CHAPTER 144

DEPARTMENT OF HEALTH

144.1205 RADIOACTIVE MATERIAL; SPECIAL NUCLEAR MATERIAL.

Subdivision 1. **Application and license renewal fee.** When a license is required for radioactive material or source or special nuclear material by a rule adopted under section 144.1202, subdivision 2, an application fee according to subdivision 4 must be paid upon initial application for a license. The licensee must renew the license 60 days before the expiration date of the license. The expiration date of a license is the date specified by rule of the commissioner of health.

[For text of subds 2 to 9, see M.S.2006]

History: *2007 c 85 s 1*

144.121 X-RAY MACHINES; OTHER SOURCES OF IONIZING RADIATION.

[For text of subd 1, see M.S.2006]

Subd. 1a. **Fees for ionizing radiation-producing equipment.** A facility with ionizing radiation-producing equipment must pay an annual initial or annual renewal registration fee consisting of a base facility fee of $66 and an additional fee for each radiation source, as follows:

(1)	medical or veterinary equipment	$ 53
(2)	dental x-ray equipment	$ 33

(3)	accelerator	$ 66
(4)	radiation therapy equipment	$ 66
(5)	x–ray equipment not used on humans or animals	$ 53
(6)	devices with sources of ionizing radiation not used on humans or animals	$ 53

[For text of subd 1b, see M.S.2006]

Subd. 1c. [Repealed, 2007 c 85 s 5]

[For text of subds 2 and 3, see M.S.2006]

Subd. 4. [Repealed, 2007 c 85 s 5]

Subd. 5. **Examination for individual operating x–ray equipment.** (a) After January 1, 2008, an individual in a facility with x–ray equipment for use on humans that is registered under subdivision 1 may not operate, nor may the facility allow the individual to operate, x–ray equipment unless the individual has passed a national examination for limited x–ray machine operators that meets the requirements of paragraphs (b) and (c) and is approved by the commissioner of health.

(b) The commissioner shall establish criteria for the approval of examinations based on national standards, such as the examination in radiography from the American Registry of Radiologic Technologists, the examination for limited scope of practice in radiography from the American Registry of Radiologic Technologists for limited x–ray machine operators, and the American Registry of Chiropractic Radiography Technologists for limited radiography in spines and extremities; or equivalent examinations approved by other states. Equivalent examinations may be approved by the commissioner, if the examination is consistent with the standards for educational and psychological testing as recommended by the American Education Research Association, the American Psychological Association, the National Council on Measurement in Education, or the National Commission for Certifying Agencies. The organization proposing the use of an equivalent examination shall submit a fee to the commissioner of $1,000 per examination to cover the cost of determining the extent to which the examination meets the examining standards. The collected fee shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) The examination for limited x–ray machine operators must include:

(1) radiation protection, equipment maintenance and operation, image production and evaluation, and patient care and management; and

(2) at least one of the following regions of the human anatomy: chest, extremities, skull and sinus, spine, or ankle and foot. The examinations must include the anatomy of, and positioning for, the specific regions.

(d) A limited x–ray operator who is required to take an examination under this subdivision must submit to the commissioner an application for the examination, a $25 processing fee, and the required examination fee set by the national organization offering the examination. The processing fee and the examination fee shall be deposited in the state treasury and credited to the state government special revenue fund. The commissioner shall submit the fee to the national organization providing the examination.

Subd. 5a. **Limited x–ray machine operator practice.** (a) A limited x–ray operator may only practice medical radiography on limited regions of the human anatomy for which the operator has successfully passed an examination identified in subdivision 5, unless the operator meets one of the exemptions described in paragraph (b). The operator may practice using only routine radiographic procedures, for the interpretation by and under the direction of a licensed practitioner, excluding computed tomography, the use of contrast media, and the use of fluoroscopic or mammographic equipment.

(b) This subdivision does not apply to:

(1) limited x–ray machine operators who passed the examination that was required before January 1, 2008;

(2) certified radiologic technologists, licensed dental hygienists, registered dental assistants, certified registered nurse anesthetists, and registered physician assistants;

(3) individuals who are licensed in Minnesota to practice medicine, osteopathy, chiropractic, podiatry, or dentistry; and

(4) individuals who are participating in a training course in any of the occupations listed in clause (2) or (3) for the duration and within the scope of the training course.

Subd. 5b. **Variance of scope of practice.** The commissioner may grant a variance according to Minnesota Rules, parts 4717.7000 to 4717.7050, to a facility for the scope of practice of an x–ray operator in cases where the delivery of health care would otherwise be compromised if a variance were not granted. The request for a variance must be in writing, state the circumstances that constitute hardship, state the period of time the facility wishes to have the variance for the scope of practice in place, and state the alternative measures that will be taken if the variance is granted. The commissioner shall set forth in writing the reasons for granting or denying the variance. Variances granted by the commissioner specify in writing the time limitation and required alternative measures to be taken by the facility. A request for the variance shall be denied if the commissioner finds the circumstances stated by the facility do not support a claim of hardship, the requested time period for the variance is unreasonable, the alternative measures proposed by the facility are not equivalent to the scope of practice, or the request for the variance is not submitted to the commissioner in a timely manner.

[For text of subds 6 and 8, see M.S.2006]

History: *2007 c 85 s 2; 2007 c 123 s 1–3*

NOTE: Subdivision 5 was also amended by Laws 2007, chapter 85, section 3, to read as follows:

"Subd. 5. **Examination for individual operating x–ray equipment.** After January 1, 1997, an individual in a facility with x–ray equipment for use on humans that is registered under subdivision 1 may not operate, nor may the facility allow the individual to operate, x–ray equipment unless the individual has passed an examination approved by the commissioner of health, or an examination determined to the satisfaction of the commissioner of health to be an equivalent national, state, or regional examination, that demonstrates the individual's knowledge of basic radiation safety, proper use of ionizing radiation–producing equipment, and quality assurance procedures. The commissioner shall establish by rule criteria for the approval of examinations required for an individual operating an x–ray machine in Minnesota."

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts gen-

erated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,555 plus $13 per bed
Non–JCAHO and non–AOA hospitals	$5,180 plus $247 per bed
Nursing home	$183 plus $91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$3,349
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$ 1,200
Psychiatric hospitals	$ 1,400
Rural health facilities	$ 1,100
Portable x–ray providers	$ 500
Home health agencies	$ 1,800
Outpatient therapy agencies	$ 800
End stage renal dialysis providers	$ 2,100
Independent therapists	$ 800
Comprehensive rehabilitation outpatient facilities	$ 1,200
Hospice providers	$ 1,700
Ambulatory surgical providers	$ 1,800
Hospitals	$ 4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

History: *2007 c 140 art 12 s 3*

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subdivision 1. **Who must pay.** Except for the limitation contained in this section, the commissioner of health shall charge a handling fee for each specimen submitted to the Department of Health for analysis for diagnostic purposes by any hospital, private laboratory, private clinic, or physician. No fee shall be charged to any entity which receives direct or

indirect financial assistance from state or federal funds administered by the Department of Health, including any public health department, nonprofit community clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged for any biological materials submitted to the Department of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological materials requested by the department to gather information for disease prevention or control purposes. The commissioner of health may establish other exceptions to the handling fee as may be necessary to protect the public's health. All fees collected pursuant to this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 2. **Fee amounts.** The commissioner of health shall charge a handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be $25 per specimen.

History: *2007 c 147 art 16 s 6*

144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL DISORDERS.

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow–up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966. The fee is $101 per specimen. Costs associated with capital expenditures and the development of new procedures may be prorated over a three–year period when calculating the amount of the fees.

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

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

parent or legal guardian and made part of the infant's medical record. A written objection exempts an infant from the requirements of this section and section 144.128.

History: *2007 c 147 art 16 s 7*

144.2219 TRANSFERS OF INFORMATION TO RESEARCH ENTITIES.

Information from the birth defects information system that does not contain identifying information may be shared with research entities upon request for studies approved by the commissioner and appropriate institutional review boards. For studies approved by the commissioner that require identifying information about a child or a parent or legal guardian of the child, the commissioner shall contact the parent or legal guardian to obtain informed consent to share identifying information with the research entity. Notwithstanding section 144.295, the parent or legal guardian must provide informed consent before the information may be shared. The commissioner must collect all reasonable costs of locating and obtaining consent from the research entity.

History: *2007 c 147 art 10 s 15*

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

[For text of subds 1 to 6, see M.S.2006]

Subd. 7. **Certified birth or death record.** (a) The state or local registrar shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner:

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

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

(vii) the party responsible for filing the vital record;

(viii) the legal custodian or guardian or conservator of the subject;

(ix) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(x) a successor of the subject, as defined in section 524.1–201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

(xii) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

(xiii) adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, or federal governmental agency upon request if the certified vital record 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 Citizenship and Immigration Services;

(3) to an attorney upon evidence of the attorney's license;

(4) 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; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state or local registrar shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

[For text of subd 8, see M.S.2006]

History: *2007 c 13 art 1 s 25*

144.291 MINNESOTA HEALTH RECORDS ACT.

Subdivision 1. **Short title.** Sections 144.291 to 144.298 may be cited as the Minnesota Health Records Act.

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(b) **Health information exchange.** "Health information exchange" means a legal arrangement between health care providers and group purchasers to enable and oversee the business and legal issues involved in the electronic exchange of health records between the entities for the delivery of patient care.

(c) **Health record.** "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

(d) **Identifying information.** "Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other nonclinical data which can be used to uniquely identify a patient.

(e) **Individually identifiable form.** "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

(f) **Medical emergency.** "Medical emergency" means medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

(g) **Patient.** "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting according to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services under sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(h) **Provider.** "Provider" means:

(1) any person who furnishes health care services and is regulated to furnish the services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A, 151, 153, or 153A;

(2) a home care provider licensed under section 144A.46;

(3) a health care facility licensed under this chapter or chapter 144A;

(4) a physician assistant registered under chapter 147A; and

(5) an unlicensed mental health practitioner regulated under sections 148B.60 to 148B.71.

(i) **Record locator service.** "Record locator service" means an electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and group purchasers.

(j) **Related health care entity.** "Related health care entity" means an affiliate, as defined in section 144.6521, subdivision 3, paragraph (b), of the provider releasing the health records.

History: *2007 c 147 art 10 s 2*

144.292 PATIENT RIGHTS.

Subdivision 1. **Scope.** Patients have the rights specified in this section regarding the treatment the patient receives and the patient's health record.

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

Subd. 3. **Additional patient rights.** A patient's right specified in this section and sections 144.293 to 144.298 are in addition to the rights specified in sections 144.651 and 144.652 and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 4. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this subdivision are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 5. **Copies of health records to patients.** Except as provided in section 144.296, upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient:

(1) copies of the patient's health record, including but not limited to laboratory reports, x–rays, prescriptions, and other technical information used in assessing the patient's health conditions; or

(2) the pertinent portion of the record relating to a condition specified by the patient.

With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x–rays. The provider may charge a patient no more than the actual cost of reproducing x–rays, plus no more than $10 for the time spent retrieving and copying the x–rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calen-

dar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis–St. Paul (CPI–U), published by the Department of Labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 7. **Withholding health records from patient.** (a) If a provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1). The other provider or third party may release the information to the patient.

(b) A provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (3), shall release information upon written request unless, prior to the request, a provider, as defined in section 144.291, subdivision 2, paragraph (h), clause (1), has designated and described a specific basis for withholding the information as authorized by paragraph (a).

Subd. 8. **Form.** By January 1, 2008, the Department of Health must develop a form that may be used by a patient to request access to health records under this section. A form developed by the commissioner must be accepted by a provider as a legally enforceable request under this section.

History: *2007 c 147 art 10 s 3*

144.293 RELEASE OR DISCLOSURE OF HEALTH RECORDS.

Subdivision 1. **Release or disclosure of health records.** Health records can be released or disclosed as specified in subdivisions 2 to 9 and sections 144.294 and 144.295.

Subd. 2. **Patient consent to release of records.** A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

(1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;

(2) specific authorization in law; or

(3) a representation from a provider that holds a signed and dated consent from the patient authorizing the release.

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

Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

Subd. 5. **Exceptions to consent requirement.** This section 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;

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

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent.

Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient explicitly gives informed consent to the release of health records for the purposes and 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 releasing provider's 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.

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 8. **Record locator service.** (a) A provider or group purchaser may release patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient, unless the patient has elected to be excluded from the service under paragraph (d). The Department of Health may not access the record locator service or receive data from the record locator service. Only a provider may have access to patient identifying information in a record locator service. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator service does not have access to patient identifying information and information about the location of the patient's health records unless the patient specifically consents to the access. A consent does not expire but may be revoked by the patient at any time by providing written notice of the revocation to the provider.

(b) A health information exchange maintaining a record locator service must maintain an audit log of providers accessing information in a record locator service that at least contains information on:

(1) the identity of the provider accessing the information;

(2) the identity of the patient whose information was accessed by the provider; and

(3) the date the information was accessed.

(c) No group purchaser may in any way require a provider to participate in a record locator service as a condition of payment or participation.

(d) A provider or an entity operating a record locator service must provide a mechanism under which patients may exclude their identifying information and information about the location of their health records from a record locator service. At a minimum, a consent form

that permits a provider to access a record locator service must include a conspicuous check–box option that allows a patient to exclude all of the patient's information from the record locator service. A provider participating in a health information exchange with a record locator service who receives a patient's request to exclude all of the patient's information from the record locator service or to have a specific provider contact excluded from the record locator service is responsible for removing that information from the record locator service.

Subd. 9. **Documentation of release.** (a) 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. In the case of a release under section 144.294, subdivision 2, the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

(b) When a health record is released using a representation from a provider that holds a consent from the patient, the releasing provider shall document:

(1) the provider requesting the health records;

(2) the identity of the patient;

(3) the health records requested; and

(4) the date the health records were requested.

Subd. 10. **Warranties regarding consents, requests, and disclosures.** (a) When requesting health records using consent, a person warrants that the consent:

(1) contains no information known to the person to be false; and

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law.

(b) When requesting health records using consent, or a representation of holding a consent, a provider warrants that the request:

(1) contains no information known to the provider to be false;

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and

(3) does not exceed any limits imposed by the patient in the consent.

(c) When disclosing health records, a person releasing health records warrants that the person:

(1) has complied with the requirements of this section regarding disclosure of health records;

(2) knows of no information related to the request that is false; and

(3) has complied with the limits set by the patient in the consent.

History: *2007 c 147 art 10 s 4*

144.294 RECORDS RELATING TO MENTAL HEALTH.

Subdivision 1. **Provider inquiry.** 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. Section 144.293, subdivisions 2 and 4, apply to consents given under this subdivision.

Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to respond to the emergency. A law enforcement agency that obtains health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose.

Subd. 3. **Records release for family and caretaker; mental health care.** (a) Notwithstanding section 144.293, a provider providing mental health care and treatment may disclose health record information described in paragraph (b) about a patient to a family member of the patient or other person who requests the information if:

(1) the request for information is in writing;

(2) the family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;

(3) the involvement under clause (2) is verified by the patient's mental health care provider, the patient's attending physician, or a person other than the person requesting the information, and is documented in the patient's medical record;

(4) before the disclosure, the patient is informed in writing of the request, the name of the person requesting the information, the reason for the request, and the specific information being requested;

(5) the patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient's decision or inability to make a decision is documented in the patient's medical record; and

(6) the disclosure is necessary to assist in the provision of care or monitoring of the patient's treatment.

(b) The information disclosed under this paragraph is limited to diagnosis, admission to or discharge from treatment, the name and dosage of the medications prescribed, side effects of the medication, consequences of failure of the patient to take the prescribed medication, and a summary of the discharge plan.

(c) If a provider reasonably determines that providing information under this subdivision would be detrimental to the physical or mental health of the patient or is likely to cause the patient to inflict self harm or to harm another, the provider must not disclose the information.

(d) This subdivision does not apply to disclosures for a medical emergency or to family members as authorized or required under subdivision 1 or section 144.293, subdivision 5, clause (1).

History: *2007 c 147 art 10 s 5*

144.295 DISCLOSURE OF HEALTH RECORDS FOR EXTERNAL RESEARCH.

Subdivision 1. **Methods of release.** (a) Notwithstanding section 144.293, subdivisions 2 and 4, 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) 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.

(b) 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.

Subd. 2. **Duties of researcher.** In making a release for research purposes, the provider shall make a reasonable effort to determine that:

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

(2) 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;

(3) 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

(4) 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.

History: *2007 c 147 art 10 s 6*

144.296 COPIES OF VIDEOTAPES.

A provider may not release a copy of a videotape of a child victim or alleged victim of physical or sexual abuse without a court order under section 13.03, subdivision 6, or as provided in section 611A.90. This section does not limit the right of a patient to view the videotape.

History: *2007 c 147 art 10 s 7*

144.297 INDEPENDENT MEDICAL EXAMINATION.

Sections 144.291 to 144.298 apply to the subject and provider of an independent medical examination requested by or paid for by a third party. Notwithstanding section 144.293, a provider may release health records created as part of an independent medical examination to the third party who requested or paid for the examination.

History: *2007 c 147 art 10 s 8*

144.298 PENALTIES.

Subdivision 1. **Licensing action.** A violation of sections 144.291 to 144.298 may be grounds for disciplinary action against a provider by the appropriate licensing board or agency.

Subd. 2. **Liability of provider or other person.** A person who does any of the following is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney fees:

(1) negligently or intentionally requests or releases a health record in violation of sections 144.291 to 144.297;

(2) forges a signature on a consent form or materially alters the consent form of another person without the person's consent; or

(3) obtains a consent form or the health records of another person under false pretenses.

Subd. 3. **Liability for record locator service.** A patient is entitled to receive compensatory damages plus costs and reasonable attorney fees if a health information exchange maintaining a record locator service, or an entity maintaining a record locator service for a health information exchange, negligently or intentionally violates the provisions of section 144.293, subdivision 8.

History: *2007 c 147 art 10 s 9*

144.334 RIGHT TO REQUEST PATIENT INFORMATION.

Upon an oral or written request by a spouse, parent, child, or sibling for information about a patient who is being evaluated for or diagnosed with mental illness, a provider must notify the requesting individual of the right under section 144.294 to have the provider request the patient's authorization to release information about the patient to a designated individual.

History: *2007 c 147 art 10 s 15*

144.3345 INTERCONNECTED ELECTRONIC HEALTH RECORD GRANTS.

Subdivision 1. **Definitions.** The following definitions are used for the purposes of this section.

(a) "Eligible community e–health collaborative" means an existing or newly established collaborative to support the adoption and use of interoperable electronic health records. A collaborative must consist of at least two or more eligible health care entities in at least two of the categories listed in paragraph (b) and have a focus on interconnecting the members of the collaborative for secure and interoperable exchange of health care information.

(b) "Eligible health care entity" means one of the following:

(1) community clinics, as defined under section 145.9268;

(2) hospitals eligible for rural hospital capital improvement grants, as defined in section 144.148;

(3) physician clinics located in a community with a population of less than 50,000 according to United States Census Bureau statistics and outside the seven–county metropolitan area;

(4) nursing facilities licensed under sections 144A.01 to 144A.27;

(5) community health boards or boards of health as established under chapter 145A;

(6) nonprofit entities with a purpose to provide health information exchange coordination governed by a representative, multi–stakeholder board of directors; and

(7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to:

(a) eligible community e–health collaborative projects to improve the implementation and use of interoperable electronic health records including but not limited to the following projects:

(1) collaborative efforts to host and support fully functional interoperable electronic health records in multiple care settings;

(2) electronic medication history and electronic patient medical history information;

(3) electronic personal health records for persons with chronic diseases and for prevention services;

(4) rural and underserved community models for electronic prescribing;

(5) modernize local public health information systems to rapidly and electronically exchange information needed to participate in community e–health collaboratives or for public health emergency preparedness and response; and

(6) implement regional or community–based health information exchange organizations;

(b) community clinics, as defined under section 145.9268, to implement and use interoperable electronic health records, including but not limited to the following projects:

(1) efforts to plan for and implement fully functional, standards–based interoperable electronic health records; and

(2) purchases and implementation of computer hardware, software, and technology to fully implement interoperable electronic health records;

(c) regional or community–based health information exchange organizations to connect and facilitate the exchange of health information between eligible health care entities, including but not limited to the development, testing, and implementation of:

(1) data exchange standards, including data, vocabulary, and messaging standards, for the exchange of health information, provided that such standards are consistent with state and national standards;

(2) security standards necessary to ensure the confidentiality and integrity of health records;

(3) computer interfaces and mechanisms for standardizing health information exchanged between eligible health care entities;

(4) a record locator service for identifying the location of patient health records; or

(5) interfaces and mechanisms for implementing patient consent requirements; and

(d) community health boards and boards of health as established under chapter 145A to modernize local public health information systems to be standards–based and interoperable with other electronic health records and information systems, or for enhanced public health emergency preparedness and response.

Grant funds may not be used for construction of health care or other buildings or facilities.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community e–health collaborative, community clinic, regional or community–based health information exchange, or community health boards and boards of health must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. In awarding grants, the commissioner shall give preference to projects benefiting providers located in rural and underserved areas of Minnesota which the commissioner has determined have an unmet need for the development and funding of electronic health records. Applicants may apply for and the commissioner may award grants for one–year, two–year, or three–year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the problem or problems the grant funds will be used to address, including an assessment of the likelihood of the project occurring absent grant funding;

(3) a description of achievable objectives, a workplan, budget, budget narrative, a project communications plan, a timeline for implementation and completion of processes or projects enabled by the grant, and an assessment of privacy and security issues and a proposed approach to address these issues;

(4) a description of the health care entities and other groups participating in the project, including identification of the lead entity responsible for applying for and receiving grant funds;

(5) a plan for how patients and consumers will be involved in development of policies and procedures related to the access to and interchange of information;

(6) evidence of consensus and commitment among the health care entities and others who developed the proposal and are responsible for its implementation;

(7) a plan for documenting and evaluating results of the grant; and

(8) a plan for use of data exchange standards, including data and vocabulary.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner shall take into consideration factors, including but not limited to, the following:

(1) the degree to which the proposal interconnects with other health care entities in the applicant's geographic community;

(2) the degree to which the project provides for the interoperability of electronic health records or related health information technology;

(3) the degree to which the project addresses current unmet needs pertaining to interoperable electronic health records in a geographic area of Minnesota and the likelihood that the needs would not be met absent grant funds;

(4) the applicant's thoroughness and clarity in describing the project, how the project will improve patient safety, quality of care, and consumer empowerment, and the role of the various collaborative members;

(5) the recommendations of the Health Information and Technology Infrastructure Advisory Committee; and

(6) other factors that the commissioner deems relevant.

(d) Grant funds shall be awarded on a three–to–one match basis. Applicants shall be required to provide $1 in the form of cash or in–kind staff or services for each $3 provided under the grant program.

(e) Grants shall not exceed $900,000 per grant. The commissioner has discretion over the size and number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress and expenditure reports to evaluate the grant program from the eligible community collaboratives receiving grants.

History: *2007 c 147 art 10 s 10*

144.335 [Repealed, 2007 c 147 art 10 s 16]

144.3351 IMMUNIZATION DATA.

Providers as defined in section 144.291, subdivision 2, group purchasers as defined in section 62J.03, subdivision 6, elementary or secondary schools or child care facilities as defined in section 121A.15, subdivision 9, public or private postsecondary educational institutions as defined in section 135A.14, subdivision 1, paragraph (b), a board of health as defined in section 145A.02, subdivision 2, community action agencies as defined in section 256E.31, subdivision 1, and the commissioner of health may exchange immunization data with one another, without the patient's consent, if the person requesting access provides services on behalf of the patient. For purposes of this section immunization data includes:

(1) patient's name, address, date of birth, gender, parent or guardian's name; and

(2) date vaccine was received, vaccine type, lot number, and manufacturer of all immunizations received by the patient, and whether there is a contraindication or an adverse reaction indication.

This section applies to all immunization data, regardless of when the immunization occurred.

History: *2007 c 147 art 10 s 15*

144.3855 LIMITATION.

To meet cross–connection control requirements, as defined in Minnesota Rules, parts 4715.1920 and 4720.0025, the use of a hose connection backflow preventer and a hose connection vacuum breaker, not rated for continuous use, are permitted at individual water supply connections in recreational camping areas as defined in section 327.14, subdivision 8.

History: *2007 c 24 s 1*

144.412 PUBLIC POLICY.

The purpose of sections 144.411 to 144.417 is to protect employees and the general public from the hazards of secondhand smoke by eliminating smoking in public places, places of employment, public transportation, and at public meetings.

History: *2007 c 82 s 2*

144.413 DEFINITIONS.

[For text of subd 1, see M.S.2006]

Subd. 1a. **Indoor area.** "Indoor area" means all space between a floor and a ceiling that is bounded by walls, doorways, or windows, whether open or closed, covering more than 50 percent of the combined surface area of the vertical planes constituting the perimeter of the area. A wall includes any retractable divider, garage door, or other physical barrier, whether temporary or permanent. A 0.011 gauge window screen with an 18 by 16 mesh count is not a wall.

Subd. 1b. **Place of employment.** "Place of employment" means any indoor area at which two or more individuals perform any type of a service for consideration of payment under any type of contractual relationship, including, but not limited to, an employment relationship with or for a private corporation, partnership, individual, or government agency. Place of employment includes any indoor area where two or more individuals gratuitously perform services for which individuals are ordinarily paid. A place of employment includes, but is not limited to, public conveyances, factories, warehouses, offices, retail stores, restaurants, bars, banquet facilities, theaters, food stores, banks, financial institutions, employee cafeterias, lounges, auditoriums, gymnasiums, restrooms, elevators, hallways, museums, libraries, bowling establishments, employee medical facilities, and rooms or areas containing photocopying equipment or other office equipment used in common. Vehicles used in whole or in part for work purposes are places of employment during hours of operation if more than one person is present. An area in which work is performed in a private residence is a place of employment during hours of operation if:

(1) the homeowner uses the area exclusively and regularly as a principal place of business and has one or more on–site employees; or

(2) the homeowner uses the area exclusively and regularly as a place to meet or deal with patients, clients, or customers in the normal course of the homeowner's trade or business.

Subd. 2. **Public place.** "Public place" means any enclosed, indoor area used by the general public, including, but not limited to, restaurants; bars; any other food or liquor establishment; retail stores and other commercial establishments; educational facilities other than public schools, as defined in section 120A.05, subdivisions 9, 11, and 13; hospitals; nursing homes; auditoriums; arenas; meeting rooms; and common areas of rental apartment buildings.

[For text of subd 3, see M.S.2006]

Subd. 4. **Smoking.** "Smoking" means inhaling or exhaling smoke from any lighted cigar, cigarette, pipe, or any other lighted tobacco or plant product. Smoking also includes carrying a lighted cigar, cigarette, pipe, or any other lighted tobacco or plant product intended for inhalation.

Subd. 5. **Public transportation.** "Public transportation" means public means of transportation, including light and commuter rail transit; buses; enclosed bus and transit stops; taxis, vans, limousines, and other for–hire vehicles other than those being operated by the lessee; and ticketing, boarding, and waiting areas in public transportation terminals.

History: *2007 c 82 s 3–7*

144.414 PROHIBITIONS.

Subdivision 1. **Public places, places of employment, public transportation, and public meetings.** Smoking shall not be permitted in and no person shall smoke in a public place, at a public meeting, in a place of employment, or in public transportation, except as provided in this section or section 144.4167.

Subd. 2. **Day care premises.** Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation. The proprietor of a family home or group family day care provider must disclose to parents or guardians of children cared for on the premises if the proprietor

permits smoking outside of its hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care–related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.

(b) Except as provided in section 246.0141, smoking by patients in a locked psychiatric unit may be allowed in a separated well–ventilated area in the unit under a policy established by the administrator of the program that allows the treating physician to approve smoking if, in the opinion of the treating physician, the benefits to be gained in obtaining patient cooperation with treatment outweigh the negative impacts of smoking.

Subd. 4. **Public transportation vehicles.** Smoking is prohibited in public transportation vehicles except that the driver of a public transportation vehicle may smoke when the vehicle is being used for personal use. For purposes of this subdivision, "personal use" means that the public transportation vehicle is being used by the driver for private purposes and no for–hire passengers are present. If a driver smokes under this subdivision, the driver must post a conspicuous sign inside the vehicle to inform passengers.

History: *2007 c 82 s 8*

144.415 [Repealed, 2007 c 82 s 15]

144.416 RESPONSIBILITIES OF PROPRIETORS.

(a) The proprietor or other person, firm, limited liability company, corporation, or other entity that owns, leases, manages, operates, or otherwise controls the use of a public place, public transportation, place of employment, or public meeting shall make reasonable efforts to prevent smoking in the public place, public transportation, place of employment, or public meeting by:

(1) posting appropriate signs or by any other means which may be appropriate; and

(2) asking any person who smokes in an area where smoking is prohibited to refrain from smoking and, if the person does not refrain from smoking after being asked to do so, asking the person to leave. If the person refuses to leave, the proprietor, person, or entity in charge shall handle the situation consistent with lawful methods for handling other persons acting in a disorderly manner or as a trespasser.

(b) The proprietor or other person or entity in charge of a public place, public meeting, public transportation, or place of employment must not provide smoking equipment, including ashtrays or matches, in areas where smoking is prohibited. Nothing in this section prohibits the proprietor or other person or entity in charge from taking more stringent measures than those under sections 144.414 to 144.417 to protect individuals from secondhand smoke. The proprietor or other person or entity in charge of a restaurant or bar may not serve an individual who is in violation of sections 144.411 to 144.417.

History: *2007 c 82 s 9*

144.4167 PERMITTED SMOKING.

Subdivision 1. **Scientific study participants.** Smoking by participants in peer reviewed scientific studies related to the health effects of smoking may be allowed in a separated room ventilated at a rate of 60 cubic feet per minute per person pursuant to a policy that is approved by the commissioner and is established by the administrator of the program to minimize exposure of nonsmokers to smoke.

Subd. 2. **Traditional Native American ceremonies.** Sections 144.414 to 144.417 do not prohibit smoking by a Native American as part of a traditional Native American spiritual or cultural ceremony. For purposes of this section, a Native American is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

Subd. 3. **Private places.** Except as provided in section 144.414, subdivision 2, nothing in sections 144.411 to 144.417 prohibits smoking in:

(1) private homes, private residences, or private automobiles when they are not in use as a place of employment, as defined in section 144.413, subdivision 1b; or

(2) a hotel or motel sleeping room rented to one or more guests.

Subd. 4. **Tobacco products shop.** Sections 144.414 to 144.417 do not prohibit the lighting of tobacco in a tobacco products shop by a customer or potential customer for the specific purpose of sampling tobacco products. For the purposes of this subdivision, a tobacco products shop is a retail establishment with an entrance door opening directly to the outside that derives more than 90 percent of its gross revenue from the sale of loose tobacco, plants, or herbs and cigars, cigarettes, pipes, and other smoking devices for burning tobacco and related smoking accessories and in which the sale of other products is merely incidental. "Tobacco products shop" does not include a tobacco department or section of any individual business establishment with any type of liquor, food, or restaurant license.

Subd. 5. **Heavy commercial vehicles.** Sections 144.414 to 144.417 do not prohibit smoking in the cabs of motor vehicles registered under section 168.013, subdivision 1e, with a total gross weight of 26,001 pounds or greater.

Subd. 6. **Farm vehicles and construction equipment.** Sections 144.414 to 144.417 do not prohibit smoking in farm trucks, as defined in section 168.011, subdivision 17; implements of husbandry, as defined in section 168A.01, subdivision 8; and special mobile equipment, as defined in section 168.011, subdivision 22. This subdivision applies to farm trucks, implements of husbandry, and special mobile equipment, when being used for their intended purposes.

Subd. 7. **Family farms.** Sections 144.414 to 144.417 do not prohibit smoking in the house, garage, barns, and other buildings on a family farm that meet the following criteria: (1) the family farm is engaged in farming, as defined in section 500.24, subdivision 2, paragraph (a); (2) the family farm meets the definition of family farm under section 500.24, subdivision 2, paragraph (b), (c), (j), or (l); and (3) the family farm employs two or fewer persons who are not family members.

Subd. 8. **Disabled veterans rest camp.** Sections 144.414 to 144.417 do not prohibit smoking in the disabled veterans rest camp located in Washington County, established as of January 1, 2007.

Subd. 9. **Theatrical productions.** Sections 144.414 to 144.417 do not prohibit smoking by actors and actresses as part of a theatrical performance conducted in compliance with section 366.01. Notice of smoking in a performance shall be given to theater patrons in advance and shall be included in performance programs.

History: *2007 c 82 s 10*

144.417 COMMISSIONER OF HEALTH, ENFORCEMENT, PENALTIES.

Subdivision 1. **Rules.** The state commissioner of health shall adopt rules necessary and reasonable to implement the provisions of sections 144.411 to 144.417.

Subd. 2. **Violations.** (a) Any proprietor, person, or entity that owns, leases, manages, operates, or otherwise controls the use of an area in which smoking is prohibited under sections 144.414 to 144.417, and that knowingly fails to comply with sections 144.414 to 144.417, is guilty of a petty misdemeanor.

(b) Any person who smokes in an area where smoking is prohibited or restricted under sections 144.414 to 144.417 is guilty of a petty misdemeanor.

(c) A proprietor, person, or entity in charge of a public place, public meeting, place of employment, or public transportation must not retaliate or take adverse action against an employee or anyone else who, in good faith, reports a violation of sections 144.414 to 144.417 to the proprietor or person in charge of the public place, public meeting, place of employment, or public transportation, or to the commissioner of health or other designee responsible for enforcing sections 144.414 to 144.417.

(d) No person or employer shall discharge, refuse to hire, penalize, discriminate against, or in any manner retaliate against any employee, applicant for employment, or customer because the employee, applicant, or customer exercises any right to a smoke–free environment provided by sections 144.414 to 144.417 or other law.

Subd. 3. **Injunction.** The state commissioner of health, a board of health as defined in section 145A.02, subdivision 2, or any affected party may institute an action in any court with jurisdiction to enjoin repeated violations of sections 144.414 to 144.417.

Subd. 4. **Local government ordinances.** (a) Nothing in sections 144.414 to 144.417 prohibits a statutory or home rule charter city or county from enacting and enforcing more stringent measures to protect individuals from secondhand smoke.

(b) Except as provided in sections 144.411 to 144.417, smoking is permitted outside of restaurants, bars, and bingo halls unless limited or prohibited by restrictions adopted in accordance with paragraph (a).

History: *2007 c 82 s 11*

144.5509 RADIATION THERAPY FACILITY CONSTRUCTION.

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

(b) Notwithstanding paragraph (a), there shall be a two–year moratorium on the construction of any radiation therapy facility located in the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright. This paragraph does not apply to the relocation or reconstruction of an existing facility owned by a hospital if the relocation or reconstruction is within one mile of the existing facility. This paragraph does not apply to a radiation therapy facility that is being built attached to a community hospital in Wright County and meets the following conditions prior to August 1, 2007: the capital expenditure report required under Minnesota Statutes, section 62J.17, has been filed with the commissioner of health; a timely construction schedule is developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits applied for. This paragraph expires August 1, 2009.

History: *2007 c 147 art 11 s 2*

144.552 PUBLIC INTEREST REVIEW.

(a) The following entities must submit a plan to the commissioner:

(1) a hospital seeking to increase its number of licensed beds; or

(2) an organization seeking to obtain a hospital license and notified by the commissioner under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing and monitoring the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding.

(c) The commissioner shall review the plan and, within 90 days, but no more than six months if extenuating circumstances apply, issue a finding on whether the plan is in the public interest. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;

(2) the financial impact of the new hospital or hospital beds on existing acute–care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low–income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

(d) If the plan is being submitted by an existing hospital seeking authority to construct a new hospital, the commissioner shall also consider:

(1) the ability of the applicant to maintain the applicant's current level of community benefit as defined in section 144.699, subdivision 5, at the existing facility; and

(2) the impact on the workforce at the existing facility including the applicant's plan for:

(i) transitioning current workers to the new facility;

(ii) retraining and employment security for current workers; and

(iii) addressing the impact of layoffs at the existing facility on affected workers.

(e) Prior to making a recommendation, the commissioner shall conduct a public hearing in the affected hospital service area to take testimony from interested persons.

(f) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house and senate committees having jurisdiction over health and human services policy and finance.

(g) If an exception to the moratorium is approved under section 144.551 after a review under this section, the commissioner shall monitor the implementation of the exception up to completion of the construction project. Thirty days after completion of the construction project, the hospital shall submit to the commissioner a report on how the construction has met the provisions of the plan originally submitted under the public interest review process or a plan submitted pursuant to section 144.551, subdivision 1, paragraph (b), clause (20).

History: *2007 c 147 art 9 s 14*

144.553 ALTERNATIVE APPROVAL PROCESS.

[For text of subds 1 and 2, see M.S.2006]

Subd. 3. **Process when hospital need is determined.** (a) If the commissioner determines that a new hospital is needed in the proposed service area, the commissioner shall notify the applicants of that finding and shall select the applicant determined under the process established in this subdivision to be best able to provide services consistent with the review criteria established in this subdivision.

(b) The commissioner shall:

(1) determine market–specific criteria that shall be used to evaluate all proposals. The criteria must include standards regarding:

(i) access to care;

(ii) quality of care;

(iii) cost of care; and

(iv) overall project feasibility;

(2) establish additional criteria at the commissioner's discretion. In establishing the criteria, the commissioner shall consider the need for:

(i) mental health services in the service area, including both inpatient and outpatient services for adults, adolescents, and children;

(ii) a significant commitment to providing uncompensated care, including discounts for uninsured patients and coordination with other providers of care to low–income uninsured persons; and

(iii) coordination with other hospitals so that specialized services are not unnecessarily duplicated and are provided in sufficient volume to ensure the maintenance of high–quality care; and

(3) define a service area for the proposed hospital. The service area shall consist of:

(i) in the 11–county metropolitan area, in St. Cloud, and in Duluth, the zip codes located within a 20–mile radius of the proposed new hospital location; and

(ii) in the remainder of the state, the zip codes within a 30–mile radius of the proposed new hospital location.

(c) If the plan is being submitted by an existing hospital, the commissioner shall also consider:

(1) the ability of the applicant to maintain the applicant's current level of community benefit as defined in section 144.699, subdivision 5, at the existing facility; and

(2) the impact on the workforce at the existing facility including the applicant's plan for:

(i) transitioning current workers to the new facility;

(ii) retraining and employment security for current workers; and

(iii) addressing the impact of layoffs at the existing facility on affected workers.

(d) The commissioner shall publish the criteria determined under paragraphs (b) and (c) in the State Register within 60 days of the determination under subdivision 2. Once published, the criteria shall not be modified with respect to the particular project and applicants to which they apply. The commissioner shall publish with the criteria guidelines for a proposal and submission review process.

(e) For 60 days after the publication under paragraph (d), the commissioner shall accept proposals to construct a hospital from organizations that have submitted a letter of intent under subdivision 1, paragraph (a), or have notified the commissioner under subdivision 1, paragraph (b). The proposal must include a plan for the new hospital and evidence of compliance with the criteria specified under paragraphs (b) and (c). Once submitted, the proposal may not be revised except:

(1) to submit corrections of material facts; or

(2) in response to a request from the commissioner to provide clarification or further information.

(f) The commissioner shall determine within 90 days of the deadline for applications under paragraph (e), which applicant has demonstrated that it is best able to provide services consistent with the published criteria. The commissioner shall make this determination by order following a hearing according to this paragraph. The hearing shall not constitute or be considered to be a contested case hearing under chapter 14 and shall be conducted solely under the procedures specified in this paragraph. The hearing shall commence upon at least 30 days' notice to the applicants by the commissioner. The hearing may be conducted by the commissioner or by a person designated by the commissioner. The designee may be an administrative law judge. The purpose of the hearing shall be to receive evidence to assist the commissioner in determining which applicant has demonstrated that it best meets the published criteria.

The parties to the hearing shall consist only of those applicants who have submitted a completed application. Each applicant shall have the right to be represented by counsel, to present evidence deemed relevant by the commissioner, and to examine and cross–examine witnesses. Persons who are not parties to the proceeding but who wish to present comments or submit information may do so in the manner determined by the commissioner or the commissioner's designee. Any person who is not a party shall have no right to examine or cross–examine witnesses. The commissioner may participate as an active finder of fact in the hearing and may ask questions to elicit information or clarify answers or responses.

(g) Prior to making a determination selecting an application, the commissioner shall hold a public hearing in the proposed hospital service area to accept comments from members of the public. The commissioner shall take this information into consideration in making

the determination. The commissioner shall appoint an advisory committee, including legislators and local elected officials who represent the service area and outside experts to assist in the recommendation process. The legislative appointees shall include, at a minimum, the chairs of the senate and house of representatives committees with jurisdiction over health care policy. The commissioner shall issue an order selecting an application following the closing of the record of the hearing as determined by the hearing officer. The commissioner's order shall include a statement of the reasons the selected application best meets the published criteria.

(h) Within 30 days following the determination under paragraph (f), the commissioner shall recommend the selected proposal to the legislature.

(i) If an exception to the moratorium is approved under section 144.551 after a review under this section, the commissioner shall monitor the implementation of the exception up to completion of the construction project. Thirty days after completion of the construction project, the hospital shall submit to the commissioner a report on how the construction has met the provisions of the plan originally submitted under the public interest review process or a plan submitted pursuant to section 144.551, subdivision 1, paragraph (b), clause (20).

[For text of subd 4, see M.S.2006]

History: *2007 c 147 art 9 s 15*

144.565 DIAGNOSTIC IMAGING FACILITIES.

Subdivision 1. **Utilization and services data; economic and financial interests.** The commissioner shall require diagnostic imaging facilities and providers of diagnostic imaging services in Minnesota to report by March 1 each year for the preceding fiscal year to the commissioner, in the form and manner specified by the commissioner:

(1) utilization data for each health plan company and each public program, including workers' compensation, of diagnostic imaging services as defined in subdivision 4, paragraph (b);

(2) the names of all physicians with any financial or economic interest excluding salaried physicians, unless the physicians' salary is adjusted for volume of service, and all other individuals with a ten percent or greater financial or economic interest in the facility;

(3) the location where procedures were performed;

(4) the number of units of each type of fixed, portable, and mobile scanner used at each location;

(5) the average number of hours per month each mobile scanner was operated at each location;

(6) the number of hours per month each scanner was leased, if applicable;

(7) the total number of diagnostic imaging procedures billed for by the provider at each location, by type of diagnostic imaging service as defined in subdivision 4, paragraph (b); and

(8) a report on major health care capital expenditures during the previous year, as required by section 62J.17.

Subd. 2. **Commissioner's right to inspect records.** If the report is not filed or the commissioner of health has reason to believe the report is incomplete or false, the commissioner shall have the right to inspect diagnostic imaging facility books, audits, and records.

Subd. 3. **Separate reports.** If any entity owns more than one diagnostic imaging facility, that entity must report by individual facility. Reports must include only services that were billed by the provider of diagnostic imaging services submitting the report. If a diagnostic imaging facility leases capacity, technical services, or professional services to one or more other providers of diagnostic imaging services, each provider must submit a separate annual report to the commissioner for all diagnostic imaging services that it provided and billed. The owner of the leased capacity must provide a report listing the names and addresses of providers to whom the diagnostic imaging services and equipment were leased.

Subd. 4. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Diagnostic imaging facility" means a health care facility that is not a hospital or location licensed as a hospital which offers diagnostic imaging services in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center.

(b) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging (MRI) or computerized tomography (CT), positron emission tomography (PET), or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

(c) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co–ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer–employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit–sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

(d) "Fixed equipment" means a stationary diagnostic imaging machine installed in a permanent location.

(e) "Mobile equipment" means a diagnostic imaging machine in a self–contained transport vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging services.

(f) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(g) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

Subd. 5. **Reports open to public inspection.** All reports filed pursuant to this section shall be open to public inspection.

History: *2007 c 147 art 9 s 16*

144.585 METHICILLIN–RESISTANT STAPHYLOCOCCUS AUREUS CONTROL PROGRAMS.

In order to improve the prevention of hospital–associated infections due to methicillin–resistant Staphylococcus aureus (MRSA), every hospital shall establish an MRSA control program that meets Minnesota Department of Health MRSA recommendations as published January 15, 2008. In developing the MRSA recommendations, the Department of Health shall consider the following infection control practices:

(1) identification of MRSA–colonized patients in all intensive care units, or other at–risk patients identified by the hospital;

(2) isolation of identified MRSA–colonized or MRSA–infected patients in an appropriate manner;

(3) adherence to hand hygiene requirements; and

(4) monitor trends in the incidence of MRSA in the hospital over time and modify interventions if MRSA infection rates do not decrease.

The Department of Health shall review the MRSA recommendations on an annual basis and revise the recommendations as necessary, in accordance with available scientific data.

History: *2007 c 147 art 9 s 17*

144.651 HEALTH CARE BILL OF RIGHTS.

[For text of subds 1 to 8, see M.S.2006]

Subd. 9. **Information about treatment.** Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. Patients and residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's medical record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

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

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

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

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

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

(4) inquiring of the physician to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient

or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

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

[For text of subds 11 to 15, see M.S.2006]

Subd. 16. **Confidentiality of records.** Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and sections 144.291 to 144.298. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law.

[For text of subds 17 to 25, see M.S.2006]

Subd. 26. **Right to associate.** (a) Residents may meet with and receive visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes:

(1) the right to join with other individuals within and outside the facility to work for improvements in long–term care;

(2) the right to visitation by an individual the patient has appointed as the patient's health care agent under chapter 145C;

(3) the right to visitation and health care decision making by an individual designated by the patient under paragraph (c).

(b) Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

(c) Upon admission to a facility, the patient or resident, or the legal guardian or conservator of the patient or resident, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

[For text of subds 27 to 33, see M.S.2006]

History: *2007 c 147 art 9 s 18–20; art 10 s 15*

144.698 REPORTING REQUIREMENTS.

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

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

(2) a detailed statement of income and expenses;

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

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

(5) information on services provided to benefit the community, including services provided at no cost or for a reduced fee to patients unable to pay, teaching and research activities, or other community or charitable activities;

(6) information required on the revenue and expense report form set in effect on July 1, 1989, or as amended by the commissioner in rule;

(7) information on changes in ownership or control;

(8) other information required by the commissioner in rule;

(9) information on the number of available hospital beds that are dedicated to certain specialized services, as designated by the commissioner, and annual occupancy rates for those beds, separately for adult and pediatric care;

(10) from outpatient surgical centers, the total number of surgeries; and

(11) a report on health care capital expenditures during the previous year, as required by section 62J.17.

[For text of subds 2 to 5, see M.S.2006]

History: *2007 c 147 art 15 s 13*

144.699 CONTINUING ANALYSIS.

[For text of subds 1 to 4, see M.S.2006]

Subd. 5. **Annual reports on community benefit, community care amounts, and state program underfunding.** (a) For each hospital reporting health care cost information under section 144.698 or 144.702, the commissioner shall report annually on the hospital's community benefit and community care, including detailed information on each component of those costs as defined in this subdivision. The information shall be reported in terms of total dollars and as a percentage of total operating costs for each hospital.

(b) For purposes of this subdivision, "community benefit" means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in–kind contributions, costs of community building activities, costs of community benefit operations, education costs, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit.

(c) For purposes of this subdivision, "community care" means the costs for medical care that a hospital has determined is charity care as defined under Minnesota Rules, part 4650.0115, or for which the hospital determines after billing for the services that there is a demonstrated inability to pay. Any costs forgiven under a hospital's community care plan or under section 62J.83 may be counted in the hospital's calculation of community care. Bad

debt expenses and discounted charges available to the uninsured shall not be included in the calculation of community care. The amount of community care is the value of costs incurred and not the charges made for services.

(d) For purposes of this subdivision, "underpayment for services provided under state health care programs" means the difference between hospital costs and public program payments.

History: *2007 c 147 art 9 s 21*

144.7065 FACILITY REQUIREMENTS TO REPORT, ANALYZE, AND CORRECT.

[For text of subds 1 to 3, see M.S.2006]

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

(1) an infant discharged to the wrong person;

(2) patient death or serious disability associated with patient disappearance, excluding events involving adults who have decision–making capacity; and

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

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

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

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

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

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

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

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

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

(8) artificial insemination with the wrong donor sperm or wrong egg.

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

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

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

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

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

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

[For text of subds 7 to 10, see M.S.2006]

History: *2007 c 41 s 1–3*

144.7411 TEST INFORMATION CONFIDENTIALITY.

Subdivision 1. **Private data.** Information concerning test results obtained under sections 144.7401 to 144.7415 is information protected from disclosure without consent under sections 144.291 to 144.298 with respect to private facilities and private data as defined in section 13.02, subdivision 12, with respect to public facilities.

[For text of subd 2, see M.S.2006]

History: *2007 c 147 art 10 s 15*

144.9501 DEFINITIONS.

Subdivision 1. **Citation.** Sections 144.9501 to 144.9512 may be cited as the "Lead Poisoning Prevention Act."

Subd. 2. **Applicability.** The definitions in this section apply to sections 144.9501 to 144.9512.

[For text of subds 3 to 31, see M.S.2006]

History: *2007 c 147 art 16 s 20*

144.9504 SECONDARY PREVENTION.

[For text of subd 1, see M.S.2006]

Subd. 2. **Lead risk assessment.** (a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (4) 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 60 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 15 micrograms of lead per deciliter of whole blood; or

(4) 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 local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. 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 assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

(d) Within the limits of appropriations, the assessing 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 15 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 primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing 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 assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing 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, and dust 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. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

(f) Each assessing 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 assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

[For text of subds 3 to 10, see M.S.2006]

History: *2007 c 147 art 16 s 20*

144.9505 LICENSING OF LEAD FIRMS AND PROFESSIONALS.

[For text of subds 1 to 4, see M.S.2006]

Subd. 6. **Duties of contracting entity.** A contracting entity intending to have regulated lead work performed for its benefit shall include in the specifications and contracts for the work a requirement that the work be performed by contractors and subcontractors licensed by the commissioner under sections 144.9501 to 144.9512 and according to rules adopted by the commissioner related to regulated lead work. No contracting entity shall allow regulated lead work to be performed for its benefit unless the contracting entity has seen that the person has a valid license or certificate. A contracting entity's failure to comply with this subdivision does not relieve a person from any responsibility under sections 144.9501 to 144.9512.

History: *2007 c 147 art 16 s 20*

144.9507 LEAD-RELATED FUNDING.

[For text of subds 1 to 5, see M.S.2006]

Subd. 6. **Medical assistance.** Medical assistance reimbursement for lead risk assessment services under section 256B.0625, subdivision 52, shall not be used to replace or decrease existing state or local funding for lead services and lead–related activities.

History: *2007 c 147 art 16 s 8*

144.9508 RULES.

[For text of subd 1, see M.S.2006]

Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

(b) In the rules required by this section, the commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead–dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead–safe practices including prohibited practices, preparation, disposal, and cleanup. The commissioner shall work cooperatively with the commissioner of the Pollution Control Agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt regulated lead work standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that removal of exterior lead–based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

[For text of subds 2a to 5, see M.S.2006]

History: *2007 c 147 art 16 s 20*

144.9509 ENFORCEMENT.

Subdivision 1. **Enforcement.** When the commissioner exercises authority for enforcement, the provisions of sections 144.9501 to 144.9512 shall be enforced under the provisions of sections 144.989 to 144.993. Boards of health shall enforce a lead order issued under section 144.9504 under a local ordinance or as a public health nuisance under chapter 145A.

Subd. 2. **Discrimination.** A person who discriminates against or otherwise sanctions an employee who complains to or cooperates with the assessing agency in administering sections 144.9501 to 144.9512 is guilty of a petty misdemeanor.

[For text of subd 3, see M.S.2006]

History: *2007 c 147 art 16 s 20*

144.9512 LEAD ABATEMENT PROGRAM.

Subdivision 1. **Definitions.** (a) The definitions in section 144.9501 and in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of health.

Subd. 2. **Grants; administration.** Within the limits of the available appropriation, the commissioner shall make grants to a nonprofit organization currently operating the CLEAR-Corps lead hazard reduction project to train workers to provide swab team services for residential property.

Subd. 3. [Repealed by amendment, 2007 c 147 art 16 s 9]

Subd. 4. **Eligible grant activities.** The nonprofit receiving a grant under this section must ensure that all participating lead supervisors or certified firms are licensed and that all swab team workers are certified by the Department of Health under section 144.9505. The nonprofit organization may participate in the program by:

(1) providing on–the–job training for swab team workers;

(2) providing swab team services to meet the requirements of sections 144.9503, subdivision 4, and 144.9504, subdivision 6;

(3) providing lead hazard reduction to meet the requirements of section 144.9501, subdivision 17;

(4) providing lead dust cleanup equipment and materials, as described in section 144.9503, subdivision 1, to residents;

(5) having a swab team worker instruct residents and property owners on appropriate lead control techniques, including the lead–safe directives developed by the commissioner of health;

(6) conducting blood lead testing events including screening children and pregnant women according to Department of Health screening guidelines;

(7) performing case management services according to Department of Health case management guidelines; or

(8) conducting mandated risk assessments under section 144.9504, subdivision 2.

Subd. 5. **Swab team workers.** Each worker engaged in swab team services established under this section must have blood lead concentrations below 15 micrograms of lead per deciliter of whole blood as determined by a baseline blood lead screening. The nonprofit organization receiving a grant under this section is responsible for lead screening and must en-

sure that all swab team workers meet the standards established in this subdivision. The nonprofit organization must use appropriate workplace procedures including following the lead–safe directives developed by the commissioner of health to reduce risk of elevated blood lead levels. The nonprofit organization and participating contractors must report all employee blood lead levels that exceed 15 micrograms of lead per deciliter of whole blood to the commissioner of health.

Subd. 6. [Repealed by amendment, 2007 c 147 art 16 s 9]

Subd. 7. [Repealed by amendment, 2007 c 147 art 16 s 9]

Subd. 8. [Repealed by amendment, 2007 c 147 art 16 s 9]

Subd. 9. **Program benefits.** As a condition of providing swab team services under this section, the nonprofit organization may require a property owner to not increase rents on a property solely as a result of a substantial improvement made with public funds under the programs in this section.

Subd. 10. **Requirements of the nonprofit organization.** The nonprofit organization that is awarded a grant under this section must prepare and submit a quarterly progress report to the commissioner beginning three months after receipt of the grant.

History: *2007 c 147 art 16 s 9*

144.966 EARLY HEARING DETECTION AND INTERVENTION PROGRAM.

Subdivision 1. **Definitions.** (a) "Child" means a person 18 years of age or younger.

(b) "False positive rate" means the proportion of infants identified as having a significant hearing loss by the screening process who are ultimately found to not have a significant hearing loss.

(c) "False negative rate" means the proportion of infants not identified as having a significant hearing loss by the screening process who are ultimately found to have a significant hearing loss.

(d) "Hearing screening test" means automated auditory brain stem response, otoacoustic emissions, or another appropriate screening test approved by the Department of Health.

(e) "Hospital" means a birthing health care facility or birthing center licensed in this state that provides obstetrical services.

(f) "Infant" means a child who is not a newborn and has not attained the age of one year.

(g) "Newborn" means an infant 28 days of age or younger.

(h) "Parent" means a natural parent, stepparent, adoptive parent, guardian, or custodian of a newborn or infant.

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard–of–hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow–up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard–of–hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech–language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard–of–hearing or the representative's designee;

(10) a representative of the Minnesota Commission Serving Deaf and Hard–of–Hearing People;

(11) a representative from the Department of Human Services Deaf and Hard–of–Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; and

(18) a representative of the Department of Education regional low–incidence facilitators.

The commissioner must complete the appointments required under this subdivision by September 1, 2007.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) This subdivision expires June 30, 2013.

Subd. 3. **Early hearing detection and intervention programs.** All hospitals shall establish an early hearing detection and intervention (EHDI) program. Each EHDI program shall:

(1) in advance of any hearing screening testing, provide to the newborn's or infant's parents or parent information concerning the nature of the screening procedure, applicable costs of the screening procedure, the potential risks and effects of hearing loss, and the benefits of early detection and intervention;

(2) comply with parental consent under section 144.125, subdivision 3;

(3) develop policies and procedures for screening and rescreening based on Department of Health recommendations;

(4) provide appropriate training and monitoring of individuals responsible for performing hearing screening tests as recommended by the Department of Health;

(5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain in the hospital for a prolonged period, testing shall be performed prior to three months of age or when medically feasible;

(6) develop and implement procedures for documenting the results of all hearing screening tests;

(7) inform the newborn's or infant's parents or parent, primary care physician, and the Department of Health according to recommendations of the Department of Health of the results of the hearing screening test or rescreening if conducted, or if the newborn or infant was not successfully tested. The hospital that discharges the newborn or infant to home is responsible for the screening; and

(8) collect performance data specified by the Department of Health.

Subd. 4. **Notification and information.** (a) Notification to the parents or parent, primary care provider, and the Department of Health shall occur prior to discharge or no later than ten days following the date of testing. Notification shall include information recommended by the Department of Health.

(b) A physician, nurse, midwife, or other health professional attending a birth outside a hospital or institution shall provide information, orally and in writing, as established by the Department of Health, to parents regarding places where the parents may have their infant's hearing screened and the importance of the screening.

(c) The professional conducting the diagnostic procedure to confirm the hearing loss must report the results to the parents, primary care provider, and Department of Health according to the Department of Health recommendations.

Subd. 5. **Oversight responsibility.** The Department of Health shall exercise oversight responsibility for EHDI programs, including establishing a performance data set and reviewing performance data collected by each hospital.

Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician or hospital shall be civilly or criminally liable for failure to conduct hearing screening testing.

(b) No physician, midwife, nurse, other health professional, or hospital acting in compliance with this section shall be civilly or criminally liable for any acts conforming with this section, including furnishing information required according to this section.

Subd. 7. **Fees.** The commissioner shall charge a fee so that the total of fees collected will approximate the costs of implementing and maintaining a system to follow up on infants and provide technical assistance, a tracking system, data management, and evaluation. The fee shall be incorporated in the fee charged under section 144.125.

History: *2007 c 147 art 16 s 10*

144.99 ENFORCEMENT.

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

[For text of subds 2 to 12, see M.S.2006]

History: *2007 c 140 art 12 s 4; 2007 c 147 art 16 s 20*

144.995 DEFINITIONS; ENVIRONMENTAL HEALTH TRACKING AND BIOMONITORING.

(a) For purposes of sections 144.995 to 144.998, the terms in this section have the meanings given.

(b) "Advisory panel" means the Environmental Health Tracking and Biomonitoring Advisory Panel established under section 144.998.

(c) "Biomonitoring" means the process by which chemicals and their metabolites are identified and measured within a biospecimen.

(d) "Biospecimen" means a sample of human fluid, serum, or tissue that is reasonably available as a medium to measure the presence and concentration of chemicals or their metabolites in a human body.

(e) "Commissioner" means the commissioner of the Department of Health.

(f) "Community" means geographically or nongeographically based populations that may participate in the biomonitoring program. A "nongeographical community" includes, but is not limited to, populations that may share a common chemical exposure through similar occupations, populations experiencing a common health outcome that may be linked to chemical exposures, populations that may experience similar chemical exposures because of comparable consumption, lifestyle, product use, and subpopulations that share ethnicity, age, or gender.

(g) "Department" means the Department of Health.

(h) "Designated chemicals" means those chemicals that are known to, or strongly suspected of, adversely impacting human health or development, based upon scientific, peer–reviewed animal, human, or in vitro studies, and baseline human exposure data, and consists of chemical families or metabolites that are included in the federal Centers for Disease Control and Prevention studies that are known collectively as the National Reports on Human Exposure to Environmental Chemicals Program and any substances specified by the commissioner after receiving recommendations under section 144.998, subdivision 3, clause (6).

(i) "Environmental hazard" means a chemical or other substance for which scientific, peer–reviewed studies of humans, animals, or cells have demonstrated that the chemical is known or reasonably anticipated to adversely impact human health.

(j) "Environmental health tracking" means collection, integration, analysis, and dissemination of data on human exposures to chemicals in the environment and on diseases potentially caused or aggravated by those chemicals.

History: *2007 c 57 art 1 s 143*

144.996 ENVIRONMENTAL HEALTH TRACKING; BIOMONITORING.

Subdivision 1. **Environmental health tracking.** In cooperation with the commissioner of the Pollution Control Agency, the commissioner shall establish an environmental health tracking program to:

(1) coordinate data collection with the Pollution Control Agency, Department of Agriculture, University of Minnesota, and any other relevant state agency and work to promote the sharing of and access to health and environmental databases to develop an environmental health tracking system for Minnesota, consistent with applicable data practices laws;

(2) facilitate the dissemination of aggregate public health tracking data to the public and researchers in accessible format;

(3) develop a strategic plan that includes a mission statement, the identification of core priorities for research and epidemiologic surveillance, and the identification of internal and external stakeholders, and a work plan describing future program development and addressing issues having to do with compatibility with the Centers for Disease Control and Prevention's National Environmental Public Health Tracking Program;

(4) develop written data sharing agreements as needed with the Pollution Control Agency, Department of Agriculture, and other relevant state agencies and organizations, and develop additional procedures as needed to protect individual privacy;

(5) organize, analyze, and interpret available data, in order to:

(i) characterize statewide and localized trends and geographic patterns of population–based measures of chronic diseases including, but not limited to, cancer, respiratory diseases, reproductive problems, birth defects, neurologic diseases, and developmental disorders;

(ii) characterize statewide and localized trends and geographic patterns in the occurrence of environmental hazards and exposures;

(iii) assess the feasibility of integrating disease rate data with indicators of exposure to the selected environmental hazards such as biomonitoring data, and other health and environmental data;

(iv) incorporate newly collected and existing health tracking and biomonitoring data into efforts to identify communities with elevated rates of chronic disease, higher likelihood of exposure to environmental hazards, or both;

(v) analyze occurrence of environmental hazards, exposures, and diseases with relation to socioeconomic status, race, and ethnicity;

(vi) develop and implement targeted plans to conduct more intensive health tracking and biomonitoring among communities; and

(vii) work with the Pollution Control Agency, the Department of Agriculture, and other relevant state agency personnel and organizations to develop, implement, and evaluate preventive measures to reduce elevated rates of diseases and exposures identified through activities performed under sections 144.995 to 144.998; and

(6) submit a biennial report to the chairs and ranking members of the committees with jurisdiction over environment and health by January 15, beginning January 15, 2009, on the status of environmental health tracking activities and related research programs, with recommendations for a comprehensive environmental public health tracking program.

Subd. 2. **Biomonitoring.** The commissioner shall:

(1) conduct biomonitoring of communities on a voluntary basis by collecting and analyzing biospecimens, as appropriate, to assess environmental exposures to designated chemicals;

(2) conduct biomonitoring of pregnant women and minors on a voluntary basis, when scientifically appropriate;

(3) communicate findings to the public, and plan ensuing stages of biomonitoring and disease tracking work to further develop and refine the integrated analysis;

(4) share analytical results with the advisory panel and work with the panel to interpret results, communicate findings to the public, and plan ensuing stages of biomonitoring work; and

(5) submit a biennial report to the chairs and ranking members of the committees with jurisdiction over environment and health by January 15, beginning January 15, 2009, on the status of the biomonitoring program and any recommendations for improvement.

Subd. 3. **Health data.** Data collected under the biomonitoring program are health data under section 13.3805.

History: *2007 c 57 art 1 s 144*

144.997 BIOMONITORING PILOT PROGRAM.

Subdivision 1. **Pilot program.** With advice from the advisory panel, and after the program guidelines in subdivision 4 are developed, the commissioner shall implement a biomonitoring pilot program. The program shall collect one biospecimen from each of the voluntary participants. The biospecimen selected must be the biospecimen that most accurately represents body concentration of the chemical of interest. Each biospecimen from the voluntary participants must be analyzed for one type or class of related chemicals. The commissioner shall determine the chemical or class of chemicals to which community members were most likely exposed. The program shall collect and assess biospecimens in accordance with the following:

(1) 30 voluntary participants from each of three communities that the commissioner identifies as likely to have been exposed to a designated chemical;

(2) 100 voluntary participants from each of two communities:

(i) that the commissioner identifies as likely to have been exposed to arsenic; and

(ii) that the commissioner identifies as likely to have been exposed to mercury; and

(3) 100 voluntary participants from each of two communities that the commissioner identifies as likely to have been exposed to perfluorinated chemicals, including perfluorobutanoic acid.

Subd. 2. **Base program.** (a) By January 15, 2008, the commissioner shall submit a report on the results of the biomonitoring pilot program to the chairs and ranking members of the committees with jurisdiction over health and environment.

(b) Following the conclusion of the pilot program, the commissioner shall:

(1) work with the advisory panel to assess the usefulness of continuing biomonitoring among members of communities assessed during the pilot program and to identify other communities and other designated chemicals to be assessed via biomonitoring;

(2) work with the advisory panel to assess the pilot program, including but not limited to the validity and accuracy of the analytical measurements and adequacy of the guidelines and protocols;

(3) communicate the results of the pilot program to the public; and

(4) after consideration of the findings and recommendations in clauses (1) and (2), and within the appropriations available, develop and implement a base program.

Subd. 3. **Participation.** (a) Participation in the biomonitoring program by providing biospecimens is voluntary and requires written, informed consent. Minors may participate in the program if a written consent is signed by the minor's parent or legal guardian. The written consent must include the information required to be provided under this subdivision to all voluntary participants.

(b) All participants shall be evaluated for the presence of the designated chemical of interest as a component of the biomonitoring process. Participants shall be provided with information and fact sheets about the program's activities and its findings. Individual participants shall, if requested, receive their complete results. Any results provided to participants shall be subject to the Department of Health Institutional Review Board protocols and guidelines. When either physiological or chemical data obtained from a participant indicate a significant known health risk, program staff experienced in communicating biomonitoring results shall consult with the individual and recommend follow–up steps, as appropriate. Program administrators shall receive training in administering the program in an ethical, culturally sensitive, participatory, and community–based manner.

Subd. 4. **Program guidelines.** (a) The commissioner, in consultation with the advisory panel, shall develop:

(1) protocols or program guidelines that address the science and practice of biomonitoring to be utilized and procedures for changing those protocols to incorporate new and more accurate or efficient technologies as they become available. The commissioner and the advisory panel shall be guided by protocols and guidelines developed by the Centers for Disease Control and Prevention and the National Biomonitoring Program;

(2) guidelines for ensuring the privacy of information; informed consent; follow–up counseling and support; and communicating findings to participants, communities, and the general public. The informed consent used for the program must meet the informed consent protocols developed by the National Institutes of Health;

(3) educational and outreach materials that are culturally appropriate for dissemination to program participants and communities. Priority shall be given to the development of materials specifically designed to ensure that parents are informed about all of the benefits of breastfeeding so that the program does not result in an unjustified fear of toxins in breast milk, which might inadvertently lead parents to avoid breastfeeding. The materials shall communicate relevant scientific findings; data on the accumulation of pollutants to community health; and the required responses by local, state, and other governmental entities in regulating toxicant exposures;

(4) a training program that is culturally sensitive specifically for health care providers, health educators, and other program administrators;

(5) a designation process for state and private laboratories that are qualified to analyze biospecimens and report the findings; and

(6) a method for informing affected communities and local governments representing those communities concerning biomonitoring activities and for receiving comments from citizens concerning those activities.

(b) The commissioner may enter into contractual agreements with health clinics, community–based organizations, or experts in a particular field to perform any of the activities described under this section.

History: *2007 c 57 art 1 s 145*

144.998 ENVIRONMENTAL HEALTH TRACKING AND BIOMONITORING ADVISORY PANEL.

Subdivision 1. **Creation.** The commissioner shall establish the Environmental Health Tracking and Biomonitoring Advisory Panel. The commissioner shall appoint, from the panel's membership, a chair. The panel shall meet as often as it deems necessary but, at a minimum, on a quarterly basis. Members of the panel shall serve without compensation but shall be reimbursed for travel and other necessary expenses incurred through performance of their duties. Members appointed by the commissioner are appointed for a three–year term and may be reappointed. Legislative appointees serve at the pleasure of the appointing authority.

Subd. 2. **Members.** (a) The commissioner shall appoint eight members, none of whom may be lobbyists registered under chapter 10A, who have backgrounds or training in designing, implementing, and interpreting health tracking and biomonitoring studies or in related fields of science, including epidemiology, biostatistics, environmental health, laboratory sciences, occupational health, industrial hygiene, toxicology, and public health, including:

(1) at least two scientists representative of each of the following:

(i) nongovernmental organizations with a focus on environmental health, environmental justice, children's health, or on specific chronic diseases; and

(ii) statewide business organizations; and

(2) at least one scientist who is a representative of the University of Minnesota.

(b) Two citizen panel members meeting the scientific qualifications in paragraph (a) shall be appointed, one by the speaker of the house and one by the senate majority leader.

(c) In addition, one representative each shall be appointed by the commissioners of the Pollution Control Agency and the Department of Agriculture, and by the commissioner of health to represent the department's Health Promotion and Chronic Disease Division.

Subd. 3. **Duties.** The advisory panel shall make recommendations to the commissioner and the legislature on:

(1) priorities for health tracking;

(2) priorities for biomonitoring that are based on sound science and practice, and that will advance the state of public health in Minnesota;

(3) specific chronic diseases to study under the environmental health tracking system;

(4) specific environmental hazard exposures to study under the environmental health tracking system, with the agreement of at least nine of the advisory panel members;

(5) specific communities and geographic areas on which to focus environmental health tracking and biomonitoring efforts;

(6) specific chemicals to study under the biomonitoring program, with the agreement of at least nine of the advisory panel members; in making these recommendations, the panel may consider the following criteria:

(i) the degree of potential exposure to the public or specific subgroups, including, but not limited to, occupational;

(ii) the likelihood of a chemical being a carcinogen or toxicant based on peer–reviewed health data, the chemical structure, or the toxicology of chemically related compounds;

(iii) the limits of laboratory detection for the chemical, including the ability to detect the chemical at low enough levels that could be expected in the general population;

(iv) exposure or potential exposure to the public or specific subgroups;

(v) the known or suspected health effects resulting from the same level of exposure based on peer–reviewed scientific studies;

(vi) the need to assess the efficacy of public health actions to reduce exposure to a chemical;

(vii) the availability of a biomonitoring analytical method with adequate accuracy, precision, sensitivity, specificity, and speed;

(viii) the availability of adequate biospecimen samples; or

(ix) other criteria that the panel may agree to; and

(7) other aspects of the design, implementation, and evaluation of the environmental health tracking and biomonitoring system, including, but not limited to:

(i) identifying possible community partners and sources of additional public or private funding;

(ii) developing outreach and educational methods and materials; and

(iii) disseminating environmental health tracking and biomonitoring findings to the public.

Subd. 4. **Liability.** No member of the panel shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under sections 144.995 to 144.998.

History: *2007 c 57 art 1 s 146*