary of the witness' testimony.

**Subd. 4. Carrier's or respondent's notice of hearing.** If the carrier or respondent petitions the court for relief from the health order or court order, the notice of preliminary hearing must contain the information in subdivision 3, clauses (1), (6), and (7).

**Subd. 5. Duty to communicate.** (a) At least five days before the date of the preliminary hearing, excluding Saturdays, Sundays, and legal holidays, the nonpetitioning party shall respond to the petition for hearing by filing and serving on the petitioning party:

(1) a statement of any disputed facts, or a statement of the nature of any other disputed matter; and

(2) the name and address of any witness that the nonpetitioning party intends to call to testify at the hearing, and a brief summary of the witness' testimony.

If the carrier seeks release from an emergency hold ordered under section 144.4807, subdivision 7, or under section 144.4808, subdivision 2, the commissioner shall file and serve on the carrier's counsel the items in clauses (1) and (2) at least 48 hours prior to the preliminary hearing, excluding Saturdays, Sundays, and legal holidays.

(b) At the hearing, the parties shall identify the efforts they made to resolve the matter prior to the preliminary hearing.

**Subd. 6. Hearing room in treatment facility.** If the carrier is infectious, the treatment facility in which the carrier is sought to be detained or to which the carrier is sought to be removed shall make reasonable accommodations to provide a room where the hearing may be held that minimizes the risk of exposing persons attending the hearing to tuberculosis. If a room is not available at the treatment facility, the court may designate another location for the hearing.

**Subd. 7. Standard of proof.** The commissioner must prove by a preponderance of the evidence that the carrier is an endangerment to the public health.

**Subd. 8. Rules of evidence.** The court shall admit all reliable relevant evidence. Medical and epidemiological data must be admitted if it conforms with section 145.31, chapter 600, Minnesota Rules of Evidence, rule 803(6), or other statutes or rules that permit reliable evidence to be admitted in civil cases. The court may rely on medical and epidemiological data, including hearsay, if it finds that physicians and other licensed health professionals rely on the data in the regular course of providing health care and treatment.

**Subd. 9. Sufficiency of evidence.** It is a sufficient basis for the court to order continued confinement of the carrier or other preventive measures requested by the commissioner if reliable testimony is provided solely by the carrier's attending physician or nurse, a public health physician or nurse, other licensed health professional, or disease prevention officer.

**Subd. 10. Failure to appear at hearing.** If the carrier or respondent fails to appear at the hearing without prior court approval, the hearing may proceed without the carrier or respondent and the court may make its determination on the basis of all reliable evidence submitted at the hearing.

**History:** 1997 c 164 s 11

#### **144.4810 FINAL HEARING.**

**Subdivision 1. Grounds for hearing.** After the preliminary hearing, the commissioner, carrier, or respondent may petition the court for relief from or enforcement of the court order issued pursuant to the preliminary hearing. The commissioner may petition the court for additional preventive measures if the carrier or respondent has not complied with the court order issued pursuant to the preliminary hearing. The petitioning party shall serve and file a

petition and notice of hearing with the probate division of the district court. The court shall hold the final hearing no later than 15 days from the date of the filing and service of the petition for a final hearing.

**Subd. 2. Notice of hearing.** The notice of the final hearing must contain the same information as for the preliminary hearing in section 144.4809, subdivision 3 or 4.

**Subd. 3. Duty to communicate.** The parties have a duty to communicate and exchange information as provided in section 144.4809, subdivision 5.

**Subd. 4. Hearing room in treatment facility.** The hearing room for the final hearing is governed by section 144.4809, subdivision 6.

**Subd. 5. Standard of proof.** The commissioner must prove by clear and convincing evidence that the carrier is an endangerment to the public health.

**Subd. 6. Rules of evidence.** The rules of evidence are governed by section 144.4809, subdivision 8.

**Subd. 7. Sufficiency of evidence.** The sufficiency of evidence is governed by section 144.4809, subdivision 9.

**Subd. 8. Failure to appear at hearing.** The failure of the carrier or respondent to appear at the hearing is governed by section 144.4809, subdivision 10.

**Subd. 9. Right of appeal.** The commissioner, carrier, or respondent may appeal the decision of the district court. The court of appeals shall hear the appeal within 60 days after filing and service of the notice of appeal.

**Subd. 10. Right of commissioner to issue subsequent order.** Notwithstanding any ruling by the district court, the commissioner may issue a subsequent health order if the commissioner has probable cause to believe that a health order is necessary based on additional facts not known or present at the time of the district court hearing.

**History:** 1997 c 164 s 12

#### **144.4811 PERIODIC REVIEW AND RELEASE FROM DETENTION.**

**Subdivision 1. Periodic review.** If the carrier has been detained in a treatment facility or has been isolated pursuant to a court order, the commissioner shall submit a report to the court, the carrier, and the carrier's counsel within 90 days of the date of the court-ordered detention and every 90 days thereafter, until the carrier is released. The report must state the treatment the carrier receives, whether the carrier is cured or noninfectious, and whether the carrier will continue to be detained. If the carrier contests the commissioner's determination for continued detention, the carrier may request a hearing. The hearing on continued detention is governed by the provisions for a final hearing under section 144.4810, excluding subdivision 5 of that section. The court shall order continued detention of the carrier if it finds that such detention is reasonable. This subdivision does not apply to consent orders or other confinement that has been voluntarily agreed upon by the parties.

**Subd. 2. Carrier's petition for release.** If the carrier is detained in a treatment facility or isolated pursuant to a court order, the carrier may make a good faith request for release from confinement prior to the 90-day review under subdivision 1 by filing a petition and notice of hearing with the court that ordered the confinement and by serving the petition and notice on the commissioner. The hearing on continued confinement is governed by the provisions for a final hearing under section 144.4810, excluding subdivision 5 of that section. The court shall order continued detention of the carrier if it finds that such detention is reasonable.

**Subd. 3. Release from detention based on order to compel examination.** A carrier who has been detained in a treatment facility under a court order to compel the carrier to submit to a diagnostic tuberculosis examination shall be released only after:

- (1) the commissioner determines that the carrier does not have active tuberculosis; or
- (2) the commissioner determines that the carrier is not an endangerment to the public health.

**Subd. 4. Release from detention based on endangerment.** A carrier who is detained in a treatment facility or isolated under a court order because the carrier is an endangerment to the public health shall be released only after:

- (1) the commissioner determines that the carrier is cured; or
- (2) the commissioner determines that the carrier is no longer an endangerment to the public health.

**History:** 1997 c 164 s 13

#### **144.4812 COSTS OF CARE.**

The costs incurred by the treatment facility and other providers of services to diagnose or treat the carrier for tuberculosis must be borne by the carrier, the carrier's health plan, or public programs. During the period of insurance coverage, a health plan may direct the implementation of the care required by the health order or court order and shall pay at the contracted rate of payment, which shall be considered payment in full. Inpatient hospital services required by the health order or court order and covered by medical assistance or general assistance medical care are not billable to any other governmental entity. If the carrier cannot pay for treatment, and the carrier does not have public or private health insurance coverage, the carrier shall apply for financial assistance with the aid of the county. For persons not otherwise eligible for public assistance, the commissioner of human services shall determine what, if any, costs the carrier shall pay. The commissioner of human services shall make payments at the general assistance medical care rate, which will be considered payment in full.

**History:** 1997 c 164 s 14

#### **144.4813 DATA PRIVACY.**

**Subdivision 1. Nonpublic data.** Data on individuals contained in the health order are health data under section 13.38. Other data on individuals collected by the commissioner as part of an investigation of a carrier under sections 144.4801 to 144.4813 are investigative data under section 13.39.

**Subd. 2. Protective order.** After a judicial action is commenced, a party may seek a protective order to protect the disclosure of portions of the court record identifying individuals or entities.

**Subd. 3. Records retention.** A records retention schedule for records developed under sections 144.4801 to 144.4813 must be established pursuant to section 138.17, subdivision 7.

**History:** 1997 c 164 s 15

#### **144.6585 IDENTIFICATION OF HEALTH CARE PROVIDERS.**

Any health care provider who is licensed, credentialed, or registered by a health-related licensing board as defined under section 214.01, subdivision 2, must wear a name tag that indicates by words, letters, abbreviations, or insignia the profession or occupation of the individual. The name tag must be worn whenever the health care provider is rendering health services to a patient, unless wearing the name tag would create a safety or health risk to the patient. The failure to wear a name tag is not reportable under chapter 214.

**History:** 1997 c 237 s 15

#### **144.664 DUTIES OF COMMISSIONER.**

*[For text of subs 1 and 2, see M.S.1996]*

**Subd. 3. Notification.** Within five days of receiving a report of traumatic brain injury or spinal cord injury, the commissioner shall notify the injured person or the injured person's family of resources and services available in Minnesota, pursuant to section 144.662, clause (2).

*[For text of subs 4 and 5, see M.S.1996]*

**History:** 1997 c 205 s 22

#### **144.665 TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY DATA.**

Data on individuals collected by the commissioner of health under sections 144.662 to 144.664 are private data on individuals as defined in section 13.02, subdivision 12, and may

be used only for the purposes set forth in sections 144.662 to 144.664 in accordance with the rules adopted by the commissioner.

**History:** 1997 c 205 s 23

#### 144.672 DUTIES OF COMMISSIONER; RULES.

Subdivision 1. **Rule authority.** The commissioner of health shall collect cancer incidence information, analyze the information, and conduct special studies designed to determine the potential public health significance of an increase in cancer incidence.

The commissioner shall adopt rules to administer the system, collect information, and distribute data. The rules must include, but not be limited to, the following:

- (1) the type of data to be reported;
- (2) standards for reporting specific types of data;
- (3) payments allowed to hospitals, pathologists, and registry systems to defray their costs in providing information to the system;
- (4) criteria relating to contracts made with outside entities to conduct studies using data collected by the system. The criteria may include requirements for a written protocol outlining the purpose and public benefit of the study, the description, methods, and projected results of the study, peer review by other scientists, the methods and facilities to protect the privacy of the data, and the qualifications of the researcher proposing to undertake the study;
- (5) specification of fees to be charged under section 13.03, subdivision 3, for all out-of-pocket expenses for data summaries or specific analyses of data requested by public and private agencies, organizations, and individuals, and which are not otherwise included in the commissioner's annual summary reports. Fees collected are appropriated to the commissioner to offset the cost of providing the data; and
- (6) establishment of a committee to assist the commissioner in the review of system activities. The committee is governed by section 15.059, except it expires June 30, 2001.

*[For text of subd 2, see M.S.1996]*

**History:** 1997 c 192 s 24

#### 144.761 DEFINITIONS.

*[For text of subs 1 to 3, see M.S.1996]*

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 144E.001 to 144E.35.

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 144E.001 to 144E.35, who provide prehospital emergency medical services;
- (4) crime lab personnel receiving a significant exposure while involved in a criminal investigation;
- (5) correctional guards employed in state and local correctional facilities and other employees of the state department of corrections, if the guard or employee experiences a significant exposure to an inmate in the performance of their duties;
- (6) employees at the Minnesota security hospital and the Minnesota sexual psychopathic personality treatment center who are employed by the state or a local unit of government and who experience a significant exposure in the performance of their duties; and

(7) other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care, and who would qualify for immunity from liability under the good samaritan law, section 604A.01.

*[For text of subd 6, see M.S.1996]*

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

(1) contact, in a manner supported by contemporary epidemiological research as a method of HIV or hepatitis B transmission, of the 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.

*[For text of subd 8, see M.S.1996]*

**History:** 1997 c 199 s 14; 1997 c 239 art 9 s 1,2

## **144.762 NOTIFICATION PROTOCOL FOR EXPOSURE TO HIV AND HEPATITIS B.**

*[For text of subd 1, see M.S.1996]*

**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 and determine whether a significant exposure has occurred. This investigation must be completed within 72 hours of receipt of the exposure report, or within a time period that will enable the patient to benefit from contemporary standards of care for reducing the risk of infection;

(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. 2a. Additional protocol requirements.** In addition to the protocol requirements under subdivision 2, the postexposure notification protocol must provide a process for a licensed physician at the facility to conduct an immediate investigation into whether a significant exposure has occurred whenever emergency medical services personnel present themselves at a facility within six hours of a possible significant exposure. If the investigation shows that a significant exposure occurred, the protocol must provide a process for determining whether the patient has hepatitis B or HIV infection by means of mandatory reporting under section 144.765, subdivision 2, and reporting of results under sections 144.761, subdivision 2, clauses (4), (5), and (6), and 144.767.

[For text of subd 3, see M.S.1996]

**History:** 1997 c 239 art 9 s 3,4

#### 144.765 PATIENT'S RIGHT TO REFUSE TESTING.

Subdivision 1. **Voluntary testing.** (a) 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.

(b) The patient shall be informed of the right to refuse to be tested, that refusal could result in a request for a court order to force reporting of hepatitis B or HIV infection status, and that information collected through this process is for medical purposes and cannot be used as evidence in any criminal proceedings. 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.

Subd. 2. **Mandatory reporting.** If a patient is subject to voluntary testing under section 144.762, subdivision 2a, and is either unavailable for immediate testing at the facility or refuses to submit to a blood test, the emergency medical services personnel employer shall locate and ask the patient to report and present documentation from a licensed physician of the patient's most recent known HIV and hepatitis B infection status within 24 hours. 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 that refusal could result in a request for a court order to force reporting, and that information collected through this process is for medical purposes and cannot be used as evidence in any criminal proceedings. If the patient refuses to report, the patient's refusal will be forwarded to the emergency medical services personnel.

Subd. 3. **Mandatory testing.** 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 or a local correctional authority as a result of a criminal conviction.

Subd. 4. **Court order.** If a patient is subject to mandatory reporting under subdivision 2, and either is unavailable for reporting to the facility or refuses to submit a report, the emergency medical services personnel may seek a court order to compel the patient to submit to reporting. Court proceedings under this subdivision shall be given precedence over other pending matters so that the court may reach a prompt decision without delay. The court shall order the patient to submit to reporting upon proof that: (1) an investigation by a licensed physician under section 144.762, subdivision 2a, showed that the emergency medical services personnel experienced a significant exposure; and (2) the information is necessary for a decision about beginning, continuing, or discontinuing a medical intervention and will not cause undue hardship or harm to the health of the patient.

**History:** 1997 c 239 art 9 s 5

#### 144.767 TEST RESULTS; REPORTS.

Subdivision 1. **Report to employer.** Results of tests conducted or reports received 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 or reports shall be reported without personally identifying information and may be used only for medical purposes and may not be used as evidence in any criminal prosecution.

[For text of subd 2, see M.S.1996]

**History:** 1997 c 239 art 9 s 6

144.801 [Repealed, 1997 c 199 s 15]

144.802 [Repealed, 1997 c 199 s 15]

**144.803** [Repealed, 1997 c 199 s 15]

**144.804** [Repealed, 1997 c 199 s 15]

**144.806** [Repealed, 1997 c 199 s 15]

**144.807** Subdivision 1. MS 1996 [Renumbered 144E.17, subd 1]

Subd. 2. MS 1996 [Renumbered 144E.17, subd 2]

Subd. 3. MS 1988 [Repealed, 1989 c 134 s 12]

**144.808** MS 1996 [Renumbered 144E.18]

**144.809** MS 1996 [Renumbered 144E.25]

**144.8091** Subdivision 1. MS 1996 [Renumbered 144E.35, subd 1]

Subd. 2. MS 1996 [Renumbered 144E.35, subd 2]

Subd. 3. MS 1988 [Repealed by amendment, 1989 c 134 s 11]

**144.8093** Subdivision 1. MS 1996 [Renumbered 144E.50, subd 1]

Subd. 2. MS 1996 [Renumbered 144E.50, subd 2]

Subd. 2a. MS 1996 [Renumbered 144E.50, subd 3]

Subd. 3. MS 1996 [Renumbered 144E.50, subd 4]

Subd. 4. MS 1996 [Renumbered 144E.50, subd 5]

**144.8095** MS 1996 [Renumbered 144E.52]

#### **144.95 MOSQUITO RESEARCH PROGRAM.**

*[For text of subs 1 to 8, see M.S.1996]*

Subd. 9. [Repealed, 1997 c 7 art 2 s 67]

*[For text of subd 10, see M.S.1996]*

#### **144.9501 DEFINITIONS.**

*[For text of subs 1 to 6, see M.S.1996]*

Subd. 6a. **Child.** "Child" means an individual up to 72 months of age.

*[For text of subs 7 to 28, see M.S.1996]*

Subd. 29. **Swab team services.** "Swab team services" means activities that provide protection from lead hazards such as:

(1) removing lead dust by washing, vacuuming with high efficiency particle accumulator (HEPA) or wet vacuum cleaners, and cleaning the interior of residential property;

(2) removing loose paint and paint chips and repainting or installing guards to protect intact paint;

(3) covering or replacing bare soil that has a lead concentration of 100 parts per million or more;

(4) health education;

(5) advice and assistance to help residents locate and move to a temporary residence while lead hazard reduction is being completed; or

(6) any other assistance necessary to meet the resident's immediate needs as a result of the relocation.

*[For text of subs 30 to 32, see M.S.1996]*

**History:** 1997 c 205 s 24,25

#### **144.9504 SECONDARY PREVENTION.**

*[For text of subd 1, see M.S.1996]*



**Subd. 2. Lead inspection.** (a) An inspecting agency shall conduct a lead inspection of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (5) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 70 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than 20 micrograms of lead per deciliter of whole blood;

(4) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification; or

(5) within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available state and federal appropriations, an inspecting agency may also conduct a lead inspection for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an inspecting agency shall inspect the individual unit in which the conditions of this section are met and shall also inspect all common areas. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the inspecting agency shall also inspect the other sites. The inspecting agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead inspection for each additional site.

(d) Within the limits of appropriations, the inspecting agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 20 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them a copy of the lead inspection guide. The inspecting agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The inspecting agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The inspecting agency shall conduct the lead inspection according to rules adopted by the commissioner under section 144.9508. An inspecting agency shall have lead inspections performed by lead inspectors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow an inspection, the inspecting agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead inspection set forth in this subdivision no longer applies. An inspector or inspecting agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, dust, and drinking water must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces.

(f) A lead inspector shall notify the commissioner and the board of health of all violations of lead standards under section 144.9508, that are identified in a lead inspection conducted under this section.

(g) Each inspecting agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the inspecting agency. Inspecting agencies must consider appeals that propose lower cost methods that make the residence lead safe.

(h) Sections 144.9501 to 144.9509 neither authorize nor prohibit an inspecting agency from charging a property owner for the cost of a lead inspection.

*[For text of subs 3 to 11, see M.S.1996]*

**History:** 1997 c 205 s 26; 1997 c 228 s 12

#### 144.9506 LICENSING OF LEAD INSPECTORS.

Subdivision 1. **License required.** (a) A lead inspector shall obtain a license before performing lead inspections and shall renew it annually. The commissioner shall charge a fee and require annual training, as specified in this section. A lead inspector shall have the inspector's license readily available at all times at an inspection site and make it available, on request, for inspection by the inspecting agency with jurisdiction over the site. A license shall not be transferred.

(b) Individuals shall not advertise or otherwise present themselves as lead inspectors unless licensed by the commissioner.

(c) An individual may use sodium rhodizonate to test paint for the presence of lead without obtaining a lead inspector license, but must not represent the test as a lead inspection.

*[For text of subs 2 to 4, see M.S.1996]*

Subd. 5. **Approval of lead inspection course.** Until the commissioner adopts rules under section 144.9508 to license lead inspectors and approve lead inspector training courses, a lead inspection course sponsored by a training course provider in one of the regional lead training consortia established by the United States Environmental Protection Agency is an approved course for the purpose of this section, providing it covers the criteria listed in section 144.9505. After adoption of rules under section 144.9508, all training courses offered for the purpose of licensing individuals as lead inspectors must be reviewed and approved by the commissioner.

**History:** 1997 c 205 s 27,28

#### 144.99 ENFORCEMENT.

*[For text of subs 1 to 8, see M.S.1996]*

Subd. 9. **Suspension or revocation of permits, licenses, registrations, or certificates.** The commissioner may suspend, place conditions on, or revoke a permit, license, registration, or certificate issued under the statutes or rules cited in subdivision 1 for:

(1) serious or repeated violations of the requirements in the statutes, rules, or other actions listed in subdivision 1 that apply to the permit, license, registration, or certificate;

(2) submitting false material information to the department in connection with activities for which the permit, license, registration, or certificate is issued;

(3) allowing the alteration or use of one's own permit, license, registration, or certificate by another; or

(4) within the previous five years, conviction of a crime in connection with activities for which the permit, license, registration, or certificate was issued.

Subd. 10. **Hearings related to denial, refusal to renew, suspension, or revocation of a permit, license, registration, or certificate.** If the commissioner proposes to deny, refuses to renew, suspends, or revokes a permit, license, registration, or certificate under subdivision 8 or 9, the commissioner must first notify, in writing, the person against whom the action is proposed to be taken and provide the person an opportunity to request a hearing under the contested case provisions of chapter 14. If the person does not request a hearing by notifying the commissioner within 20 days after receipt of the notice of proposed action, the commissioner may proceed with the action without a hearing. This subdivision does not apply to:

(1) the denial of or refusal to renew a permit, license, registration, or certificate based on the applicant's failure to meet or maintain the minimum qualifications for holding the permit, license, registration, or certificate; or

(2) the denial of, refusal to renew, suspension of, or revocation of a permit, license, registration, or certificate if the person against whom the action is proposed to be taken has been granted a hearing under this subdivision within the previous 12 months.

*[For text of subd 11, see M.S.1996]*

**History:** 1997 c 205 s 29,30