CHAPTER 144

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144.001 MS 2006 [Renumbered 15.001]

STATE COMMISSIONER OF HEALTH

144.01 [Repealed, 1977 c 305 s 46]

144.011 DEPARTMENT OF HEALTH.

Subdivision 1. **Commissioner.** The Department of Health shall be under the control and supervision of the commissioner of health who shall be appointed by the governor under the provisions of section 15.06. The State Board of Health is abolished and all powers and duties of the board are transferred to the commissioner of health. The commissioner shall be selected without regard to political affiliation but with regard to ability and experience in matters of public health.

Subd. 2. [Repealed, 2014 c 192 art 4 s 3]

History: *1977 c 305 s 39; 1983 c 260 s 30*

144.02 [Repealed, 1977 c 305 s 46]

144.03 [Repealed, 1977 c 305 s 46]

144.04 [Repealed, 1977 c 305 s 46]

144.05 GENERAL DUTIES OF COMMISSIONER; REPORTS.

Subdivision 1. **General duties.** The state commissioner of health shall have general authority as the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens. This authority shall include but not be limited to the following:

(a) Conduct studies and investigations, collect and analyze health and vital data, and identify and describe health problems;

(b) Plan, facilitate, coordinate, provide, and support the organization of services for the prevention and control of illness and disease and the limitation of disabilities resulting therefrom;

(c) Establish and enforce health standards for the protection and the promotion of the public's health such as quality of health services, reporting of disease, regulation of health facilities, environmental health hazards and personnel;

(d) Affect the quality of public health and general health care services by providing consultation and technical training for health professionals and paraprofessionals;

(e) Promote personal health by conducting general health education programs and disseminating health information;

(f) Coordinate and integrate local, state and federal programs and services affecting the public's health;

(g) Continually assess and evaluate the effectiveness and efficiency of health service systems and public health programming efforts in the state; and

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(h) Advise the governor and legislature on matters relating to the public's health.

Subd. 2. **Mission; efficiency.** It is part of the department's mission that within the department's resources the commissioner shall endeavor to:

(1) prevent the waste or unnecessary spending of public money;

(2) use innovative fiscal and human resource practices to manage the state's resources and operate the department as efficiently as possible;

(3) coordinate the department's activities wherever appropriate with the activities of other governmental agencies;

(4) use technology where appropriate to increase agency productivity, improve customer service, increase public access to information about government, and increase public participation in the business of government;

(5) utilize constructive and cooperative labor-management practices to the extent otherwise required by chapters 43A and 179A;

(6) report to the legislature on the performance of agency operations and the accomplishment of agency goals in the agency's biennial budget according to section 16A.10, subdivision 1; and

(7) recommend to the legislature appropriate changes in law necessary to carry out the mission and improve the performance of the department.

Subd. 3. **Appropriation transfers to be reported.** When the commissioner transfers operational money between programs under section 16A.285, in addition to the requirements of that section the commissioner must provide the chairs of the legislative committees that have jurisdiction over the agency's budget with sufficient detail to identify the account to which the money was originally appropriated, and the account to which the money is being transferred.

Subd. 4. **Identification of deceased individuals.** Upon receiving notice under section 149A.90, subdivision 1, of the death of an individual who cannot be identified, the commissioner must post on the department's Web site information regarding the individual for purposes of obtaining information that may aid in identifying the individual and for purposes of notifying relatives who may be seeking the individual. The information must remain on the Web site continuously until the person's identity is determined.

Subd. 5. **Firearms data.** Notwithstanding any law to the contrary, the commissioner of health is prohibited from collecting data on individuals regarding lawful firearm ownership in the state or data related to an individual's right to carry a weapon under section 624.714.

Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The commissioner of health shall provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of more than $100,000, or related agreements with the same department or agency with a cumulative value of more than $100,000; and

(2) transfers of appropriations of more than $100,000 between accounts within or between agencies.

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The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, duration of the agreement, and a copy of the agreement.

History: *(5339) RL s 2130; 1973 c 356 s 2; 1977 c 305 s 45; 1986 c 444; 1995 c 248 art 11 s 11; 1998 c 366 s 57; 1999 c 245 art 1 s 14; 2002 c 375 art 3 s 4; 1Sp2010 c 1 art 20 s 5; 2016 c 189 art 20 s 7*

144.0505 COOPERATION WITH COMMISSIONER OF HUMAN SERVICES.

The commissioner shall promptly provide to the commissioner of human services upon request information on hospital revenues, nursing home licensure, and health maintenance organization revenues specifically required by the commissioner of human services to operate the provider surcharge program.

History: *1992 c 513 art 7 s 1*

144.0506 [Repealed, 2014 c 192 art 4 s 3]

144.051 DATA RELATING TO LICENSED AND REGISTERED PERSONS.

Subdivision 1. **Purpose.** The legislature finds that accurate information pertaining to the numbers, distribution and characteristics of health-related personnel is required in order that there exist an adequate information resource at the state level for purposes of making decisions pertaining to health personnel.

Subd. 2. **Information system.** The commissioner of health shall establish a system for the collection, analysis and reporting of data on individuals licensed or registered by the commissioner or the health-related licensing boards as defined in section 214.01, subdivision 2. Individuals licensed or registered by the commissioner or the health-related licensing boards shall provide information to the commissioner of health that the commissioner may, pursuant to section 144.052, require. The commissioner shall publish at least biennially, a report which indicates the type of information available and methods for requesting the information.

Subd. 3. **Data classification; private data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the following data collected, created, or maintained by the commissioner are classified as private data on individuals as defined in section 13.02, subdivision 12:

(1) data submitted by or on behalf of applicants for licenses prior to issuance of the license;

(2) the identity of complainants who have made reports concerning licensees or applicants unless the complainant consents to the disclosure;

(3) the identity of individuals who provide information as part of surveys and investigations;

(4) Social Security numbers; and

(5) health record data.

Subd. 4. **Data classification; public data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the following data collected, created, or maintained by the commissioner are classified as public data as defined in section 13.02, subdivision 15:

(1) all application data on licensees, license numbers, and license status;

(2) licensing information about licenses previously held under this chapter;

(3) correction orders, including information about compliance with the order and whether the fine was paid;

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(4) final enforcement actions pursuant to chapter 14;

(5) orders for hearing, findings of fact, and conclusions of law; and

(6) when the licensee and department agree to resolve the matter without a hearing, the agreement and specific reasons for the agreement are public data.

Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the following data collected, created, or maintained by the Department of Health are classified as confidential data on individuals as defined in section 13.02, subdivision 3: active investigative data relating to the investigation of potential violations of law by a licensee including data from the survey process before the correction order is issued by the department.

Subd. 6. **Release of private or confidential data.** For providers regulated pursuant to sections 144A.43 to 144A.482, the department may release private or confidential data, except Social Security numbers, to the appropriate state, federal, or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, Office of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health and Developmental Disabilities, the health licensing boards, Department of Human Services, county or city attorney's offices, police, and local or county public health offices.

History: *1978 c 759 s 1; 1986 c 444; 2013 c 108 art 11 s 3-6*

144.052 USE OF DATA.

Subdivision 1. **Rules.** The commissioner, after consultation with the health-related licensing boards as defined in section 214.01, subdivision 2, shall promulgate rules in accordance with chapter 14 regarding the types of information collected and the forms used for collection. The types of information collected shall include licensure or registration status, name, address, birth date, sex, professional activity status, and educational background or similar information needed in order to make decisions pertaining to health personnel.

Subd. 2. **Coordination with licensure renewal.** In order that the collection of the information specified in this section not impose an unnecessary burden on the licensed or registered individual or require additional administrative cost to the state, the commissioner of health shall, whenever possible, collect the information at the time of the individual's licensure or registration renewal. The health-related licensing boards shall include the request for the information that the commissioner may require pursuant to subdivision 1 with the licensure renewal application materials, provided, however, that the collection of health personnel data by the commissioner shall not cause the licensing boards to incur additional costs or delays with regard to the license renewal process.

History: *1978 c 759 s 2; 1982 c 424 s 130; 1986 c 444*

144.0525 EPIDEMIOLOGIC STUDIES; HEALTH HAZARDS; HEALTH SURVEILLANCE.

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

History: *1991 c 202 s 5; 1992 c 569 s 7; 1994 c 483 s 1; 1997 c 66 s 79*

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144.053 RESEARCH STUDIES CONFIDENTIAL.

Subdivision 1. **Status of data collected by commissioner.** All information, records of interviews, written reports, statements, notes, memoranda, or other data procured by the state commissioner of health, in connection with studies conducted by the state commissioner of health, or carried on by the said commissioner jointly with other persons, agencies or organizations, or procured by such other persons, agencies or organizations, for the purpose of reducing the morbidity or mortality from any cause or condition of health shall be confidential and shall be used solely for the purposes of medical or scientific research.

Subd. 2. **Limits on use and disclosure.** Such information, records, reports, statements, notes, memoranda, or other data shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency or person. Such information, records, reports, statements, notes, memoranda, or other data shall not be exhibited nor their contents disclosed in any way, in whole or in part, by any representative of the state commissioner of health, nor by any other person, except as may be necessary for the purpose of furthering the research project to which they relate. No person participating in such research project shall disclose, in any manner, the information so obtained except in strict conformity with such research project. No employee of said commissioner shall interview any patient named in any such report, nor a relative of any such patient, unless the consent of the attending physician and surgeon is first obtained.

Subd. 3. **No liability for giving information.** The furnishing of such information to the state commissioner of health or an authorized representative, or to any other cooperating agency in such research project, shall not subject any person, hospital, sanitarium, nursing home or other person or agency furnishing such information, to any action for damages or other relief.

Subd. 4. **Violation a misdemeanor.** Any disclosure other than is provided for in this section, is hereby declared to be a misdemeanor and punishable as such.

Subd. 5. **Personally identifying information.** The commissioner of health or the commissioner's agent is not required to solicit information that personally identifies persons selected to participate in an epidemiologic study if the commissioner determines that:

(1) the study monitors incidence or prevalence of a serious disease to detect potential health problems and predict risks, provides specific information to develop public health strategies to prevent serious disease, enables the targeting of intervention resources for communities, patients, or groups at risk of the disease, and informs health professionals about risks, early detection, or treatment of the disease;

(2) the personally identifying information is not necessary to validate the quality, accuracy, or completeness of the study; or

(3) the collection of personally identifying information may seriously jeopardize the validity of study results, as demonstrated by an epidemiologic study.

History: *1955 c 769 s 1-4; 1976 c 173 s 31; 1977 c 305 s 45; 1986 c 444; 1988 c 689 art 2 s 29*

144.0535 ENTRY FOR INSPECTION.

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

History: *1989 c 282 art 2 s 7*

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144.054 SUBPOENA POWER.

Subdivision 1. **Generally.** The commissioner may, as part of an investigation to determine whether a serious health threat exists or to locate persons who may have been exposed to an agent which can seriously affect their health, issue subpoenas to require the attendance and testimony of witnesses and production of books, records, correspondence, and other information relevant to any matter involved in the investigation. The commissioner or the commissioner's designee may administer oaths to witnesses or take their affirmation. The subpoenas may be served upon any person named therein anywhere in the state by any person authorized to serve subpoenas or other processes in civil actions of the district courts. If a person to whom a subpoena is issued does not comply with the subpoena, the commissioner may apply to the district court in any district and the court shall order the person to comply with the subpoena. Failure to obey the order of the court may be punished by the court as contempt of court. Except as provided in subdivision 2, no person may be compelled to disclose privileged information as described in section 595.02, subdivision 1. All information pertaining to individual medical records obtained under this section shall be considered health data under section 13.3805, subdivision 1. The fees for the service of a subpoena must be paid in the same manner as prescribed by law for a service of process issued out of a district court. Witnesses must receive the same fees and mileage as in civil actions.

Subd. 2. **HIV; HBV.** The commissioner may subpoena privileged medical information of patients who may have been exposed by a licensed dental hygienist, dentist, physician, nurse, podiatrist, a registered dental assistant, or a physician assistant who is infected with the human immunodeficiency virus (HIV) or hepatitis B virus (HBV) when the commissioner has determined that it may be necessary to notify those patients that they may have been exposed to HIV or HBV.

History: *1988 c 579 s 1; 1992 c 559 art 1 s 1; 1999 c 227 s 22; 2014 c 291 art 4 s 58*

144.055 HOME SAFETY PROGRAMS.

Subdivision 1. **Preventing home accidents; working with local boards.** The state commissioner of health is authorized to develop and conduct by exhibit, demonstration and by health education or public health engineering activity, or by any other means or methods which the commissioner may determine to be suitable and practicable for the purpose, a program in home safety designed to prevent accidents and fatalities resulting therefrom. The commissioner shall cooperate with community health boards as defined in section 145A.02, subdivision 5, the Minnesota Safety Council, and other interested voluntary groups in its conduct of such programs.

Subd. 2. **Sharing equipment and staff.** For the purpose of assisting community health boards to develop community home safety programs and to conduct such surveys of safety hazards in municipalities and counties, the commissioner may loan or furnish exhibit, demonstration, and educational materials, and may assign personnel for a limited period to such community health boards.

History: *1957 c 290 s 1; 1977 c 305 s 45; 1987 c 309 s 24; 2014 c 291 art 7 s 28; 2015 c 21 art 1 s 109*

144.056 PLAIN LANGUAGE IN WRITTEN MATERIALS.

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

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(b) All written materials relating to services and determinations of eligibility for or amounts of benefits that will be given to applicants for or recipients of assistance under programs administered or supervised by the commissioner of health must be developed to satisfy the plain language requirements of the Plain Language Contract Act under sections 325G.29 to 325G.36. Materials may be submitted to the attorney general for review and certification. Notwithstanding section 325G.35, subdivision 1, the attorney general shall review submitted materials to determine whether they comply with the requirements of section 325G.31. The remedies available pursuant to sections 8.31 and 325G.33 to 325G.36 do not apply to these materials. Failure to comply with this section does not provide a basis for suspending the implementation or operation of other laws governing programs administered by the commissioner.

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

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

History: *1988 c 689 art 2 s 30; 1997 c 7 art 2 s 13*

144.057 BACKGROUND STUDIES ON LICENSEES AND OTHER PERSONNEL.

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

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

(2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58. If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database;

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

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

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

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

Subd. 2. **Responsibilities of Department of Human Services.** The Department of Human Services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245C. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The Department of Human Services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245C. If an individual is disqualified, the Department of Human Services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the Department of Health.

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

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

History: *1995 c 229 art 3 s 4; 1996 c 305 art 1 s 35; 1996 c 408 art 10 s 1-3; 1997 c 248 s 1; 1Sp2001 c 9 art 7 s 1; art 14 s 2; 2002 c 379 art 1 s 49,113; 2003 c 15 art 1 s 33; 2015 c 71 art 7 s 2*

144.0571 [Repealed, 1Sp2017 c 6 art 10 s 148]

144.0572 CRIMINAL HISTORY BACKGROUND CHECKS ON APPLICANTS, LICENSEES, AND OTHER OCCUPATIONS REGULATED BY COMMISSIONER OF HEALTH.

Subdivision 1. **Criminal history background check requirements.** (a) Beginning January 1, 2018, an applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an audiologist or speech-language pathologist, or an applicant for initial certification as a hearing instrument dispenser, must submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI).

(b) Beginning January 1, 2020, an applicant for a renewal license or certificate as an audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018, must submit to a criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI.

(c) An applicant must submit to a background study under chapter 245C.

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(d) The criminal history records check must be structured so that any new crimes that an applicant or licensee or certificate holder commits after the initial background check are flagged in the BCA's or FBI's database and reported back to the commissioner of human services.

Subd. 2. **Procedures.** (a) The commissioner shall contract with the Department of Human Services to process the criminal history background check requirements through NETStudy 2.0, as defined in section 245C.02.

(b) The Department of Human Services shall conduct the criminal history background checks according to section 144.057, except that:

(1) all applicants must submit to a fingerprint-based criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI;

(2) the Department of Human Services shall complete the check and the study and notify the commissioner of health if the applicant, licensee, or certificate holder has a criminal history as defined in section 245C.15; and

(3) the Department of Human Services shall simultaneously conduct a background study on each applicant according to chapter 245C.

(c) When making a determination whether to issue a license, deny a license, or issue a conditional license or other credential to practice an occupation regulated by the Department of Health, the commissioner or the commissioner's designee shall evaluate a criminal conviction, guilty plea, Alford plea, judicial determination, or preponderance of evidence to determine an applicant's risk of harm using the criteria in section 364.03.

(d) Before taking disciplinary action against an applicant or a licensee based on a criminal conviction, judicial determination, admission in court, Alford plea, or preponderance of evidence, the commissioner of health shall provide the applicant or licensee an opportunity to complete or challenge the accuracy of the criminal history information. The applicant or licensee shall have 30 calendar days following notice from the commissioner of the intent to deny licensure or take disciplinary action to request an opportunity to correct or complete the record prior to the commissioner taking disciplinary action. The commissioner shall provide the applicant up to 180 days to challenge the accuracy or completeness of the report with the agency responsible for the record. This subdivision does not affect the right of the subject of the data to contest the accuracy or completeness under section 13.04, subdivision 4.

(e) The checks and studies must be structured so that any new crimes that an applicant or licensee commits after the initial background check are flagged in the BCA's or FBI's database and reported back to the commissioner of human services.

Subd. 3. **Applicant, licensee, or other regulated individual's responsibilities.** (a) Applicants, licensees, and individuals seeking a credential to practice one of the public health occupations listed in subdivision 1 must submit a complete criminal history records check consent form, a complete background study consent form, and a full set of fingerprints as required by the Department of Human Services in section 245C.05.

(b) The applicant or license holder is responsible for paying to the Department of Human Services all fees associated with the preparation of the fingerprints, the criminal records check consent form, and the criminal background check.

History: *1Sp2017 c 6 art 10 s 56*

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144.058 INTERPRETER SERVICES QUALITY INITIATIVE.

(a) The commissioner of health shall establish a voluntary statewide roster, and develop a plan for a registry and certification process for interpreters who provide high quality, spoken language health care interpreter services. The roster, registry, and certification process shall be based on the findings and recommendations set forth by the Interpreter Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

(b) By January 1, 2009, the commissioner shall establish a roster of all available interpreters to address access concerns, particularly in rural areas.

(c) By January 15, 2010, the commissioner shall:

(1) develop a plan for a registry of spoken language health care interpreters, including:

(i) development of standards for registration that set forth educational requirements, training requirements, demonstration of language proficiency and interpreting skills, agreement to abide by a code of ethics, and a criminal background check;

(ii) recommendations for appropriate alternate requirements in languages for which testing and training programs do not exist;

(iii) recommendations for appropriate fees; and

(iv) recommendations for establishing and maintaining the standards for inclusion in the registry; and

(2) develop a plan for implementing a certification process based on national testing and certification processes for spoken language interpreters 12 months after the establishment of a national certification process.

(d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper Midwest Translators and Interpreters Association for advice on the standards required to plan for the development of a registry and certification process.

(e) The commissioner shall charge an annual fee of $50 to include an interpreter in the roster. Fee revenue shall be deposited in the state government special revenue fund.

History: *2008 c 363 art 17 s 2*

144.059 PALLIATIVE CARE ADVISORY COUNCIL.

Subdivision 1. **Membership.** The Palliative Care Advisory Council shall consist of 18 public members.

Subd. 2. **Public members.** (a) The commissioner shall appoint, in the manner provided in section 15.0597, 18 public members, including the following:

(1) two physicians, of which one is certified by the American Board of Hospice and Palliative Medicine;

(2) two registered nurses or advanced practice registered nurses, of which one is certified by the National Board for Certification of Hospice and Palliative Nurses;

(3) one care coordinator experienced in working with people with serious or chronic illness and their families;

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(4) one spiritual counselor experienced in working with people with serious or chronic illness and their families;

(5) three licensed health professionals, such as complementary and alternative health care practitioners, dietitians or nutritionists, pharmacists, or physical therapists, who are neither physicians nor nurses, but who have experience as members of a palliative care interdisciplinary team working with people with serious or chronic illness and their families;

(6) one licensed social worker experienced in working with people with serious or chronic illness and their families;

(7) four patients or personal caregivers experienced with serious or chronic illness;

(8) one representative of a health plan company;

(9) one physician assistant that is a member of the American Academy of Hospice and Palliative Medicine; and

(10) two members from any of the categories described in clauses (1) to (9).

(b) Council membership must include, where possible, representation that is racially, culturally, linguistically, geographically, and economically diverse.

(c) The council must include at least six members who reside outside Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns, Washington, or Wright Counties.

(d) To the extent possible, council membership must include persons who have experience in palliative care research, palliative care instruction in a medical or nursing school setting, palliative care services for veterans as a provider or recipient, or pediatric care.

(e) Council membership must include health professionals who have palliative care work experience or expertise in palliative care delivery models in a variety of inpatient, outpatient, and community settings, including acute care, long-term care, or hospice, with a variety of populations, including pediatric, youth, and adult patients.

Subd. 3. **Term.** Members of the council shall serve for a term of three years and may be reappointed. Members shall serve until their successors have been appointed.

Subd. 4. **Administration.** The commissioner or the commissioner's designee shall provide meeting space and administrative services for the council.

Subd. 5. **Chairs.** At the council's first meeting, and biannually thereafter, the members shall elect a chair and a vice-chair whose duties shall be established by the council.

Subd. 6. **Meeting.** The council shall meet at least twice yearly.

Subd. 7. **No compensation.** Public members of the council serve without compensation or reimbursement for expenses.

Subd. 8. **Duties.** (a) The council shall consult with and advise the commissioner on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in the state.

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(b) By February 15 of each year, the council shall submit to the chairs and ranking minority members of the committees of the senate and the house of representatives with primary jurisdiction over health care a report containing:

(1) the advisory council's assessment of the availability of palliative care in the state;

(2) the advisory council's analysis of barriers to greater access to palliative care; and

(3) recommendations for legislative action, with draft legislation to implement the recommendations.

(c) The Department of Health shall publish the report each year on the department's Web site.

Subd. 9. **Open meetings.** The council is subject to the requirements of chapter 13D.

Subd. 10. **Sunset.** The council shall sunset January 1, 2025.

History: *1Sp2017 c 6 art 10 s 57*

144.06 STATE COMMISSIONER OF HEALTH TO PROVIDE INSTRUCTION.

The state commissioner of health, hereinafter referred to as the commissioner, is hereby authorized to provide instruction and advice to expectant mothers and fathers during pregnancy and to mothers, fathers, and their infants after childbirth; and to employ such persons as may be necessary to carry out the requirements of sections 144.06 and 144.07. The instruction, advice, and care shall be given only to applicants residing within the state. No person receiving aid under this section and sections 144.07 and 144.09 shall for this reason be affected thereby in any civil or political rights, nor shall the person's identity be disclosed except upon written order of the commissioner.

History: *(5340, 5341, 5342) 1921 c 392 s 1-3; 1977 c 305 s 45; 1981 c 31 s 2*

144.061 EARLY DENTAL PREVENTION INITIATIVE.

(a) The commissioner of health, in collaboration with the commissioner of human services, shall implement a statewide initiative to increase awareness among communities of color and recent immigrants on the importance of early preventive dental intervention for infants and toddlers before and after primary teeth appear.

(b) The commissioner shall develop educational materials and information for expectant and new parents within the targeted communities that include the importance of early dental care to prevent early cavities, including proper cleaning techniques and feeding habits, before and after primary teeth appear.

(c) The commissioner shall develop a distribution plan to ensure that the materials are distributed to expectant and new parents within the targeted communities, including, but not limited to, making the materials available to health care providers, community clinics, WIC sites, and other relevant sites within the targeted communities.

(d) In developing these materials and distribution plan, the commissioner shall work collaboratively with members of the targeted communities, dental providers, pediatricians, child care providers, and home visiting nurses.

(e) The commissioner shall, with input from stakeholders listed in paragraph (d), develop and pilot incentives to encourage early dental care within one year of an infant's teeth erupting.

History: *2015 c 71 art 8 s 23*

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144.062 VACCINE COST REDUCTION PROGRAM.

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

History: *1990 c 568 art 2 s 5; 1997 c 7 art 2 s 14; 2009 c 101 art 2 s 109*

144.065 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS.

The state commissioner of health shall assist local health agencies and organizations throughout the state with the development and maintenance of services for the detection and treatment of sexually transmitted infections. These services shall provide for research, screening and diagnosis, treatment, case finding, investigation, and the dissemination of appropriate educational information. The state commissioner of health shall determine the composition of such services and shall establish a method of providing funds to community health boards as defined in section 145A.02, subdivision 5, state agencies, state councils, and nonprofit corporations, which offer such services. The state commissioner of health shall provide technical assistance to such agencies and organizations in accordance with the needs of the local area. Planning and implementation of services and technical assistance may be conducted in collaboration with community health boards; state agencies, including the University of Minnesota and the Department of Education; state councils; nonprofit organizations; and representatives of affected populations.

History: *1974 c 575 s 6; 1977 c 305 s 45; 1985 c 248 s 70; 1999 c 245 art 2 s 15; 2003 c 130 s 12; 2014 c 291 art 7 s 28*

144.07 POWERS OF COMMISSIONER.

The commissioner may:

(1) make all reasonable rules necessary to carry into effect the provisions of this section and sections 144.06 and 144.09, and may amend, alter, or repeal such rules;

(2) accept private gifts for the purpose of carrying out the provisions of those sections;

(3) cooperate with agencies, whether city, state, federal, or private, which carry on work for maternal and infant hygiene;

(4) make investigations and recommendations for the purpose of improving maternity care;

(5) promote programs and services available in Minnesota for parents and families of victims of sudden infant death syndrome; and

(6) collect and report to the legislature the most current information regarding the frequency and causes of sudden infant death syndrome.

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The commissioner shall include in the report to the legislature a statement of the operation of those sections.

History: *(5343) 1921 c 392 s 4; 1977 c 305 s 45; 1984 c 637 s 1; 1985 c 248 s 70; 1986 c 444*

144.071 [Repealed, 2014 c 192 art 4 s 3]

144.072 [Repealed, 2014 c 192 art 4 s 3]

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

Subd. 2. **Access to data.** With the exception of summary data, data on individuals that is collected, maintained, used, or disseminated by the commissioner of health under subdivision 1 is private data on individuals and shall not be disclosed to others except:

(1) under section 13.05;

(2) under a valid court order;

(3) to the nursing home or boarding care home in which the individual resided at the time the assessment was completed;

(4) to the commissioner of human services; or

(5) to county home care staff for the purpose of assisting the individual to be discharged from a nursing home or boarding care home and returned to the community.

Subd. 3. [Repealed, 1998 c 407 art 4 s 69]

Subd. 3a. [Repealed, 1998 c 407 art 4 s 69]

History: *1984 c 641 s 11; 1984 c 654 art 5 s 58; 1995 c 207 art 6 s 1,2; 1995 c 259 art 1 s 31; 1997 c 203 art 4 s 3; 1Sp2001 c 9 art 5 s 1; 2002 c 379 art 1 s 113; 2014 c 192 art 4 s 2*

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to

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obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident. The nursing home or boarding care home is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notices from the department.

Subd. 2a. **Semiannual assessment by nursing facilities.** Notwithstanding Minnesota Rules, part 9549.0059, subpart 2, item B, the individual dependencies items 21 to 24 and 28 are required to be completed in accordance with the Facility Manual for Completing Case Mix Requests for Classification, July 1987, issued by the Minnesota Department of Health.

Subd. 3. **Request for reconsideration.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the receipt of the notice of resident classification. For reconsideration requests submitted by or on behalf of the resident, the time period for submission of the request begins as of the date the resident or the resident's representative receives the classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 3a. **Access to information.** Upon written request, the nursing home or boarding care home must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home or boarding care home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues. For the purposes of this section, "representative" includes the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

Subd. 3b. **Facility's request for reconsideration.** In addition to the information required in subdivision 3, a reconsideration request from a nursing home or boarding care home must contain the following information: the date the resident reimbursement classification notices were received by the facility; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the department and the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide this

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information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

Subd. 4. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 5. **Audit authority.** The Department of Health may audit assessments of nursing home and boarding care home residents. These audits may be in addition to the assessments completed by the department under section 144.0721. The audits may be conducted at the facility, and the department may conduct the audits on an unannounced basis.

History: *1Sp1985 c 3 s 1; 1987 c 209 s 2; 1996 c 451 art 5 s 3; 2014 c 192 art 4 s 2; 2017 c 40 art 1 s 18; 1Sp2017 c 6 art 14 s 1*

144.0723 [Repealed, 1999 c 245 art 3 s 51]

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256R.17.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum data set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the Minnesota Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

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(g) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or chapter 256R;

(2) elderly waiver services under section 256B.0915;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Subd. 3. [Repealed by amendment, 2014 c 147 s 1]

Subd. 3a. **Resident reimbursement classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement classifications shall be based on the minimum data set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classifications according to the RUG-IV, 48 group, resource utilization groups. Resident classification must be established based on the individual items on the minimum data set, which must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the minimum data set according to general categories as defined in the Case Mix Classification Manual for Nursing Facilities issued by the Minnesota Department of Health.

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

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(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification.

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within seven days of the time requirements listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

(b) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than 0.1 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the commissioner of human services for a reduction in the total penalty amount. The commissioner of human services, in consultation with the commissioner of health, may, at the sole discretion of the commissioner of human services, limit the penalty for residents covered by medical assistance to ten days.

Subd. 7. **Notice of resident reimbursement classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the electronic file of notice of case mix classifications from the commissioner of health.

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(b) If a facility submits a modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was modified and the reason for the modification. The notice of modified assessment may be provided at the same time that the resident or resident's representative is provided the resident's modified notice of classification.

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, and documentation supporting the request. The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original

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classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256R.17 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

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(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone or be homeless without the person's current housing and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

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(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under sections 256B.0915 and 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

[See Note.]

Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (9).

(b) The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses (1) and (2), may request continued services pending appeal within the time period allowed to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is in effect for appeals filed between January 1, 2015, and December 31, 2016.

History: *1Sp2001 c 9 art 5 s 2; 2002 c 276 s 1-4; 2002 c 277 s 32; 2002 c 379 art 1 s 113; 2006 c 282 art 20 s 1,2; 2008 c 230 s 1; 2009 c 79 art 8 s 1-5; 2009 c 173 art 1 s 2; 2010 c 352 art 1 s 1; 1Sp2010 c 1 art 24 s 12; 2011 c 110 art 1 s 1-7; 1Sp2011 c 9 art 6 s 87; art 7 s 47,52; 2012 c 187 art 1 s 75; 2012 c 216 art 14 s 2; 2012 c 247 art 4 s 41; 2013 c 63 s 2; 2013 c 108 art 2 s 1,44; art 7 s 1; 2014 c 147 s 1; 2014 c 312 art 27 s 2; 2015 c 21 art 1 s 26; 2015 c 78 art 6 s 1; 2017 c 40 art 1 s 19-21; 1Sp2017 c 6 art 3 s 1,2*

NOTE: Subdivision 11 is effective on or after January 1, 2014, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21. Laws 2009, chapter 79, article 8, section 4, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 12, and Laws 2011, First Special Session chapter 9, article 7, section 47.

144.073 [Repealed, 2001 c 205 art 2 s 3]

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144.074 FUNDS RECEIVED FROM OTHER SOURCES.

The state commissioner of health may receive and accept money, property, or services from any person, agency, or other source for any public health purpose within the scope of statutory authority. All money so received is annually appropriated for those purposes in the manner and subject to the provisions of law applicable to appropriations of state funds.

History: *1975 c 310 s 9; 1977 c 305 s 45; 1986 c 444*

144.0741 [Expired]

144.0742 CONTRACTS FOR PROVISION OF PUBLIC HEALTH SERVICES.

The commissioner of health is authorized to enter into contractual agreements with any public or private entity for the provision of statutorily prescribed public health services by the department. The contracts shall specify the services to be provided and the amount and method of reimbursement therefor. Funds generated in a contractual agreement made pursuant to this section are appropriated to the department for purposes of providing the services specified in the contracts. All such contractual agreements shall be processed in accordance with the provisions of chapter 16C.

History: *1981 c 360 art 1 s 15; 1984 c 544 s 89; 1998 c 386 art 2 s 56*

144.075 [Repealed, 1984 c 503 s 6]

144.0751 HEALTH STANDARDS.

(a) Safe drinking water or air quality standards established or revised by the commissioner of health must:

(1) be based on scientifically acceptable, peer-reviewed information; and

(2) include a reasonable margin of safety to adequately protect the health of infants, children, and adults by taking into consideration risks to each of the following health outcomes: reproductive development and function, respiratory function, immunologic suppression or hypersensitization, development of the brain and nervous system, endocrine (hormonal) function, cancer, general infant and child development, and any other important health outcomes identified by the commissioner.

(b) For purposes of this section, "peer-reviewed" means a scientifically based review conducted by individuals with substantial knowledge and experience in toxicology, health risk assessment, or other related fields as determined by the commissioner.

History: *1Sp2001 c 9 art 1 s 27; 2002 c 379 art 1 s 113*

144.076 [Repealed, 2014 c 192 art 4 s 3]

144.077 MOBILE HEALTH CARE PROVIDERS.

Subdivision 1. **Definition.** "Mobile health evaluation and screening provider" means any provider who is transported in a vehicle mounted unit, either motorized or trailered, and readily movable without disassembling, and who regularly provides evaluation and screening services in more than one geographic location. "Mobile health evaluation and screening provider" does not include any ambulance medical transportation type services or any mobile health service provider affiliated, owned and operated, or under contract with a licensed health care facility or provider, managed care entity licensed under chapter 62D or 62N or Minnesota licensed physician or dentist, nor does it include fixed location providers who transfer or

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move during the calendar year. All mobile health evaluation and screening providers must be directly supervised by a physician licensed under chapter 147.

Subd. 2. **Licensure requirements.** A mobile health evaluation and screening provider shall be required to comply with all licensing reporting and certification, sanitation, and other requirements and regulations that apply to a health care provider supplying similar services as a fixed location provider. A mobile health evaluation and screening provider shall be subject to regulation and order of the Department of Health.

Subd. 3. **Registration requirements.** A mobile health evaluation and screening provider shall register with the commissioner and file the anticipated locations of practice, schedules, and routes annually no later than January 15. The mobile health evaluation and screening provider shall also include the name and address of the supervising physician. A mobile health evaluation and screening provider shall provide at least 30 days' written notice to the populations they intend to serve.

History: *1995 c 135 s 1*

144.08 [Repealed, 2001 c 205 art 2 s 3]

144.09 COOPERATION WITH FEDERAL AUTHORITIES.

The state of Minnesota, through its legislative authority:

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

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

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

History: *(5344) 1921 c 392 s 5; 1977 c 305 s 45; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

144.092 COORDINATED NUTRITION DATA COLLECTION.

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

History: *1986 c 404 s 6; 1987 c 209 s 3; 1997 c 7 art 2 s 15*

144.10 FEDERAL AID FOR MATERNAL AND CHILD WELFARE SERVICES.

The commissioner of management and budget is hereby appointed as the custodian of all moneys received, or which may hereafter be received, by the state by reason of any federal aid granted for maternal and child welfare service and for public health services, including the purposes as declared in Public Law 725 enacted by the 79th Congress of the United States, Chapter 958-2d Session and all amendments thereto, which moneys shall be expended in accordance with the purposes expressed in the acts of Congress granting such aid and solely in accordance with plans to be prepared by the state commissioner of health. The plans so to be prepared by the commissioner of health for maternal and child health service shall be approved by the United States Children's Bureau; and the plans of the commissioner of health for public health service

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shall be approved by the United States Public Health Service. Such plans shall include the training of personnel for both state and local health work and conform with all the requirements governing federal aid for these purposes. Such plans shall be designed to secure for the state the maximum amount of federal aid which is possible to be secured on the basis of the available state, county, and local appropriations for such purposes. The commissioner of health shall make reports, which shall be in such form and contain such information as may be required by the United States Children's Bureau or the United States Public Health Service, as the case may be; and comply with all the provisions, rules, and regulations which may be prescribed by these federal authorities in order to secure the correction and verification of such reports.

History: *(5391-1) Ex1936 c 70 s 1; 1947 c 485 s 1; 1977 c 305 s 45; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109; 2013 c 125 art 1 s 29*

144.11 RULES.

The commissioner may make such reasonable rules as may be necessary to carry into effect the provisions of section 144.10 and alter, amend, suspend, or repeal any of such rules.

History: *(5391-2) Ex1936 c 70 s 2; 1977 c 305 s 45; 1985 c 248 s 70*

144.111 RULES, NOTICE PUBLISHED.

Three weeks' published notice of such rules, if of general application throughout the state, shall be given at the seat of government; if of local application only, as near such locality as practicable. Special rules applicable to particular cases shall be sufficiently noticed when posted in a conspicuous place upon or near the premises affected. Fines collected for violations of rules adopted by the commissioner shall be paid into the state treasury; and of local boards and officers, into the county treasury.

History: *(5346) RL s 2132; 1977 c 305 s 45; 1985 c 248 s 70; 2015 c 21 art 1 s 109*

144.12 REGULATION, ENFORCEMENT, LICENSES, FEES.

Subdivision 1. **Rules.** The commissioner may adopt reasonable rules pursuant to chapter 14 for the preservation of the public health. The rules shall not conflict with the charter or ordinance of a city of the first class upon the same subject. The commissioner may control, by rule, by requiring the taking out of licenses or permits, or by other appropriate means, any of the following matters:

(1) the manufacture into articles of commerce, other than food, of diseased, tainted, or decayed animal or vegetable matter;

(2) the business of scavengering and the disposal of sewage;

(3) the location of mortuaries and cemeteries and the removal and burial of the dead;

(4) the management of boarding places for infants and the treatment of infants in them;

(5) the pollution of streams and other waters and the distribution of water by persons for drinking or domestic use;

(6) the construction and equipment, in respect to sanitary conditions, of schools, hospitals, almshouses, prisons, and other public institutions, and of lodging houses and other public sleeping places kept for gain;

(7) the treatment, in hospitals and elsewhere, of persons suffering from communicable diseases, including all manner of venereal disease and infection, the disinfection and quarantine of persons and places in case of those diseases, and the reporting of sicknesses and deaths from them;

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Neither the commissioner nor any community health board as defined in section 145A.02, subdivision 5, nor director of public health may adopt any rule or regulation for the treatment in any penal or correctional institution of any person suffering from any communicable disease or venereal disease or infection, which requires the involuntary detention of any person after the expiration of the period of sentence to the penal or correctional institution, or after the expiration of the period to which the sentence may be reduced by good time allowance or by the lawful order of any judge or the Department of Corrections;

(8) the prevention of infant blindness and infection of the eyes of the newly born by the designation, from time to time, of one or more prophylactics to be used in those cases and in the manner that the commissioner directs, unless specifically objected to by a parent of the infant;

(9) the accumulation of filthy and unwholesome matter to the injury of the public health and its removal;

(10) the collection, recording, and reporting of vital records by public officers and the furnishing of information to them by physicians, undertakers, and others of births, deaths, causes of death, and other pertinent facts;

(11) the construction, equipment, and maintenance, in respect to sanitary conditions, of lumber camps, migratory or migrant labor camps, and other industrial camps;

(12) the general sanitation of tourist camps, summer hotels, and resorts in respect to water supplies, disposal of sewage, garbage, and other wastes and the prevention and control of communicable diseases; and, to that end, may prescribe the respective duties of agents of a community health board as authorized under section 145A.04; and all community health boards shall make such investigations and reports and obey such directions as the commissioner may require or give and, under the supervision of the commissioner, enforce the rules;

(13) atmospheric pollution which may be injurious or detrimental to public health;

(14) sources of radiation, and the handling, storage, transportation, use and disposal of radioactive isotopes and fissionable materials; and

(15) the establishment, operation and maintenance of all clinical laboratories not owned, or functioning as a component of a licensed hospital. These laboratories shall not include laboratories owned or operated by five or less licensed practitioners of the healing arts, unless otherwise provided by federal law or regulation, and in which these practitioners perform tests or procedures solely in connection with the treatment of their patients. Rules promulgated under the authority of this clause, which shall not take effect until federal legislation relating to the regulation and improvement of clinical laboratories has been enacted, may relate at least to minimum requirements for external and internal quality control, equipment, facility environment, personnel, administration and records. These rules may include the establishment of a fee schedule for clinical laboratory inspections. The provisions of this clause shall expire 30 days after the conclusion of any fiscal year in which the federal government pays for less than 45 percent of the cost of regulating clinical laboratories.

Subd. 2. **Mass gatherings.** The commissioner may regulate the general sanitation of mass gatherings by promulgation of rules in respect to, but not limited to, the following areas: water supply, disposal of sewage, garbage and other wastes, the prevention and control of communicable diseases, the furnishing of suitable and adequate sanitary accommodations, and all other reasonable and necessary precautions to protect and insure the health, comfort and safety of those in attendance. No permit, license, or other prior approval shall be required of the commissioner for a mass gathering. A "mass gathering" shall mean an actual or reasonably anticipated assembly of more than 1,500 persons which will continue, or may reasonably be

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expected to continue, for a period of more than ten consecutive hours and which is held in an open space or temporary structure especially constructed, erected or assembled for the gathering. For purposes of this subdivision, "mass gatherings" shall not include public gatherings sponsored by a political subdivision or a nonprofit organization.

Subd. 3. **Licenses; permits.** Applications for licenses or permits issued pursuant to this section shall be submitted with a fee prescribed by the commissioner pursuant to section 144.122. Licenses or permits shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122.

Subd. 4. **Camper cabins and bunkhouses.** Camper cabins and bunkhouses are exempt from floor space, air space, or bed spacing requirements applicable to lodging establishments adopted by the commissioner. For the purposes of this section:

(1) "bunkhouse" means a building, structure, or enclosure intended to sleep more than one person for up to three nights that does not include a kitchen or bathroom; and

(2) "camper cabin" means a permanent rustic enclosure with walls and a floor that does not include a kitchen or bath; is located in a state park administered by the commissioner of natural resources, at a resort as defined under section 157.15, subdivision 11, or at a recreational camping area as defined under section 327.14, subdivision 8; and is intended to be a place where sleeping accommodations are furnished to the public.

History: *(5345) RL s 2131; 1917 c 345 s 1; 1923 c 227 s 1; 1951 c 537 s 1; 1953 c 134 s 1; 1957 c 361 s 1; 1975 c 310 s 4; 1975 c 351 s 1; 1977 c 66 s 10; 1977 c 305 s 45; 1977 c 406 s 1; 1983 c 359 s 9; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24; 2014 c 192 art 4 s 1; 2014 c 291 art 7 s 28; 2015 c 21 art 1 s 109; 1Sp2015 c 4 art 4 s 124*

RADIATION HAZARDS

144.1201 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 144.1201 to 144.1204, the terms defined in this section have the meanings given to them.

Subd. 2. **By-product nuclear material.** "By-product nuclear material" means a radioactive material, other than special nuclear material, yielded in or made radioactive by exposure to radiation created incident to the process of producing or utilizing special nuclear material.

Subd. 3. **Radiation.** "Radiation" means ionizing radiation and includes alpha rays; beta rays; gamma rays; x-rays; high energy neutrons, protons, or electrons; and other atomic particles.

Subd. 4. **Radioactive material.** "Radioactive material" means a matter that emits radiation. Radioactive material includes special nuclear material, source nuclear material, and by-product nuclear material.

Subd. 5. **Source nuclear material.** "Source nuclear material" means uranium or thorium, or a combination thereof, in any physical or chemical form; or ores that contain by weight 1/20 of one percent (0.05 percent) or more of uranium, thorium, or a combination thereof. Source nuclear material does not include special nuclear material.

Subd. 6. **Special nuclear material.** "Special nuclear material" means:

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(1) plutonium, uranium enriched in the isotope 233 or in the isotope 235, and any other material that the Nuclear Regulatory Commission determines to be special nuclear material according to United States Code, title 42, section 2071, except that source nuclear material is not included; and

(2) a material artificially enriched by any of the materials listed in clause (1), except that source nuclear material is not included.

History: *1999 c 245 art 2 s 16*

144.1202 UNITED STATES NUCLEAR REGULATORY COMMISSION AGREEMENT.

Subdivision 1. **Agreement authorized.** In order to have a comprehensive program to protect the public from radiation hazards, the governor, on behalf of the state, is authorized to enter into agreements with the United States Nuclear Regulatory Commission under the Atomic Energy Act of 1954, section 274b, as amended. The agreement shall provide for the discontinuance of portions of the Nuclear Regulatory Commission's licensing and related regulatory authority over by-product, source, and special nuclear materials, and the assumption of regulatory authority over these materials by the state.

Subd. 2. **Health Department designated lead.** The Department of Health is designated as the lead agency to pursue an agreement on behalf of the governor and for any assumption of specified licensing and regulatory authority from the Nuclear Regulatory Commission under an agreement with the commission. The commissioner of health shall establish an advisory group to assist in preparing the state to meet the requirements for reaching an agreement. The commissioner may adopt rules to allow the state to assume regulatory authority under an agreement under this section, including the licensing and regulation of radioactive materials. Any regulatory authority assumed by the state includes the ability to set and collect fees.

Subd. 3. **Transition.** A person who, on the effective date of an agreement under this section, possesses a Nuclear Regulatory Commission license that is subject to the agreement is deemed to possess a similar license issued by the Department of Health. A Department of Health license obtained under this subdivision expires on the expiration date specified in the federal license.

Subd. 4. [Repealed, 2004 c 236 s 7]

History: *1999 c 245 art 2 s 17; 1Sp2001 c 9 art 1 s 28; 2002 c 379 art 1 s 113; 2003 c 111 s 1*

144.1203 TRAINING; RULEMAKING.

The commissioner shall adopt rules to ensure that individuals handling or utilizing radioactive materials under the terms of a license issued by the commissioner under section 144.1202 have proper training and qualifications to do so. The rules adopted must be at least as stringent as federal regulations on proper training and qualifications adopted by the Nuclear Regulatory Commission. Rules adopted under this section may incorporate federal regulations by reference.

History: *1999 c 245 art 2 s 18*

144.1204 SURETY REQUIREMENTS.

Subdivision 1. **Financial assurance required.** The commissioner may require an applicant for a license under section 144.1202, or a person who was formerly licensed by the Nuclear Regulatory Commission and is now subject to sections 144.1201 to 144.1204, to post financial assurances to ensure the completion of all requirements established by the commissioner for the decontamination, closure, decommissioning, and reclamation of sites, structures, and equipment used in conjunction with activities related to licensure. The

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financial assurances posted must be sufficient to restore the site to unrestricted future use and must be sufficient to provide for surveillance and care when radioactive materials remain at the site after the licensed activities cease. The commissioner may establish financial assurance criteria by rule. In establishing such criteria, the commissioner may consider:

(1) the chemical and physical form of the licensed radioactive material;

(2) the quantity of radioactive material authorized;

(3) the particular radioisotopes authorized and their subsequent radiotoxicity;

(4) the method in which the radioactive material is held, used, stored, processed, transferred, or disposed of; and

(5) the potential costs of decontamination, treatment, or disposal of a licensee's equipment and facilities.

Subd. 2. **Acceptable financial assurances.** The commissioner may, by rule, establish types of financial assurances that meet the requirements of this section. Such financial assurances may include bank letters of credit, deposits of cash, or deposits of government securities.

Subd. 3. **Trust agreements.** Financial assurances must be established together with trust agreements. Both the financial assurances and the trust agreements must be in a form and substance that meet requirements established by the commissioner.

Subd. 4. **Exemptions.** The commissioner is authorized to exempt from the requirements of this section, by rule, any category of licensee upon a determination by the commissioner that an exemption does not result in a significant risk to the public health or safety or to the environment and does not pose a financial risk to the state.

Subd. 5. **Other remedies unaffected.** Nothing in this section relieves a licensee of a civil liability incurred, nor may this section be construed to relieve the licensee of obligations to prevent or mitigate the consequences of improper handling or abandonment of radioactive materials.

History: *1999 c 245 art 2 s 19*

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.

Subd. 2. **Annual fee.** A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	ANNUAL FEE
Academic broad scope - type A	$19,920
Academic broad scope - type B	19,920
Academic broad scope - type C	19,920

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Medical broad scope - type A	19,920
Medical institution - diagnostic and therapeutic	3,680
Medical institution - diagnostic (no written directives)	3,680
Medical private practice - diagnostic and therapeutic	3,680
Medical private practice - diagnostic (no written directives)	3,680
Eye applicators	3,680
Nuclear medical vans	3,680
High dose rate afterloader	3,680
Mobile high dose rate afterloader	3,680
Medical therapy - other emerging technology	3,680
Teletherapy	8,960
Gamma knife	8,960
Veterinary medicine	2,000
In vitro testing lab	2,000
Nuclear pharmacy	8,800
Radiopharmaceutical distribution (10 CFR 32.72)	3,840
Radiopharmaceutical processing and distribution (10 CFR 32.72)	8,800
Medical sealed sources - distribution (10 CFR 32.74)	3,840
Medical sealed sources - processing and distribution (10 CFR 32.74)	8,800
Well logging - sealed sources	3,760
Measuring systems - fixed gauge	2,000
Measuring systems - portable gauge	2,000
X-ray fluorescent analyzer	1,520
Measuring systems - gas chromatograph	2,000
Measuring systems - other	2,000
Broad scope manufacturing and distribution - type A	19,920
Broad scope manufacturing and distribution - type B	17,600
Broad scope manufacturing and distribution - type C	17,600

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Manufacturing and distribution - other	5,280
Nuclear laundry	18,640
Decontamination services	4,960
Leak test services only	2,000
Instrument calibration service only, less than 100 curies	2,000
Instrument calibration service only, 100 curies or more	2,000
Service, maintenance, installation, source changes, etc.	4,960
Waste disposal service, prepackaged only	6,000
Waste disposal	8,320
Distribution - general licensed devices (sealed sources)	1,760
Distribution - general licensed material (unsealed sources)	1,120
Industrial radiography - fixed location	9,840
Industrial radiography - temporary job sites	9,840
Irradiators, self-shielding, less than 10,000 curies	2,880
Irradiators, other, less than 10,000 curies	5,360
Irradiators, self-shielding, 10,000 curies or more	2,880
Research and development - type A broad scope	9,520
Research and development - type B broad scope	9,520
Research and development - type C broad scope	9,520
Research and development - other	4,480
Storage - no operations	2,000
Source material - shielding	584
Special nuclear material plutonium - neutron source in device	3,680
Pacemaker by-product and/or special nuclear material - medical (institution)	3,680
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	5,280
Accelerator-produced radioactive material	3,840

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Nonprofit educational institutions	300
General license registration	150

Subd. 3. **Fee categories; incorporation of federal licensing categories.** (a) Fee categories under this section are equivalent to the licensing categories used by the United States Nuclear Regulatory Commission under Code of Federal Regulations, title 10, parts 30 to 36, 39, 40, 70, 71, and 150, except as provided in paragraph (b).

(b) The category of "Academic, small" is the type of license required for the use of radioactive materials in a teaching institution. Radioactive materials are limited to ten radionuclides not to exceed a total activity amount of one curie.

Subd. 4. **Application fee.** A licensee must pay an application fee as follows:

TYPE	APPLICATION FEE
Academic broad scope - type A	$ 5,920
Academic broad scope - type B	5,920
Academic broad scope - type C	5,920
Medical broad scope - type A	3,920
Medical institution - diagnostic and therapeutic	1,520
Medical institution - diagnostic (no written directives)	1,520
Medical private practice - diagnostic and therapeutic	1,520
Medical private practice - diagnostic (no written directives)	1,520
Eye applicators	1,520
Nuclear medical vans	1,520
High dose rate afterloader	1,520
Mobile high dose rate afterloader	1,520
Medical therapy - other emerging technology	1,520
Teletherapy	5,520
Gamma knife	5,520
Veterinary medicine	960
In vitro testing lab	960
Nuclear pharmacy	4,880
Radiopharmaceutical distribution (10 CFR 32.72)	2,160

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Radiopharmaceutical processing and distribution (10 CFR 32.72)	4,880
Medical sealed sources - distribution (10 CFR 32.74)	2,160
Medical sealed sources - processing and distribution (10 CFR 32.74)	4,880
Well logging - sealed sources	1,600
Measuring systems - fixed gauge	960
Measuring systems - portable gauge	960
X-ray fluorescent analyzer	584
Measuring systems - gas chromatograph	960
Measuring systems - other	960
Broad scope manufacturing and distribution - type A	5,920
Broad scope manufacturing and distribution - type B	5,920
Broad scope manufacturing and distribution - type C	5,920
Manufacturing and distribution - other	2,320
Nuclear laundry	10,080
Decontamination services	2,640
Leak test services only	960
Instrument calibration service only, less than 100 curies	960
Instrument calibration service only, 100 curies or more	960
Service, maintenance, installation, source changes, etc.	2,640
Waste disposal service, prepackaged only	2,240
Waste disposal	1,520
Distribution - general licensed devices (sealed sources)	880
Distribution - general licensed material (unsealed sources)	520
Industrial radiography - fixed location	2,640
Industrial radiography - temporary job sites	2,640
Irradiators, self-shielding, less than 10,000 curies	1,440
Irradiators, other, less than 10,000 curies	2,960
Irradiators, self-shielding, 10,000 curies or more	1,440

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Research and development - type A broad scope	4,960
Research and development - type B broad scope	4,960
Research and development - type C broad scope	4,960
Research and development - other	2,400
Storage - no operations	960
Source material - shielding	136
Special nuclear material plutonium - neutron source in device	1,200
Pacemaker by-product and/or special nuclear material - medical (institution)	1,200
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	2,320
Accelerator-produced radioactive material	4,100
Nonprofit educational institutions	300
General license registration	0
Industrial radiographer certification	150

Subd. 5. **Penalty for late payment.** An annual fee or a license renewal fee submitted to the commissioner after the due date specified by rule must be accompanied by an additional amount equal to 25 percent of the fee due.

Subd. 6. **Inspections.** The commissioner of health shall make periodic safety inspections of the radioactive material and source and special nuclear material of a licensee. The commissioner shall prescribe the frequency of safety inspections by rule.

Subd. 7. **Recovery of reinspection cost.** If the commissioner finds serious violations of public health standards during an inspection under subdivision 6, the licensee must pay all costs associated with subsequent reinspection of the source. The costs shall be the actual costs incurred by the commissioner and include, but are not limited to, labor, transportation, per diem, materials, legal fees, testing, and monitoring costs.

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay $1,200. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of $300 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; and

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(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

History: *1Sp2001 c 9 art 1 s 29; 2002 c 379 art 1 s 113; 2004 c 236 s 1-4; 2007 c 85 s 1*

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

Subdivision 1. **Registration; fees.** The fee for the registration for x-ray machines and other sources of ionizing radiation required to be registered under rules adopted by the state commissioner of health pursuant to section 144.12, shall be in an amount as described in subdivision 1a pursuant to section 144.122. The registration shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122.

Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing radiation-producing equipment must pay an annual initial or annual renewal registration fee consisting of a base facility fee of $100 and an additional fee for each radiation source, as follows:

(1) medical or veterinary equipment	$	100
(2) dental x-ray equipment	$	40
(3) x-ray equipment not used on humans or animals	$	100
(4) devices with sources of ionizing radiation not used on humans or animals	$	100

(b) A facility with radiation therapy and accelerator equipment must pay an annual registration fee of $500. A facility with an industrial accelerator must pay an annual registration fee of $150.

(c) Electron microscopy equipment is exempt from the registration fee requirements of this section.

Subd. 1b. **Penalty fee for late registration.** Applications for initial or renewal registrations submitted to the commissioner after the time specified by the commissioner shall be accompanied by an amount equal to 25 percent of the fee due in addition to the fees prescribed in subdivision 1a.

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

Subd. 2. **Inspections.** Periodic radiation safety inspections of the sources of ionizing radiation shall be made by the state commissioner of health. The frequency of safety inspections shall be prescribed by the commissioner on the basis of the frequency of use of the source of ionizing radiation; provided that each source shall be inspected at least once every four years.

Subd. 3. **Exemption.** Notwithstanding rules adopted by the commissioner under section 144.12, subdivision 1, clause (15), practitioners of veterinary medicine are not required to conduct densitometry and sensitometry tests as part of any ionizing radiation quality assurance program.

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.

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(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, osteopathic medicine, 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

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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 must 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.

Subd. 6. **Inspection.** At the time a facility with x-ray equipment is inspected by the commissioner of health in accordance with subdivision 2, an individual operating x-ray equipment in the facility must be able to show compliance with the requirements of subdivision 5.

Subd. 7. [Repealed, 1999 c 86 art 2 s 6]

Subd. 8. **Exemption from examination requirements; operators of certain bone densitometers.** (a) This subdivision applies to a bone densitometer that is used on humans to estimate bone mineral content and bone mineral density in a region of a finger on a person's nondominant hand, gives an x-ray dose equivalent of less than 0.001 microsieverts per scan, and has an x-ray leakage exposure rate of less than two milliroentgens per hour at a distance of one meter, provided that the bone densitometer is operating in accordance with manufacturer specifications.

(b) An individual who operates a bone densitometer that satisfies the definition in paragraph (a) and the facility in which an individual operates such a bone densitometer are exempt from the requirements of subdivisions 5 and 6.

History: *1974 c 81 s 1; 1975 c 310 s 35; 1977 c 305 s 45; 1985 c 248 s 70; 1993 c 188 s 1,2; 1995 c 146 s 1-3; 1997 c 203 art 2 s 7-10; 1999 c 245 art 2 s 20; 2007 c 85 s 2,3; 2007 c 123 s 1-3; 2008 c 277 art 1 s 13; 2009 c 79 art 10 s 2,3; 2013 c 125 art 1 s 108; 2016 c 119 s 7*

144.1211 [Repealed, 1993 c 206 s 25]

144.1212 NOTICE TO PATIENT; MAMMOGRAM RESULTS.

Subdivision 1. **Definition.** For purposes of this section, "facility" has the meaning provided in United States Code, title 42, section 263b(a)(3)(A).

Subd. 2. **Required notice.** A facility at which a mammography examination is performed shall, if a patient is categorized by the facility as having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology, include in the summary of the written report that is sent to the patient, as required by the federal Mammography Quality Standards Act, United States Code, title 42, section 263b, notice that the patient has dense breast tissue, that this may make it more difficult to detect cancer on a mammogram, and that it may increase her risk of breast cancer. The following language may be used:

"Your mammogram shows that your breast tissue is dense. Dense breast tissue is relatively common and is found in more than 40 percent of women. However, dense breast tissue may make it more difficult to identify precancerous lesions or cancer through a mammogram and may also be associated with an increased risk of breast cancer. This information about the results of your mammogram is given to you to raise your own awareness and to help inform your conversations with your treating clinician who has received

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a report of your mammogram results. Together you can decide which screening options are right for you based on your mammogram results, individual risk factors, or physical examination."

History: *2014 c 291 art 6 s 2*

144.1215 AUTHORIZATION TO USE HANDHELD DENTAL X-RAY EQUIPMENT.

Subdivision 1. **Definition; handheld dental x-ray equipment.** For purposes of this section, "handheld dental x-ray equipment" means x-ray equipment that is used to take dental radiographs, is designed to be handheld during operation, and is operated by an individual authorized to take dental radiographs under chapter 150A.

Subd. 2. **Use authorized.** (a) Handheld dental x-ray equipment may be used if the equipment:

(1) has been approved for human use by the United States Food and Drug Administration and is being used in a manner consistent with that approval; and

(2) utilizes a backscatter shield that:

(i) is composed of a leaded polymer or a substance with a substantially equivalent protective capacity;

(ii) has at least 0.25 millimeters of lead or lead-shielding equivalent; and

(iii) is permanently affixed to the handheld dental x-ray equipment.

(b) The use of handheld dental x-ray equipment is prohibited if the equipment's backscatter shield is broken or not permanently affixed to the system.

(c) The use of handheld dental x-ray equipment shall not be limited to situations in which it is impractical to transfer the patient to a stationary x-ray system.

(d) Handheld dental x-ray equipment must be stored when not in use, by being secured in a restricted, locked area of the facility.

(e) Handheld dental x-ray equipment must be calibrated initially and at intervals that must not exceed 24 months. Calibration must include the test specified in Minnesota Rules, part 4732.1100, subpart 11.

(f) Notwithstanding Minnesota Rules, part 4732.0880, subpart 2, item C, the tube housing and the position-indicating device of handheld dental x-ray equipment may be handheld during an exposure.

Subd. 3. **Exemptions from certain shielding requirements.** Handheld dental x-ray equipment used according to this section and according to manufacturer instructions is exempt from the following requirements for the equipment:

(1) shielding requirements in Minnesota Rules, part 4732.0365, item B; and

(2) requirements for the location of the x-ray control console or utilization of a protective barrier in Minnesota Rules, part 4732.0800, subpart 2, item B, subitems (2) and (3), provided the equipment utilizes a backscatter shield that satisfies the requirements in subdivision 2, paragraph (a), clause (2).

Subd. 4. **Compliance with rules.** A registrant using handheld dental x-ray equipment shall otherwise comply with Minnesota Rules, chapter 4732.

History: *1Sp2017 c 6 art 10 s 58*

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FEES, LICENSES, PERMITS

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 Management and Budget. 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 generated 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	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018, and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020.

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

Outpatient surgical centers	$3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

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Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(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: *1974 c 471 s 1; 1975 c 310 s 36; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1987 c 403 art 2 s 7; 1989 c 209 art 1 s 14; 1989 c 282 art 1 s 16; 1992 c 513 art 6 s 1; 1Sp1993 c 1 art 9 s 18; 1995 c 207 art 9 s 4; 1996 c 451 art 4 s 5; 1Sp2001 c 9 art 1 s 30; 2002 c 379 art 1 s 113; 2005 c 56 s 1; 2005 c 85 s 1; 1Sp2005 c 4 art 6 s 7; 2007 c 140 art 12 s 3; 2009 c 79 art 4 s 8; 2009 c 101 art 2 s 109; 1Sp2017 c 6 art 10 s 59*

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POOLS; ENCLOSED SPORTS ARENAS

144.1222 PUBLIC POOLS; ENCLOSED SPORTS ARENAS.

Subdivision 1. **Public pools.** The commissioner of health shall be responsible for the adoption of rules and enforcement of applicable laws and rules relating to the operation, maintenance, design, installation, and construction of public pools and facilities related to them. The commissioner shall adopt rules governing the collection of fees under section 144.122 to cover the cost of pool construction plan review, monitoring, and inspections.

Subd. 1a. **Fees.** All plans and specifications for public pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. All public pool construction plans submitted for review after January 1, 2009, must be certified by a professional engineer registered in the state of Minnesota. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each pool, $1,500;

(2) each spa pool, $800;

(3) each slide, $600;

(4) projects valued at $250,000 or more, the greater of the sum of the fees in clauses (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum fee of $15,000;

(5) alterations to an existing pool without changing the size or configuration of the pool, $600;

(6) removal or replacement of pool disinfection equipment only, $100; and

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

Subd. 1b. **Public pool construction.** For all public pools constructed after January 1, 2009, without a gravity outlet or drain, each pump must be connected to at least two suction outlets, connected in parallel with suction outlet covers that meet ASME/ANSI standards.

Subd. 1c. **Public pools; required equipment.** (a) Beginning January 1, 2009, all public pools with the deepest water being less than four feet deep must have:

(1) an unblockable suction outlet or drain;

(2) at least two suction outlets, connected in parallel with suction outlet covers that meet ASME/ANSI standards; or

(3) a gravity outlet or drain.

(b) Beginning January 1, 2011, all other existing public pools must have:

(1) an unblockable suction outlet or drain;

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(2) at least two suction outlets, connected in parallel with suction outlet covers that meet ASME/ANSI standards;

(3) a gravity outlet or drain; or

(4) any other system determined by the commissioner to be equally effective as, or better than, the systems listed in this paragraph at preventing or eliminating the risk of injury or death associated with pool drainage systems.

(c) By June 1, 2008, all drain covers and grates must be installed with screws that meet the manufacturer's specifications.

(d) By July 1, 2008, and annually thereafter, all public pool owners must certify to the commissioner on a form prescribed by the commissioner that:

(1) all outlets except for unblockable drains are equipped with covers that have been stamped by the manufacturer that they are in compliance with ASME/ANSI standards; and

(2) all covers and grates, including mounting rings, have been inspected to ensure that they have been properly installed and are not broken or loose.

Subd. 1d. **Safety inspections.** (a) The pool operator is required to conduct a physical inspection of the drain covers and grates on a daily basis. The record required under Minnesota Rules, part 4717.0750, must indicate that this inspection was completed every day the pool is open for use.

(b) If at any time an outlet cover or grate is missing, broken, or loose, the pool must be closed immediately. The pool must not be reopened until the missing or broken cover or grate has been replaced according to the manufacturer's specifications, or the loose cover or grate has been reattached to the manufacturer's specifications.

Subd. 2. **Pools used for treatment or therapy.** A pool used by a medical or rehabilitation facility to facilitate treatment or therapy, to which only authorized access is allowed and which is not open for any other public use, is exempt from the requirements of Minnesota Rules, part 4717.1050, regarding warning signs, and Minnesota Rules, part 4717.1650, subpart 1, regarding placards.

Subd. 2a. **Portable wading pools at family day care or group family day care homes.** A portable wading pool that is located at a family day care or group family day care home licensed under Minnesota Rules, chapter 9502, or at a home at which child care services are provided under section 245A.03, subdivision 2, paragraph (a), clause (2), shall be defined as a private residential pool and not as a public pool for purposes of public swimming pool regulations under Minnesota Rules, chapter 4717, provided that the portable wading pool has a maximum depth of 24 inches and is capable of being manually emptied and moved.

Subd. 2b. **Swimming pools at family day care or group family day care homes.** Notwithstanding Minnesota Rules, part 4717.0250, subpart 8, a swimming pool that is located at a family day care or group family day care home licensed under Minnesota Rules, chapter 9502, shall not be considered a public pool, and is exempt from the requirements for public pools in Minnesota Rules, parts 4717.0150 to 4717.3975. If the provider chooses to allow children cared for at the family day care or group family day care home to use the swimming pool located at the home, the provider must satisfy the requirements in section 245A.14, subdivision 11.

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Subd. 2c. **Pools used for adult-only recreation.** Notwithstanding Minnesota Rules, part 4717.1850, a pool with a zero-depth area may be used without a lifeguard present if access to the pool area is prohibited to individuals under the age of 18 years during the time a lifeguard is not present.

Subd. 2d. **Hot tubs on rental houseboats.** (a) A hot water pool intended for seated recreational use, including a hot tub or whirlpool, that is located on a houseboat that is rented to the public is not a public pool and is exempt from the requirements for public pools under Minnesota Rules, chapter 4717.

(b) A hot water pool under this subdivision must be conspicuously posted with the following notice to renters:

"NOTICE

This spa is exempt from state and local sanitary requirements that prevent disease transmission.

USE AT YOUR OWN RISK

This notice is required under Minnesota Statutes, section 144.1222, subdivision 2d."

Subd. 3. **Enclosed sports arenas.** The commissioner of health shall be responsible for the adoption of rules and enforcement of applicable laws and rules relating to indoor air quality in the operation and maintenance of enclosed sports arenas.

Subd. 4. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ASME/ANSI standard" means a safety standard accredited by the American National Standards Institute and published by the American Society of Mechanical Engineers.

(c) "ASTM standard" means a safety standard issued by ASTM International, formerly known as the American Society for Testing and Materials.

(d) "Public pool" means any pool other than a private residential pool, that is: (1) open to the public generally, whether for a fee or free of charge; (2) open exclusively to members of an organization and their guests; (3) open to residents of a multiunit apartment building, apartment complex, residential real estate development, or other multifamily residential area; (4) open to patrons of a hotel or lodging or other public accommodation facility; or (5) operated by a person in a park, school, licensed child care facility, group home, motel, camp, resort, club, condominium, manufactured home park, or political subdivision with the exception of swimming pools at family day care homes licensed under section 245A.14, subdivision 11, paragraph (a).

(e) "Unblockable suction outlet or drain" means a drain of any size and shape that a human body cannot sufficiently block to create a suction entrapment hazard and meets ASME/ANSI standards.

Subd. 5. **Exemptions.** (a) A public swimming pond in existence before January 1, 2008, is not a public pool for purposes of this section and section 157.16, and is exempt from the requirements for public swimming pools under Minnesota Rules, chapter 4717.

(b) A naturally treated swimming pool located in the city of Minneapolis is not a public pool for purposes of this section and section 157.16, and is exempt from the requirements for public swimming pools under Minnesota Rules, chapter 4717.

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(c) Notwithstanding paragraphs (a) and (b), a public swimming pond and a naturally treated swimming pool must meet the requirements for public pools described in subdivisions 1c and 1d.

(d) For purposes of this subdivision, a "public swimming pond" means an artificial body of water contained within a lined, sand-bottom basin, intended for public swimming, relaxation, or recreational use that includes a water circulation system for maintaining water quality and does not include any portion of a naturally occurring lake or stream.

(e) For purposes of this subdivision, a "naturally treated swimming pool" means an artificial body of water contained in a basin, intended for public swimming, relaxation, or recreational use that uses a chemical free filtration system for maintaining water quality through natural processes, including the use of plants, beneficial bacteria, and microbes.

History: *1995 c 165 s 1; 2002 c 279 s 5; 2002 c 333 s 1; 1Sp2003 c 14 art 7 s 25; 2005 c 50 s 1; 2005 c 130 s 1; 2008 c 328 s 2-7; 2009 c 79 art 10 s 4; 2011 c 83 s 1; 2012 c 247 art 2 s 2; 2012 c 253 art 4 s 1; 2016 c 158 art 1 s 52*

DIAGNOSTIC IMAGING

144.1225 ADVANCED DIAGNOSTIC IMAGING SERVICES.

Subdivision 1. **Definition.** For purposes of this section, "advanced diagnostic imaging services" has the meaning given in United States Code, title 42, section 1395M, except that it does not include x-ray, ultrasound, or fluoroscopy.

Subd. 2. **Accreditation required.** (a)(1) Except as otherwise provided in paragraphs (b) and (c), advanced diagnostic imaging services eligible for reimbursement from any source, including, but not limited to, the individual receiving such services and any individual or group insurance contract, plan, or policy delivered in this state, including, but not limited to, private health insurance plans, workers' compensation insurance, motor vehicle insurance, the State Employee Group Insurance Program (SEGIP), and other state health care programs, shall be reimbursed only if the facility at which the service has been conducted and processed is licensed pursuant to sections 144.50 to 144.56 or accredited by one of the following entities:

(i) American College of Radiology (ACR);

(ii) Intersocietal Accreditation Commission (IAC);

(iii) the Joint Commission; or

(iv) other relevant accreditation organization designated by the Secretary of the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1395M.

(2) All accreditation standards recognized under this section must include, but are not limited to:

(i) provisions establishing qualifications of the physician;

(ii) standards for quality control and routine performance monitoring by a medical physicist;

(iii) qualifications of the technologist, including minimum standards of supervised clinical experience;

(iv) guidelines for personnel and patient safety; and

(v) standards for initial and ongoing quality control using clinical image review and quantitative testing.

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(b) Any facility that performs advanced diagnostic imaging services and is eligible to receive reimbursement for such services from any source in paragraph (a), clause (1), must obtain licensure pursuant to sections 144.50 to 144.56 or accreditation pursuant to paragraph (a) by August 1, 2013. Thereafter, all facilities that provide advanced diagnostic imaging services in the state must obtain licensure or accreditation within six months of commencing operations and must maintain either licensure pursuant to sections 144.50 to 144.56 or accreditation with an accrediting organization as provided in paragraph (a).

(c) Dental clinics or offices that perform diagnostic imaging through dental cone beam computerized tomography do not need to meet the accreditation or reporting requirements in this section.

Subd. 3. **Reporting.** (a) Advanced diagnostic imaging facilities and providers of advanced diagnostic imaging services must annually report to the commissioner demonstration of accreditation as required under this section.

(b) The commissioner may promulgate any rules necessary to administer the reporting required under paragraph (a).

History: *2012 c 228 s 1; 2012 c 247 art 2 s 3; 2013 c 8 s 1; 2014 c 291 art 6 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 may enter into a contractual agreement to recover costs incurred for analysis for diagnostic purposes for each specimen submitted to the Department of Health by any hospital, laboratory, clinic, or physician. The commissioner shall not charge 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. Funds generated in a contractual agreement made pursuant to this section shall be deposited in a special account and are appropriated to the commissioner for purposes of providing the services specified in the contracts. All such contractual agreements shall be processed in accordance with the provisions of chapter 16C.

Subd. 2. [Repealed, 2013 c 108 art 12 s 109]

History: *1979 c 49 s 1; 1982 c 424 s 130; 1987 c 403 art 2 s 8; 1992 c 513 art 6 s 2; 1Sp1993 c 1 art 9 s 19; 2007 c 147 art 16 s 6; 2013 c 108 art 12 s 13,109*

NEWBORN TESTS FOR MEDICAL CONDITIONS

144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL DISORDERS.

Subdivision 1. **Duty to perform testing.** (a) 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.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

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(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be $135 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

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 14.386 do not apply.

Subd. 3. **Information provided to parents and legal guardians.** (a) The department shall make information and forms available to childbirth education programs and health care providers who provide prenatal care describing the newborn screening program and the provisions of this section to be used in a discussion with expectant parents and parents of newborns. The department shall promote the materials describing the newborn screening program and encourage providers and education programs to thoroughly discuss the program with expectant parents and parents with newborns. The department shall make information and forms about newborn screening available to the persons with a duty to perform testing under this section and to expectant parents and parents of newborns using electronic and other means.

(b) Prior to collecting a sample, persons with a duty to perform testing under subdivision 1 must:

(1) provide parents or legal guardians of infants with a document that provides the following information:

(i) the benefits of newborn screening;

(ii) that the blood sample will be used to test for heritable and congenital disorders, as determined under subdivision 2;

(iii) the data that will be collected as part of the testing;

(iv) the benefits associated with the department's storage of an infant's blood sample and test results;

(v) that the Department of Health may store the blood samples and test results unless the parents or legal guardians elect to not have them stored;

(vi) that blood samples and test results will be used for program operations in accordance with subdivision 5, unless the parents or legal guardians elect not to have the blood samples and test results stored, in which case the blood samples and test results will be destroyed in accordance with subdivision 8, paragraph (b), and until destroyed will only be used for program operations described under subdivision 5, paragraph (a), clauses (1) to (7);

(vii) that parents or legal guardians have a right to elect not to have newborn screening performed and a right to secure private testing;

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(viii) that parents or legal guardians have a right to elect to have the newborn screening performed, but not have the blood samples and test results stored;

(ix) that parents or legal guardians have a right to authorize in writing that the blood samples and test results may be used for public health studies or research; and

(x) the Department of Health's Web site address where more information and forms may be obtained; and

(2) upon request, promptly provide parents or legal guardians of infants with forms necessary to request that the infant not have blood collected for testing or to request to have the newborn screening performed, but not have the blood samples and test results stored; and

(3) record in the infant's medical record that a parent or legal guardian of the infant has received the information provided pursuant to this subdivision and has had an opportunity to ask questions.

(c) Nothing in this section prohibits a parent or legal guardian of an infant from having newborn screening performed by a private entity.

Subd. 4. **Parental options.** (a) The parent or legal guardian of an infant otherwise subject to testing under this section may elect not to have newborn screening performed, or may elect to have newborn screening tests performed, but not to have the blood samples and test results stored.

(b) If a parent or legal guardian elects not to have newborn screening performed or elects not to allow the blood samples and test results to be stored, then the election must be recorded on a form that is signed by the parent or legal guardian. The signed form must be made part of the infant's medical record and a copy shall be provided to the Department of Health. When a parent or legal guardian elects not to have newborn screening performed, the person with the duty to perform testing under subdivision 1 must follow that election. A written election to decline testing exempts persons with a duty to perform testing and the Department of Health from the requirements of this section and section 144.128.

Subd. 5. **Newborn screening program operations.** (a) "Newborn screening program operations" means actions, testing, and procedures directly related to the operation of the newborn screening program, limited to the following:

(1) confirmatory testing;

(2) laboratory quality control assurance and improvement;

(3) calibration of equipment;

(4) evaluating and improving the accuracy of newborn screening tests for conditions approved for screening in Minnesota;

(5) validation of equipment and screening methods;

(6) continuity of operations to ensure testing can continue as required by Minnesota law in the event of an emergency;

(7) follow-up services for the cases of heritable and congenital disorders identified by newborn screening; and

(8) utilization of blood samples and test results for studies related to newborn screening, including studies used to develop new tests.

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(b) No research or public health studies other than those described in paragraph (a) shall be conducted without written consent as described under subdivision 7.

(c) Any sale of bloodspots, test results, or other data collected in the newborn screening program is strictly prohibited.

Subd. 6. [Repealed, 2014 c 203 s 8]

Subd. 7. **Parental options for additional research.** (a) The parent or legal guardian of an infant subject to testing under this section, or an individual who was tested as an infant if the individual is 18 years of age or older may authorize in writing that the infant's blood sample and test results be retained and used by the Department of Health for the purposes described in subdivision 9.

(b) The Department of Health must provide a consent form, with an attached Tennessen warning pursuant to section 13.04, subdivision 2. The consent form must provide the following:

(1) information as to the personal identification and use of samples and test results for public health studies or research not related to newborn screening;

(2) information that explains that, upon approval by the Department of Health's Institutional Review Board, blood samples and test results may be shared with external parties for public health studies or research; and

(3) information that explains that blood samples contain various components, including deoxyribonucleic acid (DNA).

Subd. 8. **Storage and use of samples and test results.** (a) Except as limited under paragraph (b), the Department of Health may store blood samples and test results, and may use the blood samples and test results in accordance with subdivision 5. If written informed consent of a parent, legal guardian, or individual is obtained under subdivision 7, the Department of Health may use the blood samples and test results in accordance with subdivision 9.

(b) If a parent, legal guardian, or individual elects against storage, or revokes prior consent for storage, the blood samples must be destroyed within 30 days after receipt of the request, and test results must be destroyed within 30 days after receipt of the request, or the earliest time allowed under Clinical Laboratory Improvement Amendments (CLIA) regulations, whichever is later. Until destroyed, the blood samples and test results may be used for program operations described under subdivision 5, paragraph (a), clauses (1) to (7).

Subd. 9. **Written, informed consent for other use of samples and test results.** With the written, informed consent of a parent or legal guardian, the Department of Health may use blood samples and test results for public health studies or research not related to newborn screening, and upon approval by the Department of Health's Institutional Review Board, share samples and test results with external parties for public health studies or research.

Subd. 10. **Revoking consent for storage and use.** A parent or legal guardian, or the individual whose blood was tested as an infant if the individual is 18 years of age or older, may revoke approval for storage or use of blood samples or test results at any time by providing a signed and dated form requesting destruction

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of the blood samples or test results. Blood samples and test results must be destroyed as specified under subdivision 8, paragraph (b).

History: *1965 c 205 s 1; 1977 c 305 s 45; 1Sp1981 c 4 art 1 s 75; 1985 c 248 s 70; 1986 c 444; 1988 c 689 art 2 s 31; 1994 c 636 art 2 s 2; 1997 c 203 art 2 s 11; 1997 c 205 s 19; 1Sp2003 c 14 art 7 s 26; 2007 c 147 art 16 s 7; 2009 c 79 art 10 s 5; 2012 c 292 art 4 s 3-10; 2013 c 108 art 12 s 14; 2013 c 125 art 1 s 30; 2014 c 203 s 1-7*

144.1251 NEWBORN SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD).

Subdivision 1. **Required testing and reporting.** (a) Each licensed hospital or state-licensed birthing center or facility that provides maternity and newborn care services shall provide screening for congenital heart disease to all newborns prior to discharge using pulse oximetry screening. The screening must occur after the infant is 24 hours old, before discharge from the nursery. If discharge occurs before the infant is 24 hours old, the screening must occur as close as possible to the time of discharge.

(b) For premature infants (less than 36 weeks of gestation) and infants admitted to a higher-level nursery (special care or intensive care), pulse oximetry must be performed when medically appropriate prior to discharge.

(c) Results of the screening must be reported to the Department of Health.

Subd. 2. **Implementation.** The Department of Health shall:

(1) communicate the screening protocol requirements;

(2) make information and forms available to the hospitals, birthing centers, and other facilities that are required to provide the screening; health care providers who provide prenatal care and care to newborns; and expectant parents and parents of newborns. The information and forms must include screening protocol and reporting requirements and parental options;

(3) provide training to ensure compliance with and appropriate implementation of the screening;

(4) establish the mechanism for the required data collection and reporting of screening and follow-up diagnostic results to the Department of Health according to the Department of Health's recommendations;

(5) coordinate the implementation of universal standardized screening;

(6) act as a resource for providers as the screening program is implemented, and in consultation with the Advisory Committee on Heritable and Congenital Disorders, develop and implement policies for early medical and developmental intervention services and long-term follow-up services for children and their families identified with a CCHD; and

(7) comply with sections 144.125 to 144.128.

History: *2013 c 108 art 12 s 15*

144.1255 HERITABLE AND CONGENITAL DISORDERS.

Subdivision 1. **Creation and membership.** (a) By July 1, 2003, the commissioner of health shall appoint an advisory committee to provide advice and recommendations to the commissioner concerning tests and treatments for heritable and congenital disorders found in newborn children. Membership of the committee shall include, but not be limited to, at least one member from each of the following representative groups:

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(1) parents and other consumers;

(2) primary care providers;

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

(4) genetic counselors;

(5) birth hospital representatives;

(6) newborn screening laboratory professionals;

(7) nutritionists; and

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

(b) The terms and removal of members are governed by section 15.059. Members shall not receive per diems but shall be compensated for expenses.

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

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

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

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

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

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

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

History: *1Sp2003 c 14 art 7 s 27; 2014 c 286 art 8 s 16*

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

144.128 COMMISSIONER'S DUTIES.

(a) The commissioner shall:

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

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

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

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(4) prepare a separate form for use by parents or by adults who were tested as minors to direct that blood samples or test results be destroyed;

(5) comply with a destruction request as described in section 144.125;

(6) notify individuals who request destruction of samples and test results that the samples and test results have been destroyed and the date of destruction; and

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

(b) Nothing in sections 144.125 to 144.128 shall exempt the commissioner from the requirements of the genetic privacy act in section 13.386 or from the penalties for a violation of the genetic privacy act as provided in chapter 13.

History: *1Sp1985 c 9 art 2 s 10; 1991 c 36 s 2; 1Sp2003 c 14 art 7 s 28; 2006 c 253 s 9; 2012 c 292 art 4 s 11*

144.13 [Renumbered 144.111]

PUBLIC HEALTH MEASURES

144.14 QUARANTINE OF INTERSTATE CARRIERS.

When necessary the commissioner may establish and enforce a system of quarantine against the introduction into the state of any plague or other communicable disease by common carriers doing business across its borders. Its members, officers, and agents may board any conveyance used by such carriers to inspect the same and, if such conveyance be found infected, may detain the same and isolate and quarantine any or all persons found thereon, with their luggage, until all danger of communication of disease therefrom is removed.

History: *(5347) RL s 2133; 1977 c 305 s 45*

144.145 FLUORIDATION OF MUNICIPAL WATER SUPPLIES.

For the purpose of promoting public health through prevention of tooth decay, the person, firm, corporation, or municipality having jurisdiction over a municipal water supply, whether publicly or privately owned or operated, shall control the quantities of fluoride in the water so as to maintain a fluoride content prescribed by the state commissioner of health. In the manner provided by law, the state commissioner of health shall promulgate rules relating to the fluoridation of public water supplies which shall include, but not be limited to the following: (1) the means by which fluoride is controlled; (2) the methods of testing the fluoride content; and (3) the records to be kept relating to fluoridation. The state commissioner of health shall enforce the provisions of this section. In so doing the commissioner shall require the fluoridation of water in all municipal water supplies on or before January 1, 1970. The state commissioner of health shall not require the fluoridation of water in any municipal water supply where such water supply in the state of nature contains sufficient fluorides to conform with the rules of such commissioner.

History: *1967 c 603 s 1; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444*

144.146 Subdivision 1. [Repealed, 2014 c 192 art 4 s 3]

Subd. 2. [Repealed, 1978 c 762 s 9]

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SUMMER HEALTH CARE INTERNS

144.1464 SUMMER HEALTH CARE INTERNS.

Subdivision 1. **Summer internships.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants, within available appropriations, to hospitals, clinics, nursing facilities, and home care providers to establish a secondary and postsecondary summer health care intern program. The purpose of the program is to expose interested secondary and postsecondary pupils to various careers within the health care profession.

Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall award grants to hospitals, clinics, nursing facilities, and home care providers that agree to:

(1) provide secondary and postsecondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and postsecondary summer health care interns;

(3) pay one-half the costs of employing the secondary and postsecondary summer health care intern;

(4) interview and hire secondary and postsecondary pupils for a minimum of six weeks and a maximum of 12 weeks; and

(5) employ at least one secondary student for each postsecondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital, clinic, nursing facility, or home care provider, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school; and

(2) be from a school district in proximity to the facility.

(c) In order to be eligible to be hired as a postsecondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility.

(d) Hospitals, clinics, nursing facilities, and home care providers awarded grants may employ pupils as secondary and postsecondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. **Grants.** The commissioner, through the organization under contract, shall award separate grants to hospitals, clinics, nursing facilities, and home care providers meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital, clinic, nursing facility, or home care setting during the course of the program. No more than 50 percent of the participants may be postsecondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary

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or postsecondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. **Contract.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and postsecondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

History: *1992 c 499 art 7 s 9; 1993 c 345 art 11 s 1; 1993 c 366 s 28,29; 1994 c 625 art 12 s 2; 1995 c 234 art 8 s 29-31; 1Sp2001 c 9 art 1 s 31; 2002 c 370 art 1 s 113; 1Sp2011 c 9 art 2 s 13*

RURAL HOSPITAL GRANTS

144.1465 FINDING AND PURPOSE.

The legislature finds that rural hospitals are an integral part of the health care delivery system and are fundamental to the development of a sound rural economy. The legislature further finds that access to rural health care must be assured to all Minnesota residents. The rural health care system is undergoing a restructuring that threatens to jeopardize access in rural areas to quality health services. To assure continued rural health care access the legislature proposes to establish a grant program to assist rural hospitals and their communities with the development of strategic plans and transition projects, provide subsidies for geographically isolated hospitals facing closure, and examine the problem of recruitment and retention of rural physicians, nurses, and other allied health care professionals.

History: *1990 c 568 art 2 s 6*

144.147 RURAL HOSPITAL PLANNING AND TRANSITION GRANT PROGRAM.

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

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

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

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

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

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

(3) an implementation plan.

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

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

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

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

(2) changes in service populations;

(3) availability and upgrading of ambulatory and emergency services;

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

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

(6) the extent of community support;

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

(8) the financial condition of the hospital.

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

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

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

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

(1) Description of the problem, description of the project, and the likelihood of successful outcome of the project. The applicant must explain clearly the nature of the health services problems in their service

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area, how the grant funds will be used, what will be accomplished, and the results expected. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations.

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

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

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

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

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

Subd. 5. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program. The commissioner may collect, from the hospital, and communities receiving grants, quarterly progress reports to evaluate the grant program. Information related to the financial condition of individual hospitals shall be classified as nonpublic data.

History: *1990 c 568 art 2 s 7; 1992 c 549 art 5 s 4-6; 1993 c 247 art 5 s 11; 1993 c 345 art 10 s 1; 1995 c 234 art 8 s 32; 1997 c 225 art 2 s 48-51; 1999 c 247 s 2-5; 2001 c 171 s 2; 1Sp2005 c 4 art 6 s 8,9*

144.1475 [Repealed, 2014 c 192 art 4 s 3]

RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM

144.1476 RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM.

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

(b) "Eligible rural community" means:

(1) a Minnesota community that is located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041; or

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(2) a Minnesota community that has a population of less than 10,000, according to the United States Bureau of Statistics, and that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(c) "Health care provider" means a hospital, clinic, pharmacy, long-term care institution, or other health care facility that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

(d) "Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.

(e) "Pharmacy" has the meaning given under section 151.01, subdivision 2.

Subd. 2. **Grants authorized; eligibility.** (a) The commissioner of health shall establish a program to award grants to eligible rural communities or health care providers in eligible rural communities for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist according to sections 151.01 to 151.40.

(b) To be eligible for a grant, an applicant must develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. At a minimum, a strategic plan must consist of:

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

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

(3) an implementation plan.

(c) A grant may be used by a recipient that has developed a strategic plan to implement transition projects to modify the type and extent of pharmacy services provided, in order to reflect the needs of the community. Grants may also be used by recipients:

(1) to develop pharmacy practices that integrate pharmacy and existing health care provider facilities; or

(2) to establish a pharmacy provider cooperative or initiatives that maintain local access to prescription medications and the skills of a pharmacist.

Subd. 3. **Consideration of grants.** In determining which applicants shall receive grants under this section, the commissioner of health shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues including, but not limited to, two rural pharmacists with a community pharmacy background, two health care providers from rural communities, one representative from a statewide pharmacist organization, and one representative of the Board of Pharmacy. A representative of the commissioner may serve on the committee in an ex officio status. In determining who shall receive a grant, the committee shall take into account:

(1) improving or maintaining access to prescription medications and the skills of a pharmacist;

(2) changes in service populations;

(3) the extent community pharmacy needs are not currently met by other providers in the area;

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(4) the financial condition of the applicant;

(5) the integration of pharmacy services into existing health care services; and

(6) community support.

The commissioner may also take into account other relevant factors.

Subd. 4. **Allocation of grants.** (a) The commissioner shall establish a deadline for receiving applications and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year.

(b) Any grant awarded must not exceed $50,000 a year. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until expended by the grantee.

(c) Applicants may apply to the program each year they are eligible.

(d) Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

Subd. 5. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program and may collect progress reports and other information from grantees needed for program evaluation. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a grantee or the commissioner. The commissioner shall compile summaries of successful grant projects and other model community efforts to preserve access to prescription medications and the skills of a pharmacist, and make this information available to Minnesota communities seeking to address local pharmacy issues.

History: *1Sp2005 c 4 art 6 s 10; 2006 c 282 art 16 s 2*

RURAL HOSPITAL GRANT PROGRAM

144.148 RURAL HOSPITAL CAPITAL IMPROVEMENT GRANT PROGRAM.

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

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital, including establishing an electronic health records system.

Subd. 2. **Program.** (a) The commissioner of health shall award rural hospital capital improvement grants to eligible rural hospitals. Except as provided in paragraph (b), a grant shall not exceed $500,000 per hospital. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-quarter of the grant amount, which may include in-kind services, is available for the same purposes from nonstate

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resources. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until expended by the grantee.

(b) A grant shall not exceed $1,500,000 per eligible rural hospital that also satisfies the following criteria:

(1) is the only hospital in a county;

(2) has 25 or fewer licensed hospital beds with a net hospital operating margin not greater than an average of two percent over the three fiscal years prior to application;

(3) is located in a medically underserved community (MUC) or a health professional shortage area (HPSA);

(4) is located near a migrant worker employment site and regularly treats significant numbers of migrant workers and their families; and

(5) has not previously received a grant under this section prior to July 1, 1999.

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

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the hospital's application is complete and whether the hospital and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning: a maximum of 40 points for an applicant's clarity and thoroughness in describing the problem and the project; a maximum of 40 points for the extent to which the applicant has demonstrated that it has made adequate provisions to assure proper and efficient operation of the facility once the project is completed; and a maximum of 20 points for the extent to which the proposed project is consistent with the hospital's capital improvement plan or strategic plan. The commissioner may also take into account other relevant factors. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible rural hospital based on the relative score of each eligible hospital's application and the funds available to the commissioner. The grant shall be used to update, remodel, or replace aging facilities and equipment necessary to maintain the operations of the hospital. The commissioner may collect, from the hospitals receiving grants, any information necessary to evaluate the program.

Subd. 6. [Repealed by amendment, 1999 c 245 art 2 s 21]

Subd. 7. [Repealed by amendment, 1999 c 245 art 2 s 21]

Subd. 8. [Repealed, 1Sp2001 c 9 art 1 s 62]

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Subd. 9. **Status of previous awards.** The commissioner must regard grants or loans awarded to eligible rural hospitals before August 1, 1999, as grants subject to the conditions of this section and not subject to repayment as loans under Minnesota Statutes 1998, section 144.148.

History: *1997 c 225 art 2 s 53; 1999 c 245 art 2 s 21; 2001 c 171 s 3; 1Sp2001 c 9 art 1 s 32; 2002 c 375 art 3 s 5; 2002 c 379 art 1 s 113; 2004 c 231 s 1; 1Sp2005 c 4 art 6 s 11*

RURAL AND URBAN HEALTH; HEALTH PROFESSIONS PROGRAMS

144.1481 RURAL HEALTH ADVISORY COMMITTEE.

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

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

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

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

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

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

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

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

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

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

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

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

Subd. 2. **Duties.** The advisory committee shall:

(1) advise the commissioner and other state agencies on rural health issues;

(2) provide a systematic and cohesive approach toward rural health issues and rural health care planning, at both a local and statewide level;

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(3) develop and evaluate mechanisms to encourage greater cooperation among rural communities and among providers;

(4) recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities; and

(5) develop methods for identifying individuals who are underserved by the rural health care system.

Subd. 3. **Staffing; office space; equipment.** The commissioner shall provide the advisory committee with staff support, office space, and access to office equipment and services.

History: *1992 c 549 art 5 s 7; 1993 c 247 art 5 s 12; 2001 c 161 s 20; 1Sp2003 c 14 art 7 s 29; 2014 c 286 art 8 s 17; 2016 c 119 s 7*

144.1482 OFFICE OF RURAL HEALTH.

Subdivision 1. **Duties.** The Office of Rural Health in conjunction with the University of Minnesota medical schools and other organizations in the state which are addressing rural health care problems shall:

(1) establish and maintain a clearinghouse for collecting and disseminating information on rural health care issues, research findings, and innovative approaches to the delivery of rural health care;

(2) coordinate the activities relating to rural health care that are carried out by the state to avoid duplication of effort;

(3) identify federal and state rural health programs and provide technical assistance to public and nonprofit entities, including community and migrant health centers, to assist them in participating in these programs;

(4) assist rural communities in improving the delivery and quality of health care in rural areas and in recruiting and retaining health professionals; and

(5) carry out the duties assigned in section 144.1483.

Subd. 2. **Contracts.** To carry out these duties, the office may contract with or provide grants to public and private, nonprofit entities.

History: *1992 c 549 art 5 s 8*

144.1483 RURAL HEALTH INITIATIVES.

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

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

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

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

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

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

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

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

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

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

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

History: *1992 c 549 art 5 s 9; 1995 c 212 art 3 s 59; 1998 c 257 s 1; 1999 c 245 art 2 s 22; 2001 c 171 s 4; 1Sp2003 c 14 art 7 s 30; 2005 c 107 art 2 s 60; 1Sp2005 c 4 art 6 s 12*

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

144.1485 DATABASE ON HEALTH PERSONNEL.

(a) The commissioner of health shall develop and maintain a database on health services personnel. The commissioner shall use this information to assist local communities and units of state government to develop plans for the recruitment and retention of health personnel. Information collected in the database must include, but is not limited to, data on levels of educational preparation, specialty, and place of employment. The commissioner may collect information through the registration and licensure systems of the state health licensing boards.

(b) Health professionals who report their practice or place of employment address to the commissioner of health under section 144.052 may request in writing that their practice or place of employment address be classified as private data on individuals, as defined in section 13.02, subdivision 12. The commissioner shall grant the classification upon receipt of a signed statement by the health professional that the classification

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is required for the safety of the health professional, if the statement also provides a valid, existing address where the health professional consents to receive service of process. The commissioner shall use the mailing address in place of the practice or place of employment address in all documents available to the general public. The practice or place of employment address and any information provided in the classification request, other than the mailing address, are private data on individuals and may be provided to other state agencies. The practice or place of employment address may be used to develop summary reports that show in aggregate the distribution of health care providers in Minnesota.

History: *1992 c 549 art 5 s 11; 1994 c 625 art 8 s 39*

144.1486 [Repealed, 1Sp2005 c 4 art 6 s 58]

144.1487 [Repealed, 2013 c 43 s 32]

144.1488 [Repealed, 2013 c 43 s 32]

144.1489 [Repealed, 2013 c 43 s 32]

144.1490 [Repealed, 2013 c 43 s 32]

144.1491 [Repealed, 2013 c 43 s 32]

144.1492 STATE RURAL HEALTH NETWORK REFORM INITIATIVE.

Subdivision 1. **Purpose and matching funds.** The commissioner of health shall apply for federal grant funding under the State Rural Health Network Reform Initiative, a Health Care Financing Administration program to provide grant funds to states to encourage innovations in rural health financing and delivery systems. The commissioner may use state funds appropriated to the Department of Health for the provision of technical assistance for community integrated service network development as matching funds for the federal grant.

Subd. 2. **Use of federal funds.** If the Department of Health receives federal funding under the State Rural Health Network Reform Initiative, the department shall use these funds to implement a program to provide technical assistance and grants to rural communities to establish health care networks and to develop and test a rural health network reform model.

Subd. 3. **Eligible applicants and criteria for awarding of grants to rural communities.** (a) Funding which the department receives to award grants to rural communities to establish health care networks shall be awarded through a request for proposals process. Planning grant funds may be used for community facilitation and initial network development activities including incorporation as a nonprofit organization or cooperative, assessment of network models, and determination of the best fit for the community. Implementation grant funds can be used to enable incorporated nonprofit organizations and cooperatives to purchase technical services needed for further network development such as legal, actuarial, financial, marketing, and administrative services.

(b) In order to be eligible to apply for a planning or implementation grant under the federally funded health care network reform program, an organization must be located in a rural area of Minnesota excluding the seven-county Twin Cities metropolitan area and the census-defined urbanized areas of Duluth, Rochester, St. Cloud, and Moorhead. The proposed network organization must also meet or plan to meet the criteria for a community integrated service network.

(c) In determining which organizations will receive grants, the commissioner may consider the following factors:

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(1) the applicant's description of their plans for health care network development, their need for technical assistance, and other technical assistance resources available to the applicant. The applicant must clearly describe the service area to be served by the network, how the grant funds will be used, what will be accomplished, and the expected results. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations;

(2) the extent of community support for the applicant and the health care network. The applicant should demonstrate support from private and public health care providers in the service area and local community and government leaders. Evidence of such support may include a commitment of financial support, in-kind services, or cash, for development of the network;

(3) the size and demographic characteristics of the population in the service area for the proposed network and the distance of the service area from the nearest metropolitan area; and

(4) the technical assistance resources available to the applicant from nonstate sources and the financial ability of the applicant to purchase technical assistance services with nonstate funds.

History: *1994 c 625 art 8 s 41; 1999 c 245 art 2 s 23*

144.1493 NURSING GRANT PROGRAM.

Subdivision 1. **Establishment.** A nursing grant program is established under the supervision of the commissioner of health and the administration of the Metropolitan Healthcare Foundation's Project LINC to provide grants to Minnesota health care facility employees seeking to complete a baccalaureate or master's degree in nursing.

Subd. 2. **Responsibility of Metropolitan Healthcare Foundation's Project LINC.** The Metropolitan Healthcare Foundation's Project LINC shall administer the grant program and award grants to eligible health care facility employees. To be eligible to receive a grant, a person must be:

(1) an employee of a health care facility located in Minnesota, whom the facility has recommended to the Metropolitan Healthcare Foundation's Project LINC for consideration;

(2) working part time, up to 32 hours per pay period, for the health care facility, while maintaining full salary and benefits;

(3) enrolled full time in a Minnesota school or college of nursing to complete a baccalaureate or master's degree in nursing; and

(4) a resident of the state of Minnesota.

The grant must be awarded for one academic year but is renewable for a maximum of six semesters or nine quarters of full-time study, or their equivalent. The grant must be used for tuition, fees, and books. Priority in awarding grants shall be given to persons with the greatest financial need. The health care facility may require its employee to commit to a reasonable postprogram completion of employment at the health care facility as a condition for the financial support the facility provides.

Subd. 3. **Responsibility of commissioner.** The commissioner shall distribute money each year to the Metropolitan Healthcare Foundation's Project LINC to be used to award grants under this section, provided that the commissioner shall not distribute the money unless the Metropolitan Healthcare Foundation's Project LINC matches the money with an equal amount from nonstate sources. The Metropolitan Healthcare Foundation's Project LINC shall expend nonstate money prior to expending state money and shall return to the commissioner all state money not used each year for nursing program grants to be redistributed under

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this section. The Metropolitan Healthcare Foundation's Project LINC shall report to the commissioner on its program activity as requested by the commissioner.

History: *1995 c 234 art 8 s 43*

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

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

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

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

144.1498 [Repealed, 2005 c 107 art 2 s 51]

144.1499 [Repealed, 1Sp2011 c 9 art 2 s 29]

144.15 [Repealed, 1945 c 512 s 37]

144.1501 HEALTH PROFESSIONAL EDUCATION LOAN FORGIVENESS PROGRAM.

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

(b) "Advanced dental therapist" means an individual who is licensed as a dental therapist under section 150A.06, and who is certified as an advanced dental therapist under section 150A.106.

(c) "Dental therapist" means an individual who is licensed as a dental therapist under section 150A.06.

(d) "Dentist" means an individual who is licensed to practice dentistry.

(e) "Designated rural area" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

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

(g) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18.

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

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

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

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

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

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(m) "Pharmacist" means an individual with a valid license issued under chapter 151.

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

(o) "Physician assistant" means a person licensed under chapter 147A.

(p) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

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

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

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents and mental health professionals agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

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(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

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

(1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse. The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

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

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

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

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total

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amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

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

History: *1Sp2003 c 14 art 7 s 33; 2005 c 56 s 1; 2005 c 151 art 2 s 17; 1Sp2005 c 4 art 6 s 13-16; 2008 c 298 s 25; 2009 c 159 s 6; 1Sp2011 c 9 art 2 s 14; 2013 c 43 s 3; 2014 c 312 art 23 s 2; 2015 c 71 art 8 s 12-15; 1Sp2017 c 6 art 10 s 60*

144.1502 [Repealed, 1Sp2005 c 4 art 6 s 58]

144.1503 HOME AND COMMUNITY-BASED SERVICES EMPLOYEE SCHOLARSHIP PROGRAM.

Subdivision 1. **Creation.** The home and community-based services employee scholarship grant program is established for the purpose of assisting qualified provider applicants to fund employee scholarships for education in nursing and other health care fields.

Subd. 2. **Provision of grants.** The commissioner shall make grants available to qualified providers of older adult services. Grants must be used by home and community-based service providers to recruit and train staff through the establishment of an employee scholarship fund.

Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals who are 65 years of age and older in home and community-based settings, including housing with services establishments as defined in section 144D.01, subdivision 4; adult day care as defined in section 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision 3.

(b) Qualifying providers must establish a home and community-based services employee scholarship program, as specified in subdivision 4. Providers that receive funding under this section must use the funds to award scholarships to employees who work an average of at least 16 hours per week for the provider.

Subd. 4. **Home and community-based services employee scholarship program.** Each qualifying provider under this section must propose a home and community-based services employee scholarship program. Providers must establish criteria by which funds are to be distributed among employees. At a minimum, the scholarship program must cover employee costs related to a course of study that is expected to lead to career advancement with the provider or in the field of long-term care, including home care, care of persons with disabilities, or nursing.

Subd. 5. **Participating providers.** The commissioner shall publish a request for proposals in the State Register, specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit an application to the commissioner. Applications must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the organization to enhance the education of its workforce, the process for determining which employees will be eligible for scholarships, any other sources of funding for scholarships, the expected degrees or credentials eligible for scholarships, the amount of

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funding sought for the scholarship program, a proposed budget detailing how funds will be spent, and plans for retaining eligible employees after completion of their scholarship.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award for grants and make grant selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the education of its workforce, the proposed employee scholarship selection process, the applicant's proposed budget, and other criteria as determined by the commissioner. Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires.

Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report shall include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the name of the recipient, the current position of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the expected or actual program completion date. During the grant period, the commissioner may require and collect from grant recipients other information necessary to evaluate the program.

History: *2015 c 71 art 6 s 1*

144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION GRANT PROGRAM.

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

(1) "eligible advanced practice registered nurse program" means a program that is located in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education or by the Accreditation Commission for Education in Nursing, or is a candidate for accreditation;

(2) "eligible dental therapy program" means a dental therapy education program or advanced dental therapy education program that is located in Minnesota and is either:

(i) approved by the Board of Dentistry; or

(ii) currently accredited by the Commission on Dental Accreditation;

(3) "eligible mental health professional program" means a program that is located in Minnesota and is listed as a mental health professional program by the appropriate accrediting body for clinical social work, psychology, marriage and family therapy, or licensed professional clinical counseling, or is a candidate for accreditation;

(4) "eligible pharmacy program" means a program that is located in Minnesota and is currently accredited as a doctor of pharmacy program by the Accreditation Council on Pharmacy Education;

(5) "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or is a candidate for accreditation;

(6) "mental health professional" means an individual providing clinical services in the treatment of mental illness who meets one of the qualifications under section 245.462, subdivision 18; and

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(7) "project" means a project to establish or expand clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, or mental health professionals in Minnesota.

Subd. 2. **Program.** (a) The commissioner of health shall award health professional training site grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) Funds may be used for:

(1) establishing or expanding clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental health professionals in Minnesota;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and

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mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application, other relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period, the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

History: *1Sp2017 c 6 art 10 s 61*

144.1506 PRIMARY CARE RESIDENCY EXPANSION GRANT PROGRAM.

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

(1) "eligible primary care residency program" means a program that meets the following criteria:

(i) is located in Minnesota;

(ii) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and

(iii) is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation;

(2) "eligible project" means a project to establish a new eligible primary care residency program or create at least one new residency slot in an existing eligible primary care residency program; and

(3) "new residency slot" means the creation of a new residency position and the execution of a contract with a new resident in a residency program.

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited primary care residency program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new primary care resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

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Subd. 3. **Applications for expansion grants.** Eligible primary care residency programs seeking a grant shall apply to the commissioner. Applications must include the number of new primary care residency slots planned or under contract; attestation that funding will be used to support an increase in the number of available residency slots; a description of the training to be received by the new residents, including the location of training; a description of the project, including all costs associated with the project; all sources of funds for the project; detailed uses of all funds for the project; the results expected; and a plan to maintain the new residency slot after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of expansion grant applications.** The commissioner shall review each application to determine whether or not the residency program application is complete and whether the proposed new residency program and any new residency slots are eligible for a grant. The commissioner shall award grants to support up to six family medicine, general internal medicine, or general pediatrics residents; four psychiatry residents; two geriatrics residents; and two general surgery residents. If insufficient applications are received from any eligible specialty, funds may be redistributed to applications from other eligible specialties.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Appropriations made to the program do not cancel and are available until expended.

History: *2015 c 71 art 8 s 16*

144.151 Subdivision 1. [Repealed, 1978 c 699 s 17]

Subd. 2. [Repealed, 1978 c 699 s 17]

Subd. 3. [Repealed, 1978 c 699 s 17]

Subd. 4. [Repealed, 1978 c 699 s 17]

Subd. 5. [Repealed, 1978 c 699 s 17]

Subd. 6. [Repealed, 1978 c 699 s 17]

Subd. 7. [Repealed, 1978 c 699 s 17]

Subd. 8. [Repealed, 1978 c 699 s 17; 1978 c 790 s 4]

Subd. 9. [Repealed, 1978 c 699 s 17; 1978 c 790 s 4]

144.152 [Repealed, 1978 c 699 s 17]

144.153 [Repealed, 1978 c 699 s 17]

144.154 [Repealed, 1978 c 699 s 17]

144.155 [Repealed, 1978 c 699 s 17]

144.156 [Repealed, 1978 c 699 s 17]

144.157 [Repealed, 1978 c 699 s 17]

144.158 [Repealed, 1978 c 699 s 17]

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144.159 [Repealed, 1978 c 699 s 17]

144.16 [Repealed, 1945 c 512 s 37]

144.161 [Repealed, 1978 c 699 s 17]

144.162 [Repealed, 1978 c 699 s 17]

144.163 [Repealed, 1978 c 699 s 17]

144.164 [Repealed, 1978 c 699 s 17]

144.165 [Repealed, 1978 c 699 s 17]

144.166 [Repealed, 1978 c 699 s 17]

144.167 [Repealed, 1978 c 699 s 17]

144.168 [Repealed, 1978 c 699 s 17]

144.169 [Repealed, 1978 c 699 s 17]

144.17 [Repealed, 1945 c 512 s 37]

144.171 [Repealed, 1978 c 699 s 17]

144.172 [Repealed, 1978 c 699 s 17]

144.173 [Repealed, 1978 c 699 s 17]

144.174 [Repealed, 1978 c 699 s 17]

144.175 Subdivision 1. [Repealed, 1978 c 699 s 17]

Subd. 2. [Repealed, 1978 c 699 s 17; 1978 c 790 s 4]

Subd. 3. [Repealed, 1947 c 517 s 8; 1978 c 699 s 17]

Subd. 4. [Repealed, 1978 c 699 s 17]

Subd. 5. [Repealed, 1978 c 699 s 17]

144.176 [Repealed, 1978 c 699 s 17]

144.1761 [Repealed, 1Sp2001 c 9 art 15 s 33]

144.177 [Repealed, 1978 c 699 s 17]

144.178 [Repealed, 1978 c 699 s 17]

144.18 [Repealed, 1945 c 512 s 37]

144.181 [Repealed, 1978 c 699 s 17]

144.182 [Repealed, 1978 c 699 s 17]

144.183 [Repealed, 1978 c 699 s 17]

144.19 [Repealed, 1945 c 512 s 37]

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144.191 [Repealed, 1978 c 699 s 17]

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1. **Establishment.** The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

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

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

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

Subd. 3. **Program administration.** In administering the international medical graduates assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;

(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating

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plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. **Career guidance and support services.** (a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

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(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

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(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. **Voluntary hospital programs.** A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. **Board of Medical Practice.** Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. **Consultation with stakeholders.** The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

(ii) a health plan company;

(iii) the Minnesota Medical Association;

(iv) licensed physicians experienced in working with international medical graduates; and

(v) the Minnesota Academy of Physician Assistants;

(3) community-based organizations:

(i) organizations serving immigrant and refugee communities of Minnesota;

(ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and

(iii) the Minnesota Association of Community Health Centers;

(4) higher education:

(i) University of Minnesota;

(ii) Mayo Clinic School of Health Professions;

(iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and

(iv) Minnesota physician assistant education programs; and

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(5) two international medical graduates.

Subd. 10. **Report.** The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

History: *2015 c 71 art 8 s 17*

144.1912 GREATER MINNESOTA FAMILY MEDICINE RESIDENCY GRANT PROGRAM.

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

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

(c) "Eligible family medicine residency program" means a program that meets the following criteria:

(1) is located in Minnesota outside the seven-county metropolitan area, as defined in section 473.121, subdivision 4;

(2) is accredited as a family medicine residency program or is a candidate for accreditation;

(3) is focused on the education and training of family medicine physicians to serve communities outside the metropolitan area; and

(4) demonstrates that over the most recent three years at least 25 percent of its graduates practice in Minnesota communities outside the metropolitan area.

Subd. 2. **Program administration.** (a) The commissioner shall award family medicine residency grants to existing, eligible, not-for-profit family medicine residency programs to support current and new residency positions. Funds shall be allocated first to proposed new family medicine residency positions, and remaining funds shall be allocated proportionally based on the number of existing residents in eligible programs. The commissioner may fund a new residency position for up to three years.

(b) Grant funds awarded may only be spent to cover the costs of:

(1) establishing, maintaining, or expanding training for family medicine residents;

(2) recruitment, training, and retention of residents and faculty;

(3) travel and lodging for residents; and

(4) faculty, resident, and preceptor salaries.

(c) Grant funds shall not be used to supplant any other government or private funds available for these purposes.

Subd. 3. **Applications.** Eligible family medicine residency programs seeking a grant must apply to the commissioner. The application must include objectives, a related work plan and budget, a description of the number of new and existing residency positions that will be supported using grant funds, and additional information the commissioner determines to be necessary. The commissioner shall determine whether applications are complete and responsive and may require revisions or additional information before awarding a grant.

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Subd. 4. **Program oversight.** The commissioner shall require and collect from family medicine residency programs receiving grants, information necessary to administer and evaluate the program. The evaluation shall include the scope of expansion of new residency positions and information describing specific programs to enhance current residency positions, which may include facility improvements. The commissioner shall continue to collect data on greater Minnesota family medicine residency shortages.

History: *2016 c 189 art 20 s 8*

BIOLOGICAL AND HEALTH DATA

144.192 TREATMENT OF BIOLOGICAL SPECIMENS AND HEALTH DATA HELD BY THE DEPARTMENT OF HEALTH AND HEALTH BOARDS.

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

(b) "Biological specimen" means tissue, fluids, excretions, or secretions that contain human DNA originating from an identifiable individual, either living or deceased. Biological specimen does not include infectious agents or chemicals that are isolated from a specimen. Nothing in this section or section 13.386 is intended to limit the commissioner's ability to collect, use, store, or disseminate such isolated infectious agents or chemicals.

(c) "Health data" has the meaning given in section 13.3805, subdivision 1, paragraph (a), clause (2).

(d) "Health oversight" means oversight of the health care system for activities authorized by law, limited to the following:

(1) audits;

(2) civil, administrative, or criminal investigations;

(3) inspections;

(4) licensure or disciplinary actions;

(5) civil, administrative, or criminal proceedings or actions; and

(6) other activities necessary for appropriate oversight of the health care system and persons subject to such governmental regulatory programs for which biological specimens or health data are necessary for determining compliance with program standards.

(e) "Individual" has the meaning given in section 13.02, subdivision 8. In addition, for a deceased individual, individual also means the representative of the decedent.

(f) "Person" has the meaning given in section 13.02, subdivision 10.

(g) "Program operations" means actions, testing, and procedures directly related to the operation of department programs, limited to the following:

(1) diagnostic and confirmatory testing;

(2) laboratory quality control assurance and improvement;

(3) calibration of equipment;

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(4) evaluation and improvement of test accuracy;

(5) method development and validation;

(6) compliance with regulatory requirements; and

(7) continuity of operations to ensure that testing continues in the event of an emergency.

(h) "Public health practice" means actions related to disease, conditions, injuries, risk factors, or exposures taken to protect public health, limited to the following:

(1) monitoring the health status of a population;

(2) investigating occurrences and outbreaks;

(3) comparing patterns and trends;

(4) implementing prevention and control measures;

(5) conducting program evaluations and making program improvements;

(6) making recommendations concerning health for a population;

(7) preventing or controlling known or suspected diseases and injuries; and

(8) conducting other activities necessary to protect or improve the health of individuals and populations for which biological specimens or health data are necessary.

(i) "Representative of the decedent" has the meaning given in section 13.10, subdivision 1, paragraph (c).

(j) "Research" means activities that are not program operations, public health practice, or health oversight and is otherwise defined in Code of Federal Regulations, title 45, part 46, subpart A, section 46.102 (d).

Subd. 2. **Collection, use, storage, and dissemination.** (a) The commissioner may collect, use, store, and disseminate biological specimens and health data, genetic or other, as provided in this section and as authorized under any other provision of applicable law, including any rules adopted on or before June 30, 2013. Any rules adopted after June 30, 2013, must be consistent with the requirements of this section.

(b) The provisions in this section supplement other provisions of law and do not supersede or repeal other provisions of law applying to the collection, use, storage, or dissemination of biological specimens or health data.

(c) For purposes of this section, genetic information is limited to biological specimens and health data.

Subd. 3. **Biological specimens and health data for program operations, public health practice, and health oversight.** (a) The commissioner may collect, use, store, and disseminate biological specimens and health data to conduct program operations activities, public health practice activities, and health oversight activities. Unless required under other applicable law, consent of an individual is not required under this subdivision.

(b) With the approval of the commissioner, biological specimens may be disseminated to establish a diagnosis, to provide treatment, to identify persons at risk of illness, or to conduct an epidemiologic investigation to control or prevent the spread of serious disease, or to diminish an imminent threat to the public health.

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(c) For purposes of Clinical Laboratory Improvement Amendments proficiency testing, the commissioner may disseminate de-identified biological specimens to state public health laboratories that agree, pursuant to contract, not to attempt to re-identify the biological specimens.

(d) Health data may be disseminated as provided in section 13.3805, subdivision 1, paragraph (b).

Subd. 4. **Research.** The commissioner may collect, use, store, and disseminate biological specimens and health data to conduct research in a manner that is consistent with the federal common rule for the protection of human subjects in Code of Federal Regulations, title 45, part 46.

Subd. 5. **Storage of biological specimens and health data according to storage schedules.** (a) The commissioner shall store health data according to section 138.17.

(b) The commissioner shall store biological specimens according to a specimen storage schedule. The commissioner shall develop the storage schedule by July 1, 2013, and post it on the department's Web site.

Subd. 6. **Secure storage of biological specimens.** The commissioner shall establish appropriate security safeguards for the storage of biological specimens, with regard for the privacy of the individuals from whom the biological specimens originated, and store the biological specimens accordingly. When a biological specimen is disposed of, it must be destroyed in a way that prevents determining the identity of the individual from whom it originated.

Subd. 7. **Applicability to health boards.** The provisions of subdivisions 2; 3, paragraphs (a), (c), and (d); and 4 to 6 pertaining to the commissioner also apply to community health boards organized under chapter 145A. These boards may also disseminate health data pursuant to section 13.3805, subdivision 1, paragraph (b), clause (2).

History: *2013 c 82 s 11; 2015 c 21 art 1 s 109*

144.193 INVENTORY OF BIOLOGICAL AND HEALTH DATA.

By February 1, 2014, and annually after that date, the commissioner shall prepare an inventory of biological specimens, registries, and health data and databases collected or maintained by the commissioner. In addition to the inventory, the commissioner shall provide the schedules for storage of health data and biological specimens. The inventories must be listed in reverse chronological order beginning with the year 2012. The commissioner shall make the inventory and schedules available on the department's Web site and submit the inventory and schedules to the chairs and ranking minority members of the committees of the legislature with jurisdiction over health policy and data practices issues.

History: *2013 c 82 s 12*

144.20 [Repealed, 1945 c 512 s 37]

144.201 [Repealed, 1978 c 699 s 17]

144.202 [Repealed, 1978 c 699 s 17]

144.203 [Repealed, 1978 c 699 s 17]

144.204 [Repealed, 1978 c 699 s 17]

144.205 [Repealed, 1978 c 699 s 17]

144.21 [Repealed, 1945 c 512 s 37]

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VITAL RECORDS

144.211 CITATION.

Sections 144.211 to 144.227 may be cited as the "Vital Records Act."

History: *1978 c 699 s 1; 2015 c 21 art 1 s 109*

144.212 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 144.211 to 144.227, the following terms have the meanings given.

Subd. 1a. **Amendment.** "Amendment" means completion or correction made to certification items on a vital record after a certification has been issued or more than one year after the event, whichever occurs first, that does not result in a sealed or replaced record.

Subd. 1b. **Authorized representative.** "Authorized representative" means an agent designated in a written and witnessed statement signed by the subject of the record or other qualified applicant.

Subd. 1c. **Certification item.** "Certification item" means all individual items appearing on a certificate of birth and the demographic and legal items on a certificate of death.

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

Subd. 2a. **Correction.** "Correction" means a change made to a noncertification item, including information collected for medical and statistical purposes. A correction also means a change to a certification item within one year of the event provided that no certification, whether paper or electronic, has been issued.

Subd. 2b. **Court of competent jurisdiction.** "Court of competent jurisdiction" means a court within the United States with jurisdiction over the individual and such other individuals that the court deems necessary.

Subd. 2c. **Delayed registration.** "Delayed registration" means registration of a record of birth or death filed one or more years after the date of birth or death.

Subd. 2d. **Disclosure.** "Disclosure" means to make available or make known personally identifiable information contained in a vital record, by any means of communication.

Subd. 3. **File.** "File" means to present a vital record or report for registration to the Office of Vital Records and to have the vital record or report accepted for registration by the Office of Vital Records.

Subd. 4. **Final disposition.** "Final disposition" means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or dead fetus.

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

(1) provides inpatient or outpatient medical, surgical, or diagnostic care or treatment; or

(2) provides nursing, custodial, or domiciliary care, or to which persons are committed by law.

Subd. 4b. **Legal representative.** "Legal representative" means a licensed attorney representing an individual.

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Subd. 4c. **Local issuance office.** "Local issuance office" means a county governmental office authorized by the state registrar to issue certified birth and death records.

Subd. 4d. **Record.** "Record" means a report of a vital event that has been registered by the state registrar.

Subd. 5. **Registration.** "Registration" means the process by which vital records are completed, filed, and incorporated into the official records of the Office of Vital Records.

Subd. 6. **State registrar.** "State registrar" means the commissioner of health or a designee.

Subd. 7. **System of vital records.** "System of vital records" includes the registration, collection, preservation, amendment, verification, maintenance of the security and integrity of, and certification of vital records, the collection of other reports required by sections 144.211 to 144.227, and related activities including the tabulation, analysis, publication, and dissemination of vital records.

Subd. 7a. **Verification.** "Verification" means a confirmation of the information on a vital record based on the facts contained in a certification.

Subd. 8. **Vital record.** "Vital record" means a record or report of birth, stillbirth, death, marriage, dissolution and annulment, and data related thereto. The birth record is not a medical record of the mother or the child.

Subd. 9. **Vital records statistics.** "Vital records statistics" means the data derived from records and reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment, and related reports.

Subd. 10. [Repealed by amendment, 2013 c 108 art 12 s 16]

Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed with the state registrar which sets forth the following information:

(1) the current name and address of the affiant;

(2) any previous name by which the affiant was known;

(3) the original and adopted names, if known, of the adopted child whose original birth record is to be disclosed;

(4) the place and date of birth of the adopted child;

(5) the biological relationship of the affiant to the adopted child; and

(6) the affiant's consent to disclosure of information from the original birth record of the adopted child.

History: *1978 c 699 s 2; 1986 c 444; 1997 c 228 s 3-5; 1Sp2001 c 9 art 15 s 1-7; 2002 c 379 art 1 s 113; 2005 c 60 s 2; 2013 c 108 art 12 s 16; 2015 c 21 art 1 s 109*

144.213 OFFICE OF VITAL RECORDS.

Subdivision 1. **Creation; state registrar; Office of Vital Records.** The commissioner shall establish an Office of Vital Records under the supervision of the state registrar. The commissioner shall promulgate rules for the collection, filing, and registering of vital records information by the state registrar, physicians, advanced practice registered nurses, physician assistants, morticians, and others. Except as otherwise provided in sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to the collection, filing and registering of vital records shall remain in effect until repealed, modified or superseded by a rule promulgated by the commissioner.

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Subd. 2. **General duties.** (a) The state registrar shall maintain a statewide system of vital records. The state registrar is responsible for the administration and enforcement of sections 144.211 to 144.227 and shall supervise the enforcement of sections 144.211 to 144.227 and the rules promulgated thereunder. Local issuance offices that fail to comply with the statutes or rules or to properly train employees may have their issuance privileges and access to the vital records system revoked.

(b) To preserve vital records, the state registrar is authorized to prepare typewritten, photographic, electronic, or other reproductions of original records and files in the Office of Vital Records. The reproductions, when certified by the state registrar, shall be accepted as the original records.

(c) The state registrar shall also:

(1) establish, designate, and eliminate offices in the state to aid in the efficient issuance of vital records;

(2) direct the activities of all persons engaged in activities pertaining to the operation of the system of vital records;

(3) develop and conduct training programs to promote uniformity of policy and procedures throughout the state in matters pertaining to the system of vital records; and

(4) prescribe, furnish, and distribute all forms required by sections 144.211 to 144.227 and any rules adopted under these sections, and prescribe other means for the transmission of data, including electronic submission, that will accomplish the purpose of complete, accurate, and timely reporting and registration.

Subd. 3. [Repealed by amendment, 2013 c 108 art 12 s 17]

History: *1978 c 699 s 3; 1Sp2001 c 9 art 15 s 32; 2013 c 108 art 12 s 17; 2015 c 21 art 1 s 109; 2017 c 59 s 2*

144.2131 SECURITY OF VITAL RECORDS SYSTEM.

The state registrar shall:

(1) authenticate all users of the system of vital records and document that all users require access based on their official duties;

(2) authorize authenticated users of the system of vital records to access specific components of the vital records systems necessary for their official roles and duties;

(3) establish separation of duties between staff roles that may be susceptible to fraud or misuse and routinely perform audits of staff work for the purposes of identifying fraud or misuse within the vital records system;

(4) require that authenticated and authorized users of the system of vital records maintain a specified level of training related to security and provide written acknowledgment of security procedures and penalties;

(5) validate data submitted for registration through site visits or with independent sources outside the registration system at a frequency specified by the state registrar to maximize the integrity of the data collected;

(6) protect personally identifiable information and maintain systems pursuant to applicable state and federal laws;

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(7) accept a report of death if the decedent was born in Minnesota or if the decedent was a resident of Minnesota from the United States Department of Defense or the United States Department of State when the death of a United States citizen occurs outside the United States;

(8) match death records registered in Minnesota and death records provided from other jurisdictions to live birth records in Minnesota;

(9) match death records received from the United States Department of Defense or the United States Department of State for deaths of United States citizens occurring outside the United States to live birth records in Minnesota;

(10) work with law enforcement to initiate and provide evidence for active fraud investigations;

(11) provide secure workplace, storage, and technology environments that have limited role-based access;

(12) maintain overt, covert, and forensic security measures for certifications, verifications, and automated systems that are part of the vital records system; and

(13) comply with applicable state and federal laws and rules associated with information technology systems and related information security requirements.

History: *2013 c 108 art 12 s 18; 2015 c 21 art 1 s 109*

144.214 Subdivision 1. [Repealed, 2014 c 275 art 1 s 139]

Subd. 2. [Repealed, 2014 c 275 art 1 s 139]

Subd. 3. [Repealed, 2014 c 275 art 1 s 139]

Subd. 4. [Repealed, 2005 c 106 s 68]

144.215 BIRTH REGISTRATION.

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

Subd. 2. **Rules governing birth registration.** The commissioner shall establish by rule an orderly mechanism for the registration of births including at least a designation for who must file the birth record, a procedure for registering births which occur in moving conveyances, and a provision governing the names of the parent or parents to be entered on the birth record.

Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is determined by a court of competent jurisdiction, or a recognition of parentage is executed under section 257.75, the name of the father shall be entered on the birth record. If the order of the court declares the name of the child, it shall also be entered on the birth record. If the order of the court does not declare the name of the child, or there is no court order, then upon the request of both parents in writing, the surname of the child shall be defined by both parents.

Subd. 4. **Social Security number registration.** (a) Parents of a child born within this state shall give the parents' Social Security numbers to the Office of Vital Records at the time of filing the birth record, but the numbers shall not appear on the certified record.

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(b) The Social Security numbers are classified as private data, but the Office of Vital Records shall provide a Social Security number to the public authority responsible for child support services upon request by the public authority for use in the establishment of parentage and the enforcement of child support obligations.

Subd. 5. **Births occurring in an institution.** When a birth occurs in an institution or en route to an institution, the person in charge of the institution or that person's authorized designee shall obtain the personal data required under this section and shall prepare the record of birth. For purposes of this section, "institution" means a hospital or other facility that provides childbirth services.

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

(1) the physician present at the time of the birth or immediately thereafter;

(2) in the absence of a physician, a person, other than the mother, present at the time of the birth or immediately thereafter;

(3) the father of the child;

(4) the mother of the child; or

(5) in the absence of the father and if the mother is unable, the person with primary responsibility for the premises where the child was born.

Subd. 7. **Evidence required to register noninstitution birth within first year of birth.** When a birth occurs in this state outside of an institution, as defined in subdivision 5, and the birth record is filed before the first birthday, evidence in support of the facts of birth shall be required. Evidence shall be presented by the individual responsible for filing the vital record under subdivision 6. Evidence shall consist of proof that the child was born alive, proof of pregnancy, and evidence of the mother's presence in this state on the date of the birth. If the evidence is not acceptable, the state registrar shall advise the applicant of the reason for not filing a birth record and shall further advise the applicant of the right of appeal to a court of competent jurisdiction.

History: *1978 c 699 s 5; 1980 c 589 s 28; 1Sp1993 c 1 art 6 s 1,2; 1997 c 205 s 20; 1997 c 228 s 6-8; 1Sp2001 c 9 art 15 s 11-15,32; 2002 c 379 art 1 s 113; 2013 c 108 art 12 s 19,20*

144.2151 RECORD OF BIRTH RESULTING IN STILLBIRTH.

Subdivision 1. **Filing.** A record of birth for each birth resulting in a stillbirth in this state, on or after August 1, 2005, for which a fetal death report is required under section 144.222, subdivision 1, shall be filed with the state registrar within five days after the birth if the parent or parents of the stillbirth request to have a record of birth resulting in stillbirth prepared.

Subd. 2. **Information to parents.** The party responsible for filing a fetal death report under section 144.222, subdivision 1, shall advise the parent or parents of a stillbirth:

(1) that they may request preparation of a record of birth resulting in stillbirth;

(2) that preparation of the record is optional; and

(3) how to obtain a certified copy of the record if one is requested and prepared.

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Subd. 3. **Preparation.** (a) Within five days after delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record with the state registrar if the parent or parents of the stillbirth, after being advised as provided in subdivision 2, request to have a record of birth resulting in stillbirth prepared.

(b) If the parent or parents of the stillbirth do not choose to provide a full name for the stillbirth, the parent or parents may choose to file only a last name.

(c) Either parent of the stillbirth or, if neither parent is available, another person with knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered on the record in time to permit the filing of the record within five days after delivery.

Subd. 4. **Retroactive application.** Notwithstanding subdivisions 1 to 3, if a birth that occurred in this state at any time resulted in a stillbirth for which a fetal death report was required under section 144.222, subdivision 1, but a record of birth resulting in stillbirth was not prepared under subdivision 3, a parent of the stillbirth may submit to the state registrar, on or after August 1, 2005, a written request for preparation of a record of birth resulting in stillbirth and evidence of the facts of the stillbirth in the form and manner specified by the state registrar. The state registrar shall prepare and file the record of birth resulting in stillbirth within 30 days after receiving satisfactory evidence of the facts of the stillbirth.

Subd. 5. **Responsibilities of state registrar.** The state registrar shall:

(1) prescribe the form of and information to be included on a record of birth resulting in stillbirth, which shall be as similar as possible to the form of and information included on a record of birth;

(2) prescribe the form of and information to be provided by the parent of a stillbirth requesting a record of birth resulting in stillbirth under subdivisions 3 and 4 and make this form available on the Department of Health's Web site;

(3) issue a certified copy of a record of birth resulting in stillbirth to a parent of the stillbirth that is the subject of the record if:

(i) a record of birth resulting in stillbirth has been prepared and filed under subdivision 3 or 4; and

(ii) the parent requesting a certified copy of the record submits the request in writing; and

(4) create and implement a process for entering, preparing, and handling stillbirth records identical or as close as possible to the processes for birth and fetal death records when feasible, but no later than the date on which the next reprogramming of the Department of Health's database for vital records is completed.

History: *2005 c 60 s 1*

144.216 FOUNDLING REGISTRATION.

Subdivision 1. **Reporting foundling.** Whoever finds a live born infant of unknown parentage shall report within five days to the Office of Vital Records such information as the commissioner may by rule require to identify the foundling.

Subd. 2. **Status of foundling reports.** A report registered under subdivision 1 shall constitute the record of birth for the child. If the child is identified and a record of birth is found or obtained, the report registered

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under subdivision 1 shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

History: *1978 c 699 s 6; 1981 c 311 s 39; 1982 c 545 s 24; 1Sp2001 c 9 art 15 s 32; 2013 c 108 art 12 s 21*

144.217 DELAYED RECORDS OF BIRTH.

Subdivision 1. **Evidence required for filing.** Before a delayed record of birth is registered, the person presenting the delayed vital record for registration shall offer evidence of the facts contained in the vital record, as required by the rules of the commissioner. In the absence of the evidence required, the delayed vital record shall not be registered. No delayed record of birth shall be registered for a deceased person.

Subd. 2. **Court petition.** If a delayed record of birth is rejected under subdivision 1, a person may petition the appropriate court in the county in which the birth allegedly occurred for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered. The petition shall state:

(1) that the person for whom a delayed record of birth is sought was born in this state;

(2) that no record of birth can be found in the Office of Vital Records;

(3) that diligent efforts by the petitioner have failed to obtain the evidence required in subdivision 1;

(4) that the state registrar has refused to register a delayed record of birth; and

(5) other information as may be required by the court.

Subd. 3. **Court order.** The court shall fix a time and place for a hearing on the petition and shall give the state registrar ten days' notice of the hearing. The state registrar may appear and testify in the proceeding. If the court is satisfied from the evidence received at the hearing of the truth of the statements in the petition, the court shall order the registration of the delayed vital record.

Subd. 4. [Repealed, 1Sp2001 c 9 art 15 s 16,33]

History: *1978 c 699 s 7; 1Sp2001 c 9 art 15 s 16; 2002 c 379 art 1 s 113; 2013 c 108 art 12 s 22*

144.218 REPLACEMENT BIRTH RECORDS.

Subdivision 1. **Adoption.** Upon receipt of a certified copy of an order, decree, or certificate of adoption, the state registrar shall register a replacement vital record in the new name of the adopted person. The original record of birth is confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.2252. The information contained on the original birth record, except for the registration number, shall be provided on request to a parent who is named on the original birth record. Upon the receipt of a certified copy of a court order of annulment of adoption the state registrar shall restore the original vital record to its original place in the file.

Subd. 2. **Adoption of foreign persons.** In proceedings for the adoption of a person who was born in a foreign country, the court, upon evidence presented by the commissioner of human services from information secured at the port of entry or upon evidence from other reliable sources, may make findings of fact as to the date and place of birth and parentage. Upon receipt of certified copies of the court findings and the order or decree of adoption, a certificate of adoption, or a certified copy of a decree issued under section 259.60, the state registrar shall register a birth record in the new name of the adopted person. The certified copies

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of the court findings and the order or decree of adoption, certificate of adoption, or decree issued under section 259.60 are confidential, pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.2252. The birth record shall state the place of birth as specifically as possible and that the vital record is not evidence of United States citizenship.

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

Subd. 4. **Incomplete, incorrect, and modified vital records.** If a court finds that a birth record is incomplete, inaccurate, or false or if it is being issued pursuant to section 259.10, subdivision 2, the court may order the registration of a replacement vital record, and, if necessary, set forth the correct information in the order. Upon receipt of the order, the registrar shall register a replacement vital record containing the findings of the court. The prior vital record shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

Subd. 5. **Replacement of vital records.** Upon the order of a court of this state, upon the request of a court of another state, or upon the filing of a recognition of parentage with the state registrar, a replacement birth record must be registered consistent with the findings of the court or the recognition of parentage.

History: *1978 c 699 s 8; 1980 c 561 s 1; 1981 c 311 s 24; 1982 c 545 s 24; 1984 c 654 art 5 s 58; 1994 c 465 art 1 s 62; 1994 c 631 s 31; 1995 c 259 art 1 s 32; 1997 c 205 s 21; 1998 c 406 art 1 s 1,37; 1998 c 407 art 9 s 1; 1Sp2001 c 9 art 15 s 17; 2002 c 379 art 1 s 113; 2013 c 108 art 12 s 23*

144.2181 AMENDMENT AND CORRECTION OF VITAL RECORDS.

(a) A vital record registered under sections 144.212 to 144.227 may be amended or corrected only according to sections 144.212 to 144.227 and rules adopted by the commissioner of health to protect the integrity and accuracy of vital records.

(b)(1) A vital record that is amended under this section shall indicate that it has been amended, except as otherwise provided in this section or by rule.

(2) Electronic documentation shall be maintained by the state registrar that identifies the evidence upon which the amendment or correction was based, the date of the amendment or correction, and the identity of the authorized person making the amendment or correction.

(c) Upon receipt of a certified copy of an order of a court of competent jurisdiction changing the name of a person whose birth is registered in Minnesota and upon request of such person if 18 years of age or older or having the status of emancipated minor, the state registrar shall amend the birth record to show the new name. If the person is a minor or an incapacitated person then a parent, guardian, or legal representative of the minor or incapacitated person may make the request.

(d) When an applicant does not submit the minimum documentation required for amending a vital record or when the state registrar has cause to question the validity or completeness of the applicant's statements or the documentary evidence, and the deficiencies are not corrected, the state registrar shall not amend the

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vital record. The state registrar shall advise the applicant of the reason for this action and shall further advise the applicant of the right of appeal to a court with competent jurisdiction over the Department of Health.

History: *2013 c 108 art 12 s 24*

144.219 [Repealed, 1Sp2001 c 9 art 15 s 33]

144.22 [Repealed, 1945 c 512 s 37]

144.221 DEATH REGISTRATION.

Subdivision 1. **When and where to file.** A death record for each death which occurs in the state shall be filed with the state registrar within five days after death and prior to final disposition.

Subd. 2. **Rules governing death registration.** The commissioner of health shall establish in rule an orderly mechanism for the registration of deaths including at least a designation for who must file the death record, a procedure for the registration of deaths in moving conveyances, and provision to include cause and certification of death and assurance of registration prior to final disposition.

Subd. 3. **When no body is found.** When circumstances suggest that a death has occurred although a dead body cannot be produced to confirm the fact of death, a death record shall not be registered until a court has adjudicated the fact of death.

History: *1978 c 699 s 10; 1Sp2001 c 9 art 15 s 18,19,32; 2002 c 379 art 1 s 113; 2005 c 106 s 56*

144.2215 MINNESOTA BIRTH DEFECTS INFORMATION SYSTEM.

Subdivision 1. **Establishment.** The commissioner of health shall establish and maintain an information system containing data on the cause, treatment, prevention, and cure of major birth defects. The commissioner shall consult with representatives and experts in epidemiology, medicine, insurance, health maintenance organizations, genetics, consumers, and voluntary organizations in developing the system and may phase in the implementation of the system.

Subd. 2. **Duties of commissioner.** The commissioner of health shall design a system that allows the commissioner to:

(1) monitor incidence trends of birth defects to detect potential public health problems, predict risks, and assist in responding to birth defects clusters;

(2) more accurately target intervention, prevention, and services for communities, patients, and their families;

(3) inform health professionals and citizens of the prevalence of and risks for birth defects;

(4) conduct scientific investigation and surveys of the causes, mortality, methods of treatment, prevention, and cure for birth defects;

(5) modify, as necessary, the birth defects information system through demonstration projects;

(6) remove identifying information about a child whose parent or legal guardian has chosen not to participate in the system as permitted by section 144.2216, subdivision 4;

(7) protect the individually identifiable information as required by section 144.2217;

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(8) limit the dissemination of identifying information as required by sections 144.2218 and 144.2219; and

(9) use the birth defects coding scheme defined by the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service.

History: *1996 c 451 art 4 s 6; 2004 c 288 art 6 s 11; 2004 c 290 s 25*

144.2216 BIRTH DEFECTS RECORDS AND REPORTS REQUIRED.

Subdivision 1. **Hospitals and similar institutions.** With the informed consent of a parent or guardian, as provided in subdivision 4, a hospital, medical clinic, medical laboratory, or other institution for the hospitalization, clinical or laboratory diagnosis, or care of human beings shall provide the commissioner of health with access to information on each birth defect case in the manner and at the times that the commissioner designates.

Subd. 2. **Other information repositories.** With the informed consent of a parent or guardian, as provided in subdivision 4, other repositories of information on the diagnosis or care of infants may provide the commissioner with access to information on each case of birth defects in the manner and at the times that the commissioner designates.

Subd. 3. **Reporting without liability.** Furnishing information in good faith in compliance with this section does not subject the person, hospital, medical clinic, medical laboratory, data repository, or other institution furnishing the information to any action for damages or relief.

Subd. 4. **Opt out.** A parent or legal guardian must be informed by the commissioner at the time of the initial data collection that they may request removal at any time of personal identifying information concerning a child from the birth defects information system using a written form prescribed by the commissioner. The commissioner shall advise parents or legal guardians of infants:

(1) that the information on birth defects may be retained by the Department of Health;

(2) the benefit of retaining birth defects records;

(3) that they may elect to have the birth defects information collected once, within one year of birth, but to require that all personally identifying information be destroyed immediately upon the commissioner receiving the information.

If the parents of an infant object in writing to the maintaining of birth defects information, the objection or election shall be recorded on a form that is signed by a parent or legal guardian and submitted to the commissioner of health; and

(4) that if the parent or legal guardian chooses to opt-out, the commissioner will not be able to inform the parent or legal guardian of a child of information related to the prevention, treatment, or cause of a particular birth defect.

History: *2004 c 288 art 6 s 12; 2004 c 290 s 26*

144.2217 CLASSIFICATION OF BIRTH DEFECTS INFORMATION.

Information collected on individuals for the birth defects information system are private data on individuals as defined in section 13.02, subdivision 12, and may only be used for the purposes in sections

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144.2215 to 144.2219. Any disclosure other than one provided for in sections 144.2215 to 144.2219 is a misdemeanor.

History: *2004 c 288 art 6 s 13; 2004 c 290 s 27*

144.2218 TRANSFERS OF INFORMATION TO OTHER GOVERNMENT AGENCIES.

Information collected by the birth defects information system may be disseminated to a state or local government agency in Minnesota or another state solely for purposes consistent with sections 144.2215 to 144.2219, provided that the state or local government agency agrees to maintain the classification of the information as provided under section 144.2217. Information collected by other states consistent with sections 144.2215 to 144.2219 may be received by the commissioner of health and must be maintained according to section 144.2217.

History: *2004 c 288 art 6 s 14; 2004 c 290 s 28*

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: *2004 c 288 art 6 s 15; 2004 c 290 s 29; 2007 c 147 art 10 s 15*

144.222 REPORTS OF FETAL OR INFANT DEATH.

Subdivision 1. **Fetal death report required.** A fetal death report must be filed within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions defined under section 145.4241. A fetal death report must be prepared in a format prescribed by the state registrar and filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

(1) a person in charge of an institution or that person's authorized designee if a fetus is delivered in the institution or en route to the institution;

(2) a physician, certified nurse midwife, or other licensed medical personnel in attendance at or immediately after the delivery if a fetus is delivered outside an institution; or

(3) a parent or other person in charge of the disposition of the remains if a fetal death occurred without medical attendance at or immediately after the delivery.

Subd. 2. **Sudden infant death.** Each infant death which is diagnosed as sudden infant death syndrome shall be reported within five days to the state registrar.

History: *1978 c 699 s 11; 1984 c 637 s 2; 1Sp2001 c 9 art 15 s 20; 2002 c 379 art 1 s 113; 2005 c 60 s 3*

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144.223 REPORT OF MARRIAGE.

Data relating to certificates of marriage registered shall be reported to the state registrar by the local registrar or designee of the county board in each of the 87 registration districts pursuant to the rules of the commissioner. The information in clause (1) necessary to compile the report shall be furnished by the applicant prior to the issuance of the marriage license. The report shall contain the following:

(1) personal information on bride and groom:

(i) name;

(ii) residence;

(iii) date and place of birth;

(iv) race;

(v) if previously married, how terminated; and

(vi) signature of applicant, date signed, and Social Security number; and

(2) information concerning the marriage:

(i) date of marriage;

(ii) place of marriage; and

(iii) civil or religious ceremony.

History: *1977 c 305 s 45; 1978 c 699 s 12; 1997 c 203 art 6 s 4; 1Sp2001 c 9 art 15 s 21; 2002 c 379 art 1 s 113*

144.224 [Repealed, 2000 c 372 s 3]

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

Subdivision 1. **Public information; access to vital records.** Except as otherwise provided for in this section and section 144.2252, information contained in vital records shall be public information. Physical access to vital records shall be subject to the supervision and regulation of the state registrar and employees pursuant to rules promulgated by the commissioner in order to protect vital records from loss, mutilation or destruction and to prevent improper disclosure of vital records which are confidential or private data on individuals, as defined in section 13.02, subdivisions 3 and 12.

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

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older;

(3) under paragraph (b) or (e); or

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(4) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

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

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

Subd. 2a. **Health data associated with birth registration.** Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is private data as defined in section 13.02, subdivision 12. The commissioner may disclose to a community health board, as defined in section 145A.02, subdivision 5, health data associated with birth registration which identifies a mother or child at high risk for serious disease, disability, or developmental delay in order to assure access to appropriate health, social, or educational services. Notwithstanding the designation of the private data, the commissioner of human services shall have access to health data associated with birth registration for:

(1) purposes of administering medical assistance and the MinnesotaCare program; and

(2) for other public health purposes as determined by the commissioner of health.

Subd. 2b. **Commissioner of health; duties.** Notwithstanding the designation of certain of this data as confidential under subdivision 2 or private under subdivision 2a, the commissioner shall give the commissioner of human services access to birth record data and data contained in recognitions of parentage prepared according to section 257.75 necessary to enable the commissioner of human services to identify a child who is subject to threatened injury, as defined in section 626.556, subdivision 2, paragraph (p), by a person responsible for the child's care, as defined in section 626.556, subdivision 2, paragraph (j), clause (1). The commissioner shall be given access to all data included on official birth records.

Subd. 3. **Laws and rules for preparing vital records.** No person shall prepare or issue any vital record which purports to be an original, certified copy, or copy of a vital record except as authorized in sections 144.211 to 144.227 or the rules of the commissioner.

Subd. 4. **Access to records for research purposes.** The state registrar may permit persons performing medical research access to the information restricted in subdivision 2 or 2a if those persons agree in writing not to disclose private or confidential data on individuals.

Subd. 5. **Residents of other states.** When a resident of another state is born or dies in this state, the state registrar shall send a report of the birth or death to the state of residence.

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Subd. 6. **Group purchaser identity; nonpublic data; disclosure.** (a) Except as otherwise provided in this subdivision, the named identity of a group purchaser as defined in section 62J.03, subdivision 6, collected in association with birth registration is nonpublic data as defined in section 13.02.

(b) The commissioner may publish, or by other means release to the public, the named identity of a group purchaser as part of an analysis of information collected from the birth registration process. Analysis means the identification of trends in prenatal care and birth outcomes associated with group purchasers. The commissioner may not reveal the named identity of the group purchaser until the group purchaser has had 21 days after receipt of the analysis to review the analysis and comment on it. In releasing data under this subdivision, the commissioner shall include comments received from the group purchaser related to the scientific soundness and statistical validity of the methods used in the analysis. This subdivision does not authorize the commissioner to make public any individual identifying data except as permitted by law.

(c) A group purchaser may contest whether an analysis made public under paragraph (b) is based on scientifically sound and statistically valid methods in a contested case proceeding under sections 14.57 to 14.62, subject to appeal under sections 14.63 to 14.68. To obtain a contested case hearing, the group purchaser must present a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the group purchaser must demonstrate by clear and convincing evidence the group purchaser's likelihood of succeeding on the merits. If the judge determines that the group purchaser has made this demonstration, the data may not be released during the contested case proceeding and through appeal. If the judge finds that the group purchaser has not made this demonstration, the commissioner may immediately publish, or otherwise make public, the nonpublic group purchaser data, with comments received as set forth in paragraph (b).

(d) The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office 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 and payment of the required fee:

(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, guardian or conservator, or health care agent of the subject;

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

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(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) an adoption agency 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;

(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 registrar or local issuance office 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.

Subd. 8. **Standardized format for certified birth and death records.** The commissioner shall maintain a standardized format for certified birth records and death records issued by the state registrar and local issuance offices. The format shall incorporate security features in accordance with this section.

History: *1978 c 699 s 14; 1980 c 509 s 42; 1980 c 561 s 2; 1981 c 311 s 39; 1982 c 545 s 24; 1983 c 7 s 2; 1983 c 243 s 5 subd 2; 1984 c 654 art 5 s 58; 1986 c 444; 1991 c 203 s 1,2; 1994 c 631 s 31; 1995 c 259 art 1 s 33; 1996 c 440 art 1 s 34,35; 1997 c 228 s 9-11; 1998 c 397 art 11 s 3; 2000 c 267 s 1; 2001 c 15 s 1; 2001 c 178 art 1 s 1; 1Sp2001 c 9 art 15 s 22-26,32; 2002 c 379 art 1 s 113; 2005 c 23 s 1; 2005 c 106 s 57; 2006 c 212 art 3 s 10; 2007 c 13 art 1 s 25; 2009 c 108 s 3; 2013 c 108 art 12 s 25-28; 2014 c 291 art 7 s 28; 2015 c 71 art 1 s 126; 2016 c 158 art 2 s 32,33*

144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.

(a) Whenever an adopted person requests the state registrar to disclose the information on the adopted person's original birth record, the state registrar shall act according to section 259.89.

(b) The state registrar shall provide a transcript of an adopted person's original birth record to an authorized representative of a federally recognized American Indian tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership. Information contained in the birth record may not be used to provide the adopted person information about the person's birth parents, except as provided in this section or section 259.83.

History: *1Sp2001 c 9 art 15 s 27; 2002 c 379 art 1 s 113*

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144.226 FEES.

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

(a) The fee for the administrative review and processing of a request for a certified vital record or a certification that the vital record cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

(b) The fee for processing a request for the replacement of a birth record for all events, except when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is $40. The fee is payable at the time of application and is nonrefundable.

(c) The fee for administrative review and processing of a request for the filing of a delayed registration of birth, stillbirth, or death is $40. The fee is payable at the time of application and is nonrefundable.

(d) The fee for administrative review and processing of a request for the amendment of any vital record is $40. The fee is payable at the time of application and is nonrefundable.

(e) The fee for administrative review and processing of a request for the verification of information from vital records is $9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the subject of the record. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(f) The fee for administrative review and processing of a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

Subd. 2. **Fees to state government special revenue fund.** Fees collected under this section by the state registrar shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $3 for each certified birth or stillbirth record and for a certification that the vital record cannot be found. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of management and budget that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $10 for each certified birth record. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget for deposit in the general fund.

Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $4 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local issuance office or state registrar shall forward this amount to the commissioner of management and budget to be deposited into the state government special revenue fund.

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Subd. 5. **Electronic verification.** A fee for the electronic verification or electronic certification of a vital event, when the information being verified or certified is obtained from a certified birth or death record, shall be established through contractual or interagency agreements.

Subd. 6. **Alternative payment methods.** Notwithstanding subdivision 1, alternative payment methods may be approved and implemented by the state registrar or a local issuance office.

History: *1977 c 305 s 45; 1978 c 699 s 15; 1984 c 654 art 5 s 58; 1986 c 423 s 8; 1986 c 444; 1987 c 358 s 108; 1991 c 292 art 8 s 25; 1Sp1993 c 1 art 9 s 20; 1995 c 207 art 9 s 5; 1997 c 203 art 2 s 12,13; 1998 c 406 art 1 s 2,3,37; 1998 c 407 art 9 s 2,3; 1Sp2001 c 9 art 1 s 35; art 15 s 28,29; 2002 c 379 art 1 s 113; 2003 c 112 art 2 s 50; 2005 c 60 s 4-6; 2005 c 98 art 1 s 24; 1Sp2005 c 4 art 6 s 17-20; 2009 c 79 art 4 s 9; 2009 c 101 art 2 s 109; 1Sp2010 c 1 art 20 s 6; 2013 c 108 art 12 s 29*

144.227 PENALTIES.

Subdivision 1. **False statements.** A person who intentionally makes a false statement in a certificate, vital record, or report required to be filed under sections 144.211 to 144.2131 or 144.216 to 144.227, or in an application for an amendment thereof, or in an application for a certified vital record or who supplies false information intending that the information be used in the preparation of a report, vital record, certificate, or amendment thereof, is guilty of a misdemeanor.

Subd. 2. **Fraud.** A person who, without lawful authority and with the intent to deceive, willfully and knowingly makes, counterfeits, alters, obtains, possesses, uses, or sells a certificate, vital record, or report required to be filed under sections 144.211 to 144.227 or a certified certificate, vital record, or report, is guilty of a gross misdemeanor.

Subd. 3. **Birth registration.** A person who intentionally makes a false statement in a registration required under section 144.215 or in an application for an amendment to such a registration or who intentionally supplies false information intending that the information be used in the preparation of a registration under section 144.215 is guilty of a gross misdemeanor. This offense shall be prosecuted by the county attorney.

History: *1978 c 699 s 16; 1994 c 631 s 1,2; 1Sp2001 c 9 art 15 s 30; 2002 c 379 art 1 s 113; 2015 c 21 art 1 s 27*

144.23 [Repealed, 1945 c 512 s 37]

144.24 [Repealed, 1945 c 512 s 37]

144.25 [Repealed, 1945 c 512 s 37]

144.26 [Repealed, 1945 c 512 s 37]

144.27 [Repealed, 1945 c 512 s 37]

144.28 [Repealed, 1945 c 512 s 37]

HEALTH RECORDS AND REPORTS

144.29 HEALTH RECORDS; CHILDREN OF SCHOOL AGE.

It shall be the duty of every school nurse, school physician, school attendance officer, superintendent of schools, principal, teacher, and of the persons charged with the duty of compiling and keeping the school census records, to cause a health record to be kept for each child of school age. Such record shall be kept in

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

History: *(5356-1) 1929 c 277 s 1; 1977 c 305 s 45; 1993 c 224 art 12 s 30; 1Sp1997 c 3 s 23; 1Sp1997 c 4 art 6 s 16*

MINNESOTA HEALTH RECORDS ACT

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" has the meaning given in section 62J.03, subdivision 6.

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

(f) "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" 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.

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(h) "Patient information service" means a service providing the following query options: a record locator service as defined in paragraph (j) or a master patient index or clinical data repository as defined in section 62J.498, subdivision 1.

(i) "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, 148D, 148F, 150A, 151, 153, or 153A;

(2) a home care provider licensed under section 144A.471;

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

(4) a physician assistant registered under chapter 147A.

(j) "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.

(k) "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; 2012 c 187 art 1 s 21; 2012 c 197 art 2 s 44; 2015 c 71 art 8 s 18*

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:

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(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 calendar 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 may charge the $10 retrieval fee, but must not charge a per page 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; except that no fee shall be charged to a person who is receiving public assistance, who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency. 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).

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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; 2012 c 247 art 2 s 4*

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 period specified in the consent or for a different period provided by law.

Subd. 5. **Exceptions to consent requirement.** (a) 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.

(b) A provider may release a deceased patient's health care records to another provider for the purposes of diagnosing or treating the deceased patient's surviving adult child.

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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 clause (1), (2), or (3), 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; or

(3) the release of health records to a program in the welfare system, as defined in section 13.46, to the extent necessary to coordinate services for 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 or patient information 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 or patient information 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 or patient information service or receive data from the service. Only a provider may have access to patient identifying information in a record locator or patient information service. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator or patient information 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 or patient information service must maintain an audit log of providers accessing information in the 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 or patient information service as a condition of payment or participation.

(d) A provider or an entity operating a record locator or patient information 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 or patient information service. At a minimum, a consent form that permits a provider to access a record locator or patient information service must include a

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conspicuous check-box option that allows a patient to exclude all of the patient's information from the service. A provider participating in a health information exchange with a record locator or patient information service who receives a patient's request to exclude all of the patient's information from the service or to have a specific provider contact excluded from the service is responsible for removing that information from the 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; 1Sp2010 c 1 art 20 s 7; 2015 c 71 art 2 s 4; art 8 s 19,20*

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

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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.

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(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*

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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 or an intentional, unauthorized access, 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;

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

(4) intentionally violates sections 144.291 to 144.297 by intentionally accessing a record locator or patient information service without authorization.

Subd. 3. **Liability for record locator or patient information service.** A patient is entitled to receive compensatory damages plus costs and reasonable attorney fees if a health information exchange maintaining a record locator or patient information service, or an entity maintaining a record locator or patient information 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; 2012 c 247 art 2 s 5; 2015 c 71 art 8 s 21,22*

144.30 COPIES OF RECORDS EVIDENCE IN JUVENILE COURT.

When any child shall be brought into juvenile court the court shall request, and the custodian of the record shall furnish, a complete certified copy of such record to the court, which copy shall be received as evidence in the case; and no decision or disposition of the pending matter shall be finally made until such record, if existing, shall be considered.

History: *(5356-2) 1929 c 277 s 2*

144.31 [Repealed, 1969 c 1082 s 2]

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144.32 FALSE STATEMENTS CAUSE FOR DISCHARGE.

Any intentionally false statement in such certificate and any act or omission of a superintendent or superior officer to connive at or permit the same shall be deemed good cause for summary discharge of the person at fault regardless of any contract.

History: *(5356-4) 1929 c 277 s 4*

144.33 [Repealed, 1961 c 27 s 1]

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: *2000 c 316 s 1; 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 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;

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(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 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 board 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:

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(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 work plan, 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: *2006 c 282 art 16 s 3; 2007 c 147 art 10 s 10; 2015 c 21 art 1 s 109*

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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 community health board as defined in section 145A.02, subdivision 5, 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: *1992 c 569 s 12; 1995 c 259 art 1 s 35; 1Sp1995 c 3 art 16 s 13; 1998 c 397 art 11 s 3; 2005 c 98 art 1 s 24; 2007 c 147 art 10 s 15; 2014 c 291 art 7 s 28*

144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT IMMUNIZATION.

The commissioner of health or a community health board may inform the physician attending a newborn of the hepatitis B infection status of the biological mother.

History: *1994 c 618 art 1 s 20; 2015 c 21 art 1 s 109*

144.336 REGISTRY OF PERSONS TYPED FOR HUMAN LEUKOCYTE ANTIGENS.

Subdivision 1. **Release restricted.** No person, including the state, a state agency, or a political subdivision, that maintains or operates a registry of the names of persons, their human leukocyte antigen types, and their willingness to be a tissue donor shall reveal the identity of the person or the person's human leukocyte antigen type without the person's consent. If the data are maintained by a governmental entity, the data are classified as private data on individuals as defined in section 13.02, subdivision 12.

Subd. 2. **Duties.** Persons that maintain or operate a registry described in subdivision 1 have no responsibility for any search beyond their own records to identify potential donors for the benefit of any person seeking a tissue transplant and have no duty to encourage potential donors to assist persons seeking a tissue transplant, and are not liable for their failure to do so.

History: *1984 c 436 s 33; 1986 c 444*

144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.

Any physician having under professional care any person whom the physician believes to be suffering from poisoning from lead, phosphorus, arsenic, brass, silica dust, carbon monoxide gas, wood alcohol, or mercury, or their compounds, or from anthrax or from compressed-air illness or any other disease contracted as a result of the nature of the employment of such person shall within five days mail to the Department of Health a report stating the name, address, and occupation of such patient, the name, address, and business of the patient's employer, the nature of the disease, and such other information as may reasonably be required by the department. The department shall prepare and furnish the physicians of this state suitable blanks for

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the reports herein required. No report made pursuant to the provisions of this section shall be admissible as evidence of the facts therein stated in any action at law or in any action under the Workers' Compensation Act against any employer of such diseased person. The Department of Health is authorized to investigate and to make recommendations for the elimination or prevention of occupational diseases which have been reported to it, or which shall be reported to it, in accordance with the provisions of this section. The department is also authorized to study and provide advice in regard to conditions that may be suspected of causing occupational diseases. Information obtained upon investigations made in accordance with the provisions of this section shall not be admissible as evidence in any action at law to recover damages for personal injury or in any action under the Workers' Compensation Act. Nothing herein contained shall be construed to interfere with or limit the powers of the Department of Labor and Industry to make inspections of places of employment or issue orders for the protection of the health of the persons therein employed. When upon investigation the commissioner of health reaches a conclusion that a condition exists which is dangerous to the life and health of the workers in any industry or factory or other industrial institutions the commissioner shall file a report thereon with the Department of Labor and Industry.

History: *(4327-1) 1939 c 322; 1975 c 359 s 23; 1977 c 305 s 45; 1986 c 444*

CONSENT OF MINORS FOR HEALTH SERVICES

144.341 LIVING APART FROM PARENTS AND MANAGING FINANCIAL AFFAIRS.

Notwithstanding any other provision of law, any minor who is living separate and apart from parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required.

History: *1971 c 544 s 1; 1986 c 444*

144.342 MARRIAGE OR GIVING BIRTH, CONSENT FOR HEALTH SERVICE FOR SELF OR CHILD.

Any minor who has been married or has borne a child may give effective consent to personal medical, mental, dental and other health services, or to services for the minor's child, and the consent of no other person is required.

History: *1971 c 544 s 2; 1986 c 444*

144.343 PREGNANCY, VENEREAL DISEASE, ALCOHOL OR DRUG ABUSE, ABORTION.

Subdivision 1. **Minor's consent valid.** Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

Subd. 2. **Notification concerning abortion.** Notwithstanding the provisions of section 13.02, subdivision 8, no abortion operation shall be performed upon an unemancipated minor or upon a woman for whom a guardian has been appointed pursuant to sections 524.5-101 to 524.5-502 because of a finding of incapacity, until at least 48 hours after written notice of the pending operation has been delivered in the manner specified in subdivisions 2 to 4.

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(a) The notice shall be addressed to the parent at the usual place of abode of the parent and delivered personally to the parent by the physician or an agent.

(b) In lieu of the delivery required by clause (a), notice shall be made by certified mail addressed to the parent at the usual place of abode of the parent with return receipt requested and restricted delivery to the addressee which means postal employee can only deliver the mail to the authorized addressee. Time of delivery shall be deemed to occur at 12 o'clock noon on the next day on which regular mail delivery takes place, subsequent to mailing.

[See Note.]

Subd. 3. **Parent, abortion; definitions.** For purposes of this section, "parent" means both parents of the pregnant woman if they are both living, one parent of the pregnant woman if only one is living or if the second one cannot be located through reasonably diligent effort, or the guardian or conservator if the pregnant woman has one.

For purposes of this section, "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the fetus and "fetus" means any individual human organism from fertilization until birth.

Subd. 4. **Limitations.** No notice shall be required under this section if:

(a) The attending physician certifies in the pregnant woman's medical record that the abortion is necessary to prevent the woman's death and there is insufficient time to provide the required notice; or

(b) The abortion is authorized in writing by the person or persons who are entitled to notice; or

(c) The pregnant minor woman declares that she is a victim of sexual abuse, neglect, or physical abuse as defined in section 626.556. Notice of that declaration shall be made to the proper authorities as provided in section 626.556, subdivision 3.

Subd. 5. **Penalty.** Performance of an abortion in violation of this section shall be a misdemeanor and shall be grounds for a civil action by a person wrongfully denied notification. A person shall not be held liable under this section if the person establishes by written evidence that the person relied upon evidence sufficient to convince a careful and prudent person that the representations of the pregnant woman regarding information necessary to comply with this section are bona fide and true, or if the person has attempted with reasonable diligence to deliver notice, but has been unable to do so.

Subd. 6. **Substitute notification provisions.** If subdivision 2 of this law is ever temporarily or permanently restrained or enjoined by judicial order, subdivision 2 shall be enforced as though the following paragraph were incorporated as paragraph (c) of that subdivision; provided, however, that if such temporary or permanent restraining order or injunction is ever stayed or dissolved, or otherwise ceases to have effect, subdivision 2 shall have full force and effect, without being modified by the addition of the following substitute paragraph which shall have no force or effect until or unless an injunction or restraining order is again in effect.

(c)(i) If such a pregnant woman elects not to allow the notification of one or both of her parents or guardian or conservator, any judge of a court of competent jurisdiction shall, upon petition, or motion, and after an appropriate hearing, authorize a physician to perform the abortion if said judge determines that the pregnant woman is mature and capable of giving informed consent to the proposed abortion. If said judge determines that the pregnant woman is not mature, or if the pregnant woman does not claim to be mature,

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the judge shall determine whether the performance of an abortion upon her without notification of her parents, guardian, or conservator would be in her best interests and shall authorize a physician to perform the abortion without such notification if said judge concludes that the pregnant woman's best interests would be served thereby.

(ii) Such a pregnant woman may participate in proceedings in the court on her own behalf, and the court may appoint a guardian ad litem for her. The court shall, however, advise her that she has a right to court appointed counsel, and shall, upon her request, provide her with such counsel.

(iii) Proceedings in the court under this section shall be confidential and shall be given such precedence over other pending matters so that the court may reach a decision promptly and without delay so as to serve the best interests of the pregnant woman. A judge of the court who conducts proceedings under this section shall make in writing specific factual findings and legal conclusions supporting the decision and shall order a record of the evidence to be maintained including the judge's own findings and conclusions.

(iv) An expedited confidential appeal shall be available to any such pregnant woman for whom the court denies an order authorizing an abortion without notification. An order authorizing an abortion without notification shall not be subject to appeal. No filing fees shall be required of any such pregnant woman at either the trial or the appellate level. Access to the trial court for the purposes of such a petition or motion, and access to the appellate courts for purposes of making an appeal from denial of the same, shall be afforded such a pregnant woman 24 hours a day, seven days a week.

Subd. 7. **Severability.** If any provision, word, phrase or clause of this section or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions, words, phrases, clauses or application of this section which can be given effect without the invalid provision, word, phrase, clause, or application, and to this end the provisions, words, phrases, and clauses of this section are declared to be severable.

History: *1971 c 544 s 3; 1981 c 228 s 1; 1981 c 311 s 39; 1982 c 545 s 24; 1986 c 444; 2004 c 146 art 3 s 1*

NOTE: The two-parent notification requirement in subdivision 2 was found constitutional by incorporation of paragraph (c) of subdivision 6. Hodgson v. Minnesota, 497 U.S. 417 (1990).

144.344 EMERGENCY TREATMENT.

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

History: *1971 c 544 s 4*

144.3441 HEPATITIS B VACCINATION.

A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

History: *1993 c 167 s 1*

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144.345 REPRESENTATIONS TO PERSONS RENDERING SERVICE.

The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

History: *1971 c 544 s 5; 1986 c 444*

144.346 INFORMATION TO PARENTS.

The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

History: *1971 c 544 s 6*

144.347 FINANCIAL RESPONSIBILITY.

A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services.

History: *1971 c 544 s 7*

WATER POLLUTION

144.35 POLLUTION OF WATER.

No sewage or other matter that will impair the healthfulness of water shall be deposited where it will fall or drain into any pond or stream used as a source of water supply for domestic use. The commissioner shall have general charge of all springs, wells, ponds, and streams so used and take all necessary and proper steps to preserve the same from such pollution as may endanger the public health. In case of violation of any of the provisions of this section, the commissioner may, with or without a hearing, order any person to desist from causing such pollution and to comply with such direction as the commissioner may deem proper and expedient in the premises. Such order shall be served forthwith upon the person found to have violated such provisions.

History: *(5375) RL s 2147; 1977 c 305 s 45; 1986 c 444*

144.36 APPEAL TO DISTRICT COURT.

Within five days after service of the order, any person aggrieved thereby may appeal to the district court of the county in which such polluted source of water supply is situated. During the pendency of the appeal the pollution against which the order has been issued shall not be continued and, upon violation of such order, the appeal shall forthwith be dismissed.

History: *(5376) RL s 2148; 1987 c 309 s 16*

144.37 OTHER REMEDIES PRESERVED.

Nothing in section 144.36 shall curtail the power of the courts to administer the usual legal and equitable remedies in cases of nuisances or of improper interference with private rights.

History: *(5377) RL s 2149; 1987 c 309 s 17*

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144.371 [Renumbered 115.01]

144.372 [Renumbered 115.02]

144.373 [Renumbered 115.03]

144.374 [Renumbered 115.04]

144.375 [Renumbered 115.05]

144.376 [Renumbered 115.06]

144.377 [Renumbered 115.07]

144.378 [Renumbered 115.08]

144.379 [Renumbered 115.09]

144.38 [Repealed, 1967 c 882 s 11]

SAFE DRINKING WATER ACT

144.381 CITATION.

Sections 144.381 to 144.387 may be cited as the "Safe Drinking Water Act of 1977."

History: *1977 c 66 s 1*

144.382 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144.381 to 144.387, the following terms have the meanings given.

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

Subd. 3. **Federal regulations.** "Federal regulations" means rules promulgated by the federal environmental protection agency, or its successor agencies.

Subd. 4. **Public water supply.** "Public water supply" has the meaning given to "public water system" in the federal Safe Drinking Water Act, United States Code, title 42, section 300f, clause (4).

Subd. 5. **Supplier.** "Supplier" means a person who owns, manages or operates a public water supply.

History: *1977 c 66 s 2; 1977 c 305 s 45; 1999 c 18 s 1*

144.383 AUTHORITY OF COMMISSIONER.

In order to insure safe drinking water in all public water supplies, the commissioner has the following powers:

(a) To approve the site, design, and construction and alteration of all public water supplies and, for community and nontransient noncommunity water systems as defined in Code of Federal Regulations, title 40, section 141.2, to approve documentation that demonstrates the technical, managerial, and financial capacity of those systems to comply with rules adopted under this section;

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(b) To enter the premises of a public water supply, or part thereof, to inspect the facilities and records kept pursuant to rules promulgated by the commissioner, to conduct sanitary surveys and investigate the standard of operation and service delivered by public water supplies;

(c) To contract with community health boards as defined in section 145A.02, subdivision 5, for routine surveys, inspections, and testing of public water supply quality;

(d) To develop an emergency plan to protect the public when a decline in water quality or quantity creates a serious health risk, and to issue emergency orders if a health risk is imminent;

(e) To promulgate rules, pursuant to chapter 14 but no less stringent than federal regulation, which may include the granting of variances and exemptions.

History: *1977 c 66 s 3; 1977 c 305 s 45; 1982 c 424 s 130; 1987 c 309 s 24; 1989 c 209 art 2 s 1; 1998 c 261 s 1; 2014 c 291 art 7 s 28,29*

144.3831 FEES.

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of $6.36 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

Subd. 2. **Collection and payment of fee.** The public water supply described in subdivision 1 shall:

(1) collect the fees assessed on its service connections;

(2) pay the Department of Health an amount equivalent to the fees based on the total number of service connections. The service connections for each public water supply described in subdivision 1 shall be verified every four years by the Department of Health; and

(3) pay one-fourth of the total yearly fee to the Department of Health each calendar quarter. In lieu of quarterly payments, a public water supply described in subdivision 1 with fewer than 50 service connections may make a single annual payment by June 30 each year. The fees payable to the Department of Health shall be deposited in the state treasury as nondedicated state government special revenue fund revenues.

Subd. 3. **Late fee.** The public water supply described in subdivision 1 shall pay a late fee in the amount of five percent of the amount of the fees due from the public water supply if the fees due from the public water supply are not paid within 30 days of the payment dates in subdivision 2, clause (3). The late fee that the public water supply shall pay shall be assessed only on the actual amount collected by the public water supply through fees on service connections.

History: *1992 c 513 art 6 s 3; 1Sp1993 c 1 art 9 s 21; 1995 c 186 s 42; 1Sp2001 c 5 art 7 s 3; 1Sp2005 c 4 art 6 s 21*

144.384 NOTICE OF VIOLATION.

Upon discovery of a violation of a maximum contaminant level or treatment technique, the commissioner shall promptly notify the supplier of the violation, state the rule violated, and state a date by which the violation must be corrected or by which a request for variance or exemption must be submitted.

History: *1977 c 66 s 4; 1977 c 305 s 45*

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144.385 PUBLIC NOTICE.

If a public water system has violated a rule of the commissioner, has a variance or exemption granted, or fails to comply with the terms of the variance or exemption, the supplier shall provide public notice of the fact pursuant to the rules of the commissioner.

History: *1977 c 66 s 5; 1977 c 305 s 45*

144.3855 LIMITATION.

To meet cross-connection control requirements, as defined in Minnesota Rules, parts 4714.0602 and 4720.0025, the use of a hose connection backflow preventer and a hose connection vacuum breaker, not rated for continuous use, is permitted at individual water supply connections in recreational camping areas as defined in section 327.14, subdivision 8.

History: *2007 c 24 s 1; 2017 c 40 art 1 s 121*

144.386 PENALTIES.

Subdivision 1. **Basic fine.** A person who violates a rule of the commissioner, fails to comply with the terms of a variance or exemption, or fails to request a variance or exemption by the date specified in the notice from the commissioner, may be fined up to $1,000 for each day the offense continues, in a civil action brought by the commissioner in district court. All fines shall be deposited in the general fund of the state treasury.

Subd. 2. **Gross misdemeanor fine.** A person who intentionally or repeatedly violates a rule of the commissioner, or fails to comply with an emergency order of the commissioner, is guilty of a gross misdemeanor, and may be fined not more than $10,000, imprisoned not more than one year, or both.

Subd. 3. **Drinking water notice; fine.** A supplier who fails to comply with the provisions of section 144.385, or disseminates false or misleading information relating to the notice required in section 144.385, is subject to the penalties described in subdivision 2.

Subd. 4. [Repealed, 1993 c 206 s 25]

History: *1977 c 66 s 6; 1977 c 305 s 45; 1984 c 628 art 3 s 11*

144.387 COSTS.

If the state prevails in any civil action under section 144.386, the court may award reasonable costs and expenses to the state.

History: *1977 c 66 s 7*

144.3871 [Repealed, 1996 c 418 s 18]

FEMALE GENITAL MUTILATION; EDUCATION AND OUTREACH

144.3872 FEMALE GENITAL MUTILATION; EDUCATION AND OUTREACH.

The commissioner of health shall carry out appropriate education, prevention, and outreach activities in communities that traditionally practice female circumcision, excision, or infibulation to inform people in those communities about the health risks and emotional trauma inflicted by those practices and to inform

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them and the medical community of the criminal penalties contained in section 609.2245. The commissioner shall work with culturally appropriate groups to obtain private funds to help finance these prevention and outreach activities.

History: *1994 c 636 art 9 s 9*

144.388 [Repealed, 1988 c 689 art 2 s 269]

144.39 [Repealed, 1967 c 882 s 11]

PROMOTION OF NONSMOKING

144.391 PUBLIC POLICY.

The legislature finds that:

(1) smoking causes premature death, disability, and chronic disease, including cancer and heart disease, and lung disease;

(2) smoking related diseases result in excess medical care costs; and

(3) smoking initiation occurs primarily in adolescence.

The legislature desires to prevent young people from starting to smoke, to encourage and assist smokers to quit, and to promote clean indoor air.

History: *1Sp1985 c 14 art 19 s 13*

144.392 DUTIES OF COMMISSIONER.

The commissioner of health shall:

(1) provide assistance to workplaces to develop policies that promote nonsmoking and are consistent with the Minnesota Clean Indoor Air Act;

(2) provide technical assistance, including design and evaluation methods, materials, and training to local health departments, communities, and other organizations that undertake community programs for the promotion of nonsmoking;

(3) collect and disseminate information and materials for smoking prevention;

(4) evaluate new and existing nonsmoking programs on a statewide and regional basis using scientific evaluation methods;

(5) conduct surveys in school-based populations regarding the epidemiology of smoking behavior, knowledge, and attitudes related to smoking, and the penetration of statewide smoking control programs; and

(6) report to the legislature each biennium on activities undertaken, smoking rates in the population and subgroups of the total population, evaluation activities and results of those activities, and recommendations for further action.

History: *1Sp1985 c 14 art 19 s 14*

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144.393 PUBLIC COMMUNICATIONS PROGRAM.

The commissioner may conduct a long-term coordinated public information program that includes public service announcements, public education forums, mass media, and written materials. The program must promote nonsmoking and include background survey research and evaluation. The program must be designed to run over at least five years, subject to the availability of money.

History: *1Sp1985 c 14 art 19 s 15*

144.394 HEALTH PROMOTION AND EDUCATION.

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

History: *1995 c 207 art 9 s 6; 1997 c 203 art 2 s 14*

TOBACCO USE PREVENTION

144.395 [Repealed, 2006 c 282 art 14 s 15]

144.396 TOBACCO USE PREVENTION.

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

Subd. 2. **Measurable outcomes.** The commissioner, in consultation with other public, private, or nonprofit organizations involved in tobacco use prevention efforts, shall establish measurable outcomes to determine the effectiveness of the grants receiving funds under this section in reducing the use of tobacco among youth.

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

Subd. 4. **Process.** (a) The commissioner shall develop the criteria and procedures to allocate the grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. The outcomes established under subdivision 2 must be specified to the grant recipients receiving grants under this section at the time the grant is awarded.

(b) A recipient of a grant under this section must coordinate its tobacco use prevention activities with other entities performing tobacco use prevention activities within the recipient's service area.

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

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

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

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

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

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

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

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

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

Subd. 6. **Local tobacco prevention grants.** (a) The commissioner shall award grants to eligible applicants for local and regional projects and initiatives directed at tobacco prevention in coordination with other health areas aimed at reducing high-risk behaviors in youth that lead to adverse health-related problems. The project areas for grants include:

(1) school-based tobacco prevention programs aimed at youth and parents;

(2) local public awareness and education projects aimed at tobacco prevention in coordination with locally assessed community public health needs pursuant to chapter 145A; or

(3) local initiatives aimed at reducing high-risk behavior in youth associated with tobacco use and the health consequences of these behaviors.

(b) Eligible applicants may include, but are not limited to, community health boards, school districts, community clinics, Indian tribes, nonprofit organizations, and other health care organizations. Applicants must submit proposals to the commissioner. The proposals must specify the strategies to be implemented to target tobacco use among youth, and must be targeted to achieve the outcomes established in subdivision 2.

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

(1) is supported by the community in which the applicant serves;

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

(3) is designed to coordinate with other community activities related to other health initiatives;

(4) incorporates an understanding of the role of community in influencing behavioral changes among youth regarding tobacco use and other high-risk health-related behaviors; or

(5) addresses disparities among populations of color related to tobacco use and other high-risk health-related behaviors.

(d) The commissioner shall divide the state into specific geographic regions and allocate a percentage of the money available for distribution to projects or initiatives aimed at that geographic region. If the

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commissioner does not receive a sufficient number of grant proposals from applicants that serve a particular region or the proposals submitted do not meet the criteria developed by the commissioner, the commissioner shall provide technical assistance and expertise to ensure the development of adequate proposals aimed at addressing the public health needs of that region. In awarding the grants, the commissioner shall consider locally assessed community public health needs pursuant to chapter 145A.

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

Subd. 8. **Coordination.** The commissioner shall coordinate the projects and initiatives funded under this section with the tobacco use prevention efforts of the Minnesota partnership for action against tobacco, community health boards, and other public, private, and nonprofit organizations and the tobacco prevention efforts that are being conducted on the national level.

Subd. 8a. **Smoking cessation.** The commissioner of health must prioritize smoking prevention and smoking cessation activities in low-income, indigenous, and minority communities in their collaborations with the organization specifically described in subdivision 8.

Subd. 9. **Evaluation.** Using the outcome measures established in subdivision 2, the commissioner of health shall conduct a biennial evaluation of the statewide and local tobacco use prevention projects and community health board activities funded under this section. The evaluation must include:

(1) the effect of these activities on the amount of tobacco use by youth and rates at which youth start to use tobacco products; and

(2) a longitudinal tracking of outcomes for youth.

Grant recipients and community health boards shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation. Beginning January 15, 2003, the results of each evaluation must be submitted to the chairs and members of the house of representatives Health and Human Services Finance Committee and the senate Health and Family Security Budget Division.

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

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

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

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Subd. 13. [Repealed, 2000 c 488 art 11 s 12]

History: *1999 c 245 art 11 s 5; 2000 c 488 art 11 s 5,6; 2003 c 130 s 12; 1Sp2003 c 14 art 7 s 35-40; 2008 c 277 art 1 s 14; 2009 c 79 art 10 s 47*

144.40 [Repealed, 1967 c 882 s 11]

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

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

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

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

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

144.41 [Repealed, 1967 c 882 s 11]

CLEAN INDOOR AIR ACT

144.411 CITATION.

Sections 144.411 to 144.417 may be cited as the "Minnesota Clean Indoor Air Act."

History: *1975 c 211 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: *1975 c 211 s 2; 1987 c 399 s 1; 2007 c 82 s 2*

144.413 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 144.411 to 144.416, the terms defined in this section have the meanings given them.

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

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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.

Subd. 3. **Public meeting.** "Public meeting" includes all meetings open to the public pursuant to section 13D.01.

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: *1975 c 211 s 3; 1992 c 576 s 1; 1994 c 520 s 1; 1998 c 397 art 11 s 3; 1999 c 245 art 2 s 24; 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.** (a) Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0170, 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.

(b) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

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

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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.

(c) For purposes of this subdivision, the definition of smoking includes the use of electronic cigarettes, including the inhaling and exhaling of vapor from any electronic delivery device as defined in section 609.685, subdivision 1.

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.

Subd. 5. **Electronic cigarettes.** (a) The use of electronic cigarettes, including the inhaling or exhaling of vapor from any electronic delivery device, as defined in section 609.685, subdivision 1, is prohibited in the following locations:

(1) any building owned or operated by the state, home rule charter or statutory city, county, township, school district, or other political subdivision;

(2) any facility owned by Minnesota State Colleges and Universities and the University of Minnesota;

(3) any facility licensed by the commissioner of human services; or

(4) any facility licensed by the commissioner of health, but only if the facility is also subject to federal licensing requirements.

(b) Nothing in this subdivision shall prohibit political subdivisions or businesses from adopting more stringent prohibitions on the use of electronic cigarettes or electronic delivery devices.

History: *1975 c 211 s 4; 1977 c 305 s 45; 1984 c 654 art 2 s 113; 1987 c 399 s 2; 1992 c 576 s 2; 1993 c 14 s 1; 1995 c 165 s 2; 1999 c 245 art 2 s 25; 1Sp2003 c 14 art 7 s 41; 2007 c 82 s 8; 2014 c 291 art 6 s 4-6; 2016 c 158 art 1 s 53*

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

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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: *1975 c 211 s 6; 2007 c 82 s 9*

144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product, or inhale or exhale vapor from an electronic delivery device as defined in section 609.685, subdivision 1, in a public school, as defined in section 120A.05, subdivisions 9, 11, and 13, and no person under the age of 18 shall possess any of these items. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755 subdivision 12.

History: *1992 c 576 s 3; 1993 c 224 art 9 s 42; 1996 c 412 art 13 s 30; 1998 c 397 art 11 s 3; 1999 c 139 art 4 s 2; 1999 c 245 art 2 s 26; 2014 c 291 art 6 s 7*

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

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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 168.002, subdivision 8; implements of husbandry, as defined in section 168A.01, subdivision 8; and special mobile equipment, as defined in section 168.002, subdivision 31. 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.

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Subd. 3. **Injunction.** The state commissioner of health, a community health board as defined in section 145A.02, subdivision 5, 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: *1975 c 211 s 7; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24; 1992 c 576 s 4,5; 1995 c 165 s 3; 2002 c 375 art 3 s 7; 2007 c 82 s 11; 2014 c 291 art 7 s 28*

HEALTH THREAT PROCEDURES

144.4171 SCOPE.

Subdivision 1. **Authority.** Under the powers and duties assigned to the commissioner in sections 144.05 and 144.12, the commissioner shall proceed according to sections 144.4171 to 144.4186 with respect to persons who pose a health threat to others or who engage in noncompliant behavior.

Subd. 2. **Preemption.** Sections 144.4171 to 144.4186 preempt and supersede any local ordinance or rule concerning persons who pose a health threat to others or who engage in noncompliant behavior.

History: *1987 c 209 s 4*

144.4172 DEFINITIONS.

Subdivision 1. **Carrier.** "Carrier" means a person who serves as a potential source of infection and who harbors or who the commissioner reasonably believes to be harboring a specific infectious agent whether or not there is present discernible clinical disease. In the absence of a medically accepted test, the commissioner may reasonably believe an individual to be a carrier only when a determination based upon specific facts justifies an inference that the individual harbors a specific infectious agent.

Subd. 2. **Communicable disease.** "Communicable disease" means a disease or condition that causes serious illness, serious disability, or death, the infectious agent of which may pass or be carried, directly or indirectly, from the body of one person to the body of another.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Contact notification program.** "Contact notification program" means an ongoing program established by the commissioner to encourage carriers of a communicable disease whose primary route of transmission is through an exchange of blood, semen, or vaginal secretions, such as treponema pallidum, neisseria gonorrhea, chlamydia trachomatis, and human immunodeficiency virus, to identify others who may be at risk by virtue of contact with the carrier.

Subd. 5. **Directly transmitted.** "Directly transmitted" means predominately:

(1) sexually transmitted;

(2) bloodborne; or

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(3) transmitted through direct or intimate skin contact.

Subd. 6. **Health directive.** "Health directive" means a written statement, or, in urgent circumstances, an oral statement followed by a written statement within three days, from the commissioner, or community health board as defined in section 145A.02, subdivision 5, with delegated authority from the commissioner, issued to a carrier who constitutes a health threat to others. A health directive must be individual, specific, and cannot be issued to a class of persons. The directive may require a carrier to cooperate with health authorities in efforts to prevent or control transmission of communicable disease, including participation in education, counseling, or treatment programs, and undergoing medical tests necessary to verify the person's carrier status. The written directive shall be served in the same manner as a summons and complaint under the Minnesota Rules of Civil Procedure.

Subd. 7. **Licensed health professional.** "Licensed health professional" means a person licensed in Minnesota to practice those professions described in section 214.01, subdivision 2.

Subd. 8. **Health threat to others.** "Health threat to others" means that a carrier demonstrates an inability or unwillingness to act in such a manner as to not place others at risk of exposure to infection that causes serious illness, serious disability, or death. It includes one or more of the following:

(1) With respect to an indirectly transmitted communicable disease:

(a) behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others; or

(b) a substantial likelihood that a carrier will transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention.

(2) With respect to a directly transmitted communicable disease:

(a) repeated behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others;

(b) a substantial likelihood that a carrier will repeatedly transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention;

(c) affirmative misrepresentation by a carrier of the carrier's status prior to engaging in any behavior which has been demonstrated epidemiologically to transmit the disease; or

(d) the activities referenced in clause (1) if the person whom the carrier places at risk is: (i) a minor, (ii) of diminished capacity by reason of mood altering chemicals, including alcohol, (iii) has been diagnosed as having significantly subaverage intellectual functioning, (iv) has an organic disorder of the brain or a psychiatric disorder of thought, mood, perception, orientation, or memory which substantially impairs judgment, behavior, reasoning, or understanding; (v) adjudicated as an incompetent; or (vi) a vulnerable adult as defined in section 626.5572.

(3) Violation by a carrier of any part of a court order issued pursuant to this chapter.

Subd. 9. **Indirectly transmitted.** "Indirectly transmitted" means any transmission not defined by subdivision 5.

Subd. 10. **Noncompliant behavior.** "Noncompliant behavior" means a failure or refusal by a carrier to comply with a health directive.

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Subd. 11. **Respondent.** "Respondent" means any person against whom an action is commenced under sections 144.4171 to 144.4186.

History: *1986 c 444; 1987 c 209 s 5; 1987 c 309 s 24; 1995 c 229 art 4 s 4; 2014 c 291 art 7 s 28*

144.4173 CAUSE OF ACTION.

Subdivision 1. **Compliance with directive.** Failure or refusal of a carrier to comply with a health directive is grounds for proceeding under subdivision 2.

Subd. 2. **Commencement of action.** The commissioner, or a community health board as defined in section 145A.02, subdivision 5, with express delegated authority from the commissioner, may commence legal action against a carrier who is a health threat to others and, unless a court order is sought under section 144.4182, who engages in noncompliant behavior, by filing with the district court in the county in which respondent resides, and serving upon respondent, a petition for relief and notice of hearing.

History: *1987 c 209 s 6; 1987 c 309 s 24; 2014 c 291 art 7 s 28*

144.4174 STANDING.

Only the commissioner, or a community health board as defined in section 145A.02, subdivision 5, with express delegated authority from the commissioner, may commence an action under sections 144.4171 to 144.4186.

History: *1987 c 209 s 7; 1987 c 309 s 24; 2014 c 291 art 7 s 28*

144.4175 REPORTING.

Subdivision 1. **Voluntary reporting.** Any licensed health professional or other human services professional regulated by the state who has knowledge or reasonable cause to believe that a person is a health threat to others or has engaged in noncompliant behavior, as defined in section 144.4172, may report that information to the commissioner.

Subd. 2. **Liability for reporting.** A licensed health professional or other human services professional regulated by the state who has knowledge or reasonable cause to believe that a person is a health threat to others or has engaged in noncompliant behavior, and who makes a report in good faith under subdivision 1, is not subject to liability for reporting in any civil, administrative, disciplinary, or criminal action.

Subd. 3. **Falsified reports.** Any person who knowingly or recklessly makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury.

Subd. 4. **Waiver of privilege.** Any privilege otherwise created in section 595.02, clauses (d), (e), (g), and (j), with respect to persons who make a report under subdivision 1, is waived regarding any information about a carrier as a health threat to others or about a carrier's noncompliant behavior in any investigation or action under sections 144.4171 to 144.4186.

History: *1987 c 209 s 8*

144.4176 PETITION; NOTICE.

Subdivision 1. **Petition.** The petition must set forth the following:

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(1) the grounds and underlying facts that demonstrate that the respondent is a health threat to others and, unless an emergency court order is sought under section 144.4182, has engaged in noncompliant behavior;

(2) the petitioner's efforts to alleviate the health threat to others prior to the issuance of a health directive, unless an emergency court order is sought under section 144.4182;

(3) the petitioner's efforts to issue the health directive to the respondent in person, unless an emergency court order is sought under section 144.4182;

(4) the type of relief sought; and

(5) a request for a court hearing on the allegations contained in the petition.

Subd. 2. **Hearing notice.** The notice must contain the following information:

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

(2) respondent's right to appear at the hearing;

(3) respondent's right to present and cross-examine witnesses; and

(4) respondent's right to counsel, including the right, if indigent, to representation by counsel designated by the court or county of venue.

History: *1987 c 209 s 9*

144.4177 TIME OF HEARING AND DUTIES OF COUNSEL.

Subdivision 1. **Time of hearing.** A hearing on the petition must be held before the district court in the county in which respondent resides as soon as possible, but no later than 14 days from service of the petition and hearing notice.

Subd. 2. **Duties of counsel.** In all proceedings under this section, counsel for the respondent shall (1) consult with the person prior to any hearing; (2) be given adequate time to prepare for all hearings; (3) continue to represent the person throughout any proceedings under this charge unless released as counsel by the court; and (4) be a vigorous advocate on behalf of the client.

History: *1987 c 209 s 10*

144.4178 CRIMINAL IMMUNITY.

In accordance with section 609.09, subdivision 2, no person shall be excused in an action under sections 144.4171 to 144.4186 from giving testimony or producing any documents, books, records, or correspondence, tending to be self-incriminating; but the testimony or evidence, or other testimony or evidence derived from it, must not be used against the person in any criminal case, except for perjury committed in the testimony.

History: *1987 c 209 s 11*

144.4179 STANDARD OF PROOF; EVIDENCE.

Subdivision 1. **Clear and convincing.** The commissioner must prove the allegations in the petition by clear and convincing evidence.

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Subd. 2. **All relevant evidence.** The court shall admit all reliable relevant evidence. Medical and epidemiologic data must be admitted if it otherwise comports with section 145.30, chapter 600, Minnesota Rules of Evidence 803(6), or other statutes or rules that permit reliable evidence to be admitted in civil cases.

Subd. 3. **Carrier status.** Upon a finding by the court that the commissioner's suspicion of carrier status is reasonable as established by presentation of facts justifying an inference that the respondent harbors a specific infectious agent, there shall exist a rebuttable presumption that the respondent is a carrier. This presumption may be rebutted if the respondent demonstrates noncarrier status after undergoing medically accepted tests.

Subd. 4. **Failure to appear.** If a party fails to appear at the hearing without prior court approval, the hearing may proceed without the absent party and the court may make its determination on the basis of all reliable evidence submitted at the hearing.

Subd. 5. **Records.** The court shall take and preserve an accurate stenographic record of the proceedings.

History: *1987 c 209 s 12*

144.4180 REMEDIES.

Subdivision 1. **Remedies available.** Upon a finding by the court that the commissioner has proven the allegations set forth in the petition, the court may order that the respondent must:

(1) participate in a designated education program;

(2) participate in a designated counseling program;

(3) participate in a designated treatment program;

(4) undergo medically accepted tests to verify carrier status or for diagnosis, or undergo treatment that is consistent with standard medical practice as necessary to make respondent noninfectious;

(5) notify or appear before designated health officials for verification of status, testing, or other purposes consistent with monitoring;

(6) cease and desist the conduct which constitutes a health threat to others;

(7) live part time or full time in a supervised setting for the period and under the conditions set by the court;

(8) subject to the provisions of subdivision 2, be committed to an appropriate institutional facility for the period and under the conditions set by the court, but not longer than six months, until the respondent is made noninfectious, or until the respondent completes a course of treatment prescribed by the court, whichever occurs first, unless the commissioner shows good cause for continued commitment; and

(9) comply with any combination of the remedies in clauses (1) to (8), or other remedies considered just by the court. In no case may a respondent be committed to a correctional facility.

Subd. 2. **Commitment review panel.** The court may not order the remedy specified in subdivision 1, clause (8), unless it first considers the recommendation of a commitment review panel appointed by the commissioner to review the need for commitment of the respondent to an institutional facility.

The duties of the commitment review panel shall be to:

(1) review the record of the proceeding;

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(2) interview the respondent. If the respondent is not interviewed, the reasons must be documented; and

(3) identify, explore, and list the reasons for rejecting or recommending alternatives to commitment.

Subd. 3. **Construction.** This section shall be construed so that the least restrictive alternative is used to achieve the desired purpose of preventing or controlling communicable disease.

Subd. 4. **Additional requirements.** If commitment or supervised living is ordered, the court shall require the head of the institutional facility or the person in charge of supervision to submit: (a) a plan of treatment within ten days of initiation of commitment or supervised living; and (b) a written report, with a copy to both the commissioner and the respondent, at least 60 days, but not more than 90 days, from the start of respondent's commitment or supervised living arrangement, setting forth the following:

(1) the types of support or therapy groups, if any, respondent is attending and how often respondent attends;

(2) the type of care or treatment respondent is receiving, and what future care or treatment is necessary;

(3) whether respondent has been cured or made noninfectious, or otherwise no longer poses a threat to public health;

(4) whether continued commitment or supervised living is necessary; and

(5) other information the court considers necessary.

History: *1987 c 209 s 13*

144.4181 APPEAL.

The petitioner or respondent may appeal the decision of the district court. The Court of Appeals shall hear the appeal within 30 days after service of the notice of appeal. However, respondent's status as determined by the district court remains unchanged, and any remedy ordered by the district court remains in effect while the appeal is pending.

History: *1987 c 209 s 14*

144.4182 TEMPORARY EMERGENCY HOLD.

Subdivision 1. **Apprehend and hold.** To protect the public health in an emergency, the court may order an agent of a community health board as authorized under section 145A.04 or peace officer to take a person into custody and transport the person to an appropriate emergency care or treatment facility for observation, examination, testing, diagnosis, care, treatment, and, if necessary, temporary detention. If the person is already institutionalized, the court may order the institutional facility to hold the person. These orders may be issued in an ex parte proceeding upon an affidavit of the commissioner or a designee of the commissioner. An order shall issue upon a determination by the court that reasonable cause exists to believe that the person is: (a) for indirectly transmitted diseases, an imminent health threat to others; or (b) for directly transmitted diseases, a substantial likelihood of an imminent health threat to others.

The affidavit must set forth the specific facts upon which the order is sought and must be served on the person immediately upon apprehension or detention. An order under this section may be executed on any day and at any time.

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Subd. 2. **Duration of hold.** No person may be held under subdivision 1 longer than 72 hours, exclusive of Saturdays, Sundays, and legal holidays, without a court hearing to determine if the emergency hold should continue.

History: *1987 c 209 s 15; 1987 c 309 s 24; 2015 c 21 art 1 s 109*

144.4183 EMERGENCY HOLD HEARING.

Subdivision 1. **Time of notice.** Notice of the emergency hold hearing must be served upon the person held under section 144.4182, subdivision 1, at least 24 hours before the hearing.

Subd. 2. **Contents of notice.** The notice must contain the following information:

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

(2) the grounds and underlying facts upon which continued detention is sought;

(3) the person's right to appear at the hearing;

(4) the person's right to present and cross-examine witnesses; and

(5) the person's right to counsel, including the right, if indigent, to representation by counsel designated by the court or county of venue.

Subd. 3. **Order for continued emergency hold.** The court may order the continued holding of the person if it finds, by a preponderance of the evidence, that the person would pose an imminent health threat to others if released. However, in no case may the emergency hold continue longer than five days, unless a petition is filed under section 144.4173. If a petition is filed, the emergency hold must continue until a hearing on the petition is held under section 144.4177. That hearing must occur within five days of the filing of the petition, exclusive of Saturdays, Sundays, and legal holidays.

History: *1987 c 209 s 16*

144.4184 CONTACT DATA.

Identifying information voluntarily given to the commissioner, or an agent of the commissioner, by a carrier through a contact notification program must not be used as evidence in a court proceeding to determine noncompliant behavior.

History: *1987 c 209 s 17*

144.4185 COSTS.

Subdivision 1. **Costs of care.** The court shall determine what part of the cost of care or treatment ordered by the court, if any, the respondent can pay. The respondent shall provide the court documents and other information necessary to determine financial ability. If the respondent cannot pay the full cost of care, the rest must be paid by the county in which respondent resides. If the respondent provides inaccurate or misleading information, or later becomes able to pay the full cost of care, the respondent becomes liable to the county for costs paid by the county.

Subd. 2. **Court-appointed counsel.** If the court appoints counsel to represent respondent free of charge, counsel must be compensated by the county in which respondent resides, except to the extent that the court finds that the respondent is financially able to pay for counsel's services. In these situations, the rate of compensation for counsel shall be determined by the court.

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Subd. 3. **Report.** The commissioner shall report any recommendations for appropriate changes in the modes of financing of services provided under subdivision 1 by January 15, 1988.

History: *1987 c 209 s 18*

DATA PRACTICES

144.4186 DATA PRIVACY.

Subdivision 1. **Nonpublic data.** Data contained in a health directive are classified as protected nonpublic data under section 13.02, subdivision 13, in the case of data not on individuals, and private under section 13.02, subdivision 12, in the case of data on individuals. Investigative data shall have the classification accorded it under section 13.39.

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

Subd. 3. **Records retention.** A records retention schedule for records developed under sections 144.4171 to 144.4186 shall be established pursuant to section 138.17, subdivision 7.

History: *1987 c 209 s 19*

ISOLATION AND QUARANTINE

144.419 ISOLATION AND QUARANTINE OF PERSONS.

Subdivision 1. **Definitions.** For purposes of sections 144.419 to 144.4196, the following definitions apply:

(1) "bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population;

(2) "communicable disease" means a disease caused by a living organism or virus and believed to be caused by bioterrorism or a new or novel or previously controlled or eradicated infectious agent or biological toxin that can be transmitted person to person and for which isolation or quarantine is an effective control strategy, excluding a disease that is directly transmitted as defined under section 144.4172, subdivision 5;

(3) "isolation" means separation, during the period of communicability, of a person infected with a communicable disease, in a place and under conditions so as to prevent direct or indirect transmission of an infectious agent to others; and

(4) "quarantine" means restriction, during a period of communicability, of activities or travel of an otherwise healthy person who likely has been exposed to a communicable disease to prevent disease transmission during the period of communicability in the event the person is infected.

Subd. 2. **General requirements.** (a) The commissioner of health or any person acting under the commissioner's authority shall comply with paragraphs (b) to (h) when isolating or quarantining individuals or groups of individuals.

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(b) Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of a communicable or potentially communicable disease to others and may include, but are not limited to, confinement to private homes or other private or public premises.

(c) Isolated individuals must be confined separately from quarantined individuals.

(d) The health status of isolated and quarantined individuals must be monitored regularly to determine if they require continued isolation or quarantine. To adequately address emergency health situations, isolated and quarantined individuals shall be given a reliable means to communicate 24 hours a day with health officials and to summon emergency health services.

(e) If a quarantined individual subsequently becomes infectious or is reasonably believed to have become infectious with a communicable or potentially communicable disease, the individual must be isolated according to section 144.4195.

(f) Isolated and quarantined individuals must be immediately released when they pose no known risk of transmitting a communicable or potentially communicable disease to others.

(g) The needs of persons isolated and quarantined shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication between those in isolation or quarantine and those outside these settings, medication, and competent medical care.

(h) Premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection or other harms to persons isolated and quarantined.

Subd. 3. **Termination.** The isolation or quarantine of a person must terminate automatically on the expiration date of a court order authorizing isolation or quarantine that is issued according to section 144.4195, or before the expiration date if the commissioner of health determines that isolation or quarantine of the person is no longer necessary to protect the public.

Subd. 4. **Right to refuse treatment.** Any person who is isolated or quarantined according to this section and section 144.4195 has a fundamental right to refuse medical treatment, testing, physical or mental examination, vaccination, participation in experimental procedures and protocols, collection of specimens, and preventive treatment programs. A person who has been directed by the commissioner of health or any person acting under the commissioner's authority to submit to medical procedures and protocols because the person is infected with or reasonably believed by the commissioner or by the person acting under the commissioner's authority to be infected with or exposed to a communicable disease and who refuses to submit to them may be subject to continued isolation or quarantine according to the parameters set forth in section 144.4195.

Subd. 5. **Restricted entry.** (a) No person, other than a person authorized by the commissioner of health or authorized by any person acting under the commissioner's authority, shall enter an isolation or quarantine area. If, by reason of an unauthorized entry into an isolation or quarantine area, a person poses a danger to public health, the person may be subject to isolation or quarantine according to this section and section 144.4195.

(b) A family member or health care agent of a person isolated or quarantined has a right to choose to enter into an isolation or quarantine area. The commissioner of health must permit the family member or health care agent entry into the isolation or quarantine area if the family member or health care agent signs a consent form stating that the family member or health care agent has been informed of the potential health

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risks, isolation and quarantine guidelines, and the consequences of entering the area. The family member or health care agent may not hold the Department of Health, the commissioner of health, or the state responsible for any consequences of entering the isolation or quarantine area. If, by reason of entry into an isolation or quarantine area under this paragraph, a person poses a danger to public health, the person may be subject to isolation or quarantine according to this section and section 144.4195.

History: *2002 c 402 s 18; 2005 c 149 s 1; 2009 c 108 s 4*

144.4195 DUE PROCESS FOR ISOLATION OR QUARANTINE OF PERSONS.

Subdivision 1. **Ex parte order for isolation or quarantine.** (a) Before isolating or quarantining a person or group of persons, the commissioner of health shall obtain a written, ex parte order authorizing the isolation or quarantine from the District Court of Ramsey County, the county where the person or group of persons is located, or a county adjoining the county where the person or group of persons is located. The evidence or testimony in support of an application may be made or taken by telephone, facsimile transmission, video equipment, or other electronic communication. The court shall grant the order upon a finding that probable cause exists to believe isolation or quarantine is warranted to protect the public health.

(b) The order must state the specific facts justifying isolation or quarantine, must state that the person being isolated or quarantined has a right to a court hearing under this section and a right to be represented by counsel during any proceeding under this section, and must be provided immediately to each person isolated or quarantined. The commissioner of health shall provide a copy of the authorizing order to the commissioner of public safety and other peace officers known to the commissioner to have jurisdiction over the site of the isolation or quarantine. If feasible, the commissioner of health shall give each person being isolated or quarantined an estimate of the expected period of the person's isolation or quarantine.

(c) If it is impracticable to provide individual orders to a group of persons isolated or quarantined, one order shall suffice to isolate or quarantine a group of persons believed to have been commonly infected with or exposed to a communicable disease. A copy of the order and notice shall be posted in a conspicuous place:

(1) in the isolation or quarantine premises, but only if the persons to be isolated or quarantined are already at the isolation or quarantine premises and have adequate access to the order posted there; or

(2) in another location where the group of persons to be isolated or quarantined is located, such that the persons have adequate access to the order posted there.

If the court determines that posting the order according to clause (1) or (2) is impractical due to the number of persons to be isolated or quarantined or the geographical area affected, the court must use the best means available to ensure that the affected persons are fully informed of the order and notice.

(d) Any peace officer, as defined in section 144.4803, subdivision 16, may apprehend, hold, transport, quarantine, or isolate a person subject to the order. This subdivision is authority to carry out enforcement duties under this section. The commissioner or an agent of a community health board authorized under section 145A.04 shall advise the peace officer on request of protective measures recommended to protect the officer from possible transmission of the communicable disease. The peace officer may act upon telephone, facsimile, or other electronic notification of the order from the court, commissioner of health, agent of a community health board, or commissioner of public safety.

(e) No person may be isolated or quarantined pursuant to an order issued under this subdivision for longer than 21 days without a court hearing under subdivision 3 to determine whether isolation or quarantine

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should continue. A person who is isolated or quarantined may request a court hearing under subdivision 3 at any time before the expiration of the order.

Subd. 2. **Temporary hold upon commissioner's directive.** (a) Notwithstanding subdivision 1, the commissioner of health may by directive isolate or quarantine a person or group of persons without first obtaining a written, ex parte order from the court if a delay in isolating or quarantining the person or group of persons would significantly jeopardize the commissioner of health's ability to prevent or limit the transmission of a communicable or potentially communicable life-threatening disease to others. The directive shall specify the known period of incubation or communicability or the estimated period under the commissioner's best medical judgment when the disease is unknown. The directive remains in effect for the period specified unless amended by the commissioner or superseded by a court order. The commissioner must provide the person or group of persons subject to the temporary hold with notice that the person has a right to request a court hearing under this section and a right to be represented by counsel during a proceeding under this section. If it is impracticable to provide individual notice to each person subject to the temporary hold, notice of these rights may be posted in the same manner as the posting of orders under subdivision 1, paragraph (c). Immediately upon executing the directive and initiating notice of the parties subject to it, the commissioner shall initiate the process to apply for a written, ex parte order pursuant to subdivision 1 authorizing the isolation or quarantine. The court must rule within 24 hours of receipt of the application or sooner if practicable or necessary. If the person is under a temporary hold, the person may not be held in isolation or quarantine after the temporary hold expires unless the court issues an ex parte order under subdivision 1. If the court does not rule within 36 hours after the execution of the directive, the directive shall expire.

(b) At the same time the commissioner initiates the process to apply for a written, ex parte order under paragraph (a), the commissioner shall notify the governor, the majority and minority leaders of the senate, the speaker and majority and minority leaders of the house of representatives, and the chairs and the ranking minority members of the senate and house of representatives committees having jurisdiction over health policy that a directive for a temporary hold has been issued under this subdivision. Notice under this paragraph is governed by the data privacy provisions of subdivision 6.

(c) Any peace officer, as defined in section 144.4803, subdivision 16, may assist a public health official to apprehend, hold, transport, quarantine, or isolate a person subject to the commissioner's directive. This subdivision is authority to carry out enforcement duties under this section. The commissioner or an agent of a community health board authorized under section 145A.04 shall advise the peace officer on request of protective measures recommended to protect the officer from possible transmission of the communicable disease. The peace officer may act upon telephone, facsimile, or other electronic notification of the commissioner's directive or upon the request of an agent of a community health board.

(d) If a person subject to a commissioner's directive under paragraph (a) is already institutionalized in an appropriate health care facility, the commissioner of health may direct the facility to continue to hold the person. The facility shall take all reasonable measures to prevent the person from exposing others to the communicable disease.

Subd. 3. **Court hearing.** (a) A person isolated or quarantined under an order issued pursuant to subdivision 1 or a temporary hold under subdivision 2 or the person's representative may petition the court to contest the court order or temporary hold at any time prior to the expiration of the order or temporary hold. If a petition is filed, the court must hold a hearing within 72 hours from the date of the filing. A petition for a hearing does not stay the order of isolation or quarantine. At the hearing, the commissioner of health must show by clear and convincing evidence that the isolation or quarantine is warranted to protect the public health.

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(b) If the commissioner of health wishes to extend the order for isolation or quarantine past the period of time stated in subdivision 1, paragraph (e), the commissioner must request the court to do so. Notice of the hearing must be served upon the person or persons who are being isolated or quarantined at least three days before the hearing. If it is impracticable to provide individual notice to large groups who are isolated or quarantined, a copy of the notice may be posted in the same manner as described under subdivision 1, paragraph (c).

(c) The notice must contain the following information:

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

(2) the grounds and underlying facts upon which continued isolation or quarantine is sought;

(3) the person's right to appear at the hearing; and

(4) the person's right to counsel, including the right to be represented by counsel designated by the court.

(d) The court may order the continued isolation or quarantine of the person or group of persons if it finds by clear and convincing evidence that the person or persons would pose an imminent health threat to others if isolation or quarantine was lifted. In no case may the isolation or quarantine continue longer than 30 days from the date of the court order issued under this subdivision unless the commissioner petitions the court for an extension. Any hearing to extend an order is governed by this subdivision.

Subd. 4. **Hearing on conditions of isolation or quarantine.** A person isolated or quarantined may request a hearing in district court for remedies regarding the treatment during and the terms and conditions of isolation or quarantine. Upon receiving a request for a hearing under this subdivision, the court shall fix a date for a hearing that is within seven days of the receipt of the request by the court. The request for a hearing does not alter the order for isolation or quarantine. If the court finds that the isolation or quarantine of the individual is not in compliance with section 144.419, the court may fashion remedies appropriate to the circumstances of the emergency and in keeping with this chapter.

Subd. 5. **Judicial procedures and decisions.** (a) Court orders issued pursuant to subdivision 3 or 4 shall be based upon clear and convincing evidence and a written record of the disposition of the case shall be made and retained.

(b) Any person subject to isolation or quarantine has the right to be represented by counsel. Persons not otherwise represented may request the court to appoint counsel at the expense of the Department of Health or of a community health board that has entered into a written delegation agreement with the commissioner under subdivision 7. The court shall appoint counsel when so requested and may have one counsel represent a group of persons similarly situated. The appointments shall be only for representation under subdivisions 3 and 4 and for appeals of orders under subdivisions 3 and 4. On counsel's request, the commissioner or an agent of a community health board authorized under section 145A.04 shall advise counsel of protective measures recommended to protect counsel from possible transmission of the communicable disease. Appointments shall be made and counsel compensated according to procedures developed by the Supreme Court. The Supreme Court shall also develop procedures for compensating language interpreters and medical experts reasonably necessary to defense preparations. The procedures shall provide standards for determining indigency for purposes of appeal. Upon motion by the commissioner of health or community health board, the court may order a person who is not indigent to reimburse the Department of Health or community health board for the attorney fees and costs paid on behalf of the person in the person's appeal. Counsel appointed for a respondent must be allowed to withdraw from representation and is not required to pursue an appeal if, in the opinion of counsel, there is insufficient basis for proceeding.

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(c) The court may choose to conduct a hearing under subdivision 3 or 4 by telephonic, interactive video, or other electronic means to maintain isolation or quarantine precautions and reduce the risk of spread of a communicable disease. Otherwise, the manner in which the request for a hearing is filed and acted upon shall be in accordance with the existing laws and rules of the courts of this state or, if the isolation or quarantine occurs during a national security or peacetime emergency, any rules that are developed by the courts for use during a national security or peacetime emergency.

Subd. 6. **Data privacy.** Data on individuals contained in the commissioner's directive under subdivision 2 are health data under section 13.3805, subdivision 1.

Subd. 7. **Delegation.** The commissioner may delegate any authority prescribed in subdivision 1 or 3 to the community health board, according to chapter 145A.

History: *2002 c 402 s 19; 2005 c 149 s 2-4; 2009 c 41 s 1-4; 2015 c 21 art 1 s 109*

144.4196 EMPLOYEE PROTECTION.

Subdivision 1. **Definitions.** For purposes of this section:

(1) "qualifying employee" means a person who performs services for hire in Minnesota and who has been subject to isolation or quarantine for a communicable disease as defined in section 144.419, subdivision 1, clause (2). The term applies to persons who comply with isolation or quarantine restrictions because of:

(i) a commissioner's directive;

(ii) an order of a federal quarantine officer;

(iii) a state or federal court order; or

(iv) a written recommendation of the commissioner or designee that the person enter isolation or quarantine; and

(2) "employer" means any person having one or more employees in Minnesota and includes the state and any political subdivision of the state.

Subd. 2. **Protections.** (a) An employer shall not discharge, discipline, threaten, or penalize a qualifying employee, or otherwise discriminate in the work terms, conditions, location, or privileges of the employee, because the employee has been in isolation or quarantine.

(b) A qualifying employee claiming a violation of paragraph (a) may bring a civil action for recovery of lost wages or benefits, for reinstatement, or for other relief within 180 days of the claimed violation or 180 days of the end of the isolation or quarantine, whichever is later. A qualifying employee who prevails shall be allowed reasonable attorney fees fixed by the court.

(c) Nothing in this subdivision is intended to alter sick leave or sick pay terms of the employment relationship.

Subd. 3. **Limitations.** The protections of subdivision 2 do not apply to work absences due to isolation or quarantine for periods longer than 21 consecutive workdays. However, absences due to isolation or quarantine for periods longer than 21 consecutive workdays resulting in loss of employment shall be treated for purposes of unemployment compensation in the same manner as loss of employment due to a serious illness.

History: *2005 c 149 s 5*

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PUBLIC HEALTH EMERGENCY; VACCINATION; TREATMENT

144.4197 EMERGENCY VACCINE ADMINISTRATION; LEGEND DRUG.

When a mayor, county board chair, or legal successor to such official has declared a local emergency under section 12.29 or the governor has declared an emergency under section 12.31, subdivision 1 or 2, or a community health board or its appointed agent under chapter 145A has requested the commissioner's assistance in response to an event threatening public health in its jurisdiction, the commissioner of health may authorize any person, including, but not limited to, any person licensed or otherwise credentialed under chapters 144E, 147 to 148, 150A, 151, 153, or 156, to administer vaccinations or dispense legend drugs if the commissioner determines that such action is necessary to protect the health and safety of the public. The authorization shall be in writing and shall contain the categories of persons included in the authorization, any additional training required before performance of the vaccination or drug dispensing by such persons, any supervision required for performance of the vaccination or drug dispensing, and the duration of the authorization. The commissioner may, in writing, extend the scope and duration of the authorization as the emergency warrants. Any person authorized by the commissioner under this section shall not be subject to criminal liability, administrative penalty, professional discipline, or other administrative sanction for good faith performance of the vaccination or drug dispensing duties assigned according to this section.

History: *2005 c 149 s 6; 2009 c 41 s 5; 2015 c 21 art 1 s 109*

144.4198 MASS DISPENSING UNDER AUTHORITY OF COMMISSIONER OF HEALTH.

Subdivision 1. **Definition.** "Closed point of dispensing (POD)" means a dispensing or vaccinating location, including but not limited to a business, nonprofit, governmental, correctional, educational, health care, religious, or other entity that dispenses to a limited group such as employees and their household members, residents, business guests, students, or inmates. A closed POD is not open to the public.

Subd. 2. **Alternative and expedited mass dispensing.** (a) When the commissioner of health has determined that a pandemic influenza, other life-threatening disease, or terrorist, accidental, or natural event requires urgent treatment or prophylactic measures, the commissioner may designate persons and entities to expedite legend drug dispensing, by means of any of the methods in paragraphs (b), (c), and (d), or any method the commissioner deems warranted.

(b) Legend drugs may be distributed and dispensed to a household representative by the commissioner, or by a local public health or tribal public health agency authorized by the commissioner. The household representative shall convey medical information and distribute legend drugs to individuals who have entrusted the household representative with drug collection responsibilities. Each individual must meet medical protocol criteria established by the commissioner. The household representative may be a mature minor who appears able to understand and carry out the responsibility of legend drug distribution.

(c) Legend drugs from the United States Department of Health and Human Services, from state or regional pharmaceutical caches, or from other sources available to the commissioner may be distributed by United States Postal Service postal carriers to residences designated by the commissioner.

(d) Legend drugs may be dispensed or administered via the closed POD according to a plan approved by the commissioner or by local or tribal public health agencies and the medical protocol criteria established by the commissioner.

(e) The methods in this subdivision shall be carried out under the commissioner's powers in section 151.37, subdivisions 2 and 10.

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Subd. 3. **Liability protections for closed POD's.** A person, corporation, charitable organization, government entity, religious entity, nonprofit entity, or other legal entity, or an employee or agent of the person, corporation, charitable organization, or entity, who, during the preparation for and setup, operation, and demobilization of a closed POD, acts in good faith and under the direction of a closed POD plan that has been approved by the commissioner of health, local public health agency, or tribal public health authority, shall not be liable for civil damages or administrative sanctions for causing the death or injury of a person, or for damage to property. This section does not apply in case of malfeasance or willful or wanton actions.

Subd. 4. **Continuing benefits.** This section does not affect the right of any person to receive benefits to which the person otherwise would be entitled under the workers' compensation law or under any pension law, nor does it affect entitlement to any other benefits or compensation authorized by state law. This section does not affect the right of any person to receive benefits to which the person would otherwise be entitled under federal law, including, but not limited to, the injury compensation fund under the Public Readiness and Preparedness Act, United States Code, title 42, section 247d-6e.

History: *2009 c 41 s 6*

144.4199 PUBLIC HEALTH RESPONSE CONTINGENCY ACCOUNT.

Subdivision 1. **Public health response contingency account.** A public health response contingency account is created in the special revenue fund in the state treasury. Money in the public health response contingency account does not cancel and is appropriated to the commissioner of health for the purposes specified in subdivision 4 when the determination criteria in subdivision 3 and the requirements in subdivisions 5, paragraph (a), and 7, are satisfied.

Subd. 2. **Definition.** For purposes of this section, "public health response" means immediate public health activities required to protect the health and safety of the public due to pandemic influenza or an outbreak of a communicable or infectious disease.

Subd. 3. **Determination criteria.** The commissioner may make expenditures from the public health response contingency account only if:

(1) the commissioner determines the pandemic influenza or outbreak of a communicable or infectious disease requires a public health response;

(2) the commissioner determines that the public health response is reasonably expected to require supplies, equipment, personnel, and other resources in excess of the resources available for public health response and preparedness activities in the affected jurisdictions; and

(3) the commissioner has notified the relevant federal agency that the pandemic influenza or communicable or infectious disease:

(i) is reasonably expected to require the evacuation of the impacted population, relocation of seriously ill or injured persons to temporary care facilities, or the provision of replacement essential community services;

(ii) poses a probability of a large number of deaths, serious injuries, or long-term disabilities in the affected population;

(iii) involves widespread exposure to an infectious agent that poses a significant risk of substantial future harm to a large number of people in the affected area; or

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(iv) poses a significant risk of harm to a large number of people or a high rate of morbidity or mortality in the affected population.

Subd. 4. **Uses of funds.** (a) When the determination criteria in subdivision 3 are satisfied and the commissioner has complied with subdivisions 5, paragraph (a), and 7, the commissioner may make expenditures from the public health response contingency account for the following purposes attributable to a public health response:

(1) staffing;

(2) information technology;

(3) supplies, equipment, and services to protect people in the affected area or population, health care providers, and public safety workers;

(4) training for and coordination with local public health departments and health care providers;

(5) communication with and outreach to affected areas or populations;

(6) to provide a state match for federal assistance obtained for the public health response;

(7) laboratory testing, including enhancements to laboratory capacity necessary to conduct testing related to the event, and supplies, equipment, shipping, and security;

(8) the purchase of vaccines, antibiotics, antivirals, and other medical resources to prevent the spread of the pandemic influenza or communicable or infectious disease or to treat related medical conditions;

(9) reimbursement to community health boards or other local units of government for incurred costs for the goods and services listed in clauses (1) to (8) that are attributable to the public health response;

(10) reimbursement to health care organizations and health care providers for incurred costs that are attributable to the public health response; and

(11) funding to support other state agencies for costs incurred by those agencies that are attributable to the public health response.

(b) Money in the account must not be used to increase the total number of full-time equivalent permanent employees at the Department of Health, unless expressly authorized by law. Money in the account shall be used only for public health response activities to protect the health and safety of the public.

Subd. 5. **Assistance from other sources.** (a) As a condition of making expenditures from the public health response contingency account, the commissioner must seek any appropriate assistance from other available sources, including the federal government, to assist with costs attributable to the public health response.

(b) If the commissioner recovers eligible costs for the public health response from a nonstate source after making expenditures from the public health response contingency account, the commissioner shall reimburse the public health response contingency account for those costs, up to the amount recovered for eligible costs from the nonstate source.

Subd. 6. **Emergency management authority.** Nothing in this section shall be construed to limit the emergency management authority of the governor or any local or county organization for emergency management under chapter 12 or other law.

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Subd. 7. **Notice and expenditure review.** (a) For pandemic influenza or an outbreak of a communicable or infectious disease that begins on or after July 1, 2017, if the commissioner determines that a public health response to pandemic influenza or an outbreak of a communicable or infectious disease may require the diversion of Department of Health staff or resources, the commissioner shall provide written notice to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance with information on the event requiring the public health response, the public health response that may be required, and estimates of the staff hours and resources that the commissioner may need to divert to provide the public health response. For pandemic influenza or an outbreak of a communicable or infectious disease that begins prior to July 1, 2017, the commissioner must provide the notice required by this paragraph no later than July 10, 2017.

(b) Prior to authorizing expenditures from the public health response contingency account, the commissioner shall seek review and recommendation from the Legislative Advisory Commission according to the procedures in section 3.3005, subdivision 5, that would otherwise apply if the funds were federal funds. The commissioner is prohibited from seeking review and recommendation for any expenditures for public health response activities that were made before the commissioner provided the notice required in paragraph (a).

Subd. 8. **Report.** By January 15 of each year, the commissioner shall submit a report to the chairs and ranking minority members of the house of representatives Ways and Means Committee, the senate Finance Committee, and the house of representatives and senate committees with jurisdiction over health and human services finance, detailing expenditures made in the previous calendar year from the public health response contingency account.

History: *1Sp2017 c 6 art 10 s 62*

TUBERCULOSIS

144.42 [Repealed, 1980 c 357 s 22]

144.421 [Repealed, 1980 c 357 s 22]

144.422 [Repealed, 1987 c 209 s 40]

144.423 [Repealed, 1951 c 314 s 8]

144.424 [Repealed, 1987 c 209 s 40]

144.425 [Repealed, 1987 c 209 s 40]

144.426 [Repealed, 1951 c 314 s 8]

144.427 [Repealed, 1980 c 357 s 22]

144.428 [Repealed, 1980 c 357 s 22]

144.429 [Repealed, 1980 c 357 s 22]

144.43 [Repealed, 1980 c 357 s 22]

144.44 [Renumbered 144.423]

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144.441 TUBERCULOSIS SCREENING IN SCHOOLS.

Subdivision 1. **Definitions.** As used in sections 144.441 and 144.442, the following terms have the meanings given them:

(a) "Person employed by a school or school district" means a person employed by a school, school district, or by a service cooperative as a member of the instructional, supervisory, or support staff including, but not limited to, superintendents, principals, supervisors, teachers, librarians, counselors, school psychologists, school nurses, school social workers, audiovisual directors or coordinators, recreation personnel, media generalists or supervisors, speech therapists, athletic coaches, teachers' aids, clerical workers, custodians, school bus drivers, and food service workers.

(b) "Person enrolled in a school" means a person enrolled in grades kindergarten through 12 and a disabled child receiving special instruction and services in a school.

(c) "School" includes any public elementary, middle, secondary, or vocational center school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or nonpublic school, church, or religious organization in which a child is provided instruction in compliance with sections 120A.22 and 120A.24.

Subd. 2. **Designation of schools.** Based on the occurrence of active tuberculosis or evidence of a higher than expected prevalence of tuberculosis infection in the population attending or employed by one or more schools in a school district, the commissioner of health may designate schools or a school district in which screening of some or all persons enrolled in or employed by the school or school district for tuberculosis is a necessary public health measure. In making the designation, the commissioner shall also determine the frequency with which proof of screening must be submitted. In determining whether the population attending or employed by a school or school district has a higher than expected prevalence of tuberculosis infection, the commissioner shall consider factors such as race or ethnicity, age, and the geographic location of residence of the student population; the expected background prevalence of tuberculosis infection in the community; and currently accepted public health standards pertaining to the control of tuberculosis.

Subd. 3. **Screening of students.** As determined by the commissioner under subdivision 2, no person may enroll or remain enrolled in any school which the commissioner has designated under subdivision 2 until the person has submitted to the administrator or other person having general control and supervision of the school, one of the following statements:

(1) a statement from a physician, advanced practice registered nurse, physician assistant, or public clinic stating that the person has had a negative Mantoux test reaction within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(2) a statement from a physician, advanced practice registered nurse, physician assistant, or public clinic stating that a person who has a positive Mantoux test reaction has had a negative chest roentgenogram (X-ray) for tuberculosis within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(3) a statement from a physician, advanced practice registered nurse, physician assistant, or public health clinic stating that the person (i) has a history of adequately treated active tuberculosis; (ii) is currently receiving tuberculosis preventive therapy; (iii) is currently undergoing therapy for active tuberculosis and the person's presence in a school building will not endanger the health of other people; or (iv) has completed a course of tuberculosis preventive therapy or was intolerant to preventive therapy, provided the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; or

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(4) a notarized statement signed by the minor child's parent or guardian or by the emancipated person stating that the person has not submitted the proof of tuberculosis screening as required by this subdivision because of the conscientiously held beliefs of the parent or guardian of the minor child or of the emancipated person. This statement must be forwarded to the commissioner.

Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision 2, a person employed by the designated school or school district shall submit to the administrator or other person having general control and supervision of the school one of the following:

(1) a statement from a physician or public clinic stating that the person has had a negative Mantoux test reaction within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(2) a statement from a physician or public clinic stating that a person who has a positive Mantoux test reaction has had a negative chest roentgenogram (X-ray) for tuberculosis within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(3) a statement from a physician or public health clinic stating that the person (i) has a history of adequately treated active tuberculosis; (ii) is currently receiving tuberculosis preventive therapy; (iii) is currently undergoing therapy for active tuberculosis and the person's presence in a school building will not endanger the health of other people; or (iv) has completed a course of preventive therapy or was intolerant to preventive therapy, provided the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; or

(4) a notarized statement signed by the person stating that the person has not submitted the proof of tuberculosis screening as required by this subdivision because of conscientiously held beliefs. This statement must be forwarded to the commissioner of health.

Subd. 5. **Exceptions.** Subdivisions 3 and 4 do not apply to:

(1) a person with a history of either a past positive Mantoux test reaction or active tuberculosis who has a documented history of completing a course of tuberculosis therapy or preventive therapy when the school or school district holds a statement from a physician or public health clinic indicating that such therapy was provided to the person and that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; and

(2) a person with a history of a past positive Mantoux test reaction who has not completed a course of preventive therapy. This determination shall be made by the commissioner based on currently accepted public health standards and the person's health status.

Subd. 6. **Programs using school facilities.** The commissioner may require the statements described in subdivisions 3 and 4 to be submitted by participants or staff of a program or activity that uses the facilities of a school or school district on a regular and ongoing basis, if the commissioner has determined that tuberculosis screening is necessary.

Subd. 7. **Implementation.** The administrator or other person having general control and supervision of the school or school district designated by the commissioner under subdivision 2 shall take the measures that are necessary, including the exclusion of persons from the premises of a school, to obtain the proof of screening required by subdivisions 3 and 4.

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Subd. 8. **Access to records.** The commissioner shall have access to any school or school district records, including health records of persons enrolled in or employed by a school or school district, that are needed to determine whether a tuberculosis screening program is necessary, or to administer a screening program.

Subd. 9. **Reports.** The administrator or other person having general control and supervision of a school or school district that the commissioner has designated under subdivision 2 shall provide the commissioner with any reports determined by the commissioner to be necessary to implement a screening or control program or to evaluate the need for further tuberculosis screening or control efforts in a school.

Subd. 10. **Waiver.** The commissioner may waive any portion of the requirements of subdivisions 3 to 9 if the commissioner determines that it is not necessary in order to protect the public health.

History: *1993 c 167 s 2; 1996 c 305 a 1 s 138; 1998 c 397 art 11 s 3; 2005 c 56 s 1; 2014 c 192 art 3 s 4; 2017 c 59 s 3*

144.442 TESTING IN SCHOOL CLINICS.

Subdivision 1. **Administration; notification.** In the event that the commissioner designates a school or school district under section 144.441, subdivision 2, the school or school district or community health board may administer Mantoux screening tests to some or all persons enrolled in or employed by the designated school or school district. Any Mantoux screening provided under this section shall be under the direction of a licensed physician.

Prior to administering the Mantoux test to such persons, the school or school district or community health board shall inform in writing such persons and parents or guardians of minor children to whom the test may be administered, of the following:

(1) that there has been an occurrence of active tuberculosis or evidence of a higher than expected prevalence of tuberculosis infection in that school or school district;

(2) that screening is necessary to avoid the spread of tuberculosis;

(3) the manner by which tuberculosis is transmitted;

(4) the risks and possible side effects of the Mantoux test;

(5) the risks from untreated tuberculosis to the infected person and others;

(6) the ordinary course of further diagnosis and treatment if the Mantoux test is positive;

(7) that screening has been scheduled; and

(8) that no person will be required to submit to the screening if the person submits a statement of objection due to the conscientiously held beliefs of the person employed or of the parent or guardian of a minor child.

Subd. 2. **Consent of minors.** Minors may give consent for testing as set forth in sections 144.341 to 144.347.

Subd. 3. **Screening of minors.** Prior to administering a Mantoux test to a minor, the school or school district or community health board shall prepare a form for signature in which the parent or guardian shall consent or submit a statement of objection to the test. The parent or guardian of a minor child shall return a signed form to the school or school district or community health board which is conducting the screening indicating receipt of the notice and consent or objection to the administration of the test. In the event that the form with a signed consent or objection is not returned, the school or school district or community health

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board may undertake such steps as are reasonable to secure such consent or objection. If after such steps the school or school district or community health board chooses to screen the minor without consent, it shall send a notice of intent to test by certified mail, restricted delivery with return receipt, to the address given to the school or school district by the parent or guardian for emergency contact of the parent or guardian. The accuracy of the address shall be checked with the person enrolled, if possible. Placing notice as specified in this subdivision shall constitute service. Reasonable efforts shall be made to provide this notice in a language understood by the parent or guardian. If this notice cannot be delivered or a form with a signed consent or objection is not returned, the school or school district or community health board shall check the permanent medical record required by section 144.29 to determine if the parent or guardian previously withheld consent to immunizations or other medical treatment because of conscientiously held beliefs. If there is such a statement on file or if the school district otherwise has notice of such a statement, the school or school district or community health board shall not administer the Mantoux test unless the consent of the parent or guardian is obtained. If there is no such statement in the permanent medical record or known to exist otherwise, the school or school district or community health board may administer the Mantoux test at the time and place specified in the notice unless medically contraindicated. The school or school district or community health board shall document in the permanent medical record its efforts to notify the parent or guardian of the minor child, and its efforts to check the permanent medical records.

Subd. 4. **Consent for subsequent testing or treatment.** In the event the Mantoux test is positive, no further diagnosis of or treatment for tuberculosis in a minor child shall be undertaken without the signed consent of the parent or guardian of the minor child.

History: *1986 c 444; 1993 c 167 s 3; 2015 c 21 art 1 s 109*

144.443 [Repealed, 2014 c 192 art 3 s 5]

144.444 [Repealed, 2014 c 192 art 3 s 5]

144.445 TUBERCULOSIS SCREENING IN CORRECTIONAL INSTITUTIONS.

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

(b) If an inmate refuses to submit to an annual test as specified in paragraph (a), the commissioner of corrections may order the inmate to be tested.

Subd. 2. **Screening of employees.** All employees of facilities operated, licensed, or inspected by the Department of Corrections shall be screened for tuberculosis before employment in the facility and annually thereafter, with either a Mantoux test or a chest roentgenogram (X-ray) as consistent with screening and follow-up practices recommended by the United States Public Health Service or the Department of Health, as determined by the commissioner of health.

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

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

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

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

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

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

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

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

Subd. 4. **Reports.** The administrator or other person having general control and supervision of a facility operated, licensed, or inspected by the Department of Corrections shall provide the commissioner with any reports determined by the commissioner of health to be necessary to evaluate the need for further tuberculosis screening or control efforts in a facility or facilities.

Subd. 5. **Waiver.** The commissioner may waive any portion of the requirements of subdivisions 1 to 4 if the commissioner of health determines that it is not necessary to protect the public health or if the screening may have a detrimental effect on a person's health status.

History: *1993 c 167 s 6; 1997 c 164 s 1,2; 2006 c 260 art 4 s 2*

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144.45 [Repealed, 2014 c 192 art 3 s 5]

144.46 [Repealed, 1980 c 357 s 22]

144.47 [Repealed, 1980 c 357 s 22]

144.471 [Repealed, 1987 c 209 s 40]

144.48 [Renumbered 144.427]

TUBERCULOSIS HEALTH THREAT ACT

144.4801 TITLE.

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

History: *1997 c 164 s 3*

144.4802 AUTHORITY.

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

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

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

History: *1997 c 164 s 4; 2014 c 192 art 3 s 4*

144.4803 DEFINITIONS.

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

(1) a condition evidenced by a positive culture for mycobacterium tuberculosis taken from a pulmonary or laryngeal source;

(2) a condition evidenced by a positive culture for mycobacterium tuberculosis taken from an extrapulmonary source when there is clinical evidence such as a positive skin test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with pulmonary tuberculosis; or

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

Subd. 2. [Renumbered subd 5a]

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

Subd. 4. **Clinically suspected of having active tuberculosis.** "Clinically suspected of having active tuberculosis" means presenting a reasonable possibility of having active tuberculosis based upon epidemiologic, clinical, or radiographic evidence, laboratory test results, or other reliable evidence as determined by a physician using currently accepted standards of medical practice.

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

Subd. 5a. **Community health board.** "Community health board" means an administrative authority established under section 145A.03.

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

Subd. 7. **Department.** "Department" means the Department of Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) a hospital or other treatment facility;

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

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

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

Subd. 16. **Peace officer.** "Peace officer" means an employee or an elected or appointed official of a political subdivision or law enforcement agency who is licensed by the Board of Peace Officer Standards and Training, is charged with the prevention and detection of crime and the enforcement of the general criminal laws of the state, and has the full power of arrest. "Peace officer" includes an officer of the Minnesota State Patrol.

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

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

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

History: *1997 c 164 s 5; 2015 c 21 art 1 s 109*

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144.4804 REPORTING RELATING TO TUBERCULOSIS.

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

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

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

(1) a person who has been diagnosed with active tuberculosis;

(2) a person who is clinically suspected of having active tuberculosis;

(3) a person who refuses or fails to submit to a diagnostic tuberculosis examination when the person is clinically suspected of having tuberculosis;

(4) a carrier who has refused or failed to initiate or complete treatment for tuberculosis, including refusal or failure to take medication for tuberculosis or keep appointments for directly observed therapy or other treatment of tuberculosis; or

(5) a person who refuses or fails to follow contagion precautions for tuberculosis after being instructed on the precautions by a licensed health professional or by the commissioner.

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

(1) the reportable person's name, birth date, address or last known location, and telephone number;

(2) the date and specific circumstances that cause the person to be a reportable person;

(3) the reporting person's name, title, address, and telephone number; and

(4) any other information relevant to the reportable person's case of tuberculosis.

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

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

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

Subd. 8. **Tuberculosis notification.** If an emergency medical services person, as defined in section 144.7401, subdivision 4, is exposed to a person with active tuberculosis during the performance of duties, the treatment facility's designated infection control coordinator shall notify the emergency medical services agency's exposure control officer by telephone and by written correspondence. The facility's designated infection control coordinator shall provide the emergency medical services person with information about screening and, if indicated, follow-up.

History: *1997 c 164 s 6; 2000 c 422 s 4*

144.4805 HEALTH ORDER; RIGHTS OF CARRIER AND RESPONDENT.

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

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

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

(1) a citation to this section as the legal authority under which the order is issued;

(2) a summary of evidence upon which the person is alleged to be a carrier;

(3) a description of the alleged conduct of the carrier that makes the carrier an endangerment to the public health;

(4) a description of less restrictive alternatives that the commissioner considered and rejected, together with the reasons for the rejection, or a description of less restrictive alternatives that the commissioner used and that were unsuccessful;

(5) the preventive measure ordered; and

(6) a notice advising the carrier or respondent that:

(i) a hearing will be held if the carrier or respondent petitions the court for a hearing or if the commissioner determines that the carrier has not complied with the health order;

(ii) the carrier or respondent has the right to appear at the hearing;

(iii) the carrier or respondent has the right to present and cross-examine witnesses at the hearing;

(iv) the carrier has the right to court-appointed counsel in a proceeding under sections 144.4801 to 144.4813; and

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(v) the carrier or respondent has the right to the assistance of an interpreter in a proceeding under sections 144.4801 to 144.4813.

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

(1) at the time the court issues an order under section 144.4807, subdivision 7, authorizing the continued detention of the carrier;

(2) at the time the court issues an order under section 144.4808, subdivision 2, authorizing the carrier to be apprehended and held; or

(3) in all other cases, at the time either party files a notice for a preliminary hearing under section 144.4810, subdivision 2.

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

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

(1) a copy of the health order;

(2) a certified copy of relevant portions of the carrier's medical records; and

(3) the name and address of the licensed health professional, including the carrier's attending physician or nurse, or the public health physician or nurse whom the commissioner intends to have testify at the preliminary hearing, and a summary of the witness' testimony, including a copy of the witness' affidavit, if any.

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

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

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

History: *1997 c 164 s 7; 2015 c 21 art 1 s 109*

144.4806 PREVENTIVE MEASURES UNDER HEALTH ORDER.

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

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

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

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

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

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

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

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

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

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

History: *1997 c 164 s 8*

144.4807 NOTICE OF OBLIGATION TO ISOLATE OR EXAMINE.

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

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

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

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

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

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

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

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

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

History: *1997 c 164 s 9*

144.4808 APPREHEND AND HOLD ORDER.

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

(1) an endangerment to the public health; and

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

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

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

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

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(2) apprehend and isolate the carrier.

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

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

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

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

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

History: *1997 c 164 s 10*

144.4809 PRELIMINARY HEARING.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1997 c 164 s 11*

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144.4810 FINAL HEARING.

Subdivision 1. **Grounds for hearing.** After the preliminary hearing, the commissioner, carrier, or respondent may petition the court for relief from or enforcement of the court order issued pursuant to the preliminary hearing. The commissioner may petition the court for additional preventive measures if the carrier or respondent has not complied with the court order issued pursuant to the preliminary hearing. The petitioning party shall serve and file a petition and notice of hearing with the probate division of the district court. The court shall hold the final hearing no later than 15 days from the date of the filing and service of the petition for a final hearing.

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

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

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

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

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

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

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

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

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

History: *1997 c 164 s 12*

144.4811 PERIODIC REVIEW AND RELEASE FROM DETENTION.

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

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

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

(1) the commissioner determines that the carrier does not have active tuberculosis; or

(2) the commissioner determines that the carrier is not an endangerment to the public health.

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

(1) the commissioner determines that the carrier is cured; or

(2) the commissioner determines that the carrier is no longer an endangerment to the public health.

History: *1997 c 164 s 13*

144.4812 COSTS OF CARE.

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

History: *1997 c 164 s 14; 2016 c 158 art 2 s 34*

144.4813 DATA PRIVACY.

Subdivision 1. **Nonpublic data.** Data on individuals contained in the health order are health data under section 13.3805, subdivision 1. Other data on individuals collected by the commissioner as part of an investigation of a carrier under sections 144.4801 to 144.4813 are investigative data under section 13.39.

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

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

History: *1997 c 164 s 15; 1999 c 227 s 22*

144.49 VIOLATIONS; PENALTIES.

Subdivision 1. **Violating rules or board directions.** Any person violating any rule of the commissioner or any lawful direction of a community health board as defined in section 145A.02, subdivision 5, or an agent of a community health board as authorized under section 145A.04 is guilty of a misdemeanor.

Subd. 2. [Repealed, 1979 c 50 s 14]

Subd. 3. [Repealed, 1979 c 50 s 14]

Subd. 4. [Repealed, 1979 c 50 s 14]

Subd. 5. [Repealed, 1987 c 209 s 40]

Subd. 6. **Operating without license.** Any person, partnership, association, or corporation establishing, conducting, managing, or operating any hospital, sanitarium, or other institution in accordance with the provisions of sections 144.50 to 144.56, without first obtaining a license therefor is guilty of a misdemeanor.

Subd. 7. **Operating outside law or rules.** Any person, partnership, association, or corporation which establishes, conducts, manages or operates any hospital, sanitarium or other institution required to be licensed under sections 144.50 to 144.56, in violation of any provision of sections 144.50 to 144.56 or any rule established thereunder, is guilty of a misdemeanor.

Subd. 8. **False statements in reports.** Any person lawfully engaged in the practice of healing who willfully makes any false statement in any report required to be made is guilty of a misdemeanor.

History: *(5346, 5356, 5367, 5388) RL s 2132; 1913 c 434 s 8; 1913 c 579; 1917 c 220 s 6; 1939 c 89 s 1; 1941 c 549 s 10; 1943 c 649 s 1; 1945 c 512 s 35,37; 1949 c 471 s 14; 1976 c 173 s 32,33; 1977 c 305 s 45; 1980 c 357 s 11,12; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24; 1987 c 384 art 2 s 1; 1991 c 199 art 2 s 15; 2014 c 192 art 3 s 4; 2014 c 291 art 7 s 28*

144.491 [Repealed, 1998 c 407 art 2 s 109]

STROKE CENTERS AND STROKE HOSPITALS

144.492 DEFINITIONS.

Subdivision 1. **Applicability.** For the purposes of sections 144.492 to 144.494, the terms defined in this section have the meanings given them.

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

Subd. 3. **Joint commission.** "Joint commission" means the independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.

Subd. 4. **Stroke.** "Stroke" means the sudden death of brain cells in a localized area due to inadequate blood flow.

History: *2013 c 108 art 12 s 30*

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144.493 CRITERIA.

Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a comprehensive stroke center if the hospital has been certified as a comprehensive stroke center by the joint commission or another nationally recognized accreditation entity and the hospital participates in the Minnesota stroke registry program.

Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke center if the hospital has been certified as a primary stroke center by the joint commission or another nationally recognized accreditation entity and the hospital participates in the Minnesota stroke registry program.

Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute stroke ready hospital if the hospital has the following elements of an acute stroke ready hospital:

(1) an acute stroke team available or on call 24 hours a day, seven days a week;

(2) written stroke protocols, including triage, stabilization of vital functions, initial diagnostic tests, and use of medications;

(3) a written plan and letter of cooperation with emergency medical services regarding triage and communication that are consistent with regional patient care procedures;

(4) emergency department personnel who are trained in diagnosing and treating acute stroke;

(5) the capacity to complete basic laboratory tests, electrocardiograms, and chest x-rays 24 hours a day, seven days a week;

(6) the capacity to perform and interpret brain injury imaging studies 24 hours a day, seven days a week;

(7) written protocols that detail available emergent therapies and reflect current treatment guidelines, which include performance measures and are revised at least annually;

(8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;

(9) transfer protocols and agreements for stroke patients; and

(10) a designated medical director with experience and expertise in acute stroke care.

History: *2013 c 108 art 12 s 31; 2014 c 291 art 6 s 8,9*

144.494 DESIGNATING STROKE CENTERS AND STROKE HOSPITALS.

Subdivision 1. **Naming privileges.** Unless it has been designated as a stroke center or stroke hospital pursuant to section 144.493, no hospital shall use the term "stroke center" or "stroke hospital" in its name or its advertising or shall otherwise indicate it has stroke treatment capabilities.

Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive stroke center, primary stroke center, or acute stroke ready hospital may apply to the commissioner for designation, and upon the commissioner's review and approval of the application, shall be designated as a comprehensive stroke center, a primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke center or primary stroke center from the joint commission or other nationally recognized accreditation entity, or no longer participates in the Minnesota stroke registry program, its Minnesota designation shall be immediately withdrawn. Prior to the expiration of the three-year

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designation, a hospital seeking to remain part of the voluntary acute stroke system may reapply to the commissioner for designation.

History: *2013 c 108 art 12 s 32; 2014 c 291 art 6 s 10*

144.4941 ST SEGMENT ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTERS.

Subdivision 1. **Criteria for STEMI receiving center designation.** A hospital meets the criteria for a STEMI receiving center designation if the hospital has been accredited as a STEMI receiving center by the Society of Cardiovascular Patient Care, the Joint Commission, the American Heart Association, or another nationally recognized accreditation entity that provides STEMI receiving center accreditation for the care of ST segment elevation myocardial infarction. A hospital may apply to the Department of Health for designation as a STEMI receiving center by providing relevant and current documentation of STEMI receiving center accreditation by a nationally recognized accreditation entity.

Subd. 2. **Designation of STEMI receiving centers.** If a hospital voluntarily meeting the criteria for designation as a STEMI receiving center applies to the commissioner for STEMI receiving center designation, then, upon the commissioner's review and approval of its application, the commissioner shall designate the hospital as a STEMI receiving center for a three-year period. If a hospital loses its accreditation as a STEMI receiving center from a nationally recognized accreditation entity, the commissioner shall immediately withdraw the hospital's STEMI designation.

Subd. 3. **Coordination among hospitals.** STEMI receiving centers are encouraged to coordinate, through agreement, with STEMI referring hospitals throughout the state to provide appropriate access to care for ST segment elevation myocardial infarction patients.

History: *2016 c 88 s 1*

FORMALDEHYDE GASES IN BUILDING MATERIALS

144.495 FORMALDEHYDE RULES.

The legislature finds that building materials containing urea formaldehyde may emit unsafe levels of formaldehyde in newly constructed housing units. The product standards prescribed in section 325F.181 are intended to provide indoor air levels of formaldehyde that do not exceed 0.4 parts per million. If the commissioner of health determines that the standards prescribed in section 325F.181 result in indoor air levels of formaldehyde that exceed 0.4 parts per million, the commissioner may adopt different building materials product standards to ensure that the 0.4 parts per million level is not exceeded. The commissioner may adopt rules under chapter 14 to establish product standards as provided in this section. The rules of the commissioner governing ambient air levels of formaldehyde, Minnesota Rules, parts 4620.1600 to 4620.2100, are repealed, except that the rule of the commissioner relating to new installations of urea formaldehyde foam insulation in residential housing units remains in effect.

History: *1980 c 594 s 1; 1982 c 424 s 130; 1985 c 216 s 1*

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MINNESOTA RADON AWARENESS ACT

144.496 MINNESOTA RADON AWARENESS ACT.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Awareness Act."

Subd. 2. **Definitions.** (a) The following terms used in this section have the meanings given them.

(b) "Buyer" means a person negotiating or offering to acquire for value, legal or equitable title, or the right to acquire legal or equitable title to residential real property.

(c) "Mitigation" means measures designed to permanently reduce indoor radon concentrations.

(d) "Radon test" means a measurement of indoor radon concentrations according to established industry standards for residential real property.

(e) "Residential real property" means property occupied as, or intended to be occupied as, a single-family residence, including a unit in a common interest community as defined in section 515B.1-103, clause (10), regardless of whether the unit is in a common interest community not subject to chapter 515B.

(f) "Seller" means a person who owns legal or equitable title to residential real property.

(g) "Elevated radon concentration" means a radon concentration at or above the United States Environmental Protection Agency's radon action level.

Subd. 3. **Radon disclosure.** (a) Before signing an agreement to sell or transfer residential real property, the seller shall disclose in writing to the buyer any knowledge the seller has of radon concentrations in the dwelling. The disclosure shall include:

(1) whether a radon test or tests have occurred on the real property;

(2) the most current records and reports pertaining to radon concentrations within the dwelling;

(3) a description of any radon concentrations, mitigation, or remediation;

(4) information regarding the radon mitigation system, including system description and documentation, if such system has been installed in the dwelling; and

(5) a radon warning statement meeting the requirements of subdivision 4.

(b) The seller shall provide the buyer with a copy of the Minnesota Department of Health publication entitled "Radon in Real Estate Transactions."

(c) The seller's radon disclosure requirements in this section apply to the transfer of any interest in residential real estate, whether by sale, exchange, deed, contract for deed, lease with an option to purchase, or any other option.

(d) The seller's radon disclosure requirements in this section do not apply to any of the following:

(1) real property that is not residential real property;

(2) a gratuitous transfer;

(3) a transfer made pursuant to a court order;

(4) a transfer to a government or governmental agency;

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(5) a transfer by foreclosure or deed in lieu of foreclosure;

(6) a transfer to heirs or devisees of a decedent;

(7) a transfer from a cotenant to one or more other cotenants;

(8) a transfer made to a spouse, parent, grandparent, child, or grandchild of the seller;

(9) a transfer between spouses resulting from a decree of marriage dissolution or from a property settlement agreement incidental to that decree;

(10) an option to purchase a unit in a common interest community, until exercised;

(11) a transfer to a person who controls or is controlled by the grantor as those terms are defined with respect to a declarant under section 515B.1-103, clause (2);

(12) a transfer to a tenant who is in possession of the residential real property; or

(13) a transfer of special declarant rights under section 515B.3-104.

(e) A seller may provide the written disclosure required under this section to a real estate licensee representing or assisting a prospective buyer. The written disclosure provided to the real estate licensee representing or assisting a prospective buyer is considered to have been provided to the prospective buyer. If the written disclosure is provided to the real estate licensee representing or assisting the prospective buyer, the real estate licensee must provide a copy to the prospective buyer.

Subd. 4. **Radon warning statement.** The radon warning statement must include the following language:

"Radon Warning Statement

The Minnesota Department of Health strongly recommends that ALL homebuyers have an indoor radon test performed prior to purchase or taking occupancy, and recommends having the radon levels mitigated if elevated radon concentrations are found. Elevated radon concentrations can easily be reduced by a qualified, certified, or licensed, if applicable, radon mitigator.

Every buyer of any interest in residential real property is notified that the property may present exposure to dangerous levels of indoor radon gas that may place the occupants at risk of developing radon-induced lung cancer. Radon, a Class A human carcinogen, is the leading cause of lung cancer in nonsmokers and the second leading cause overall. The seller of any interest in residential real property is required to provide the buyer with any information on radon test results of the dwelling."

Subd. 5. **Liability; transfer not invalidated.** (a) A seller who fails to make a radon disclosure as required by this section, and is aware of material facts pertaining to radon concentrations in the dwelling, is liable to the buyer.

(b) A buyer who is injured by a violation of this section may bring a civil action and recover damages and receive other equitable relief as determined by the court. An action under this subdivision must be commenced within two years after the date on which the buyer closed the purchase or transfer of the real property.

(c) This section does not invalidate a transfer solely because of the failure of any person to comply with a provision of this section. This section does not prevent a court from ordering a rescission of the transfer.

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Subd. 6. **Effective date.** This section is effective January 1, 2014, and applies to agreements to sell or transfer residential real property executed on or after that date.

History: *2013 c 43 s 4*

MINNESOTA RADON LICENSING ACT

144.4961 MINNESOTA RADON LICENSING ACT.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given them.

(b) "Mitigation" means the act of repairing or altering a building or building design for the purpose in whole or in part of reducing the concentration of radon in the indoor atmosphere.

(c) "Radon" means both the radioactive, gaseous element produced by the disintegration of radium, and the short-lived radionuclides that are decay products of radon.

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules establishing licensure requirements and work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings. Rules adopted by the commissioner under this subdivision are effective beginning January 1, 2019.

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after January 1, 2019, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Subd. 5. **License required annually.** Effective January 1, 2019, a license is required annually for every person, firm, or corporation that performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere.

Subd. 6. **Exemptions.** This section does not apply to:

(1) employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes as specified in subdivision 11;

(2) a person authorized as a building official under Minnesota Rules, part 1300.0070, or that person's designee; or

(3) any person, firm, corporation, or entity that distributes radon testing devices or information for general educational purposes.

Subd. 7. **License applications and other reports.** The professionals, companies, and laboratories listed in subdivision 8 must submit applications for licenses, system tags, and any other reporting required under this section and Minnesota Rules on forms prescribed by the commissioner.

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the

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necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, $150 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building the person does not own or lease.

(2) Each mitigation professional license, $250 per year. "Mitigation professional" means an individual who installs or designs a radon mitigation system in a building the individual does not own or lease, or provides on-site supervision of radon mitigation and mitigation technicians. "On-site supervision" means a review at the property of mitigation work upon completion of the work and attachment of a system tag. Employees or subcontractors who are supervised by a licensed mitigation professional are not required to be licensed under this clause. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, $100 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the mitigation company employs only one licensed mitigation professional.

(4) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, $75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Enforcement.** The commissioner shall enforce this section under the provisions of sections 144.989 to 144.993.

Subd. 10. **Local inspections or permits.** This section does not preclude local units of government from requiring additional permits or inspections for radon control systems, and does not supersede any local inspection or permit requirements.

Subd. 11. **Application; newly constructed homes.** This section does not apply to newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy.

History: *2015 c 71 art 8 s 24; 2016 c 189 art 20 s 9-15; 1Sp2017 c 6 art 10 s 63-65*

ST ELEVATION MYOCARDIAL INFARCTION HEART ATTACKS

144.497 ST ELEVATION MYOCARDIAL INFARCTION.

The commissioner of health shall assess and report on the quality of care provided in the state for ST elevation myocardial infarction response and treatment. The commissioner shall:

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(1) utilize and analyze data provided by ST elevation myocardial infarction receiving centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that does not identify individuals or associate specific ST elevation myocardial infarction heart attack events with an identifiable individual;

(2) quarterly post a summary report of the data in aggregate form on the Department of Health Web site;

(3) annually inform the legislative committees with jurisdiction over public health of progress toward improving the quality of care and patient outcomes for ST elevation myocardial infarctions; and

(4) coordinate to the extent possible with national voluntary health organizations involved in ST elevation myocardial infarction heart attack quality improvement to encourage ST elevation myocardial infarction receiving centers to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial infarction heart attacks within the state and encourage sharing of information among health care providers on ways to improve the quality of care of ST elevation myocardial infarction patients in Minnesota.

History: *2014 c 291 art 6 s 11*

HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS

144.50 HOSPITALS, LICENSES; DEFINITIONS.

Subdivision 1. **License required.** (a) No person, partnership, association, or corporation, nor any state, county, or local governmental units, nor any division, department, board, or agency thereof, shall establish, operate, conduct, or maintain in the state any hospital, sanitarium or other institution for the hospitalization or care of human beings without first obtaining a license therefor in the manner provided in sections 144.50 to 144.56. No person or entity shall advertise a facility providing services required to be licensed under sections 144.50 to 144.56 without first obtaining a license.

(b) A violation of this subdivision is a misdemeanor punishable by a fine of not more than $300. The commissioner may seek an injunction in the district court against the continuing operation of the unlicensed institution. Proceedings for securing an injunction may be brought by the attorney general or by the appropriate county attorney.

(c) The sanctions in this subdivision do not restrict other available sanctions.

Subd. 2. **Hospital, sanitarium, other institution; definition.** Hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which any accommodation is maintained, furnished, or offered for five or more persons for: the hospitalization of the sick or injured; the provision of care in a swing bed authorized under section 144.562; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings. Nothing in sections 144.50 to 144.56 shall apply to a clinic, a physician's office or to hotels or other similar places that furnish only board and room, or either, to their guests.

Subd. 3. **Hospitalization.** "Hospitalization" means the reception and care of persons for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of such persons.

Subd. 4. [Repealed, 1980 c 357 s 22]

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Subd. 5. **Separate licensing for healing; medicine.** Nothing in sections 144.50 to 144.56 shall authorize any person, partnership, association, or corporation, nor any state, county, or local governmental units, nor any division, department, board, or agency thereof, to engage, in any manner, in the practice of healing, or the practice of medicine, as defined by law.

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

(b) Class B supervised living facilities shall be classified as follows for purposes of the State Building Code:

(1) Class B supervised living facilities for six or less persons must meet Group R, Division 3, occupancy requirements; and

(2) Class B supervised living facilities for seven to 16 persons must meet Group R, Division 1, occupancy requirements.

(c) Class B facilities classified under paragraph (b), clauses (1) and (2), must meet the fire protection provisions of chapter 21 of the 1985 Life Safety Code, NFPA 101, for facilities housing persons with impractical evacuation capabilities, except that Class B facilities licensed prior to July 1, 1990, need only continue to meet institutional fire safety provisions. Class B supervised living facilities shall provide the necessary physical plant accommodations to meet the needs and functional disabilities of the residents. For Class B supervised living facilities licensed after July 1, 1990, and housing nonambulatory or nonmobile persons, the corridor access to bedrooms, common spaces, and other resident use spaces must be at least five feet in clear width, except that a waiver may be requested in accordance with Minnesota Rules, part 4665.0600.

(d) The commissioner may license as a Class A supervised living facility a residential program for chemically dependent individuals that allows children to reside with the parent receiving treatment in the facility. The licensee of the program shall be responsible for the health, safety, and welfare of the children residing in the facility. The facility in which the program is located must be provided with a sprinkler system approved by the state fire marshal. The licensee shall also provide additional space and physical plant accommodations appropriate for the number and age of children residing in the facility. For purposes of license capacity, each child residing in the facility shall be considered to be a resident.

Subd. 6a. **Supervised living facility; tuberculosis prevention and control.** (a) A supervised living facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the supervised living facility.

Subd. 7. **Residents with AIDS or hepatitis.** Boarding care homes and supervised living facilities licensed by the commissioner of health must accept as a resident a person who is infected with the human immunodeficiency virus or the hepatitis B virus unless the facility cannot meet the needs of the person under

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Minnesota Rules, part 4665.0200, subpart 5, or 4655.1500, subpart 2, or the person is otherwise not eligible for admission to the facility under state laws or rules.

History: *1941 c 549 s 1; 1943 c 649 s 1; 1951 c 304 s 1; 1969 c 358 s 1; 1976 c 173 s 34; 1977 c 218 s 1; 1981 c 95 s 1; 1Sp1985 c 3 s 2; 1987 c 209 s 20,21; 1988 c 689 art 2 s 32; 1989 c 282 art 2 s 8; art 3 s 4; 1990 c 568 art 3 s 3; 1991 c 286 s 3; 1992 c 513 art 6 s 4; 2005 c 56 s 1; 2013 c 43 s 5*

144.51 LICENSE APPLICATIONS.

Before a license shall be issued under sections 144.50 to 144.56, the person applying shall submit evidence satisfactory to the state commissioner of health that the person is not less than 18 years of age and of reputable and responsible character; in the event the applicant is an association or corporation or governmental unit like evidence shall be submitted as to the members thereof and the persons in charge. All applicants shall, in addition, submit satisfactory evidence of their ability to comply with the provisions of sections 144.50 to 144.56 and all rules and minimum standards adopted thereunder.

History: *1941 c 549 s 2; 1943 c 649 s 2; 1951 c 304 s 2; 1973 c 725 s 7; 1976 c 173 s 35; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444*

144.52 APPLICATION.

Any person, partnership, association, or corporation, including state, county, or local governmental units, or any division, department, board, or agency thereof, desiring a license under sections 144.50 to 144.56 shall file with the state commissioner of health a verified application containing the name of the applicant desiring said license; whether such persons so applying are 18 years of age; the type of institution to be operated; the location thereof; the name of the person in charge thereof, and such other information pertinent thereto as the state commissioner of health by rule may require. Application on behalf of a corporation or association or other governmental unit shall be made by any two officers thereof or by its managing agents.

History: *1941 c 549 s 3; 1943 c 649 s 3; 1951 c 304 s 3; 1973 c 725 s 8; 1977 c 305 s 45; 1985 c 248 s 70*

144.53 FEES.

Each application for a license, or renewal thereof, to operate a hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56, except applications by the Minnesota Veterans Home, the commissioner of human services for the licensing of state institutions or by the administrator for the licensing of the University of Minnesota hospitals, shall be accompanied by a fee to be prescribed by the state commissioner of health pursuant to section 144.122. No fee shall be refunded. Licenses shall expire and shall be renewed as prescribed by the commissioner of health pursuant to section 144.122.

No license granted hereunder shall be assignable or transferable.

History: *1941 c 549 s 4; 1945 c 192 s 1; 1951 c 304 s 4; 1959 c 466 s 1; 1974 c 471 s 3; 1975 c 63 s 1; 1975 c 310 s 5; 1976 c 173 s 36; 1976 c 239 s 69; 1977 c 305 s 45; 1984 c 654 art 5 s 58*

144.54 INSPECTIONS.

Every building, institution, or establishment for which a license has been issued shall be periodically inspected by a duly appointed representative of the state commissioner of health under the rules to be established by the state commissioner of health. No institution of any kind licensed pursuant to the provisions

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of sections 144.50 to 144.56 shall be required to be licensed or inspected under the laws of this state relating to hotels, restaurants, lodging houses, boarding houses, and places of refreshment.

History: *1941 c 549 s 5; 1951 c 304 s 5; 1977 c 305 s 45; 1985 c 248 s 70*

144.55 LICENSES; ISSUANCE, SUSPENSION AND REVOCATION.

Subdivision 1. **Issuance.** The state commissioner of health is hereby authorized to issue licenses to operate hospitals, sanitariums, outpatient surgical centers, or other institutions for the hospitalization or care of human beings, which are found to comply with the provisions of sections 144.50 to 144.56 and any reasonable rules promulgated by the commissioner. The commissioner shall not require an outpatient surgical center licensed as part of a hospital to obtain a separate outpatient surgical center license. All decisions of the commissioner thereunder may be reviewed in the district court in the county in which the institution is located or contemplated.

Subd. 1a. **License fee.** The annual license fee for outpatient surgical centers is $1,512.

Subd. 1b. **Standards for nursing care.** As a condition of licensure, outpatient surgical centers must provide nursing care consistent with nationally accepted nursing clinical standards for perioperative nursing, including, but not limited to Association of Operating Room Nurses and American Nurses Association standards, which are generally accepted in the professional nursing community.

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given:

(a) "Outpatient surgical center" or "center" means a freestanding facility organized for the specific purpose of providing elective outpatient surgery for preexamined, prediagnosed, low-risk patients. Admissions are limited to procedures that utilize general anesthesia or conscious sedation and that do not require overnight inpatient care. An outpatient surgical center is not organized to provide regular emergency medical services and does not include a physician's or dentist's office or clinic for the practice of medicine, the practice of dentistry, or the delivery of primary care.

(b) "Approved accrediting organization" means any organization recognized as an accreditation organization by the Centers for Medicare and Medicaid Services.

Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56, for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations promulgated pursuant to Title XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq. The commissioner may use as minimum standards changes in the federal hospital certification regulations promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably necessary to protect public health and safety. The commissioner shall also promulgate in rules additional minimum standards for new construction.

(b) Each hospital and outpatient surgical center shall establish policies and procedures to prevent the transmission of human immunodeficiency virus and hepatitis B virus to patients and within the health care setting. The policies and procedures shall be developed in conformance with the most recent recommendations issued by the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control. The commissioner of health shall evaluate a hospital's compliance with the policies and procedures according to subdivision 4.

(c) An outpatient surgical center must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published

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in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(d) Written compliance with this subdivision must be maintained by the outpatient surgical center.

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

Subd. 5. **Coordination of inspections.** Prior to conducting routine inspections of hospitals and outpatient surgical centers, a state agency shall notify the commissioner of its intention to inspect. The commissioner shall then determine whether the inspection is necessary in light of any previous inspections conducted by the commissioner, any other state agency, or an approved accrediting organization. The commissioner shall notify the agency of the determination and may authorize the agency to conduct the inspection. No state agency may routinely inspect any hospital without the authorization of the commissioner. The commissioner shall coordinate, insofar as is possible, routine inspections conducted by state agencies, so as to minimize the number of inspections to which hospitals are subject.

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians who have a "financial or economic interest," as defined

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in section 144.6521, subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

Subd. 7. **Hearing.** Prior to any suspension, revocation or refusal to renew a license, the licensee shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. At each hearing, the commissioner shall have the burden of establishing that a violation described in subdivision 6 has occurred.

If a license is revoked, suspended, or not renewed, a new application for license may be considered by the commissioner if the conditions upon which revocation, suspension, or refusal to renew was based have been corrected and evidence of this fact has been satisfactorily furnished. A new license may then be granted after proper inspection has been made and all provisions of sections 144.50 to 144.56 and any rules promulgated thereunder, or Minnesota Rules, chapters 4650 and 4675, have been complied with and recommendation has been made by the inspector as an agent of the commissioner.

Subd. 8. **Rules.** The commissioner may promulgate rules necessary to implement the provisions of this section, except that the standards described in subdivision 3 shall constitute the sole minimum quality standards for licensure of hospitals.

Subd. 9. **Expiration of presently valid licenses.** All licenses presently in effect shall remain valid following May 7, 1981, and shall expire on the dates specified on the licenses unless suspended or revoked.

Subd. 10. **Evaluation report.** On November 15, 1983, the commissioner shall provide the legislature and the governor with a written report evaluating the utilization of the accreditation program, paying particular attention to its effect upon the public health and safety.

Subd. 11. **State hospitals not affected.** Subdivisions 3, 4, and 5 do not apply to state hospitals and other facilities operated under the direction of the commissioner of human services.

History: *1941 c 549 s 6; 1951 c 304 s 6; 1976 c 173 s 37; 1977 c 305 s 45; 1978 c 674 s 60; 1981 c 95 s 2; 1982 c 424 s 130; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1987 c 384 art 2 s 1; 1987 c 403 art 4 s 1; 1992 c 559 art 1 s 2; 2004 c 198 s 1-8; 2005 c 85 s 2-4; 2010 c 274 s 1; 2013 c 43 s 6*

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 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. Beginning January 1, 2013, this paragraph does not apply to any construction necessary to relocate a radiation therapy machine from a community hospital-owned radiation therapy facility located in

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the city of Maplewood to a community hospital campus in the city of Woodbury within the same health system. This paragraph expires December 31, 2020.

(c) Notwithstanding paragraph (a), after December 31, 2020, the construction of a radiation therapy facility located in any of the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright, may occur only if the following requirements are met:

(1) the entity constructing the radiation therapy facility is controlled by or is under common control with a hospital licensed under sections 144.50 to 144.56; and

(2) the new radiation therapy facility is located outside of a 15-mile radius from any existing radiation therapy facility.

(d) Any referring physician located within a county identified in paragraph (c) must provide each patient who is in need of radiation therapy services with a list of all radiation therapy facilities located within the counties identified in paragraph (c). Physicians with a financial interest in any radiation therapy facility must disclose to the patient the existence of the interest.

(e) For purposes of this section, "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the policies, operations, or activities of an entity, through the ownership of, or right to vote or to direct the disposition of shares, membership interests, or ownership interests of the entity.

(f) For purposes of this section, "financial interest in any radiation therapy facility" means a direct or indirect ownership or investment interest in a radiation therapy facility or a compensation arrangement with a radiation therapy facility.

(g) This section does not apply to the relocation or reconstruction of an existing radiation therapy facility if:

(1) the relocation or reconstruction of the facility remains owned by the same entity;

(2) the relocation or reconstruction is located within one mile of the existing facility; and

(3) the period in which the existing facility is closed and the relocated or reconstructed facility begins providing services does not exceed 12 months.

History: *1Sp2003 c 14 art 7 s 42; 2006 c 190 s 1; 2007 c 147 art 11 s 2; 2008 c 213 s 1; 2009 c 6 s 1; 2012 c 217 s 1; 2012 c 247 art 2 s 6; 2013 c 11 s 1*

144.551 HOSPITAL CONSTRUCTION MORATORIUM.

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

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

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

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

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

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

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

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of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

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

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

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

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

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

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(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner

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of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review; or

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission.

Subd. 2. **Emergency waiver.** The commissioner shall grant an emergency waiver from the provisions of this section if the need for the project is a result of fire, tornado, flood, storm damage, or other similar disaster, if adequate health care facilities are not available for the people who previously used the applicant facility, and if the request for an emergency waiver is limited in nature and scope only to those repairs necessitated by the natural disaster.

Subd. 3. **Enforcement.** The district court in Ramsey County has jurisdiction to enjoin an alleged violation of subdivision 1. At the request of the commissioner of health, the attorney general may bring an action to enjoin an alleged violation. The commissioner of health shall not issue a license for any portion of a hospital in violation of subdivision 1. No hospital in violation of subdivision 1 may apply for or receive public funds under chapters 245 to 256B, or from any other source.

Subd. 4. **Definitions.** Except as indicated in this subdivision, the terms used in this section have the meanings given them under Minnesota Statutes 1982, sections 145.832 to 145.845, and the rules adopted under those sections.

The term "hospital" has the meaning given it in section 144.50.

History: *1990 c 500 s 1; 1990 c 568 art 2 s 8; 1993 c 243 s 1; 2000 c 488 art 9 s 1; 1Sp2001 c 9 art 1 s 37; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 7 s 43; 2004 c 187 s 1; 1Sp2005 c 4 art 6 s 22; 2006 c 172 s 1; 2006 c 249 s 1; 2009 c 51 s 1; 2010 c 198 s 1; 2011 c 51 s 1; 2014 c 312 art 23 s 3; 2015 c 71 art 2 s 5; 2016 c 158 art 2 s 35; 1Sp2017 c 6 art 10 s 66*

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.

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(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 of representatives 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: *2004 c 231 s 2; 2006 c 249 s 2; 2007 c 147 art 9 s 14*

144.553 ALTERNATIVE APPROVAL PROCESS.

Subdivision 1. **Letter of intent; publication; acceptance of additional proposals.** (a) An organization seeking to obtain a hospital license must submit a letter of intent to the commissioner, specifying the community in which the proposed hospital would be located and the number of beds proposed for the new hospital. When multiple letters of intent are received, the commissioner shall determine whether they

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constitute requests for separate projects or are competing proposals to serve the same or a similar service area.

(b) Upon receipt of a letter under paragraph (a), the commissioner shall publish a notice in the State Register that includes the information received from the organization under paragraph (a). The notice must state that another organization interested in seeking a hospital license to serve the same or a similar service area must notify the commissioner within 30 days.

(c) If no responses are received from additional organizations under paragraph (b), the commissioner shall notify the entity seeking a license that it is required to submit a plan under section 144.552 and shall notify the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance that the project is subject to sections 144.551 and 144.552.

Subd. 2. **Needs assessment.** (a) If one or more responses are received by the commissioner under subdivision 1, paragraph (b), the commissioner shall complete within 90 days a needs assessment to determine if a new hospital is needed in the proposed service area.

(b) The organizations that have filed or responded to a letter of intent under subdivision 1 shall provide to the commissioner within 30 days of a request from the commissioner a statement justifying the need for a new hospital in the service area and sufficient information, as determined by the commissioner, to allow the commissioner to determine the need for a new hospital. The information may include, but is not limited to, a demographic analysis of the proposed service area, the number of proposed beds, the types of hospital services to be provided, and distances and travel times to existing hospitals currently providing services in the service area.

(c) The commissioner shall make a determination of need for the new hospital. If the commissioner determines that a new hospital in the service area is not justified, the commissioner shall notify the applicants in writing, stating the reasons for the decision.

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;

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(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

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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).

Subd. 4. **Payment of commissioner's expenses.** Notwithstanding section 16A.1283, applicants who are a party at any stage of the administrative process established in this section shall pay the cost of that stage of the process, as determined by the commissioner. The cost of the needs assessment, criteria development, and hearing shall be divided equally among the applicants. Money received by the commissioner under this subdivision is appropriated to the commissioner for the purpose of administering this section.

History: *2006 c 249 s 3,6; 2007 c 147 art 9 s 15; art 10 s 16*

144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.

For hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities, the commissioner shall collect a fee for the review and approval of architectural, mechanical, and electrical plans and specifications submitted before construction begins for each project relative to construction of new buildings, additions to existing buildings, or remodeling or alterations of existing buildings. All fees collected in this section shall be deposited in the state treasury and credited to the state government special revenue fund. Fees must be paid at the time of submission of final plans for review and are not refundable. The fee is calculated as follows:

Construction project total estimated cost	Fee
$0 - $10,000	$30
$10,001 - $50,000	$150
$50,001 - $100,000	$300

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$100,001 - $150,000	$450
$150,001 - $200,000	$600
$200,001 - $250,000	$750
$250,001 - $300,000	$900
$300,001 - $350,000	$1,050
$350,001 - $400,000	$1,200
$400,001 - $450,000	$1,350
$450,001 - $500,000	$1,500
$500,001 - $550,000	$1,650
$550,001 - $600,000	$1,800
$600,001 - $650,000	$1,950
$650,001 - $700,000	$2,100
$700,001 - $750,000	$2,250
$750,001 - $800,000	$2,400
$800,001 - $850,000	$2,550
$850,001 - $900,000	$2,700
$900,001 - $950,000	$2,850
$950,001 - $1,000,000	$3,000
$1,000,001 - $1,050,000	$3,150
$1,050,001 - $1,100,000	$3,300
$1,100,001 - $1,150,000	$3,450
$1,150,001 - $1,200,000	$3,600
$1,200,001 - $1,250,000	$3,750
$1,250,001 - $1,300,000	$3,900
$1,300,001 - $1,350,000	$4,050
$1,350,001 - $1,400,000	$4,200
$1,400,001 - $1,450,000	$4,350

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$1,450,001 - $1,500,000	$4,500
$1,500,001 and over	$4,800

History: *2013 c 108 art 12 s 33*

144.555 HOSPITAL CLOSINGS; PATIENT RELOCATIONS.

Subdivision 1. **Notice of closing or curtailing service.** If a facility licensed under sections 144.50 to 144.56 voluntarily plans to cease operations or to curtail operations to the extent that patients or residents must be relocated, the controlling persons of the facility must notify the commissioner of health at least 90 days before the scheduled cessation or curtailment. The commissioner shall cooperate with the controlling persons and advise them about relocating the patients or residents.

Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 may result in issuance of a correction order under section 144.653, subdivision 5.

History: *1987 c 209 s 22*

144.56 STANDARDS.

Subdivision 1. **Commissioner's powers.** The state commissioner of health shall, in the manner prescribed by law, adopt and enforce reasonable rules and standards under sections 144.50 to 144.56 which the commissioner finds to be necessary and in the public interests and may rescind or modify them from time to time as may be in the public interest, insofar as such action is not in conflict with any provision thereof.

Subd. 2. **Content of rules and standards.** In the public interest the commissioner of health, by such rules and standards, may regulate and establish minimum standards as to the construction, equipment, maintenance, and operation of the institutions insofar as they relate to sanitation and safety of the buildings and to the health, treatment, comfort, safety, and well-being of the persons accommodated for care. Construction as used in this subdivision means the erection of new buildings or the alterations of or additions to existing buildings commenced after April 7, 1951.

Subd. 2a. **Double beds in boarding care homes.** The commissioner shall not adopt any rule which unconditionally prohibits double beds in a boarding care home. The commissioner may adopt rules setting criteria for when double beds will be allowed.

Subd. 2b. **Boarding care homes.** The commissioner shall not adopt or enforce any rule that limits:

(1) a certified boarding care home from providing nursing services in accordance with the home's Medicaid certification; or

(2) a noncertified boarding care home registered under chapter 144D from providing home care services in accordance with the home's registration.

Subd. 2c. **Boarding care home; tuberculosis prevention and control.** (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

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(b) Written compliance with this subdivision must be maintained by the boarding care home.

Subd. 3. **Maternity patients.** The commissioner of health shall, with the advice of the commissioner of human services, prescribe such general rules for the conduct of all institutions receiving maternity patients as shall be necessary to effect the purposes of all laws of the state relating to maternity patients and newborn infants so far as the same are applicable.

Subd. 4. **Classes of institutions.** The commissioner of health may classify the institutions licensed under sections 144.50 to 144.56 on the basis of the type of care provided and may prescribe separate rules and minimum standards for each class.

History: *1941 c 549 s 7; 1943 c 649 s 7; 1951 c 304 s 7; 1977 c 305 s 45; 1981 c 23 s 2; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1995 c 207 art 7 s 6; 1999 c 245 art 2 s 27; 2013 c 43 s 7; 2013 c 125 art 1 s 31*

144.561 DESCRIPTION OF CERTAIN MEDICAL FACILITIES.

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

(a) "Person" means an individual, partnership, association, corporation, state, county or local governmental unit or a division, department, board or agency of a governmental unit.

(b) "Medical facility" means an institution, office, clinic, or building, not attached to a licensed hospital, where medical services for the diagnosis or treatment of illness or injury or the maintenance of health are offered in an outpatient or ambulatory setting.

Subd. 2. **Prohibition.** No person shall use the words "emergency," "emergent," "trauma," "critical," or any form of these words which suggest, offer, or imply the availability of immediate care for any medical condition likely to cause death, disability or serious illness in the name of any medical facilities, or in advertising, publications or signs identifying the medical facility unless the facility is licensed under the provisions of section 144.50.

History: *1984 c 534 s 2*

144.562 SWING BED APPROVAL; ISSUANCE OF LICENSE CONDITIONS.

Subdivision 1. **Definition.** For the purposes of this section, "swing bed" means a hospital bed licensed under sections 144.50 to 144.56 that has been granted a license condition under this section and which has been certified to participate in the federal Medicare program under United States Code, title 42, section 1395 (tt).

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached

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nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total of 2,000 days of swing bed use per year. Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law.

(c) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.

(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

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

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

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

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

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

(e) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a

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swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

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

Subd. 4. **Issuance of license condition; renewals.** The commissioner of health shall issue a license condition to a hospital that complies with subdivisions 2 and 3. The license condition must be granted when the license is first issued, when it is renewed, or during the hospital's licensure year. The condition is valid for the hospital's licensure year. The license condition can be renewed at the time of the hospital's license renewal if the hospital complies with subdivisions 2 and 3.

Subd. 5. **Inspections.** Notwithstanding section 144.55, subdivision 4, the commissioner of health may conduct inspections of a hospital granted a condition under this section to assess compliance with this section.

Subd. 6. **Violations.** Notwithstanding section 144.55, subdivision 4, if the hospital fails to comply with subdivision 2 or 3, the commissioner of health shall issue a correction order and penalty assessment under section 144.653 or may suspend, revoke, or refuse to renew the license condition under section 144.55, subdivision 6. The penalty assessment for a violation of subdivision 2 or 3 is $500.

Subd. 7. [Obsolete]

History: *1Sp1985 c 3 s 3; 1986 c 420 s 1; 1989 c 282 art 2 s 9,10; 1995 c 207 art 7 s 7; 1Sp2005 c 4 art 6 s 23; 1Sp2017 c 6 art 3 s 3*

144.563 NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.

A hospital that has been granted a license condition under section 144.562 must not provide to patients not reimbursed by Medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or Medicare as services of a skilled nursing facility or intermediate care facility for more than 42 days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

History: *1Sp1985 c 3 s 4*

144.564 MONITORING OF SUBACUTE OR TRANSITIONAL CARE SERVICES.

Subdivision 1. **Hospital data.** The commissioner of health shall monitor the provision of subacute or transitional care services provided in hospitals. All hospitals providing these services must report statistical data on the extent and utilization of these services on forms supplied by the commissioner. The data must include the following information: the number of admissions to and discharges from subacute or transitional care beds, charges for services in these beds, the length of stay and total patient days, admission origin and discharge destination, and other information required by the commissioner to assess the utilization of these services. For purposes of this subdivision, subacute or transitional care services is care provided in a hospital bed to patients who have been hospitalized and no longer meet established acute care criteria, and care provided to patients who are admitted for respite care.

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Subd. 2. **Nursing home data.** Nursing homes which provide services to individuals whose length of stay in the facility is less than 42 days shall report the data required by subdivision 1 on forms supplied by the commissioner of health.

Subd. 3. **Annual report.** The commissioner shall monitor the provision of services described in this section and shall report annually to the legislature concerning these services, including recommendations on the need for legislation.

History: *1986 c 420 s 2*

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

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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: *2004 c 198 s 9; 2007 c 147 art 9 s 16*

144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.

Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have the meanings given.

(b) "Act of violence" means an act by a patient or visitor against a health care worker that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections 609.221 to 609.2241.

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

(d) "Health care worker" means any person, whether licensed or unlicensed, employed by, volunteering in, or under contract with a hospital, who has direct contact with a patient of the hospital for purposes of either medical care or emergency response to situations potentially involving violence.

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(e) "Hospital" means any facility licensed as a hospital under section 144.55.

(f) "Incident response" means the actions taken by hospital administration and health care workers during and following an act of violence.

(g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's ability to report acts of violence, including by retaliating or threatening to retaliate against a health care worker.

(h) "Preparedness" means the actions taken by hospital administration and health care workers to prevent a single act of violence or acts of violence generally.

(i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against, or penalize a health care worker regarding the health care worker's compensation, terms, conditions, location, or privileges of employment.

Subd. 2. **Hospital duties.** (a) All hospitals must design and implement preparedness and incident response action plans to acts of violence by January 15, 2016, and review the plan at least annually thereafter.

(b) A hospital shall designate a committee of representatives of health care workers employed by the hospital, including nonmanagerial health care workers, nonclinical staff, administrators, patient safety experts, and other appropriate personnel to develop preparedness and incident response action plans to acts of violence. The hospital shall, in consultation with the designated committee, implement the plans under paragraph (a). Nothing in this paragraph shall require the establishment of a separate committee solely for the purpose required by this subdivision.

(c) A hospital shall provide training to all health care workers employed or contracted with the hospital on safety during acts of violence. Each health care worker must receive safety training annually and upon hire. Training must, at a minimum, include:

(1) safety guidelines for response to and de-escalation of an act of violence;

(2) ways to identify potentially violent or abusive situations; and

(3) the hospital's incident response reaction plan and violence prevention plan.

(d) As part of its annual review required under paragraph (a), the hospital must review with the designated committee:

(1) the effectiveness of its preparedness and incident response action plans;

(2) the most recent gap analysis as provided by the commissioner; and

(3) the number of acts of violence that occurred in the hospital during the previous year, including injuries sustained, if any, and the unit in which the incident occurred.

(e) A hospital shall make its action plans and the information listed in paragraph (d) available to local law enforcement and, if any of its workers are represented by a collective bargaining unit, to the exclusive bargaining representatives of those collective bargaining units.

(f) A hospital, including any individual, partner, association, or any person or group of persons acting directly or indirectly in the interest of the hospital, shall not interfere with or discourage a health care worker if the health care worker wishes to contact law enforcement or the commissioner regarding an act of violence.

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(g) The commissioner may impose an administrative fine of up to $250 for failure to comply with the requirements of this subdivision.

History: *2015 c 71 art 8 s 25*

144.57 [Repealed, 1951 c 304 s 8]

144.571 [Repealed, 1983 c 260 s 68]

144.572 INSTITUTIONS EXCEPTED.

No rule nor requirement shall be made, nor standard established under sections 144.50 to 144.56 for any sanitarium conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and treatment for those who select and depend upon spiritual means through prayer alone, in lieu of medical care, for healing, except as to the sanitary and safe condition of the premises, cleanliness of operation, and its physical equipment.

History: *1951 c 304 s 10; 1976 c 173 s 39; 1985 c 248 s 70; 1996 c 451 art 4 s 7*

144.573 PETS IN CERTAIN INSTITUTIONS.

Facilities for the institutional care of human beings licensed under section 144.50, may keep pet animals on the premises subject to reasonable rules as to the care, type and maintenance of the pet.

History: *1979 c 38 s 2*

144.574 DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.

Subdivision 1. **Education by hospitals.** (a) A hospital licensed under sections 144.50 to 144.56 shall make available for viewing by the parents of each newborn baby delivered in the hospital a video presentation on the dangers associated with shaking infants and young children.

(b) A hospital shall use a video obtained from the commissioner or approved by the commissioner. The commissioner shall provide to a hospital and any interested individuals, at cost, copies of an approved video. The commissioner shall review other video presentations for possible approval upon the request of a hospital. The commissioner shall not require a hospital to use videos that would require the hospital to pay royalties for use of the video, restrict viewing in order to comply with public viewing or other restrictions, or be subject to other costs or restrictions associated with copyrights.

(c) A hospital shall, whenever possible, request both parents to view the video.

(d) The showing or distribution of the video shall not subject any person or facility to any action for damages or other relief provided the person or facility acted in good faith.

Subd. 2. **Education by health care providers.** The commissioner shall establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with the parents and primary caregivers of infants and young children up to the age of three at each well-baby visit.

History: *1Sp2005 c 4 art 6 s 24*

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144.58 INFORMATION, CONFIDENTIAL.

Information of a confidential nature received by the state commissioner of health through inspections and authorized under sections 144.50 to 144.56 shall not be disclosed except in a proceeding involving the question of licensure.

History: *1941 c 549 s 9; 1951 c 304 s 11; 1977 c 305 s 45*

144.581 HOSPITAL AUTHORITIES.

Subdivision 1. **Nonprofit corporation powers.** A municipality, political subdivision, state agency, or other governmental entity that owns or operates a hospital authorized, organized, or operated under chapters 158, 250, 376, and 397, or under sections 412.221, 447.05 to 447.13, 447.31, or 471.59, or under any special law authorizing or establishing a hospital or hospital district shall, relative to the delivery of health care services, have, in addition to any authority vested by law, the authority and legal capacity of a nonprofit corporation under chapter 317A, including authority to:

(1) enter shared service and other cooperative ventures;

(2) join or sponsor membership in organizations intended to benefit the hospital or hospitals in general;

(3) enter partnerships;

(4) incorporate other corporations;

(5) have members of its governing authority or its officers or administrators serve as directors, officers, or employees of the ventures, associations, or corporations;

(6) own shares of stock in business corporations;

(7) offer, directly or indirectly, products and services of the hospital, organization, association, partnership, or corporation to the general public;

(8) expend funds, including public funds in any form, or devote the resources of the hospital or hospital district to recruit or retain physicians whose services are necessary or desirable for meeting the health care needs of the population, and for successful performance of the hospital or hospital district's public purpose of the promotion of health. Allowable uses of funds and resources include the retirement of medical education debt, payment of onetime amounts in consideration of services rendered or to be rendered, payment of recruitment expenses, payment of moving expenses, and the provision of other financial assistance necessary for the recruitment and retention of physicians, provided that the expenditures in whatever form are reasonable under the facts and circumstances of the situation; and

(9) notwithstanding any limitation in chapter 118A, invest hospital funds in any security which has been recommended by an investment adviser registered under the federal Investment Advisers Act of 1940, United States Code, title 15, sections 80b-1 to 80b-21, or by a bank or trust company exercising its trust powers. Funds invested under this clause must be invested according to written investment policies and written investment procedures established by the governmental entity.

Subd. 2. **Use of hospital funds for corporate projects.** In the event that the municipality, political subdivision, state agency, or other governmental entity provides direct financial subsidy to the hospital from tax revenue at the time an undertaking authorized under subdivision 1, clauses (1) to (7), is established or funded, the hospital may not contribute funds to the undertaking for more than three years and thereafter all funds must be repaid, with interest in no more than ten years.

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Subd. 3. **Converting public funds for individual benefit.** The conversion of public funds for the benefit of any individual shall constitute grounds for review and action by the attorney general or the county attorney under section 609.54.

Subd. 4. **Other laws governing hospital board.** The execution of the functions of the board of directors of a hospital by an organization established under this section shall be subject to the public purchasing requirements of section 471.345, the Open Meeting Law, chapter 13D, and the Data Practices Act, chapter 13.

Subd. 5. **Closed meetings; recording.** (a) Notwithstanding subdivision 4 or chapter 13D, a public hospital or an organization established under this section may hold a closed meeting to discuss specific marketing activity and contracts that might be entered into pursuant to the marketing activity in cases where the hospital or organization is in competition with health care providers that offer similar goods or services, and where disclosure of information pertaining to those matters would cause harm to the competitive position of the hospital or organization, provided that the goods or services do not require a tax levy. No contracts referred to in this paragraph may be entered into earlier than 15 days after the proposed contract has been described at a public meeting and the description entered in the minutes, except for contracts for consulting services or with individuals for personal services.

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

(c) The board of directors may not discuss a tax levy, bond issuance, or other expenditure of money unless the expenditure is directly related to specific marketing activities and contracts described in paragraph (a) at a closed meeting.

History: *1984 c 554 s 1; 1984 c 655 art 2 s 15 subd 1; 1987 c 384 art 2 s 1; 1989 c 304 s 137; 1989 c 351 s 15; 1990 c 568 art 2 s 9; 1992 c 549 art 5 s 13; 1994 c 618 art 1 s 21; 1994 c 625 art 8 s 44; 2008 c 277 art 1 s 15; 2017 c 18 s 1*

144.583 [Repealed, 1973 c 139 s 2]

144.584 [Repealed, 1976 c 173 s 64]

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;

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(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*

144.586 REQUIREMENTS FOR CERTAIN NOTICES AND DISCHARGE PLANNING.

Subdivision 1. **Observation stay notice.** (a) Each hospital, as defined under section 144.50, subdivision 2, shall provide oral and written notice to each patient that the hospital places in observation status of such placement not later than 24 hours after such placement. The oral and written notices must include:

(1) a statement that the patient is not admitted to the hospital but is under observation status;

(2) a statement that observation status may affect the patient's Medicare coverage for:

(i) hospital services, including medications and pharmaceutical supplies; or

(ii) home or community-based care or care at a skilled nursing facility upon the patient's discharge; and

(3) a recommendation that the patient contact the patient's health insurance provider or the Office of the Ombudsman for Long-Term Care or Office of the Ombudsman for State Managed Health Care Programs or the Beneficiary and Family Centered Care Quality Improvement Organization to better understand the implications of placement in observation status.

(b) The hospital shall document the date in the patient's record that the notice required in paragraph (a) was provided to the patient, and the patient's designated representative such as the patient's health care agent, legal guardian, conservator, or another person acting as the patient's representative.

Subd. 2. **Postacute care discharge planning.** Each hospital, including hospitals designated as critical access hospitals, must comply with the federal hospital requirements for discharge planning which include:

(1) conducting a discharge planning evaluation that includes an evaluation of:

(i) the likelihood of the patient needing posthospital services and of the availability of those services; and

(ii) the patient's capacity for self-care or the possibility of the patient being cared for in the environment from which the patient entered the hospital;

(2) timely completion of the discharge planning evaluation under clause (1) by hospital personnel so that appropriate arrangements for posthospital care are made before discharge, and to avoid unnecessary delays in discharge;

(3) including the discharge planning evaluation under clause (1) in the patient's medical record for use in establishing an appropriate discharge plan. The hospital must discuss the results of the evaluation with the patient or individual acting on behalf of the patient. The hospital must reassess the patient's discharge plan if the hospital determines that there are factors that may affect continuing care needs or the appropriateness of the discharge plan; and

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(4) providing counseling, as needed, for the patient and family members or interested persons to prepare them for posthospital care. The hospital must provide a list of available Medicare-eligible home care agencies or skilled nursing facilities that serve the patient's geographic area, or other area requested by the patient if such care or placement is indicated and appropriate. Once the patient has designated their preferred providers, the hospital will assist the patient in securing care covered by their health plan or within the care network. The hospital must not specify or otherwise limit the qualified providers that are available to the patient. The hospital must document in the patient's record that the list was presented to the patient or to the individual acting on the patient's behalf.

History: *2015 c 71 art 8 s 26*

144.59 [Repealed, 1980 c 567 s 2]

144.60 [Repealed, 1980 c 567 s 2]

STATEWIDE TRAUMA SYSTEM

144.602 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 144.602 to 144.608, the terms defined in this section have the meanings given them.

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

Subd. 3. **Major trauma.** "Major trauma" means a sudden severe injury or damage to the body caused by an external force that results in potentially life-threatening injuries or that could result in the following disabilities:

(1) impairment of cognitive or mental abilities;

(2) impairment of physical functioning; or

(3) disturbance of behavioral or emotional functioning.

Subd. 4. **Trauma hospital.** "Trauma hospital" means a hospital that voluntarily meets the commissioner's criteria under section 144.603 and that has been designated as a trauma hospital under section 144.605.

History: *1Sp2005 c 4 art 6 s 25; 2006 c 212 art 3 s 12*

144.603 STATEWIDE TRAUMA SYSTEM CRITERIA.

Subdivision 1. **Criteria established.** The commissioner shall adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. Minimum criteria shall address emergency medical service trauma triage and transportation guidelines as approved under section 144E.101, subdivision 14, designation of hospitals as trauma hospitals, interhospital transfers, a trauma registry, and a trauma system governance structure.

Subd. 2. **Basis; verification.** The commissioner shall base the establishment, implementation, and modifications to the criteria under subdivision 1 on the department-published Minnesota comprehensive statewide trauma system plan. The commissioner shall seek the advice of the Trauma Advisory Council in implementing and updating the criteria, using accepted and prevailing trauma transport, treatment, and referral standards of the American College of Surgeons, the American College of Emergency Physicians, the Minnesota Emergency Medical Services Regulatory Board, the national Trauma Center Association of

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America, and other widely recognized trauma experts. The commissioner shall adapt and modify the standards as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution and shall verify that the criteria are met by each hospital voluntarily participating in the statewide trauma system.

Subd. 3. **Rule exemption.** In developing and adopting the criteria under this section, the commissioner of health is exempt from chapter 14, including section 14.386.

History: *1Sp2005 c 4 art 6 s 26; 1Sp2010 c 1 art 20 s 8*

144.604 TRAUMA TRIAGE AND TRANSPORTATION.

Subdivision 1. **Transport requirement.** Unless the Emergency Medical Services Regulatory Board has approved a licensed ambulance service's deviation from the guidelines under section 144E.101, subdivision 14, the ambulance service must transport major trauma patients from the scene according to subdivision 2.

Subd. 2. **Ground ambulance transportation.** Ground ambulances must immediately transport patients with compromised airways to the nearest designated trauma hospital. If no designated trauma hospital exists within 30 minutes transport time, the patient must be transported to the closest hospital. In cases where a patient does not have a compromised airway, the ground ambulance must transport major trauma patients:

(1) to a level I or level II trauma hospital within 30 minutes transport time;

(2) if no level I or level II trauma hospital exists within 30 minutes transport time, the patient must be transported to the closest designated trauma hospital within 30 minutes transport time or to a more appropriate higher designated trauma hospital if predetermined by the ambulance service medical director; or

(3) if no designated trauma hospital exists within 30 minutes transport time, the patient must be transported to the closest hospital.

Subd. 3. [Repealed, 2009 c 74 s 4]

History: *1Sp2005 c 4 art 6 s 27; 2008 c 156 s 3; 2009 c 74 s 1,2*

144.605 DESIGNATING TRAUMA HOSPITALS.

Subdivision 1. **Naming privileges.** Unless it has been designated a trauma hospital by the commissioner, no hospital shall use the term trauma center or trauma hospital in its name or its advertising or shall otherwise indicate it has trauma treatment capabilities.

Subd. 2. **Designation; reverification.** The commissioner shall designate six levels of trauma hospitals. A hospital that voluntarily meets the criteria for a particular level of trauma hospital shall apply to the commissioner for designation and, upon the commissioner's verifying the hospital meets the criteria, be designated a trauma hospital at the appropriate level for a three-year period. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary system must apply for and successfully complete a reverification process, be awaiting the site visit for the reverification, or be awaiting the results of the site visit. The commissioner may extend a hospital's existing designation for up to 18 months on a provisional basis if the hospital has applied for reverification in a timely manner but has not yet completed the reverification process within the expiration of the three-year designation and the extension is in the best interest of trauma system patient safety. To be granted a provisional extension, the hospital must be:

(1) scheduled and awaiting the site visit for reverification;

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(2) awaiting the results of the site visit; or

(3) responding to and correcting identified deficiencies identified in the site visit.

Subd. 3. **ACS verification.** The commissioner shall grant the appropriate level I, II, or III trauma hospital or level I or II pediatric trauma hospital designation to a hospital that successfully completes and passes the American College of Surgeons (ACS) verification standards at the hospital's cost, submits verification documentation to the Trauma Advisory Council, and formally notifies the Trauma Advisory Council of ACS verification.

Subd. 4. **Level III designation; not ACS verified.** (a) The commissioner shall grant the appropriate level III trauma hospital designation to a hospital that is not ACS verified but that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level III trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the commissioner shall arrange a site review visit. Upon successful completion of the site review, the review team shall make written recommendations to the Trauma Advisory Council. If approved by the Trauma Advisory Council, a letter of recommendation shall be sent to the commissioner for final approval and designation.

Subd. 5. **Level IV designation.** (a) The commissioner shall grant the appropriate level IV trauma hospital designation to a hospital that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level IV trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the commissioner shall arrange a site review visit. Upon successful completion of the site review, the review team shall make written recommendations to the Trauma Advisory Council. If approved by the Trauma Advisory Council, a letter of recommendation shall be sent to the commissioner for final approval and designation.

Subd. 6. **Changes in designation.** Changes in a trauma hospital's ability to meet the criteria for the hospital's level of designation must be self-reported to the Trauma Advisory Council and to other regional hospitals and local emergency medical services providers and authorities. If the hospital cannot correct its ability to meet the criteria for its level within six months, the hospital may apply for redesignation at a different level.

Subd. 7. **Higher designation.** A trauma hospital may apply for a higher trauma hospital designation one time during the hospital's three-year designation by completing the designation process for that level of trauma hospital.

Subd. 8. **Loss of designation.** The commissioner may refuse to designate or redesignate or may revoke a previously issued trauma hospital designation if a hospital does not meet the criteria of the statewide trauma plan, in the interests of patient safety, or if a hospital denies or refuses a reasonable request by the commissioner or the commissioner's designee to verify information by correspondence or an on-site visit.

Subd. 9. **Designation process protection.** Data on patients in information and reports related to the designation and redesignation of trauma hospitals pursuant to subdivisions 3 to 5 are private data on individuals, as defined in section 13.02, subdivision 12.

History: *1Sp2005 c 4 art 6 s 28; 1Sp2010 c 1 art 20 s 9-11; 2016 c 179 s 3*

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144.606 INTERHOSPITAL TRANSFERS.

Subdivision 1. **Written procedures required.** A level III or IV trauma hospital must have predetermined, written procedures that direct the internal process for rapidly and efficiently transferring a major trauma patient to definitive care, including:

(1) clearly identified anatomic and physiologic criteria that, if met, will immediately initiate transfer to definitive care;

(2) a listing of appropriate ground and air transport services, including primary and secondary telephone contact numbers; and

(3) immediately available supplies, records, or other necessary resources that will accompany a patient.

Subd. 2. **Transfer agreements.** (a) A level III or IV trauma hospital may transfer patients to a hospital with which the trauma hospital has a written transfer agreement.

(b) Each agreement must be current and with a trauma hospital or trauma hospitals capable of caring for major trauma injuries.

(c) A level III or IV trauma hospital must have a current transfer agreement with a hospital that has special capabilities in the treatment of burn injuries and a transfer agreement with a second hospital that has special capabilities in the treatment of burn injuries, should the primary transfer hospital be unable to accept a burn patient.

History: *1Sp2005 c 4 art 6 s 29*

COMPREHENSIVE ADVANCED LIFE SUPPORT

144.6062 COMPREHENSIVE ADVANCED LIFE SUPPORT.

The commissioner of health shall establish a comprehensive advanced life-support educational program to train rural medical personnel, including physicians, physician assistants, nurses, and allied health care providers, in a team approach to anticipate, recognize, and treat life-threatening emergencies before serious injury or cardiac arrest occurs.

History: *1999 c 245 art 9 s 45; 1Sp2010 c 1 art 20 s 18,23*

144.607 [Repealed, 1Sp2010 c 1 art 20 s 24]

144.6071 TRAUMA REGISTRY.

Subdivision 1. **Registry.** The commissioner of health shall establish and maintain a central registry of persons who sustain major trauma as defined in section 144.602, subdivision 3. The registry shall collect information to facilitate the development of clinical and system quality improvement, injury prevention, treatment, and rehabilitation programs.

Subd. 2. **Registry participation required.** A trauma hospital must participate in the statewide trauma registry. The consent of the injured person is not required.

Subd. 3. **Registry information.** Trauma hospitals must electronically submit the following information to the registry:

(1) demographic information of the injured person;

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(2) information about the date, location, and cause of the injury;

(3) information about the condition of the injured person;

(4) information about the treatment, comorbidities, and diagnosis of the injured person;

(5) information about the outcome and disposition of the injured person; and

(6) other trauma-related information required by the commissioner, if necessary to facilitate the development of clinical and system quality improvement, treatment, and rehabilitation programs.

Subd. 4. **Rules.** The commissioner may adopt rules to collect other information required to facilitate the development of clinical and system quality improvement, injury prevention, treatment, and rehabilitation programs. The commissioner may adopt rules at any time to implement this section and is not subject to the requirements of section 14.125.

Subd. 5. **Reporting without liability.** Any person or facility furnishing information required in this section shall not be subject to any action for damages or other relief, provided that the person or facility is acting in good faith.

Subd. 6. **Data classification.** Data on individuals collected by the commissioner of health under this section are private data on individuals, as defined in section 13.02, subdivision 12. Data not on individuals are nonpublic data as defined in section 13.02, subdivision 9. The commissioner shall provide summary registry data to public and private entities to conduct studies using data collected by the registry. The commissioner may charge a fee under section 13.03, subdivision 3, for all out-of-pocket expenses associated with the provision of data or data analysis.

Subd. 7. **Report requirements.** The commissioner shall use the registry to annually publish a report that includes comparative demographic and risk-adjusted epidemiological data on designated trauma hospitals. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. The provider shall have 21 days to review the data for accuracy.

History: *1Sp2010 c 1 art 20 s 12*

144.608 TRAUMA ADVISORY COUNCIL.

Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (e);

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

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(5) an emergency physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) a trauma program manager or coordinator who practices in a level III or IV trauma hospital;

(7) a physician certified by the American Board of Family Medicine or the American Osteopathic Board of Family Practice whose practice includes emergency department care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (e);

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph (l), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph (o), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (e);

(9) a physician certified in pediatric emergency medicine by the American Board of Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency Medicine or certified by the American Osteopathic Board of Pediatrics whose practice primarily includes emergency department medical care in a level I, II, III, or IV trauma hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose practice involves the care of pediatric trauma patients in a trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (e);

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (e); and

(15) the commissioner of public safety or the commissioner's designee.

Subd. 2. **Council administration.** (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059. The council expires June 30, 2025.

(c) The council may appoint subcommittees and work groups. Subcommittees shall consist of council members. Work groups may include noncouncil members. Noncouncil members shall be compensated for work group activities under section 15.059, subdivision 3, but shall receive expenses only.

Subd. 3. **Regional trauma advisory councils.** (a) Up to eight regional trauma advisory councils may be formed as needed.

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(b) Regional trauma advisory councils shall advise, consult with, and make recommendation to the state Trauma Advisory Council on suggested regional modifications to the statewide trauma criteria that will improve patient care and accommodate specific regional needs. The commissioner, in consultation with the Emergency Medical Services Regulatory Board and the emergency medical services and trauma hospitals in each region, shall provide quarterly data updates on major trauma scene ground ambulance transports to each regional trauma advisory council.

(c) Each regional advisory council must have no more than 15 members. The commissioner, in consultation with the Emergency Medical Services Regulatory Board, shall name the council members.

(d) Regional council members may receive expenses in the same manner and amount as authorized by the plan adopted under section 43A.18, subdivision 2.

History: *1Sp2005 c 4 art 6 s 31; 2009 c 74 s 3; 1Sp2010 c 1 art 20 s 13; 2014 c 286 art 8 s 18; 2015 c 42 s 2; 2016 c 158 art 1 s 54; 2016 c 179 s 4*

144.61 [Repealed, 1980 c 567 s 2]

144.611 CAPTIONING REQUIRED.

(a) This section applies to health care facilities licensed under this chapter.

(b) Any television in a waiting room provided for use by the general public, or by individuals using or requesting services, must have a closed captioning feature activated at all times if the television includes a captioning feature. A health care facility must make reasonable efforts to prevent members of the general public and individuals using or requesting services from independently deactivating a captioning feature.

(c) It is not a violation of this section if the captioning feature is deactivated by a member of the general public or an individual using or requesting services, so long as the captioning is reactivated as soon as practicable by a member of the facility staff upon knowledge that the deactivation has occurred.

(d) This section does not affect any other provision of law relating to disability discrimination or providing reasonable accommodations or diminish the rights of a person with a disability under other law.

History: *2016 c 150 s 1*

144.615 BIRTH CENTERS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions have the meanings given them.

(b) "Birth center" means a facility licensed for the primary purpose of performing low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy.

(c) "CABC" means the Commission for the Accreditation of Birth Centers.

(d) "Low-risk pregnancy" means a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

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Subd. 2. **License required.** (a) Beginning January 1, 2011, no birth center shall be established, operated, or maintained in the state without first obtaining a license from the commissioner of health according to this section.

(b) A license issued under this section is not transferable or assignable and is subject to suspension or revocation at any time for failure to comply with this section.

(c) A birth center licensed under this section shall not assert, represent, offer, provide, or imply that the center is or may render care or services other than the services it is permitted to render within the scope of the license or the accreditation issued.

(d) The license must be conspicuously posted in an area where patients are admitted.

Subd. 3. **Temporary license.** For new birth centers planning to begin operations after January 1, 2011, the commissioner may issue a temporary license to the birth center that is valid for a period of six months from the date of issuance. The birth center must submit to the commissioner an application and applicable fee for licensure as required under subdivision 4. The application must include the information required in subdivision 4, clauses (1) to (3) and (5) to (7), and documentation that the birth center has submitted an application for accreditation to the CABC. Upon receipt of accreditation from the CABC, the birth center must submit to the commissioner the information required in subdivision 4, clause (4), and the applicable fee under subdivision 8. The commissioner shall issue a new license.

Subd. 4. **Application.** An application for a license to operate a birth center and the applicable fee under subdivision 8 must be submitted to the commissioner on a form provided by the commissioner and must contain:

(1) the name of the applicant;

(2) the site location of the birth center;

(3) the name of the person in charge of the center;

(4) documentation that the accreditation described under subdivision 6 has been issued, including the effective date and the expiration date of the accreditation, and the date of the last site visit by the CABC;

(5) the number of patients the birth center is capable of serving at a given time;

(6) the names and license numbers, if applicable, of the health care professionals on staff at the birth center; and

(7) any other information the commissioner deems necessary.

Subd. 5. **Suspension, revocation, and refusal to renew.** The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the grounds described under section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or upon the loss of accreditation by the CABC. The applicant or licensee is entitled to notice and a hearing as described under section 144.55, subdivision 7, and a new license may be issued after proper inspection of the birth center has been conducted.

Subd. 6. **Standards for licensure.** (a) To be eligible for licensure under this section, a birth center must be accredited by the CABC or must obtain accreditation within six months of the date of the application for licensure. If the birth center loses its accreditation, the birth center must immediately notify the commissioner.

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(b) The center must have procedures in place specifying criteria by which risk status will be established and applied to each woman at admission and during labor.

(c) Upon request, the birth center shall provide the commissioner of health with any material submitted by the birth center to the CABC as part of the accreditation process, including the accreditation application, the self-evaluation report, the accreditation decision letter from the CABC, and any reports from the CABC following a site visit.

Subd. 7. **Limitations of services.** (a) The following limitations apply to the services performed at a birth center:

(1) surgical procedures must be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair;

(2) no abortions may be administered; and

(3) no general or regional anesthesia may be administered.

(b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center if the administration of the anesthetic is performed within the scope of practice of a health care professional.

Subd. 8. **Fees.** (a) The biennial license fee for a birth center is $365.

(b) The temporary license fee is $365.

(c) Fees shall be collected and deposited according to section 144.122.

Subd. 9. **Renewal.** (a) Except as provided in paragraph (b), a license issued under this section expires two years from the date of issue.

(b) A temporary license issued under subdivision 3 expires six months from the date of issue and may be renewed for one additional six-month period.

(c) An application for renewal shall be submitted at least 60 days prior to expiration of the license on forms prescribed by the commissioner of health.

Subd. 10. **Records.** All health records maintained on each client by a birth center are subject to sections 144.292 to 144.298.

Subd. 11. **Report.** (a) The commissioner of health, in consultation with the commissioner of human services and representatives of the licensed birth centers, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Minnesota Hospital Association, and the Minnesota Ambulance Association, shall evaluate the quality of care and outcomes for services provided in licensed birth centers, including, but not limited to, the utilization of services provided at a birth center, the outcomes of care provided to both mothers and newborns, and the numbers of transfers to other health care facilities that are required and the reasons for the transfers. The commissioner shall work with the birth centers to establish a process to gather and analyze the data within protocols that protect the confidentiality of patient identification.

(b) The commissioner of health shall report the findings of the evaluation to the legislature by January 15, 2014.

History: *1Sp2010 c 1 art 20 s 14*

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144.62 [Repealed, 1980 c 567 s 2]

144.63 [Repealed, 1980 c 567 s 2]

144.64 [Repealed, 1980 c 567 s 2]

144.65 [Repealed, 1980 c 567 s 2]

NURSING HOME ADMISSION CONTRACTS; CARE OF RESIDENTS

144.6501 NURSING HOME ADMISSION CONTRACTS.

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

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

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

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

(d) "Responsible party" means a person who has access to the resident's income and assets and who agrees to apply the resident's income and assets to pay for the resident's care or who agrees to make and complete an application for medical assistance on behalf of the resident.

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

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

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

(c) An admission contract must be printed in black type of at least ten-point type size. The facility shall give a complete copy of the admission contract to the resident or the resident's legal representative promptly after it has been signed by the resident or legal representative.

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

(e) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT.

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ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

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

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

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

(d) A person who desires to assume financial responsibility for the resident's care may contract with the facility to do so. A person other than the resident or a financially responsible spouse who signs an admission contract must not be required by the facility to assume personal financial liability for the resident's care. However, if the responsible party has signed the admission contract and fails to make timely payment of the facility obligation, or knowingly fails to spend down the resident's assets appropriately for the purpose of obtaining medical assistance, then the responsible party shall be liable to the facility for the resident's costs of care which are not paid for by medical assistance. A responsible party shall be personally liable only to the extent the resident's income or assets were misapplied.

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

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

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

Subd. 6. **Medical assistance payment.** (a) An admission contract for a facility that is certified for participation in the medical assistance program must state that neither the prospective resident, nor anyone on the resident's behalf, is required to pay privately any amount for which the resident's care at the facility has been approved for payment by medical assistance or to make any kind of donation, voluntary or otherwise. Except as permitted under section 6015 of the Deficit Reduction Act of 2005, Public Law 109-171, an admission contract must state that the facility does not require as a condition of admission, either in its admission contract or by oral promise before signing the admission contract, that residents remain in private pay status for any period of time.

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

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

(d) If a facility's charges incurred by the resident are delinquent for 30 days, and no person has agreed to apply for medical assistance for the resident, the facility may petition the court under chapter 524 to appoint a representative for the resident in order to apply for medical assistance for the resident.

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

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

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

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

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

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

History: *1989 c 285 s 2; 1990 c 426 art 1 s 19; 1995 c 136 s 1,2; 2005 c 10 art 4 s 1; 2006 c 282 art 17 s 23; 2009 c 86 art 1 s 17*

144.6503 FACILITIES FOR ALZHEIMER'S DISEASE OR RELATED DISORDER.

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

(b) Areas of required training include:

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

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

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(4) communication skills.

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

(d) The facility shall document compliance with this section.

(e) The commissioner of health has enforcement authority under section 144A.10, subdivision 1, to ensure compliance of the training requirements in this section.

(f) At each facility inspection under section 144A.10, subdivision 2, if the facility is not in compliance, the commissioner has authority to issue a correction order under section 144A.10, subdivision 4.

History: *2003 c 37 s 1; 2008 c 230 s 2*

SUBACUTE CARE WAIVERS

144.6505 SUBACUTE CARE WAIVERS.

Subdivision 1. **Subacute care; waiver from state and federal rules and regulations.** The commissioners of health and human services shall work with providers to examine state and federal rules and regulations governing the provision of care in nursing facilities and apply for federal waivers and pursue state law changes to any impediments to the provision of subacute care in skilled nursing facilities.

Subd. 2. **Definition of subacute care.** (a) For the purpose of this section, "subacute care" means comprehensive inpatient care, as further defined in this subdivision, designed for persons who:

(1) have or have had an acute illness or accident, or an acute exacerbation of a chronic illness, and who require a moderate level of service intensity;

(2) do not require, or no longer require, technologically intensive diagnosis or management;

(3) have concurrent medical, nursing, and discharge and/or nondischarge oriented rehabilitation objectives that are expected to be achieved within a specified time; and

(4) require interdisciplinary management.

(b) Subacute care includes goal-oriented treatment rendered immediately after, or as an appropriate alternative to, acute hospitalization with the goal of transitioning patients towards increased independence or lower acuity level in a cost-effective environment, to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a patient's underlying long-term conditions and overall situation.

(c) Subacute care does not generally depend heavily on high technology monitoring or complex diagnostic procedures.

(d) Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures.

(e) Subacute care is provided as part of a specifically defined program.

(f) Subacute care includes more intensive care than traditional nursing facility care and less intensive care than acute care and may be provided at a variety of sites, including hospitals and skilled nursing facilities.

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(g) Subacute care requires recurrent patient assessment on a daily to weekly basis and review of the clinical course and treatment plan for a limited time period ranging from several days to several months, until the condition is stabilized or a predetermined treatment course is completed.

History: *1995 c 207 art 7 s 8; 1995 c 263 s 14*

PATIENTS BILL OF RIGHTS

144.651 HEALTH CARE BILL OF RIGHTS.

Subdivision 1. **Legislative intent.** It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.6405 to 9530.6590.

Subd. 3. **Public policy declaration.** It is declared to be the public policy of this state that the interests of each patient and resident be protected by a declaration of a patients' bill of rights which shall include but not be limited to the rights specified in this section.

Subd. 4. **Information about rights.** Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients

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in residential programs. Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

Subd. 5. **Courteous treatment.** Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

Subd. 6. **Appropriate health care.** Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.

Subd. 7. **Physician's identity.** Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care 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.

Subd. 8. **Relationship with other health services.** Patients and residents who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed, in writing, of any health care services which are provided to those residents by individuals, corporations, or organizations other than their facility. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care 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.

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

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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.

Subd. 11. **Continuity of care.** Patients and residents shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

Subd. 12. **Right to refuse care.** Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit

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the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's or resident's medical record.

Subd. 13. **Experimental research.** Written, informed consent must be obtained prior to a patient's or resident's participation in experimental research. Patients and residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

Subd. 14. **Freedom from maltreatment.** Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

Subd. 15. **Treatment privacy.** Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

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.

Subd. 17. **Disclosure of services available.** Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the Medicare or medical assistance program will pay for any or all of the aforementioned services.

Subd. 18. **Responsive service.** Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.

Subd. 19. **Personal privacy.** Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

Subd. 20. **Grievances.** Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

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Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. 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. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Subd. 22. **Personal property.** Patients and residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

Subd. 23. **Services for the facility.** Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

Subd. 24. **Choice of supplier.** Residents may purchase or rent goods or services not included in the per diem rate from a supplier of their choice unless otherwise provided by law. The supplier shall ensure that these purchases are sufficient to meet the medical or treatment needs of the residents.

Subd. 25. **Financial affairs.** Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

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

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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.

Subd. 27. **Advisory councils.** Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

Subd. 28. **Married residents.** Residents, if married, shall be assured privacy for visits by their spouses and, if both spouses are residents of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical records.

Subd. 29. **Transfers and discharges.** Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.

Subd. 30. **Protection and advocacy services.** Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient

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may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

Subd. 31. **Isolation and restraints.** A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

Subd. 32. **Treatment plan.** A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to a written treatment plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and the minor patient's parents or guardian shall be involved in the development of the treatment and discharge plan.

Subd. 33. **Restraints.** (a) Competent nursing home residents, family members of residents who are not competent, and legally appointed conservators, guardians, and health care agents as defined under section 145C.01, have the right to request and consent to the use of a physical restraint in order to treat the medical symptoms of the resident.

(b) Upon receiving a request for a physical restraint, a nursing home shall inform the resident, family member, or legal representative of alternatives to and the risks involved with physical restraint use. The nursing home shall provide a physical restraint to a resident only upon receipt of a signed consent form authorizing restraint use and a written order from the attending physician that contains statements and determinations regarding medical symptoms and specifies the circumstances under which restraints are to be used.

(c) A nursing home providing a restraint under paragraph (b) must:

(1) document that the procedures outlined in that paragraph have been followed;

(2) monitor the use of the restraint by the resident; and

(3) periodically, in consultation with the resident, the family, and the attending physician, reevaluate the resident's need for the restraint.

(d) A nursing home shall not be subject to fines, civil money penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a physical restraint as authorized in this subdivision. Nothing in this subdivision shall preclude the commissioner from taking action to protect the health and safety of a resident if:

(1) the use of the restraint has jeopardized the health and safety of the resident; and

(2) the nursing home failed to take reasonable measures to protect the health and safety of the resident.

(e) For purposes of this subdivision, "medical symptoms" include:

(1) a concern for the physical safety of the resident; and

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(2) physical or psychological needs expressed by a resident. A resident's fear of falling may be the basis of a medical symptom.

A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the physical restraint.

(f) When determining nursing facility compliance with state and federal standards for the use of physical restraints, the commissioner of health is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms. For purposes of this order, "medical symptoms" include the request by a competent resident, family member of a resident who is not competent, or legally appointed conservator, guardian, or health care agent as defined under section 145C.01, that the facility provide a physical restraint in order to enhance the physical safety of the resident.

History: *1973 c 688 s 1; 1976 c 274 s 1; 1982 c 504 s 1; 1983 c 248 s 1; 1984 c 654 art 5 s 8; 1984 c 657 s 1; 1986 c 326 s 1-6; 1986 c 444; 1989 c 186 s 1; 1989 c 282 art 3 s 5; 1991 c 255 s 19; 1993 c 54 s 1-3; 1995 c 136 s 3,4; 1995 c 189 s 8; 1995 c 229 art 4 s 5,6; 1996 c 277 s 1; 1998 c 254 art 2 s 10; 1999 c 83 s 1; 2004 c 198 s 10; 2007 c 147 art 9 s 18-20; art 10 s 15; 1Sp2010 c 1 art 20 s 15; 2013 c 62 s 4; 2016 c 158 art 1 s 55*

144.652 BILL OF RIGHTS NOTICE TO PATIENT OR RESIDENT; VIOLATION.

Subdivision 1. **Distribution; posting.** Except as provided below, section 144.651 shall be posted conspicuously in a public place in all facilities licensed under the provisions of sections 144.50 to 144.58, or 144A.02. Copies of the law shall be furnished the patient or resident and the patient or resident's guardian or conservator upon admittance to the facility. Facilities providing services to patients may delete section 144.651, subdivisions 24 to 29, and those portions of other subdivisions that apply only to residents, from copies posted or distributed to patients with appropriate notation that residents have additional rights under law. The policy statement shall include the address and telephone number of the Board of Medical Practice and/or the name and phone number of the person within the facility to whom inquiries about the medical care received may be directed. The notice shall include a brief statement describing how to file a complaint with the Office of Health Facility Complaints established pursuant to section 144A.52 concerning a violation of section 144.651 or any other state statute or rule. This notice shall include the address and phone number of the Office of Health Facility Complaints.

Subd. 2. **Correction order; emergencies.** A substantial violation of the rights of any patient or resident as defined in section 144.651, shall be grounds for issuance of a correction order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf of a patient or resident to enforce any unreasonable violation of the patient's or resident's rights. Compliance with the provisions of section 144.651 shall not be required whenever emergency conditions, as documented by the attending physician in a patient's medical record or a resident's care record, indicate immediate medical treatment, including but not limited to surgical procedures, is necessary and it is impossible or impractical to comply with the provisions of section 144.651 because delay would endanger the patient's or resident's life, health, or safety.

History: *1973 c 688 s 2; 1976 c 173 s 41; 1976 c 222 s 28; 1976 c 274 s 2; 1977 c 326 s 1; 1983 c 248 s 2; 1986 c 444; 1991 c 106 s 6*

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HEALTH CARE FACILITIES

144.6521 DISCLOSURE OF FINANCIAL INTEREST.

Subdivision 1. **Disclosure.** No health care provider with a financial or economic interest in, or an employment or contractual arrangement that limits referral options with, a hospital, outpatient surgical center or diagnostic imaging facility, or an affiliate of one of these entities, shall refer a patient to that hospital, center, or facility, or an affiliate of one of these entities, unless the health care provider discloses in writing to the patient, in advance of the referral, the existence of such an interest, employment, or arrangement.

The written disclosure form must be printed in letters of at least 12-point boldface type and must read as follows: "Your health care provider is referring you to a facility or service in which your health care provider has a financial or economic interest."

Hospitals, outpatient surgical centers, and diagnostic imaging facilities shall promptly report to the commissioner of health any suspected violations of this section by a health care provider who has made a referral to such hospital, outpatient surgical center, or diagnostic imaging facility without providing the written notice.

Subd. 2. **Posting of notice.** In addition to the requirement in subdivision 1, each health care provider who makes referrals to a hospital, outpatient surgical center or diagnostic imaging facility, or an affiliate of one of these entities in which the health care provider has a financial or economic interest, or has an employment or contractual arrangement with one of these entities that limits referral options, shall post a notice of this interest, employment, or arrangement in a patient reception area or waiting room or other conspicuous public location within the provider's facility.

Subd. 3. **Definition.** (a) For purposes of this section, the following definitions apply.

(b) "Affiliate" means an entity that controls, is controlled by, or is under common control with another entity.

(c) "Diagnostic imaging facility" has the meaning provided in section 144.565, subdivision 4.

(d) "Employment or contractual arrangement that limits referral options" means a requirement of, or a financial incentive, provided to a health care provider to refer a patient to a specific hospital, outpatient surgical center or diagnostic imaging facility, or an affiliate of one of these entities even if other options exist for the patient.

(e) "Freestanding" has the meaning provided in section 144.565, subdivision 4.

(f) "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,

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the group practice of which the provider is a member or employee or a related party with respect to any of them.

(g) "Health care provider" means an individual licensed by a health licensing board as defined in section 214.01, subdivision 2, who has the authority, within the individual's scope of practice, to make referrals to a hospital, outpatient surgical center, or diagnostic imaging facility.

(h) "Mobile" has the meaning provided in section 144.565, subdivision 4.

History: *2004 c 198 s 11*

144.6522 DESIGNATION OF A CAREGIVER.

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Aftercare" means any assistance provided to a patient in the patient's residence by a caregiver designated by the patient in accordance with this section after the patient's discharge from a hospital. Assistance may include, but is not limited to, assisting with basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), or carrying out medical or nursing tasks, such as managing wound care, assisting in administering medications, and operating medical equipment.

(b) "Agent" means a court-appointed guardian, the parent of a minor child whose authority to act on behalf of the patient as to health care decisions has not been restricted by the court, or a health agent authorized to act on behalf of the patient under chapter 145C.

(c) "Designated caregiver" means any individual 18 years of age or older who is designated as a caregiver by a patient to provide aftercare assistance to the patient in the patient's residence after the patient's discharge from a hospital and who, in the professional opinion of the patient's health care provider, is capable of providing aftercare assistance. A designated caregiver may include, but is not limited to, a relative, partner, friend, or neighbor who has a relationship with the patient.

(d) "Discharge" means a patient's exit or release from a hospital to the patient's residence following an inpatient admission.

(e) "Entry" means a patient's admission to a hospital for the purposes of inpatient medical care.

(f) "Hospital" means a facility licensed under sections 144.50 to 144.56.

(g) "Residence" means a dwelling that the patient considers to be the patient's home. For the purposes of this section, a residence does not include a rehabilitation facility, hospital, nursing facility, or other health care or residential facility where health care staff are responsible for performing necessary medical and nursing tasks for the patient.

Subd. 2. **Opportunity to designate a caregiver.** (a) A hospital shall provide each patient or, if applicable, the patient's agent with an opportunity to designate at least one caregiver no later than 24 hours upon the patient's entry into a hospital and before the patient is discharged from the hospital or transferred to another health care facility. If the patient is unconscious or otherwise incapacitated upon entry into the hospital, the hospital shall provide the patient or the patient's agent with an opportunity to designate a caregiver within 24 hours following the patient's recovery of consciousness or capacity.

(b) If the patient or the patient's agent designates an individual as a caregiver, the hospital shall record the patient's designation of caregiver, the relationship of the designated caregiver to the patient, and the name, telephone number, and address of the patient's designated caregiver in the patient's medical record.

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If the patient or the patient's agent declines to designate a caregiver, the hospital shall document this in the patient's medical record.

(c) If the patient designates a caregiver, the hospital shall be deemed to have obtained the written consent of the patient to release medical information to the designated caregiver following the hospital's established procedures for releasing personal health information and in compliance with all federal and state laws. The patient or the patient's agent may revoke prior consent to release medical information to the designated caregiver at any time and, if consent is revoked, the hospital is not required to provide notice to the designated caregiver under subdivision 3 or provide information contained in the patient's discharge plan under subdivision 4.

(d) A patient may elect to change their designated caregiver at any time, and the hospital shall record the change in the patient's medical record within 24 hours.

(e) A designation of a caregiver by a patient or a patient's agent does not obligate the designated caregiver to perform any aftercare tasks for the patient.

Subd. 3. **Notice to designated caregiver.** (a) A hospital shall notify, as soon as practicable, the patient's designated caregiver of the patient's discharge or transfer to another hospital or health care facility after the patient's health care provider issues a discharge or transfer order.

(b) Failure to contact a designated caregiver or failure of the designated caregiver to be present at the hospital to receive the discharge plan and aftercare instructions described in subdivision 4 shall not interfere with or delay the discharge or transfer of the patient so long as the hospital has made a good faith effort to contact the designated caregiver within a reasonable time period. The hospital shall document the efforts made to contact the designated caregiver in the patient's medical record.

(c) This subdivision shall not apply if the patient is transferred to another health care facility due to an emergency situation.

Subd. 4. **Discharge plan and aftercare instructions to designated caregiver.** (a) Prior to a patient's discharge from the hospital to the patient's residence, the hospital shall consult with the designated caregiver and the patient, and issue a discharge plan that describes the patient's aftercare needs and instructions for all aftercare tasks described in the discharge plan.

(b) At a minimum, a discharge plan must include:

(1) the name and contact information of the designated caregiver;

(2) a description of and instructions for all aftercare tasks necessary to maintain the patient's ability to reside at home, taking into account the capabilities and limitations of the designated caregiver;

(3) contact information for any health care, community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan; and

(4) contact information of a hospital representative who can respond to questions about the discharge plan and instructions that are required to be provided under this subdivision after the patient has been discharged.

(c) At a minimum, the instructions for aftercare tasks included in the discharge plan must include:

(1) a live demonstration or video instruction of the aftercare tasks performed by a hospital employee, or an individual with whom the hospital has a contractual relationship who has the appropriate education

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and competency in the task to be performed and is authorized to perform the task, in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law; and

(2) an opportunity for the designated caregiver and patient to ask questions about the aftercare tasks, and to provide answers to any questions in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law.

(d) The hospital shall document the discharge plan and a description of the instructions provided in the patient's medical record, including, at a minimum, the date, time, and content of the instructions provided.

Subd. 5. **Limitations.** (a) Nothing in this section shall be construed to create a separate private cause of action against a hospital, a hospital employee, or an individual with whom a hospital has a contractual relationship, or to otherwise supersede or replace existing duties, rights, or remedies under any other provision of state or federal law. This section does not establish a separate standard of care for use in an action against a hospital, health care facility, or health care provider.

(b) Nothing in this section shall be construed to require a patient or a patient's agent to designate a caregiver.

(c) Nothing in this section shall be construed to interfere with the powers of a health care agent operating under a valid health care directive in compliance with chapter 145C.

History: *2016 c 103 s 1*

144.653 RULES; PERIODIC INSPECTIONS; ENFORCEMENT.

Subdivision 1. **Rules.** The state commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under the provisions of sections 144.50 to 144.58. The state commissioner of health shall enforce its rules subject only to the authority of the Department of Public Safety respecting the enforcement of fire and safety standards in licensed health care facilities and the responsibility of the commissioner of human services pursuant to sections 245A.01 to 245A.16 and 252.28.

Subd. 2. **Periodic inspection.** All facilities required to be licensed under the provisions of sections 144.50 to 144.58 shall be periodically inspected by the state commissioner of health to ensure compliance with rules and standards. Inspections shall occur at different times throughout the calendar year. The commissioner of health may enter into agreements with political subdivisions providing for the inspection of such facilities by locally employed inspectors.

The commissioner of health shall conduct inspections and reinspections of facilities licensed under the provisions of sections 144.50 to 144.56 with a frequency and in a manner calculated to produce the greatest benefit to residents within the limits of the resources available to the commissioner. In performing this function, the commissioner may devote proportionately more resources to the inspection of those facilities in which conditions present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being.

These conditions include but are not limited to: change in ownership; frequent change in administration in excess of normal turnover rates; complaints about care, safety, or rights; where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; and, where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity. Any health

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care facility that has none of the above conditions or any other condition established by the commissioner that poses a risk to resident care, safety, or rights shall be inspected once every two years.

Subd. 3. **Enforcement.** With the exception of the Department of Public Safety which has the exclusive jurisdiction to enforce state fire and safety standards, the state commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting facilities required to be licensed under the provisions of sections 144.50 to 144.58 and enforcing the rules and standards prescribed by it.

The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a licensed facility if the commissioner considers them necessary for the discharge of responsibilities. For the purposes of inspections and securing information to determine compliance with the licensure laws and rules, the commissioner need not present a release, waiver, or consent of the individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

Subd. 4. **Without notice.** One or more unannounced inspections of each facility required to be licensed under the provisions of sections 144.50 to 144.58 or Minnesota Rules, chapter 4675, shall be made annually.

Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state commissioner of health finds upon inspection of a facility required to be licensed under the provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, or 626.557, or the applicable rules promulgated under those sections, a correction order shall be issued to the licensee. The correction order shall state the deficiency, cite the specific rule violated, and specify the time allowed for correction.

Subd. 6. **Reinspections; fines.** If upon reinspection it is found that the licensee of a facility required to be licensed under the provisions of sections 144.50 to 144.58 has not corrected deficiencies specified in the correction order, a notice of noncompliance with a correction order shall be issued stating all deficiencies not corrected. Unless a hearing is requested under subdivision 8, the licensee shall forfeit to the state within 15 days after receipt by the licensee of such notice of noncompliance with a correction order up to $1,000 for each deficiency not corrected. For each subsequent reinspection, the licensee may be fined an additional amount for each deficiency which has not been corrected. All forfeitures shall be paid into the general fund. The commissioner of health shall promulgate by rule a schedule of fines applicable for each type of uncorrected deficiency.

Subd. 7. **Recovery.** Any unpaid forfeitures may be recovered by the attorney general.

Subd. 8. **Hearings.** A licensee of a facility required to be licensed under the provisions of sections 144.50 to 144.58 is entitled to a hearing on any notice of noncompliance with a correction order issued to the licensee as a result of a reinspection, provided that the licensee makes a written request therefor within 15 days of receipt by the licensee of the notice of noncompliance with a correction order. Failure to request a hearing shall result in the forfeiture of a penalty as determined by the commissioner of health in accordance with subdivision 6. A request for a hearing shall operate as a stay during the hearing and review process of the payment of any forfeiture provided for in this section. Upon receipt of the request for a hearing, a hearing officer, who shall not be an employee of the state commissioner of health, shall be appointed by the state commissioner of health, and the hearing officer shall promptly schedule a hearing on the matter, giving at least ten days' notice of the date, time, and place of the hearing to the licensee. Upon determining that the licensee of a facility required to be licensed under sections 144.50 to 144.58 has not corrected the deficiency specified in the correction order, the hearing officer shall impose a penalty as determined by the commissioner

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of health in accordance with subdivision 6. The hearing and review thereof shall be in accordance with the relevant provisions of the Administrative Procedure Act.

Subd. 9. **Nonlimiting.** Nothing in this section shall be construed to limit the powers granted to the state commissioner of health in section 144.55.

History: *1973 c 688 s 3; 1975 c 310 s 6,7,37; 1976 c 173 s 42; 1977 c 305 s 45; 1Sp1981 c 4 art 1 s 76; 1983 c 312 art 1 s 16; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1987 c 209 s 23; 1989 c 209 art 2 s 1; 1991 c 286 s 4; 2004 c 198 s 12*

144.6535 VARIANCE OR WAIVER.

Subdivision 1. **Request for variance or waiver.** A hospital may request that the commissioner grant a variance or waiver from the provisions of Minnesota Rules, chapter 4640 or 4645. A request for a variance or waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific rule or rules for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the variance or waiver.

Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the variance or waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in Minnesota Rules, chapter 4640 or 4645; and

(3) whether compliance with the rule or rules would impose an undue burden upon the applicant.

Subd. 3. **Notification of variance.** The commissioner must notify the applicant in writing of the decision. If a variance or waiver is granted, the notification must specify the period of time for which the variance or waiver is effective and the alternative measures or conditions, if any, to be met by the applicant.

Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or conditions attached to a variance or waiver have the same force and effect as the rules under Minnesota Rules, chapter 4640 or 4645, and are subject to the issuance of correction orders and penalty assessments in accordance with section 144.55.

(b) Fines for a violation of this section shall be in the same amount as that specified for the particular rule for which the variance or waiver was requested.

Subd. 5. **Renewal.** A request for renewal of a variance or waiver must be submitted in writing at least 45 days before its expiration date. Renewal requests must contain the information specified in subdivision 1. A variance or waiver must be renewed by the commissioner if the applicant continues to satisfy the criteria in subdivision 2 and the alternative measures or conditions, if any, specified under subdivision 3 and

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demonstrates compliance with the alternative measures or conditions imposed at the time the original variance or waiver was granted.

Subd. 6. **Denial, revocation, or refusal to renew.** The commissioner must deny, revoke, or refuse to renew a variance or waiver if it is determined that the criteria in subdivision 2 or the alternative measures or conditions, if any, specified under subdivision 3 are not met. The applicant must be notified in writing of the reasons for the decision and informed of the right to appeal the decision.

Subd. 7. **Appeal procedure.** An applicant may contest the denial, revocation, or refusal to renew a variance or waiver by requesting a contested case hearing under chapter 14. The applicant must submit, within 15 days of the receipt of the commissioner's decision, a written request for a hearing. The request for hearing must set forth in detail the reasons why the applicant contends the decision of the commissioner should be reversed or modified. At the hearing, the applicant has the burden of proving that it satisfied the criteria specified in subdivision 2 or the alternative measures or conditions, if any, specified under subdivision 3, except in a proceeding challenging the revocation of a variance or waiver.

History: *2001 c 29 s 1*

144.654 EXPERTS MAY BE EMPLOYED.

The state commissioner of health may employ experts in the field of health care to assist the staffs of facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, in programming and providing adequate care of the patients and residents of the facility. Alternate methods of care for patients and residents of the facilities shall be researched by the state commissioner of health using the knowledge and experience of experts employed therefor.

History: *1973 c 688 s 4; 1976 c 173 s 43; 1977 c 305 s 45*

144.655 PROGRAM FOR VOLUNTARY MEDICAL AID.

Licensed physicians may visit a facility required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, and examine patients and residents thereof under a program which shall be established by the state commissioner of health and regulated and governed by rules promulgated by the state commissioner of health pursuant to the Administrative Procedure Act. The rules shall protect the privacy of patients and residents of facilities. No patient or resident of any facility shall be required to submit to an examination under the program. The state commissioner of health shall consult with medical schools and other experts for the purpose of establishing the program. The state commissioner of health shall encourage the active participation of all licensed physicians on a voluntary basis in the program.

History: *1973 c 688 s 5; 1976 c 173 s 44; 1977 c 305 s 45*

144.656 EMPLOYEES TO BE COMPENSATED.

All employees of facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, participating in orientation programs or in in-service training provided by the facility shall be compensated therefor at their regular rate of pay, provided, however, that this section will be effective only to the extent that facilities are reimbursed for the compensation by the commissioner of human services in the proportion of welfare to total residents and patients in the facility.

History: *1973 c 688 s 6; 1976 c 173 s 45; 1984 c 654 art 5 s 58*

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144.657 VOLUNTEER EFFORTS ENCOURAGED.

The state commissioner of health, through the dissemination of information to appropriate organizations, shall encourage citizens to promote improved care in facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, throughout the state.

History: *1973 c 688 s 7; 1976 c 173 s 46; 1977 c 305 s 45*

EPIDEMIOLOGICAL DATA

144.658 EPIDEMIOLOGIC DATA DISCOVERY.

Notwithstanding any law to the contrary, health data on an individual collected by public health officials conducting an epidemiologic investigation to reduce morbidity or mortality is not subject to discovery in a legal action.

History: *1985 c 298 s 41*

144.6581 DETERMINATION OF WHETHER DATA IDENTIFIES INDIVIDUALS.

The commissioner of health may: (1) withhold access to health or epidemiologic data if the commissioner determines the data are data on an individual, as defined in section 13.02, subdivision 5; or (2) grant access to health or epidemiologic data, if the commissioner determines the data are summary data as defined in section 13.02, subdivision 19. In the exercise of this discretion, the commissioner shall consider whether the data requested, alone or in combination, may constitute information from which an individual subject of data may be identified using epidemiologic methods. In making this determination, the commissioner shall consider disease incidence, associated risk factors for illness, and similar factors unique to the data by which it could be linked to a specific subject of the data. This discretion is limited to health or epidemiologic data maintained by the commissioner of health or a community health board, as defined in section 145A.02.

History: *1993 c 351 s 26; 2014 c 291 art 7 s 28*

144.6585 IDENTIFICATION OF HEALTH CARE PROVIDERS.

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

History: *1997 c 237 s 15*

SEXUAL ASSAULT VICTIMS RIGHTS

144.6586 NOTICE OF RIGHTS TO SEXUAL ASSAULT VICTIM.

Subdivision 1. **Notice required.** A hospital shall give a written notice about victim rights and available resources to a person seeking medical services in the hospital who reports to hospital staff or presents evidence of a sexual assault or other unwanted sexual contact or sexual penetration. The hospital shall make a good faith effort to provide this notice prior to medical treatment or the examination performed for the purpose of gathering evidence, subject to applicable federal and state laws and regulations regarding the

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provision of medical care, and in a manner that does not interfere with any medical screening examination or initiation of treatment necessary to stabilize a victim's emergency medical condition.

Subd. 2. **Contents of notice.** The commissioners of health and public safety, in consultation with sexual assault victim advocates and health care professionals, shall develop the notice required by subdivision 1. The notice must inform the victim, at a minimum, of:

(1) the obligation under section 609.35 of the county where the criminal sexual conduct occurred to pay for the examination performed for the purpose of gathering evidence, that payment is not contingent on the victim reporting the criminal sexual conduct to law enforcement, and that the victim may incur expenses for treatment of injuries; and

(2) the victim's rights if the crime is reported to law enforcement, including the victim's right to apply for reparations under sections 611A.51 to 611A.68, information on how to apply for reparations, and information on how to obtain an order for protection or a harassment restraining order.

History: *2014 c 291 art 6 s 12*

144.659 [Repealed, 1982 c 419 s 2]

144.66 [Repealed, 1987 c 403 art 2 s 164]

TRAUMATIC BRAIN AND SPINAL CORD INJURIES

144.661 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 144.661 to 144.665, the following terms have the meanings given them.

Subd. 2. **Traumatic brain injury.** "Traumatic brain injury" means a sudden insult or damage to the brain or its coverings caused by an external physical force which may produce a diminished or altered state of consciousness and which results in the following disabilities:

(1) impairment of cognitive or mental abilities;

(2) impairment of physical functioning; or

(3) disturbance of behavioral or emotional functioning.

These disabilities may be temporary or permanent and may result in partial or total loss of function. "Traumatic brain injury" does not include injuries of a degenerative or congenital nature.

Subd. 3. **Spinal cord injury.** "Spinal cord injury" means an injury that occurs as a result of trauma which may involve spinal vertebral fracture and where the injured person suffers an acute, traumatic lesion of neural elements in the spinal canal, resulting in any degree of temporary or permanent sensory deficit, motor deficit, or bladder or bowel dysfunction. "Spinal cord injury" does not include intervertebral disc disease.

History: *1991 c 292 art 2 s 5*

144.662 TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY REGISTRY.

The commissioner of health shall establish and maintain a central registry of persons who sustain traumatic brain injury or spinal cord injury. The purpose of the registry is to:

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(1) collect information to facilitate the development of injury prevention, treatment, and rehabilitation programs; and

(2) ensure the provision to persons with traumatic brain injury or spinal cord injury of information regarding appropriate public or private agencies that provide rehabilitative services so that injured persons may obtain needed services to alleviate injuries and avoid secondary problems, such as mental illness and chemical dependency.

History: *1991 c 292 art 2 s 6*

144.663 DUTY TO REPORT.

Subdivision 1. **Establishment of reporting system.** The commissioner shall design and establish a reporting system which designates either the treating hospital, medical facility, or physician to report to the department within a reasonable period of time after the identification of a person with traumatic brain injury or spinal cord injury. The consent of the injured person is not required.

Subd. 2. **Information.** The report must be submitted on forms provided by the department and must include the following information:

(1) the name, age, and residence of the injured person;

(2) the date and cause of the injury;

(3) the initial diagnosis; and

(4) other information required by the commissioner.

Subd. 3. **Reporting without liability.** The furnishing of information required by the commissioner shall not subject any person or facility required to report to any action for damages or other relief, provided that the person or facility is acting in good faith.

History: *1991 c 292 art 2 s 7*

144.664 DUTIES OF COMMISSIONER.

Subdivision 1. **Studies.** The commissioner shall collect injury incidence information, analyze the information, and conduct special studies regarding traumatic brain injury and spinal cord injury.

Subd. 2. **Provision of data.** The commissioner shall provide summary registry data to public and private entities to conduct studies using data collected by the registry. The commissioner may charge a fee under section 13.03, subdivision 3, for all out-of-pocket expenses associated with the provision of data or data analysis.

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

Subd. 4. [Repealed, 1999 c 86 art 2 s 6]

Subd. 5. **Rules.** The commissioner shall adopt rules to administer the registry, collect information, and distribute data. The rules must include, but are not limited to, the following:

(1) the specific ICD-9 procedure codes included in the definitions of "traumatic brain injury" and "spinal cord injury";

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(2) the type of data to be reported;

(3) standards for reporting specific types of data;

(4) the persons and facilities required to report and the time period in which reports must be submitted;

(5) criteria relating to the use of registry data by public and private entities engaged in research; and

(6) specification of fees to be charged under section 13.03, subdivision 3, for out-of-pocket expenses.

History: *1991 c 292 art 2 s 8; 1994 c 483 s 1; 1997 c 205 s 22*

144.665 TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY DATA.

Data on individuals collected by the commissioner of health under sections 144.662 to 144.664 are private data on individuals as defined in section 13.02, subdivision 12, and may be used only for the purposes set forth in sections 144.662 to 144.664 in accordance with the rules adopted by the commissioner.

History: *1991 c 292 art 2 s 9; 1994 c 483 s 1; 1997 c 205 s 23*

144.67 [Repealed, 1987 c 403 art 2 s 164]

CANCER SURVEILLANCE SYSTEM

144.671 CANCER SURVEILLANCE SYSTEM; PURPOSE.

The commissioner of health shall establish a statewide population-based cancer surveillance system. The purpose of this system is to:

(1) monitor incidence trends of cancer to detect potential public health problems, predict risks, and assist in investigating cancer clusters;

(2) more accurately target intervention resources for communities and patients and their families;

(3) inform health professionals and citizens about risks, early detection, and treatment of cancers known to be elevated in their communities; and

(4) promote high quality research to provide better information for cancer control and to address public concerns and questions about cancer.

History: *1987 c 403 art 2 s 9*

144.672 DUTIES OF COMMISSIONER; RULES.

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

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

(1) the type of data to be reported;

(2) standards for reporting specific types of data;

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(3) payments allowed to hospitals, pathologists, and registry systems to defray their costs in providing information to the system;

(4) criteria relating to contracts made with outside entities to conduct studies using data collected by the system. The criteria may include requirements for a written protocol outlining the purpose and public benefit of the study, the description, methods, and projected results of the study, peer review by other scientists, the methods and facilities to protect the privacy of the data, and the qualifications of the researcher proposing to undertake the study; and

(5) specification of fees to be charged under section 13.03, subdivision 3, for all out-of-pocket expenses for data summaries or specific analyses of data requested by public and private agencies, organizations, and individuals, and which are not otherwise included in the commissioner's annual summary reports. Fees collected are appropriated to the commissioner to offset the cost of providing the data.

Subd. 2. **Biennial report required.** The commissioner of health shall prepare and transmit to the governor and to members of the legislature under section 3.195, a biennial report on the incidence of cancer in Minnesota and a compilation of summaries and reports from special studies and investigations performed to determine the potential public health significance of an increase in cancer incidence, together with any findings and recommendations. The first report shall be delivered by February 1989, with subsequent reports due in February of each of the following odd-numbered years.

History: *1987 c 403 art 2 s 10; 1988 c 629 s 37; 1994 c 411 s 1; 1997 c 192 s 24; 2001 c 161 s 21*

144.68 RECORDS AND REPORTS REQUIRED.

Subdivision 1. **Person practicing healing arts.** Every person licensed to practice the healing arts in any form, upon request of the commissioner of health, shall prepare and forward to the commissioner, in the manner and at such times as the commissioner designates, a detailed record of each case of cancer treated or seen by the person professionally.

Subd. 2. **Hospitals and similar institutions.** Every hospital, medical clinic, medical laboratory, or other institution for the hospitalization, clinical or laboratory diagnosis, or care of human beings, upon request of the commissioner of health, shall prepare and forward to the commissioner, in the manner and at the times designated by the commissioner, a detailed record of each case of cancer.

Subd. 3. **Reporting without liability.** The furnishing of the information required under subdivisions 1 and 2 shall not subject the person, hospital, medical clinic, medical laboratory, or other institution furnishing the information, to any action for damages or other relief.

History: *1949 c 350 s 3; 1976 c 173 s 47,48; 1977 c 305 s 45; 1986 c 444; 1987 c 403 art 2 s 11*

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected on individuals by the cancer surveillance system, including the names and personal identifiers of persons required in section 144.68 to report, shall be private and may only be used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure other than is provided for in this section and sections 144.671, 144.672, and 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by rule, and as part of an epidemiologic investigation, an officer or employee of the commissioner

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of health may interview patients named in any such report, or relatives of any such patient, only after the consent of the attending physician or surgeon is obtained.

History: *1949 c 350 s 4; 1987 c 403 art 2 s 12*

144.6905 [Repealed, 2002 c 220 art 16 s 3]

GRIEVANCES OR COMPLAINTS

144.691 GRIEVANCE PROCEDURES.

Subdivision 1. **Facilities.** Every hospital licensed as such pursuant to sections 144.50 to 144.56, and every outpatient surgery center shall establish a grievance or complaint mechanism designed to process and resolve promptly and effectively grievances by patients or their representatives related to billing, inadequacies of treatment, and other factors which may have an impact on the incidence of malpractice claims and suits.

For the purposes of sections 144.691 to 144.693, "outpatient surgery center" shall mean a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

Subd. 2. **Patient notice.** Each patient receiving treatment at a hospital or an outpatient surgery center shall be notified of the grievance or complaint mechanism which is available to the patient.

Subd. 3. **Rules.** The state commissioner of health shall, by January 1, 1977, establish by rule promulgated pursuant to chapter 15:

(a) minimum standards and procedural requirements for grievance and complaint mechanism;

(b) a list of patient complaints which may be processed through a complaint or grievance mechanism;

(c) the form and manner in which patient notices shall be made; and

(d) a schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of this section.

Subd. 4. [Repealed, 1996 c 451 art 4 s 71]

History: *1976 c 325 s 8; 1977 c 305 s 45; 1981 c 311 s 39; 1982 c 545 s 24; 1986 c 444*

144.692 [Repealed, 1987 c 209 s 40]

MEDICAL MALPRACTICE CLAIMS

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

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(a) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(b) the date each new claim was filed with the insurer;

(c) the allegations contained in each claim filed during the reporting period;

(d) the disposition and closing date of each claim closed during the reporting period;

(e) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(f) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.

History: *1976 c 325 s 10; 1977 c 305 s 45; 1981 c 311 s 39; 1982 c 545 s 24; 1986 c 444*

HEALTH CARE COST INFORMATION

144.695 CITATION.

Sections 144.695 to 144.703 may be cited as the "Minnesota Health Care Cost Information Act of 1984."

History: *1976 c 296 art 2 s 1; 1984 c 534 s 3*

144.696 DEFINITIONS.

Subdivision 1. **Scope.** Unless the context clearly indicates otherwise, for the purposes of sections 144.695 to 144.703, the terms defined in this section have the meanings given them.

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

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Subd. 3. **Hospital.** "Hospital" means any acute care institution licensed pursuant to sections 144.50 to 144.58, but does not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

Subd. 4. **Outpatient surgical center.** "Outpatient surgical center" means a facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

History: *1976 c 296 art 2 s 2; 1977 c 305 s 45; 1984 c 534 s 4*

144.697 GENERAL POWERS AND DUTIES OF STATE COMMISSIONER OF HEALTH.

Subdivision 1. **Contracts.** The commissioner of health may contract with third parties for services necessary to carry out the commissioner's activities where this will promote economy, avoid duplication of effort, and make best use of available expertise.

Subd. 2. **Grants; gifts.** The commissioner of health may apply for and receive grants and gifts from any governmental agency, private entity or other person.

Subd. 3. **Committees.** To further the purposes of sections 144.695 to 144.703, the commissioner of health may create committees from the membership and may appoint ad hoc advisory committees.

Subd. 4. **Coordinating rules and inspections.** The commissioner of health shall coordinate regulation and inspection of hospitals to avoid, to the extent possible, conflicting rules and duplicative inspections.

History: *1976 c 296 art 2 s 3; 1977 c 305 s 45; 1986 c 444*

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;

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(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.

Subd. 2. **Separate reports for facilities.** If more than one licensed hospital or outpatient surgical center is operated by the reporting organization, the commissioner of health may require that the information be reported separately for each hospital and each outpatient surgical center.

Subd. 3. **Attestation.** The commissioner of health may require attestation by responsible officials of the hospital or outpatient surgical center that the contents of the reports are true.

Subd. 4. **Reports open to public inspection.** All reports, except privileged medical information, filed pursuant to this section, section 144.701 or section 144.702, subdivision 3 or 4 shall be open to public inspection.

Subd. 5. **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 hospital and outpatient surgical center books, audits, and records.

History: *1976 c 296 art 2 s 4; 1977 c 305 s 45; 1984 c 534 s 5; 1989 c 282 art 2 s 11; 1991 c 202 s 7; 2004 c 198 s 13,14; 2007 c 147 art 15 s 13*

144.699 CONTINUING ANALYSIS.

Subdivision 1. **Acute care costs.** The commissioner of health may:

(1) undertake analyses and studies relating to acute care costs and to the financial status of any hospital or outpatient surgical center subject to the provisions of sections 144.695 to 144.703; and

(2) publish and disseminate the information relating to acute care costs.

Subd. 2. **Fostering price competition.** The commissioner of health shall:

(1) encourage hospitals, outpatient surgical centers, home care providers, and professionals regulated by the health-related licensing boards as defined in section 214.01, subdivision 2, and by the commissioner of health under section 214.13, to publish prices for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment; and

(2) analyze and disseminate available price information and analyses so as to foster the development of price competition among hospitals, outpatient surgical centers, home care providers, and health professionals.

Subd. 3. **Cooperation with attorney general.** Upon request of the attorney general, the commissioner of health shall make available to the attorney general all requested information provided under sections 144.695 to 144.703 in order to assist the attorney general in discharging the responsibilities of section 8.31.

Subd. 4. **Other reports or costs.** The commissioner of health shall prepare and file summaries and compilations or other supplementary reports based on the information filed with or made available to the commissioner of health, which reports will advance the purposes of sections 144.695 to 144.703.

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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: *1976 c 296 art 2 s 5; 1977 c 305 s 45; 1984 c 534 s 6; 1987 c 378 s 2; 2007 c 147 art 9 s 21*

144.70 BIENNIAL REPORT.

Subdivision 1. **Content.** The commissioner of health shall prepare a report every two years concerning the status and operations of the health care markets in Minnesota. The commissioner of health shall transmit the reports to the governor, and to the members of the legislature under section 3.195. The first report must be submitted on January 15, 1987, and succeeding reports on January 15 every two years. Each report must contain information, analysis, and appropriate recommendations concerning the following issues associated with Minnesota health care markets:

(1) the overall status of the health care cost problem, including the costs faced by employers and individuals, and prospects for the problem's improving or getting worse;

(2) the status of competitive forces in the market for health services and the market for health plans, and the effect of the forces on the health care cost problem;

(3) the feasibility and cost-effectiveness of facilitating development of strengthened competitive forces through state initiatives;

(4) the feasibility of limiting health care costs by means other than competitive forces, including direct forms of government intervention such as price regulation; the commissioner of health may exclude this issue from the report if the report concludes that the overall status of the health care cost problem is improving, or that competitive forces are contributing significantly to health care cost containment;

(5) the overall status of access to adequate health services by citizens of Minnesota, the scope of financial and geographic barriers to access, the effect of competitive forces on access, and prospects for access improving or getting worse;

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(6) the feasibility and cost-effectiveness of enhancing access to adequate health services by citizens of Minnesota through state initiatives; and

(7) the commissioner of health's operations and activities for the preceding two years as they relate to the duties imposed on the commissioner of health by sections 144.695 to 144.703.

Subd. 2. **Interagency cooperation.** In completing the report required by subdivision 1, in fulfilling the requirements of sections 144.695 to 144.703, and in undertaking other initiatives concerning health care costs, access, or quality, the commissioner of health shall cooperate with and consider potential benefits to other state agencies that have a role in the market for health services or the market for health plans. Other agencies include the Department of Management and Budget, as administrator of the state employee health benefits program; the Department of Human Services, as administrator of health services entitlement programs; the Department of Commerce, in its regulation of health plans; the Department of Labor and Industry, in its regulation of health service costs under workers' compensation.

History: *1976 c 296 art 2 s 6; 1977 c 305 s 45; 1Sp1985 c 9 art 2 s 11; 1991 c 345 art 2 s 37; 1994 c 411 s 2; 2008 c 204 s 42; 2009 c 101 art 2 s 109*

144.701 RATE DISCLOSURE.

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

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

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

Subd. 4. **Filing fees.** Each report which is required to be submitted to the commissioner of health under sections 144.695 to 144.703 and which is not submitted to a voluntary, nonprofit reporting organization in accordance with section 144.702 shall be accompanied by a filing fee in an amount prescribed by rule of the commissioner of health. Upon the withdrawal of approval of a reporting organization, or the decision of the commissioner to not renew a reporting organization, fees collected under section 144.702 shall be submitted to the commissioner. Fees received under this subdivision shall be deposited in a revolving fund and are appropriated to the commissioner of health for the purposes of sections 144.695 to 144.703. The commissioner shall report the termination or nonrenewal of the voluntary reporting organization to the chair of the Health and Human Services Finance Committee of the house of representatives, to the chair of the Health and Human Services Division of the Finance Committee of the senate, and the commissioner of management and budget.

History: *1976 c 296 art 2 s 7; 1977 c 305 s 45; 1982 c 424 s 130; 1984 c 534 s 7; 1989 c 282 art 2 s 12; 1998 c 407 art 2 s 27-29; 2004 c 284 art 2 s 15; 2009 c 101 art 2 s 109*

144.702 HOSPITAL AND OUTPATIENT SURGICAL CENTER COSTS.

Subdivision 1. **Reporting through a reporting organization.** A hospital or outpatient surgical center may agree to submit its financial, utilization, and services reports to a voluntary, nonprofit reporting organization whose reporting procedures have been approved by the commissioner of health in accordance

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with this section. Each report submitted to the voluntary, nonprofit reporting organization under this section shall be accompanied by a filing fee.

Subd. 2. **Approval of organization's reporting procedures.** The commissioner of health may approve voluntary reporting procedures consistent with written operating requirements for the voluntary, nonprofit reporting organization which shall be established annually by the commissioner. These written operating requirements shall specify reports, analyses, and other deliverables to be produced by the voluntary, nonprofit reporting organization, and the dates on which those deliverables must be submitted to the commissioner. These written operating requirements shall specify deliverable dates sufficient to enable the commissioner of health to process and report health care cost information system data to the commissioner of human services by August 15 of each year. The commissioner of health shall, by rule, prescribe standards for submission of data by hospitals and outpatient surgical centers to the voluntary, nonprofit reporting organization or to the commissioner. These standards shall provide for:

(1) the filing of appropriate financial, utilization, and services information with the reporting organization;

(2) adequate analysis and verification of that financial, utilization, and services information; and

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

Subd. 3. **Cost and rate information; time limits on filing.** Any voluntary, nonprofit reporting organization which collects information on costs, revenues, and rates of a hospital or outpatient surgical center located in this state shall file a copy of the information received for each hospital and outpatient surgical center with the commissioner of health within 30 days of completion of the information collection process, together with a summary of the financial information acquired by the organization during the course of its review.

Subd. 4. **Making information available to commissioner.** Any voluntary, nonprofit reporting organization which receives the financial information required by sections 144.695 to 144.703 shall make the information and all summaries and analyses of the information available to the commissioner of health in accordance with procedures prescribed by the commissioner of health.

Subd. 5. **Laws governing restraint of trade.** If the reporting and procedures of a voluntary, nonprofit reporting organization have been approved by the commissioner of health those reporting activities of the organization shall be exempt from the provisions of sections 325D.49 to 325D.66.

Subd. 6. **Reporting organization; definition.** For the purposes of this section "reporting organization" means an association or other organization which has as one of its primary functions the collection and dissemination of acute care cost information.

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

Subd. 8. **Termination or nonrenewal of reporting organization.** The commissioner may withdraw approval of any voluntary, nonprofit reporting organization for failure on the part of the voluntary, nonprofit reporting organization to comply with the written operating requirements under subdivision 2. Upon the effective date of the withdrawal, all funds collected by the voluntary, nonprofit reporting organization under

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subdivision 1, but not expended shall be deposited in a revolving fund and are appropriated to the commissioner of health for the purposes of sections 144.695 to 144.703.

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

History: *1976 c 296 art 2 s 8; 1977 c 305 s 45; 1984 c 534 s 8; 1989 c 282 art 2 s 13-15; 1995 c 207 art 6 s 3; 1998 c 407 art 2 s 30-32*

144.7021 [Repealed, 1984 c 534 s 33]

144.7022 REPORTING ORGANIZATIONS; PENALTY ORDERS.

Subdivision 1. **Authorization.** The commissioner may issue an order to the voluntary, nonprofit reporting organization requiring violations to be corrected and administratively assess monetary penalties for violations of sections 144.695 to 144.703 or rules, written operating requirements, orders, stipulation agreements, settlements, or compliance agreements adopted, enforced, or issued by the commissioner.

Subd. 2. **Contents of order.** An order assessing an administrative penalty under this section must include:

(1) a concise statement of the facts alleged to constitute a violation;

(2) a reference to the section of law, rule, written operating requirement, order, stipulation agreement, settlement, or compliance agreement that has been violated;

(3) a statement of the amount of the administrative penalty to be imposed and the factors upon which the penalty is based;

(4) a statement of the corrective actions necessary to correct the violation; and

(5) a statement of the right to request a hearing according to sections 14.57 to 14.62.

Subd. 3. **Concurrent corrective order.** The commissioner may issue an order assessing an administrative penalty and requiring the violations cited in the order be corrected within 30 calendar days from the date the order is received. Before the 31st day after the order was received, the voluntary, nonprofit reporting organization that is subject to the order shall provide the commissioner with information demonstrating that the violation has been corrected or that a corrective plan acceptable to the commissioner has been developed. The commissioner shall determine whether the violation has been corrected and notify the voluntary, nonprofit reporting organization of the commissioner's determination.

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

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

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

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

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

Subd. 5. **Amount of penalty; considerations.** (a) The maximum amount of an administrative penalty order is $5,000 for each specific violation identified in an inspection, investigation, or compliance review, up to an annual maximum total for all violations of ten percent of the fees collected by the voluntary, nonprofit reporting organization under section 144.702, subdivision 1. The annual maximum is based on a reporting year.

(b) In determining the amount of the administrative penalty, the commissioner shall consider the following:

(1) the willfulness of the violation;

(2) the gravity of the violation;

(3) the history of past violations;

(4) the number of violations;

(5) the economic benefit gained by the person allowing or committing the violation; and

(6) other factors as justice may require, if the commissioner specifically identifies the additional factors in the commissioner's order.

(c) In determining the amount of a penalty for a violation subsequent to an initial violation under paragraph (a), the commissioner shall also consider:

(1) the similarity of the most recent previous violation and the violation to be penalized;

(2) the time elapsed since the last violation; and

(3) the response of the voluntary, nonprofit reporting organization to the most recent previous violation.

Subd. 6. **Request for hearing; hearing; and final order.** A request for hearing must be in writing, delivered to the commissioner by certified mail within 20 calendar days after the receipt of the order, and specifically state the reasons for seeking review of the order. The commissioner must initiate a hearing within 30 calendar days from the date of receipt of the written request for hearing. The hearing shall be conducted pursuant to the contested case procedures in sections 14.57 to 14.62. No earlier than ten calendar days after and within 30 calendar days of receipt of the presiding administrative law judge's report, the commissioner shall, based on all relevant facts, issue a final order modifying, vacating, or making the original order permanent. If, within 20 calendar days of receipt of the original order, the voluntary, nonprofit reporting organization fails to request a hearing in writing, the order becomes the final order of the commissioner.

Subd. 7. **Review of final order and payment of penalty.** Once the commissioner issues a final order, any penalty due under that order shall be paid within 30 calendar days after the date of the final order, unless review of the final order is requested. The final order of the commissioner may be appealed in the manner

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prescribed in sections 14.63 to 14.69. If the final order is reviewed and upheld, the penalty shall be paid 30 calendar days after the date of the decision of the reviewing court. Failure to request an administrative hearing pursuant to subdivision 6 shall constitute a waiver of the right to further agency or judicial review of the final order.

Subd. 8. **Reinspections and effect of noncompliance.** If, upon reinspection, or in the determination of the commissioner, it is found that any deficiency specified in the order has not been corrected or an acceptable corrective plan has not been developed, the voluntary, nonprofit reporting organization is in noncompliance. The commissioner shall issue a notice of noncompliance and may impose any additional remedy available under this chapter.

Subd. 9. **Enforcement.** The attorney general may proceed on behalf of the commissioner to enforce penalties that are due and payable under this section in any manner provided by law for the collection of debts.

Subd. 10. **Termination or nonrenewal of reporting organization.** The commissioner may withdraw or not renew approval of any voluntary, nonprofit reporting organization for failure on the part of the voluntary, nonprofit reporting organization to pay penalties owed under this section.

Subd. 11. **Cumulative remedy.** The authority of the commissioner to issue an administrative penalty order is in addition to other lawfully available remedies.

Subd. 12. **Mediation.** In addition to review under subdivision 6, the commissioner is authorized to enter into mediation concerning an order issued under this section if the commissioner and the voluntary, nonprofit reporting organization agree to mediation.

History: *1998 c 407 art 2 s 33; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

144.703 ADDITIONAL POWERS.

Subdivision 1. **Rulemaking.** In addition to the other powers granted to the commissioner of health by law, the commissioner of health may:

(1) adopt, amend, and repeal rules in accordance with chapter 14;

(2) adopt in rule a schedule of fines, ranging from $100 to $1,000, for failure of a hospital or an outpatient surgical center to submit, or to make a timely submission of, information called for by sections 144.695 to 144.703.

Subd. 2. **Contested cases.** Any person aggrieved by a final determination of the commissioner of health as to any rule or determination under sections 144.695 to 144.703 shall be entitled to an administrative hearing and judicial review in accordance with the contested case provisions of chapter 14.

History: *1976 c 296 art 2 s 9; 1977 c 305 s 45; 1982 c 424 s 130; 1984 c 534 s 9*

144.704 [Repealed, 1984 c 534 s 33]

144.705 [Repealed, 1984 c 534 s 33]

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STAFFING PLAN REPORTS

144.7055 STAFFING PLAN REPORTS.

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

(b) "Core staffing plan" means the projected number of full-time equivalent nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit.

(c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and other health care workers, which may include but is not limited to nursing assistants, nursing aides, patient care technicians, and patient care assistants, who perform nonmanagerial direct patient care functions for more than 50 percent of their scheduled hours on a given patient care unit.

(d) "Inpatient care unit" means a designated inpatient area for assigning patients and staff for which a distinct staffing plan exists and that operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

(e) "Staffing hours per patient day" means the number of full-time equivalent nonmanagerial care staff who will ordinarily be assigned to provide direct patient care divided by the expected average number of patients upon which such assignments are based.

(f) "Patient acuity tool" means a system for measuring an individual patient's need for nursing care. This includes utilizing a professional registered nursing assessment of patient condition to assess staffing need.

Subd. 2. **Hospital staffing report.** (a) The chief nursing executive or nursing designee of every reporting hospital in Minnesota under section 144.50 will develop a core staffing plan for each patient care unit.

(b) Core staffing plans shall specify the full-time equivalent for each patient care unit for each 24-hour period.

(c) Prior to submitting the core staffing plan, as required in subdivision 3, hospitals shall consult with representatives of the hospital medical staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about the core staffing plan and the expected average number of patients upon which the staffing plan is based.

Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota Hospital Association shall include each reporting hospital's core staffing plan on the Minnesota Hospital Association's Minnesota Hospital Quality Report Web site by April 1, 2014. Any substantial changes to the core staffing plan shall be updated within 30 days.

(b) The Minnesota Hospital Association shall include on its Web site for each reporting hospital on a quarterly basis the actual direct patient care hours per patient and per unit. Hospitals must submit the direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly thereafter.

History: *2013 c 51 s 1*

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ADVERSE HEALTH CARE EVENTS REPORTING

144.706 CITATION.

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

History: *2003 c 99 s 1*

144.7063 DEFINITIONS.

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

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

Subd. 3. **Facility.** "Facility" means a hospital or outpatient surgical center licensed under sections 144.50 to 144.58.

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

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

History: *2003 c 99 s 2,7; 1Sp2003 c 14 art 7 s 84; 2004 c 198 s 15*

144.7065 FACILITY REQUIREMENTS TO REPORT, ANALYZE, AND CORRECT.

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

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

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

(2) surgery or other invasive procedure performed on the wrong patient;

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

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

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

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

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

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

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

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

(1) a patient of any age, who does not have decision-making capacity, discharged to the wrong person;

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

(3) patient suicide, attempted suicide resulting in serious injury, or self-harm resulting in serious injury or death 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 injury 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 injury associated with unsafe administration of blood or blood products;

(3) maternal death or serious injury 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) death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

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

(6) artificial insemination with the wrong donor sperm or wrong egg;

(7) patient death or serious injury associated with a fall while being cared for in a facility;

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(8) the irretrievable loss of an irreplaceable biological specimen; and

(9) patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

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

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

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

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

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

(2) abduction of a patient of any age;

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

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

Subd. 7a. **Radiologic events.** Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area are reportable events under this subdivision.

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

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

Subd. 10. **Relation to other law; data classification.** (a) Adverse health events described in subdivisions 2 to 6 do not constitute "maltreatment," "neglect," or "a physical injury that is not reasonably explained" under section 626.556 or 626.557 and are excluded from the reporting requirements of sections 626.556 and 626.557, provided the facility makes a determination within 24 hours of the discovery of the event that this section is applicable and the facility files the reports required under this section in a timely fashion.

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(b) A facility that has determined that an event described in subdivisions 2 to 6 has occurred must inform persons who are mandated reporters under section 626.556, subdivision 3, or 626.5572, subdivision 16, of that determination. A mandated reporter otherwise required to report under section 626.556, subdivision 3, or 626.557, subdivision 3, paragraph (e), is relieved of the duty to report an event that the facility determines under paragraph (a) to be reportable under subdivisions 2 to 6.

(c) The protections and immunities applicable to voluntary reports under sections 626.556 and 626.557 are not affected by this section.

(d) Notwithstanding section 626.556, 626.557, or any other provision of Minnesota statute or rule to the contrary, a lead agency under section 626.556, subdivision 3c, a lead investigative agency under section 626.5572, subdivision 13, the commissioner of health, or the director of the Office of Health Facility Complaints is not required to conduct an investigation of or obtain or create investigative data or reports regarding an event described in subdivisions 2 to 6. If the facility satisfies the requirements described in paragraph (a), the review or investigation shall be conducted and data or reports shall be obtained or created only under sections 144.706 to 144.7069, except as permitted or required under sections 144.50 to 144.564, or as necessary to carry out the state's certification responsibility under the provisions of sections 1864 and 1867 of the Social Security Act. If a licensed health care provider reports an event to the facility required to be reported under subdivisions 2 to 6 in a timely manner, the provider's licensing board is not required to conduct an investigation of or obtain or create investigative data or reports regarding the individual reporting of the events described in subdivisions 2 to 6.

(e) Data contained in the following records are nonpublic and, to the extent they contain data on individuals, confidential data on individuals, as defined in section 13.02:

(1) reports provided to the commissioner under sections 147.155, 147A.155, 148.267, 151.301, and 153.255;

(2) event reports, findings of root cause analyses, and corrective action plans filed by a facility under this section; and

(3) records created or obtained by the commissioner in reviewing or investigating the reports, findings, and plans described in clause (2).

For purposes of the nonpublic data classification contained in this paragraph, the reporting facility shall be deemed the subject of the data.

History: *2003 c 99 s 3; 1Sp2003 c 14 art 7 s 85; 2004 c 186 s 1; 2007 c 41 s 1-3; 2009 c 159 s 7,8; 2011 c 28 s 1; 2013 c 43 s 8-14*

144.7067 COMMISSIONER DUTIES AND RESPONSIBILITIES.

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

(b) The reporting system shall consist of:

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

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

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

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

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

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

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

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

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

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

(4) publish an annual report:

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

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

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

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

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

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

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

History: *2003 c 99 s 4*

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144.7068 REPORTS FROM LICENSING BOARDS.

(a) Effective upon full implementation of the adverse health care events reporting system, the records maintained under sections 147.155, 147A.155, 148.267, 151.301, and 153.255, shall be reported to the commissioner on the schedule established in those sections.

(b) The commissioner shall forward these reports to the facility named in the report.

(c) The facility shall determine whether the event has been previously reported under section 144.7065. The facility shall notify the commissioner whether the event has been reported previously. If the event has not been previously reported, the facility shall make a determination whether the event was reportable under section 144.7065. If the facility determines the event was reportable, the date of discovery of the event for the purposes of section 144.7065, subdivision 10, paragraph (d), shall be as follows:

(1) if the commissioner determines that the facility knew or reasonably should have known about the occurrence of the event, the date the event occurred shall be the date of discovery. The facility shall be considered out of compliance with the reporting act, and the event shall be subject to sections 626.556 and 626.557; or

(2) if the commissioner determines that the facility did not know about the occurrence of the event, the date the facility receives the report from the commissioner shall serve as the date of discovery.

If the facility determines that the event was not reportable under section 144.7065, the facility shall notify the commissioner of that determination.

History: *2004 c 186 s 2*

144.7069 INTERSTATE COORDINATION; REPORTS.

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

History: *2003 c 99 s 5*

YOUTH CAMPS

144.71 PURPOSE; DEFINITIONS.

Subdivision 1. **Health and safety.** The purpose of sections 144.71 to 144.74 is to protect the health and safety of persons in attendance at youth camps.

Subd. 2. **Definition.** For the purpose of such sections, a youth camp is defined as a parcel or parcels of land with permanent buildings, tents or other structures together with appurtenances thereon, established or maintained as living quarters where both food and beverage service and lodging or the facilities therefor are provided for ten or more people, operated continuously for a period of five days or more each year for

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educational, recreational or vacation purposes, and the use of the camp is offered to minors free of charge or for payment of a fee.

Subd. 3. **What not included in definition.** This definition does not include cabin and trailer camps, fishing and hunting camps, resorts, penal and correctional camps, industrial and construction camps, nor does it include homes operated for care or treatment of children and for the operation of which a license is required under the provisions of chapter 257.

History: *1951 c 285 s 1; 1974 c 406 s 21; 1993 c 206 s 6; 1996 c 451 art 4 s 8,9*

144.72 OPERATION.

Subdivision 1. **License required.** The state commissioner of health is authorized to issue a license according to chapter 157.

Subd. 2. **Application.** On or before June first annually, every person, partnership, limited liability company or corporation, operating or seeking to operate a youth camp, shall make application in writing to the commissioner for a permit to conduct a youth camp. Such application shall be in such form and shall contain such information as the commissioner may find necessary to determine that the youth camp will be operated and maintained in such a manner as to protect and preserve the health and safety of the persons using the camp. Where a person, partnership, limited liability company or corporation operates or is seeking to operate more than one youth camp, a separate application shall be made for each camp.

Subd. 3. **Issuance of license.** If the commissioner should determine from the application that the health and safety of the persons using the camp will be properly safeguarded, the commissioner may, prior to actual inspection of the camp, issue the license in writing. The license shall be posted in a conspicuous place on the premises occupied by the camp.

History: *1951 c 285 s 2; 1977 c 305 s 45; 1986 c 444; 1996 c 451 art 4 s 10,11; 2009 c 79 art 10 s 6,7*

144.73 STATE COMMISSIONER OF HEALTH, DUTIES.

Subdivision 1. **Inspection of camps.** It shall be the duty of the state commissioner of health to make an annual inspection of each youth camp, and where, upon inspection it is found that there is a failure to protect the health and safety of the persons using the camp, or a failure to comply with the camp rules prescribed by the commissioner, the commissioner shall give notice to the camp operator of such failure, which notice shall set forth the reason or reasons for such failure.

Subd. 2. [Repealed, 1993 c 206 s 25]

Subd. 3. [Repealed, 1993 c 206 s 25]

Subd. 4. [Repealed, 1993 c 206 s 25]

History: *1951 c 285 s 3; 1977 c 305 s 45; 1978 c 674 s 60; 1985 c 248 s 70; 1986 c 444; 1993 c 286 s 2; 1994 c 465 art 3 s 68; 1996 c 451 art 4 s 12*

144.74 RULES, STANDARDS.

The state commissioner of health is authorized to adopt and enforce such reasonable rules and standards as the commissioner determines necessary to protect the health and safety of persons in attendance at youth camps. Such rules and standards may include reasonable restrictions and limitations on the following:

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(1) camp sites and buildings, including location, layout, lighting, ventilation, heating, plumbing, drainage and sleeping quarters;

(2) sanitary facilities, including water supply, toilet and shower facilities, sewage and excreta disposal, waste and garbage disposal, and the control of insects and rodents; and

(3) food service, including storage, refrigeration, sanitary preparation and handling of food, the cleanliness of kitchens and the proper functioning of equipment.

History: *1951 c 285 s 4; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1996 c 451 art 4 s 13*

BLOOD-BORNE PATHOGENS; EMERGENCY MEDICAL SERVICES PERSON

144.7401 DEFINITIONS.

Subdivision 1. **Scope of definitions.** For purposes of sections 144.7401 to 144.7415, the following terms have the meanings given them.

Subd. 2. **Blood-borne pathogens.** "Blood-borne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

Subd. 3. **Emergency medical services agency.** "Emergency medical services agency" means an agency, entity, or organization that employs or uses emergency medical services persons as employees or volunteers.

Subd. 4. **Emergency medical services person.** "Emergency medical services person" means:

(1) an individual employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service as defined under chapter 144E or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties;

(2) an individual employed as a licensed peace officer under section 626.84, subdivision 1;

(3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation;

(4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a Good Samaritan under section 604A.01; and

(5) any individual who, in the process of executing a citizen's arrest under section 629.30, may have experienced a significant exposure to a source individual.

Subd. 5. **Source individual.** "Source individual" means an individual, living or dead, whose blood, tissue, or potentially infectious body fluids may be a source of blood-borne pathogen exposure to an emergency medical services person. Examples include, but are not limited to, a victim of an accident, injury, or illness or a deceased person.

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Subd. 6. **Significant exposure.** "Significant exposure" means contact likely to transmit a blood-borne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes:

(1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and

(2) contact, in a manner that may transmit a blood-borne pathogen, with blood, tissue, or potentially infectious body fluids.

Subd. 7. **Facility.** "Facility" means a hospital licensed under sections 144.50 to 144.56 or a freestanding emergency medical care facility licensed under Laws 1988, chapter 467, that receives an emergency medical services person for evaluation for significant exposure or a source individual cared for by an emergency medical services person.

Subd. 8. **Peace officer; applicability.** An individual licensed as a peace officer under section 626.84, subdivision 1, is considered an emergency medical services person for purposes of sections 144.7401 to 144.7415 regardless of whether the officer is engaged in performing emergency services.

History: *2000 c 422 s 5; 2006 c 260 art 3 s 4*

144.7402 CONDITIONS FOR APPLICABILITY OF PROCEDURES.

Subdivision 1. **Request for procedures.** An emergency medical services person or emergency medical services agency may request that a facility follow the procedures of sections 144.7401 to 144.7415 when an emergency medical services person may have experienced a significant exposure to a source individual.

Subd. 2. **Conditions.** A facility shall follow the procedures outlined in sections 144.7401 to 144.7415 when all of the following conditions are met:

(1) the facility determines that significant exposure has occurred, following the protocol under section 144.7414;

(2) the licensed physician for the emergency medical services person needs the source individual's blood-borne pathogen test results to begin, continue, modify, or discontinue treatment, in accordance with the most current guidelines of the United States Public Health Service, because of possible exposure to a blood-borne pathogen; and

(3) the emergency medical services person consents to provide a blood sample for testing for a blood-borne pathogen. If the emergency medical services person consents to blood collection, but does not consent at that time to blood-borne pathogen testing, the facility shall preserve the sample for at least 90 days. If the emergency medical services person elects to have the sample tested within 90 days, the testing shall be done as soon as feasible.

Subd. 3. **Locating source individual.** If the source individual is not received by a facility but the facility is providing treatment to the emergency medical services person, the emergency medical services agency shall make reasonable efforts to locate the source individual and inform the facility of the source individual's identity and location. The facility shall make a reasonable effort to contact the source individual in order to follow the procedures in sections 144.7401 to 144.7415. The emergency medical services agency and facilities may exchange private data about the source individual as necessary to fulfill their responsibilities under this subdivision, notwithstanding any provision of law to the contrary.

History: *2000 c 422 s 6*

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144.7403 INFORMATION REQUIRED TO BE GIVEN TO INDIVIDUALS.

Subdivision 1. **Information to source individual.** (a) Before seeking any consent required by the procedures under sections 144.7401 to 144.7415, a facility shall inform the source individual that the source individual's blood-borne pathogen test results, without the individual's name, address, or other uniquely identifying information, shall be reported to the emergency medical services person if requested, and that test results collected under sections 144.7401 to 144.7415 are for medical purposes as set forth in section 144.7409 and may not be used as evidence in any criminal proceedings or civil proceedings, except for procedures under sections 144.4171 to 144.4186.

(b) The facility shall inform the source individual of the insurance protections in section 72A.20, subdivision 29.

(c) The facility shall inform the source individual that the individual may refuse to provide a blood sample and that the source individual's refusal may result in a request for a court order to require the source individual to provide a blood sample.

(d) The facility shall inform the source individual that the facility will advise the emergency medical services person of the confidentiality requirements and penalties before disclosing any test information.

Subd. 2. **Information to EMS person.** (a) Before disclosing any information about the source individual, the facility shall inform the emergency medical services person of the confidentiality requirements of section 144.7411 and that the person may be subject to penalties for unauthorized release of information about the source individual under section 144.7412.

(b) The facility shall inform the emergency medical services person of the insurance protections in section 72A.20, subdivision 29.

History: *2000 c 422 s 7*

144.7404 DISCLOSURE OF POSITIVE BLOOD-BORNE PATHOGEN TEST RESULTS.

If the conditions of sections 144.7402 and 144.7403 are met, the facility shall ask the source individual and the emergency medical services person if they have ever had a positive test for a blood-borne pathogen. The facility must attempt to get existing test results under this section before taking any steps to obtain a blood sample or to test for blood-borne pathogens. The facility shall disclose the source individual's blood-borne pathogen test results to the emergency medical services person without the source individual's name, address, or other uniquely identifying information.

History: *2000 c 422 s 8*

144.7405 CONSENT PROCEDURES GENERALLY.

(a) For purposes of sections 144.7401 to 144.7415, whenever the facility is required to seek consent, the facility shall follow its usual procedure for obtaining consent from an individual or an individual's representative consistent with other law applicable to consent.

(b) Consent from a source individual's representative for blood-borne pathogen testing of an existing blood sample obtained from the source individual is not required if the facility has made reasonable efforts to obtain the representative's consent and consent cannot be obtained within 24 hours of a significant exposure.

(c) If testing of the source individual's blood occurs without consent because the source individual is unable to provide consent or has left the facility and cannot be located, and the source individual's

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representative cannot be located, the facility shall provide the information required in section 144.7403 to the source individual or representative whenever it is possible to do so.

(d) If a source individual dies before an opportunity to consent to blood collection or testing under sections 144.7401 to 144.7415, the facility does not need consent of the deceased person's representative for purposes of sections 144.7401 to 144.7415.

History: *2000 c 422 s 9*

144.7406 TESTING OF AVAILABLE BLOOD.

Subdivision 1. **Procedures with consent.** If the source individual is or was under the care or custody of the facility and a sample of the source individual's blood is available with the consent of the source individual, the facility shall test that blood for blood-borne pathogens with the consent of the source individual, provided the conditions in sections 144.7402 and 144.7403 are met.

Subd. 2. **Procedures without consent.** If the source individual has provided a blood sample with consent but does not consent to blood-borne pathogen testing, the facility shall test for blood-borne pathogens if the emergency medical services person or emergency medical services agency requests the test, provided all of the following criteria are met:

(1) the emergency medical services person or emergency medical services agency has documented exposure to blood or body fluids during performance of that person's occupation or while acting as a Good Samaritan under section 604A.01 or executing a citizen's arrest under section 629.30;

(2) the facility has determined that a significant exposure has occurred and a licensed physician for the emergency medical services person has documented in the emergency medical services person's medical record that blood-borne pathogen test results are needed for beginning, modifying, continuing, or discontinuing medical treatment for the emergency medical services person under section 144.7414, subdivision 2;

(3) the emergency medical services person provides a blood sample for testing for blood-borne pathogens as soon as feasible;

(4) the facility asks the source individual to consent to a test for blood-borne pathogens and the source individual does not consent;

(5) the facility has provided the source individual with all of the information required by section 144.7403; and

(6) the facility has informed the emergency medical services person of the confidentiality requirements of section 144.7411 and the penalties for unauthorized release of source information under section 144.7412.

Subd. 3. **Follow-up.** The facility shall inform the source individual and the emergency medical services person of their own test results. The facility shall inform the emergency medical services person of the source individual's test results without the source individual's name, address, or other uniquely identifying information.

History: *2000 c 422 s 10*

144.7407 BLOOD SAMPLE COLLECTION FOR TESTING.

Subdivision 1. **Procedures with consent.** (a) If a blood sample is not otherwise available, the facility shall obtain consent from the source individual before collecting a blood sample for testing for blood-borne

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pathogens. The consent process shall include informing the source individual that the individual may refuse to provide a blood sample and that the source individual's refusal may result in a request for a court order under subdivision 2 to require the source individual to provide a blood sample.

(b) If the source individual consents to provide a blood sample, the facility shall collect a blood sample and test the sample for blood-borne pathogens.

(c) The facility shall inform the emergency medical services person about the source individual's test results without the individual's name, address, or other uniquely identifying information. The facility shall inform the source individual of the test results.

(d) If the source individual refuses to provide a blood sample for testing, the facility shall inform the emergency medical services person of the source individual's refusal.

Subd. 2. **Procedures without consent.** (a) An emergency medical services agency, or, if there is no agency, an emergency medical services person, may bring a petition for a court order to require a source individual to provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in the district court in the county where the source individual resides or is hospitalized. The petitioner shall serve the petition on the source individual at least three days before a hearing on the petition. The petition shall include one or more affidavits attesting that:

(1) the facility followed the procedures in sections 144.7401 to 144.7415 and attempted to obtain blood-borne pathogen test results according to those sections;

(2) it has been determined under section 144.7414, subdivision 2, that a significant exposure has occurred to the emergency medical services person; and

(3) a physician with specialty training in infectious diseases, including HIV, has documented that the emergency medical services person has provided a blood sample and consented to testing for blood-borne pathogens and blood-borne pathogen test results are needed for beginning, continuing, modifying, or discontinuing medical treatment for the emergency medical services person.

(b) Facilities shall cooperate with petitioners in providing any necessary affidavits to the extent that facility staff can attest under oath to the facts in the affidavits.

(c) The court may order the source individual to provide a blood sample for blood-borne pathogen testing if:

(1) there is probable cause to believe the emergency medical services person has experienced a significant exposure to the source individual;

(2) the court imposes appropriate safeguards against unauthorized disclosure that must specify the persons who have access to the test results and the purposes for which the test results may be used;

(3) a licensed physician for the emergency medical services person needs the test results for beginning, continuing, modifying, or discontinuing medical treatment for the emergency medical services person; and

(4) the court finds a compelling need for the test results. In assessing compelling need, the court shall weigh the need for the court-ordered blood collection and test results against the interests of the source individual, including, but not limited to, privacy, health, safety, or economic interests. The court shall also consider whether the involuntary blood collection and testing would serve the public interest.

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(d) The court shall conduct the proceeding in camera unless the petitioner or the source individual requests a hearing in open court and the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(e) The court shall conduct an ex parte hearing if the source individual does not attend the noticed hearing and the petitioner complied with the notice requirements in paragraph (a).

(f) The source individual has the right to counsel in any proceeding brought under this subdivision.

(g) The court may order a source individual taken into custody by a peace officer for purposes of obtaining a blood sample if the source individual does not comply with an order issued by the court pursuant to paragraph (c). The source individual shall be held no longer than is necessary to secure a blood sample. A person may not be held for more than 24 hours without receiving a court hearing.

History: *2000 c 422 s 11; 2016 c 145 s 1*

144.7408 NO DISCRIMINATION.

A facility shall not base decisions about admission to a facility or the provision of care or treatment on any requirement that the source individual consent to blood-borne pathogen testing under sections 144.7401 to 144.7415.

History: *2000 c 422 s 12*

144.7409 USE OF TEST RESULTS.

Blood-borne pathogen test results of a source individual obtained under sections 144.7401 to 144.7415 are for diagnostic purposes and to determine the need for treatment or medical care specific to a blood-borne pathogen-related illness of an emergency medical services person. The test results may not be used as evidence in any criminal proceedings or civil proceedings, except for procedures under sections 144.4171 to 144.4186.

History: *2000 c 422 s 13*

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.

Subd. 2. **Consent to release information.** No facility, individual, or employer shall disclose to an emergency medical services person the name, address, or other uniquely identifying information about a source individual without a written release signed by the source individual or the source individual's legally authorized representative. The facility shall not record the name, address, or other uniquely identifying information about the source individual's test results in the emergency medical services person's medical records.

History: *2000 c 422 s 14; 2007 c 147 art 10 s 15*

144.7412 PENALTY FOR UNAUTHORIZED RELEASE OF INFORMATION.

Unauthorized release by an individual, facility, or agency of a source individual's name, address, or other uniquely identifying information under sections 144.7401 to 144.7415 is subject to the remedies and

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penalties under sections 13.08 and 13.09. This section does not preclude private causes of action against an individual, state agency, statewide system, political subdivision, or person responsible for releasing private data or information protected from disclosure.

History: *2000 c 422 s 15*

144.7413 RESPONSIBILITY FOR TESTING AND TREATMENT; COSTS.

(a) The facility shall ensure that tests under sections 144.7401 to 144.7415 are performed if requested by the emergency medical services person or emergency medical services agency, provided the conditions set forth in sections 144.7401 to 144.7415 are met.

(b) The emergency medical services agency that employs the emergency medical services person who requests testing under sections 144.7401 to 144.7415 must pay or arrange payment for the cost of counseling, testing, and treatment of the emergency medical services person and costs associated with the testing of the source individual.

(c) A facility shall have a protocol that states whether the facility will pay for the cost of counseling, testing, or treatment of a person executing a citizen's arrest under section 629.30 or acting as a Good Samaritan under section 604A.01.

History: *2000 c 422 s 16*

144.7414 PROTOCOLS FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.

Subdivision 1. **EMS agency requirements.** The emergency medical services agency shall have procedures for an emergency medical services person to notify a facility that the person may have experienced a significant exposure from a source individual. The emergency medical services agency shall also have a protocol to locate the source individual if the facility has not received the source individual and the emergency medical services agency knows the source individual's identity.

Subd. 2. **Facility protocol requirements.** Every facility shall adopt and follow a postexposure protocol for emergency medical services persons who have experienced a significant exposure. The postexposure protocol must adhere to the most current recommendations of the United States Public Health Service and include, at a minimum, the following:

(1) a process for emergency medical services persons to report an exposure in a timely fashion;

(2) a process for an infectious disease specialist, or a licensed physician who is knowledgeable about the most current recommendations of the United States Public Health Service in consultation with an infectious disease specialist, (i) to determine whether a significant exposure to one or more blood-borne pathogens has occurred and (ii) to provide, under the direction of a licensed physician, a recommendation or recommendations for follow-up treatment appropriate to the particular blood-borne pathogen or pathogens for which a significant exposure has been determined;

(3) if there has been a significant exposure, a process to determine whether the source individual has a blood-borne pathogen through disclosure of test results, or through blood collection and testing as required by sections 144.7401 to 144.7415;

(4) a process for providing appropriate counseling prior to and following testing for a blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and follow-up recommendations according to the most current recommendations of the United States Public Health Service, recommendations for testing, and treatment to the emergency medical services person;

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(5) a process for providing appropriate counseling under clause (4) to the emergency medical services person and the source individual; and

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

History: *2000 c 422 s 17*

144.7415 PENALTIES AND IMMUNITY.

Subdivision 1. **Penalties.** Any facility or person who willfully violates the provisions of sections 144.7401 to 144.7415 is guilty of a misdemeanor.

Subd. 2. **Immunity.** A facility, licensed physician, and designated health care personnel are immune from liability in any civil, administrative, or criminal action relating to the disclosure of test results to an emergency medical services person or emergency medical services agency and the testing of a blood sample from the source individual for blood-borne pathogens if a good faith effort has been made to comply with sections 144.7401 to 144.7415.

History: *2000 c 422 s 18*

144.75 [Repealed, 1973 c 250 s 2]

144.76 [Repealed, 1993 c 206 s 25]

144.761 [Repealed, 2000 c 422 s 55]

144.762 [Repealed, 2000 c 422 s 55]

144.763 [Repealed, 2000 c 422 s 55]

144.764 [Repealed, 2000 c 422 s 55]

144.765 [Repealed, 2000 c 422 s 55]

144.766 [Repealed, 2000 c 422 s 55]

144.767 [Repealed, 2000 c 422 s 55]

144.768 [Repealed, 2000 c 422 s 55]

144.769 [Repealed, 2000 c 422 s 55]

144.7691 [Repealed, 2000 c 422 s 55]

144.801 [Repealed, 1997 c 199 s 15]

144.802 [Repealed, 1997 c 199 s 15]

144.803 [Repealed, 1997 c 199 s 15]

144.804 [Repealed, 1997 c 199 s 15]

144.805 [Repealed, 1989 c 134 s 12]

144.806 [Repealed, 1997 c 199 s 15]

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144.807 Subdivision 1. [Renumbered 144E.17, subdivision 1]

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

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

144.808 [Renumbered 144E.18]

144.809 [Renumbered 144E.25]

144.8091 Subdivision 1. [Renumbered 144E.35, subdivision 1]

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

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

144.8092 [Repealed, 1989 c 134 s 12]

144.8093 Subdivision 1. [Renumbered 144E.50, subdivision 1]

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

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

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

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

144.8095 [Renumbered 144E.52]

144.8097 [Repealed, 1995 c 207 art 9 s 61 subd 2]

ALCOHOLISM COUNSELOR

144.81 [Repealed, 1973 c 572 s 18]

144.82 [Repealed, 1973 c 572 s 18]

144.83 [Repealed, 1967 c 893 s 5]

144.831 [Repealed, 1973 c 572 s 18]

144.832 [Repealed, 1973 c 572 s 18]

144.833 [Repealed, 1973 c 572 s 18]

144.834 [Repealed, 1973 c 572 s 18]

144.84 CIVIL SERVICE CLASSIFICATION.

The commissioner of management and budget and the Civil Service Commission shall establish a classification to be known as "counselor on alcoholism" the qualifications of which shall give recognition to the value and desirability of recovered alcoholics in performing the duties of their employment.

History: *1953 c 705 s 4; 1973 c 507 s 45; 1980 c 617 s 47; 2008 c 204 s 42; 2009 c 101 art 2 s 109*

144.851 [Repealed, 1990 c 533 s 8]

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144.852 [Repealed, 1990 c 533 s 8]

144.853 [Repealed, 1990 c 533 s 8]

144.854 [Repealed, 1990 c 533 s 8]

144.856 [Repealed, 1990 c 533 s 8]

144.860 [Repealed, 1990 c 533 s 8]

144.861 [Repealed, 1991 c 345 art 2 s 69]

144.862 [Repealed, 1990 c 533 s 8]

144.871 [Repealed, 1995 c 213 art 1 s 13]

144.872 [Repealed, 1995 c 213 art 1 s 13]

144.8721 [Repealed, 1993 c 286 s 34; 1Sp1993 c 1 art 9 s 75]

144.873 [Repealed, 1995 c 213 art 1 s 13]

144.874 [Repealed, 1995 c 213 art 1 s 13]

144.876 [Repealed, 1995 c 213 art 1 s 13]

144.877 Subdivision 1. [Repealed, 1995 c 213 art 1 s 13]

Subd. 2. [Repealed, 1995 c 213 art 1 s 13]

Subd. 3. [Repealed, 1995 c 213 art 1 s 13]

Subd. 4. [Repealed, 1995 c 213 art 1 s 13]

Subd. 5. [Repealed, 1995 c 165 s 17; 1995 c 213 art 1 s 13]

Subd. 6. [Repealed, 1995 c 213 art 1 s 13]

Subd. 7. [Repealed, 1995 c 213 art 1 s 13]

144.8771 [Repealed, 1995 c 213 art 1 s 13]

144.878 [Repealed, 1995 c 213 art 1 s 13]

144.8781 Subdivision 1. [Repealed, 1994 c 567 s 24]

Subd. 2. [Repealed, 1994 c 567 s 24]

Subd. 3. [Repealed, 1994 c 567 s 24]

Subd. 4. [Repealed, 1995 c 165 s 17; 1995 c 213 art 1 s 13]

Subd. 5. [Repealed, 1994 c 567 s 24]

Subd. 6. [Repealed, 1995 c 213 art 1 s 13]

144.8782 [Repealed, 1995 c 213 art 1 s 13]

144.879 [Repealed, 1995 c 213 art 1 s 13]

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HUMAN GENETICS

144.91 POWERS AND DUTIES.

The state commissioner of health is authorized to develop and carry on a program in the field of human genetics which shall include the collection and interpretation of data relating to human hereditary diseases and pathologic conditions; the assembly, preparation and dissemination of informational material on the subject for professional counselors and the lay public; the conduct of such research studies as may stimulate reduction in the frequency of manifestation of various deleterious genes, and the provision of counseling services to the public on problems of human genetics. It shall consult and cooperate with the University of Minnesota, the Public Health Service and the Children's Bureau of the Department of Health, Education and Welfare, and with nationally recognized scientific and professional organizations engaged in studying the problems of human genetics.

History: *1959 c 572 s 1; 1977 c 305 s 45*

144.92 GRANTS OR GIFTS.

The board is authorized to receive and expend in accordance with approved plans such funds as may be granted by the Public Health Service or any other federal agency which may appropriate funds for this purpose, or such funds as may be received as gifts from private organizations and individuals to the state for carrying out the purposes of section 144.91.

History: *1959 c 572 s 2; 1Sp1981 c 4 art 1 s 78*

144.93 [Repealed, 1973 c 250 s 2]

144.94 [Repealed, 1987 c 209 s 40]

MOSQUITO CONTROL

144.945 ZIKA PREPAREDNESS AND RESPONSE.

The commissioner of health shall seek additional federal funds for the following statewide planning, coordination, preparation, and response activities related to the Zika virus:

(1) maintaining state and local public health readiness to address Zika-related public health threats;

(2) conducting diagnostic tests of patients who meet criteria for Zika testing and maintaining enhanced laboratory surveillance activities related to Zika;

(3) engaging in Zika surveillance activities, including evaluating patients for testing based on criteria, advising health care providers on Zika virus research, providing recommendations and interpretations of test results, and conducting Zika-related public awareness and prevention activities; and

(4) conducting mosquito surveillance activities under section 144.95 to enhance monitoring of areas where mosquitoes carrying the Zika virus may be found in Minnesota, notwithstanding section 144.95, subdivision 10.

History: *2016 c 179 s 5*

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144.95 MOSQUITO RESEARCH PROGRAM.

Subdivision 1. **Research program.** The commissioner of health shall establish and maintain a long-range program of research to study:

(1) the basic biology, distribution, population ecology, and biosystematics of Minnesota mosquitoes;

(2) the impact of mosquitoes on human and animal health and the economy, including such areas as recreation, tourism, and livestock production;

(3) the baseline population and environmental status of organisms other than mosquitoes that may be affected by mosquito management;

(4) the effects of mosquito management strategies on animals and plants that may result in changes in ecology of specific areas;

(5) the development of mosquito management strategies that are effective, practical, and environmentally safe; and

(6) the costs and benefits of development of local and regional management and educational programs.

Subd. 2. **Research facility and field stations.** (a) The commissioner of health shall establish and maintain mosquito management research and development facilities, including but not limited to field research stations in the major mosquito ecologic regions and a center for basic mosquito management research and development. The commissioner shall, to the extent possible, contract with the University of Minnesota in establishing, maintaining, and staffing the research facilities.

(b) The commissioner of health shall establish and implement a program of contractual research grants with public and private agencies and individuals in order to:

(1) undertake supplemental research studies on basic mosquito biology, physiology, and life cycle history beyond those described in subdivision 1;

(2) undertake research into the effects of mosquitoes on human health, including vector-borne diseases, and on animal health, including agricultural and wildlife effects;

(3) undertake studies of other economic factors including tourism and recreation;

(4) collect and analyze baseline data on the ecology and distribution of organisms other than mosquitoes that may be affected as a result of mosquito management strategies;

(5) develop new, effective, practical, and biologically compatible control methods and materials;

(6) conduct additional monitoring of the environmental effects of mosquito control methods and materials; and

(7) undertake demonstration, training, and education programs for development of local and regional mosquito management programs.

Subd. 3. **Conduct research trials.** The commissioner of health may develop and conduct research trials of mosquito management methods and materials. Trials may be conducted, with the agreement of the public or private landholder, wherever and whenever the commissioner considers necessary to provide accurate data for determining the efficacy of a method or material in controlling mosquitoes.

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Subd. 4. **Research trials.** Research trials of mosquito management methods and materials are subject to the following laws and rules unless a specific written exemption, license, or waiver is granted; sections 84.0895, 103G.615, 97A.045, subdivision 1, 103A.201, 103G.255, and 103G.275 to 103G.285; and Minnesota Rules, chapters 1505, 6115, 6120, 6134, and 6140.

Subd. 5. **General authority.** (a) To carry out subdivisions 1 to 4, the commissioner of health may:

(1) accept money, property, or services from any source;

(2) receive and hold lands;

(3) accept gifts;

(4) cooperate with city, state, federal, or private agencies whose research on mosquito control or on other environmental matters may be affected by the commissioner's mosquito management and research activities; and

(5) enter into contracts with any public or private entity.

(b) The contracts must specify the duties performed, services provided, and the amount and method of reimbursement for them. Money collected by the commissioner under contracts made under this subdivision is appropriated to the commissioner for the purposes specified in the contracts. Contractual agreements must be processed under section 16C.08.

Subd. 6. **Authority to enter property.** The commissioner of health, officers, employees, or agents may, with express permission of the owner, enter upon any property at reasonable times to:

(1) determine whether mosquito breeding exists;

(2) examine, count, study, or collect laboratory samples to determine the property's geographic, geologic, and biologic characteristics; or

(3) study and collect laboratory samples to determine the effect on animals and vegetation of an insecticide, herbicide, or other method used to control mosquitoes.

Subd. 7. **Research plots.** The commissioner of health may lease and maintain experimental plots of land for mosquito research. The commissioner of health shall determine the locations of the experimental plots and may enter into agreements with any public or private agency or individual to lease the land. The commissioners of agriculture, natural resources, transportation, and iron range resources and rehabilitation shall cooperate with the commissioner of health.

Subd. 8. **Emergencies.** The commissioner may suspend or revoke a contract, agreement, or delegated authority granted in this section at any time and without prior notice if an emergency, accident, or hazard threatens the public health.

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

Subd. 10. **Contingency.** This section is effective only if the tax on cigarettes imposed by United States Code, title 26, section 5701, as amended, is reduced after June 1, 1985, or if other public or private funds sufficient to fund the program are made available to the commissioner for the purposes of this program.

History: *1Sp1985 c 14 art 19 s 17; 1987 c 149 art 2 s 10; 1987 c 312 art 1 s 26 subd 2; 1990 c 391 art 8 s 29; art 10 s 3; 1993 c 163 art 1 s 25; 1998 c 386 art 2 s 57*

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LEAD POISONING PREVENTION ACT

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.

Subd. 3. **Abatement.** "Abatement" means any set of measures intended to eliminate known or presumed lead hazards. Abatement includes:

(1) the removal of lead-based paint and lead-contaminated dust, the permanent enclosure or encapsulation of lead-based paint, the replacement of lead-painted surfaces or fixtures, and the removal or enclosure of lead-contaminated soil; and

(2) all preparation, cleanup, disposal, and postabatement clearance testing activities associated with these measures.

Subd. 4. **Areas at high risk for toxic lead exposure.** "Areas at high risk for toxic lead exposure" means a census tract in a city of the first class or a county or area within a county outside a city of the first class that has been determined to be at high risk for toxic lead exposure under section 144.9503.

Subd. 4a. **Assessing agency.** "Assessing agency" means the commissioner or a community health board with authority and responsibility to conduct lead risk assessments in response to reports of children or pregnant women with elevated blood lead levels.

Subd. 5. **Bare soil.** "Bare soil" means any visible soil that is at least an area of 36 contiguous square inches.

Subd. 6. [Renumbered subd 7a]

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

Subd. 6b. **Clearance inspection.** "Clearance inspection" means a visual identification of deteriorated paint and bare soil and a resampling and analysis of interior dust lead concentrations in a residence to ensure that the lead standards established in rules adopted under section 144.9508 are not exceeded.

Subd. 6c. **Capillary blood sample.** "Capillary blood sample" means a quantity of blood drawn from a capillary. The sample generally is collected by finger stick.

Subd. 6d. **Certified lead firm.** "Certified lead firm" means a person that employs individuals to perform regulated lead work, with the exception of renovation, and is certified by the commissioner under section 144.9505.

Subd. 6e. **Certified renovation firm.** "Certified renovation firm" means a person that employs individuals to perform renovation and is certified by the commissioner under section 144.9505.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Health.

Subd. 7a. [Renumbered subd 7b]

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Subd. 7a. **Community health board.** "Community health board" means an administrative authority established under section 145A.03.

Subd. 7b. **Contracting entity.** "Contracting entity" means a public or private body, board, individual, corporation, partnership, proprietorship, joint venture, fund, authority, or similar entity that contracts with a person to do regulated lead work.

Subd. 8. **Deteriorated paint.** "Deteriorated paint" means paint that is chipped, peeled, or otherwise separated from its substrate or that is attached to damaged substrate.

Subd. 8a. **Disclosure pamphlet.** "Disclosure pamphlet" means the EPA pamphlet titled "Renovate Right: Important Lead Hazard Information for Families, Child Care Providers and Schools" developed under section 406(a) of the Toxic Substance Control Act.

Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic blood lead test with a result that is equal to or greater than ten micrograms of lead per deciliter of whole blood in any person, unless the commissioner finds that a lower concentration is necessary to protect public health.

[See Note.]

Subd. 10. **Encapsulation.** "Encapsulation" means covering a surface coated with paint that exceeds the standards under section 144.9508 with a liquid or solid material that adheres to the surface, rather than mechanically attaches to it; or covering bare soil that exceeds the standards under section 144.9508 with a permeable material such as vegetation, mulch, or soil that meets the standards under section 144.9508.

Subd. 11. **Enclosure.** "Enclosure" means covering a surface coated with paint that exceeds the standards under section 144.9508 by mechanically fastening to the surface a durable, solid material; or covering bare soil that exceeds the standards under section 144.9508 with an impermeable material, such as asphalt or concrete.

Subd. 12. [Repealed, 1998 c 407 art 2 s 109]

Subd. 13. **Intact paint.** "Intact paint" means paint that is not chipped, peeled, or otherwise separated from its substrate or attached to damaged substrate. Painted surfaces which may generate dust but are not chipped, peeled, or otherwise separated from their substrate or attached to damaged substrate are considered to be intact paint.

Subd. 13a. **Interim controls.** "Interim controls" means a set of measures intended to temporarily reduce human exposure or likely exposure to known or presumed lead hazards, including specialized cleaning, repairs, maintenance, painting, temporary encapsulation, or enclosure.

Subd. 14. [Repealed, 1998 c 407 art 2 s 109]

Subd. 15. **Lead hazard.** "Lead hazard" means a condition that causes exposure to lead from dust, bare soil, drinking water, or deteriorated paint that exceeds the standards adopted under section 144.9508.

Subd. 16. [Repealed, 1998 c 407 art 2 s 109]

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim controls undertaken to make a residence, child care facility, school, or playground lead-safe by complying with the lead standards and methods adopted under section 144.9508.

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Subd. 17a. **Lead hazard screen.** "Lead hazard screen" means a limited risk assessment activity that involves the visual identification of dust, paint, or bare soil and sampling and analysis of dust.

Subd. 17b. [Repealed, 2009 c 79 art 10 s 51]

Subd. 18. **Lead inspection.** "Lead inspection" means a surface by surface investigation to determine the presence of lead content of paint and a visual identification of the existence and location of bare soil.

Subd. 19. **Lead inspector.** "Lead inspector" means a person who is licensed by the commissioner to perform a lead inspection under section 144.9505.

Subd. 19a. **Lead project design.** "Lead project design" means site-specific written project specifications for a regulated lead work project. Lead project design includes written technical project specifications incorporated into bidding documents.

Subd. 20. **Lead order.** "Lead order" means a legal instrument to compel a property owner to engage in lead hazard reduction according to the specifications given by the assessing agency.

Subd. 20a. **Lead project designer.** "Lead project designer" means an individual who is responsible for planning the site-specific performance of regulated lead work and who has been licensed by the commissioner under section 144.9505.

Subd. 20b. **Lead risk assessment.** "Lead risk assessment" means an investigation to determine the existence, nature, severity, and location of lead hazards.

Subd. 20c. **Lead risk assessor.** "Lead risk assessor" means an individual who performs lead risk assessments or lead inspections and who has been licensed by the commissioner under section 144.9505.

Subd. 21. **Lead-safe.** "Lead-safe" means a condition in which:

(1) lead is not present;

(2) lead may be present at the residence, child care facility, school, or playground, if the lead concentration in the dust, paint, soil, and water of a residence does not exceed the standards adopted under section 144.9508; or

(3) if the lead concentrations in the paint or soil do exceed the standards, the paint is intact and the soil is not bare soil.

Subd. 22. **Lead-safe practices.** "Lead-safe practices" means methods for construction, renovation, remodeling, or maintenance activities that are not regulated lead work and that are performed so that they do not:

(1) violate the standards under section 144.9508;

(2) create lead dust through the use of prohibited practices;

(3) leave debris or a lead residue that can form a dust;

(4) provide a readily accessible source of lead dust, lead paint, lead paint chips, or lead-contaminated soil, after the use of containment methods; and

(5) result in improper disposal of lead-contaminated debris, dust, or soil.

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Subd. 22a. **Lead supervisor.** "Lead supervisor" means an individual who is responsible for the on-site performance of abatement or interim controls and who has been licensed by the commissioner under section 144.9505.

Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an individual who performs clearance inspections for renovation sites and lead dust sampling for nonabatement sites.

Subd. 23. **Lead worker.** "Lead worker" means an individual who performs abatement or interim control work and who has been licensed by the commissioner under section 144.9505.

Subd. 24. **Person.** "Person" has the meaning given in section 326.71, subdivision 8.

Subd. 25. **Persons at high risk for elevated blood lead level.** "Persons at high risk for elevated blood lead level" means:

(1) a child between six and 72 months of age:

(a) who lives in or visits, at least weekly, a residence, child care facility, or school built before 1978 which has peeling or chipping paint, ongoing remodeling or renovation, or bare soil; or

(b) who has a sibling, housemate, or playmate who has been diagnosed with an elevated blood lead level in the last 12 months; and

(2) a pregnant female or a child between six and 72 months of age:

(a) who lives in a census tract found to have a median foundation soil lead value exceeding 100 parts per million of lead;

(b) who lives near an industrial point source that emits lead;

(c) who lives near a road with an average daily traffic which exceeded 5,000 vehicles per day in 1986 or earlier; or

(d) who lives with a person whose occupation or hobby involves exposure to lead.

Subd. 25a. **Play area.** "Play area" means any established area where children play, or on residential property, any established area where children play or bare soil is accessible to children.

Subd. 26. **Primary prevention.** "Primary prevention" means preventing toxic lead exposure before blood levels become elevated.

Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

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(8) lead sampling technician services;

(9) swab team services;

(10) renovation activities; or

(11) activities performed to comply with lead orders issued by a community health board.

(b) Regulated lead work does not include abatement, interim controls, swab team services, or renovation activities that disturb painted surfaces that total no more than:

(1) 20 square feet (two square meters) on exterior surfaces; or

(2) six square feet (0.6 square meters) in an interior room.

Subd. 26b. **Renovation.** "Renovation" means the modification of any pre-1978 affected property that results in the disturbance of known or presumed lead-containing painted surfaces defined under section 144.9508, unless that activity is performed as lead hazard reduction. A renovation performed for the purpose of converting a building or part of a building into an affected property is a renovation under this subdivision.

Subd. 26c. **Lead renovator.** "Lead renovator" means an individual who directs individuals who perform renovations. A lead renovator also performs renovation, surface coating testing, and cleaning verification.

Subd. 27. **Safe housing.** "Safe housing" means a residence that is lead-safe.

Subd. 28. **Secondary prevention.** "Secondary prevention" means intervention to mitigate health effects on people with elevated blood lead levels.

Subd. 28a. **Standard.** "Standard" means a quantitative assessment of lead in any environmental media or consumer product.

Subd. 29. **Swab team services.** "Swab team services" means activities that provide protection from lead hazards primarily through the use of interim controls, such as:

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

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

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

(4) health education;

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

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

Subd. 30. **Swab team worker.** "Swab team worker" means an individual who performs swab team services and who has been licensed by the commissioner as a lead worker under section 144.9505.

Subd. 31. **Venous blood sample.** "Venous blood sample" means a quantity of blood drawn from a vein.

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Subd. 32. [Repealed, 2001 c 205 art 1 s 43]

History: *1995 c 213 art 1 s 3; 1997 c 205 s 24,25; 1998 c 407 art 2 s 34-49; 2001 c 205 art 1 s 1-25; 2007 c 147 art 16 s 20; 2009 c 79 art 10 s 8-11; 2015 c 21 art 1 s 109; 2015 c 71 art 8 s 27-31*

NOTE: The commissioner of health found that in order to protect public health, the definition of an "elevated blood lead level," as defined in Minnesota Statutes, section 144.9501, subdivision 9, shall be modified to be a diagnostic blood lead test with a result that is equal to or greater than five micrograms of lead per deciliter of whole blood in any person. Order dated April 16, 2014. 38 SR 1507-1508, May 12, 2014.

144.9502 STATEWIDE LEAD SURVEILLANCE SYSTEM.

Subdivision 1. **Surveillance.** The commissioner of health shall establish a statewide lead surveillance system. The purpose of this system is to:

(1) monitor blood lead levels in children and adults to identify trends and populations at high risk for elevated blood lead levels;

(2) ensure that screening services are provided to populations at high risk for elevated blood lead levels;

(3) ensure that medical and environmental follow-up services for children with elevated blood lead levels are provided; and

(4) provide accurate and complete data for planning and implementing primary prevention programs that focus on the populations at high risk for elevated blood lead levels.

Subd. 2. **Studies and surveys.** The commissioner of health shall collect blood lead level and exposure information, analyze the information, and conduct studies designed to determine the potential for high risk for elevated blood lead levels among children and adults.

Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic, medical laboratory, other facility, or individual performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission, with written or electronic confirmation within one month, for a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission, for any capillary result or for a venous blood lead level less than 15 micrograms of lead per deciliter of whole blood.

(b) If a blood lead analysis is performed outside of Minnesota and the facility performing the analysis does not report the blood lead analysis results and epidemiological information required in this section to the commissioner, the provider who collected the blood specimen must satisfy the reporting requirements of this section. For purposes of this section, "provider" has the meaning given in section 62D.02, subdivision 9.

(c) The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

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Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis reports required in this section must specify:

(1) whether the specimen was collected as a capillary or venous sample;

(2) the date the sample was collected;

(3) the results of the blood lead analysis;

(4) the date the sample was analyzed;

(5) the method of analysis used;

(6) the full name, address, and phone number of the laboratory performing the analysis;

(7) the full name, address, and phone number of the physician or facility requesting the analysis;

(8) the full name, address, and phone number of the person with the blood lead level, and the person's birthdate, gender, and race.

Subd. 5. **Follow-up epidemiologic information.** The follow-up epidemiologic information required in this section must specify:

(1) the name, address, and phone number of the agency or individual contacted to investigate the environment of the person with the elevated blood lead level to determine the sources of lead exposure; and

(2) the name, address, and phone number of all agencies or individuals to whom the person or the person's guardian was referred for education about the sources, effects, and prevention of lead exposure.

Subd. 6. [Repealed, 2001 c 205 art 1 s 43]

Subd. 7. **Reporting without liability.** The furnishing of the information required under this section shall not subject the person, laboratory, or other facility furnishing the information to any action for damages or relief.

Subd. 8. **Laboratory standards.** (a) A laboratory performing blood lead analysis shall use methods that:

(1) meet or exceed the proficiency standards established in the federal Clinical Laboratory Improvement Regulations, Code of Federal Regulations, title 42, section 493, promulgated in accordance with the Clinical Laboratory Improvement Act amendments of 1988, Public Law 100-578; or

(2) meet or exceed the Occupational Safety and Health Standards for Lead in General Industries, Code of Federal Regulations, section 1910.1025, and Occupational Safety and Health Standards for Lead in Construction, Code of Federal Regulations, section 1926.62.

(b) A laboratory performing lead analysis of paint, soil, or dust must be a laboratory recognized by the United States Environmental Protection Agency under the Toxic Substances Control Act, United States Code, title 15, section 2685, paragraph (b). Analysis of samples of drinking water must be performed by a laboratory certified by the commissioner to analyze lead in water.

Subd. 9. **Classification of data.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected by the commissioner of health about persons with blood lead levels, including analytic results from samples of paint, soil, dust, and drinking water taken from the individual's home and immediate property, shall be private and may only be used by the commissioner of health, the commissioner

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of labor and industry, authorized agents of Indian tribes, and authorized employees of community health boards for the purposes set forth in this section.

History: *1995 c 213 art 1 s 4; 1998 c 407 art 2 s 50-52; 2001 c 205 art 1 s 26; 2015 c 21 art 1 s 109*

144.9503 PRIMARY PREVENTION.

Subdivision 1. **Primary prevention program.** The commissioner shall develop and maintain a primary prevention program to reduce lead exposure in young children and pregnant women. A community health board serving a city of the first class shall determine areas at high risk for toxic lead exposure before doing primary prevention lead hazard reduction activities. The program shall provide primary prevention lead education materials, promote primary prevention swab team services, provide lead cleanup equipment and material grants as funding allows, monitor regulated lead work, and develop and maintain lead-safe practices in cooperation with the commissioner of administration.

Subd. 2. **Priorities for primary prevention.** (a) The commissioner of health and community health boards serving cities of the first class shall determine areas at high risk for toxic lead exposure.

(b) A community health board serving a city of the first class shall rank order census tracts by awarding points as specified in this paragraph. The priority for primary prevention in census tracts at high risk for toxic lead exposure shall be based on the cumulative points awarded to each census tract. A greater number of points means a higher priority.

(1) One point may be awarded to a census tract for each ten percent of children who were under six years old at the time they were screened for lead in blood and whose blood lead level exceeds ten micrograms of lead per deciliter of whole blood, provided the commissioner has determined that the data used to award the points are comprehensive and representative.

(2) One point may be awarded for every five percent of housing that is defined as dilapidated or deteriorated by the planning department or similar agency of the city in which the housing is located. Where data is available by neighborhood or section within a city, the percent of dilapidated or deteriorated housing shall apply equally to each census tract within the neighborhood or section.

(3) One point may be awarded for every 100 parts per million of lead in soil, based on the median soil lead values of foundation soil samples, calculated on 100 parts per million intervals, or fraction thereof. A community health board shall use data from its own soil survey conducted according to rules adopted under section 144.9508, except that a community health board serving Minneapolis or St. Paul that has not conducted its own soil survey shall use the June 1988 census tract version of the houseside map titled "Distribution of Houseside Lead Content of Soil-Dust in the Twin Cities," prepared by the Center for Urban and Regional Affairs, Humphrey Institute, University of Minnesota, Publication 1989, Center for Urban and Regional Affairs 89-4. Where the map displays a census tract that is crossed by two or more intervals, the community health board shall make a reasoned determination of the median foundation soil lead value for that census tract.

(4) A community health board may award one point to each census tract for each of the following factors based on cutoff criteria to be determined by the community health board:

(i) percent of minority population;

(ii) number of children less than six years of age;

(iii) percent of housing built before 1950; and

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(iv) percent of population living in poverty.

(c) The commissioner may determine areas at high risk for toxic lead exposure at the county level or within a county outside a city of the first class using one or more of the following criteria:

(1) blood lead levels greater than ten micrograms per deciliter of whole blood in children under six years of age;

(2) percent of dilapidated or deteriorated housing;

(3) soil lead levels in excess of 100 parts per million;

(4) percent of minority population;

(5) percent of housing built before 1950;

(6) percent of children living in poverty; or

(7) other factors appropriate in preventing lead exposure, as determined by a federal agency including the United States Centers for Disease Control and Prevention, the United States Environmental Protection Agency, or the United States Department of Housing and Urban Development.

Subd. 3. **Primary prevention lead education strategy.** The commissioner of health shall develop and maintain a primary prevention lead education strategy to prevent lead exposure. The strategy includes:

(1) lead education materials that describe the health effects of lead exposure, safety measures, and methods to be used in the lead hazard reduction process;

(2) providing lead education materials to the general public;

(3) providing lead education materials to property owners, landlords, and tenants by swab team workers and public health professionals, such as nurses, sanitarians, health educators, nonprofit organizations working on lead issues, and other public health professionals in areas at high risk for toxic lead exposure; and

(4) promoting awareness of community, legal, and housing resources.

Subd. 4. **Swab team services.** Primary prevention may include the use of swab team services. The swab team services may be provided based on lead hazard screens whenever possible and must at least include lead hazard reduction for deteriorated interior lead-based paint, bare soil, and dust.

Subd. 5. [Repealed, 1998 c 407 art 2 s 109]

Subd. 6. [Repealed, 2001 c 205 art 1 s 27,43]

Subd. 7. **Lead-safe practices information.** The commissioner shall develop and maintain in cooperation with the commissioner of administration provisions and procedures to define lead-safe practices information for residential remodeling, renovation, installation, and rehabilitation activities that are not lead hazard reduction, but may disrupt lead-based paint surfaces and guidance documents for the regulated industry.

Subd. 8. [Repealed, 1998 c 407 art 2 s 109]

Subd. 9. [Repealed, 1998 c 407 art 2 s 109]

History: *1995 c 213 art 1 s 5; 1996 c 451 art 4 s 14-16; 1998 c 407 art 2 s 53-55; 2001 c 205 art 1 s 27; 2004 c 206 s 28; 2015 c 21 art 1 s 109*

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144.9504 SECONDARY PREVENTION.

Subdivision 1. **Jurisdiction.** (a) A community health board serving cities of the first class must conduct lead risk assessments for purposes of secondary prevention, according to the provisions of this section. A board of health not serving cities of the first class must conduct lead risk assessments for the purposes of secondary prevention, unless they certified in writing to the commissioner by January 1, 1996, that they desired to relinquish these duties back to the commissioner. At the discretion of the commissioner, a community health board may, upon written request to the commissioner, resume these duties.

(b) Lead risk assessments must be conducted by a community health board serving a city of the first class. The commissioner must conduct lead risk assessments in any area not including cities of the first class where a community health board has relinquished to the commissioner the responsibility for lead risk assessments. The commissioner shall coordinate with the community health board to ensure that the requirements of this section are met.

(c) The commissioner may assist community health boards by providing technical expertise, equipment, and personnel to community health boards. The commissioner may provide laboratory or field lead-testing equipment to a community health board or may reimburse a community health board for direct costs associated with lead risk assessments.

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,

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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.

Subd. 3. **Lead education strategy.** At the time of a lead risk assessment or following a lead order, the assessing agency shall ensure that a family will receive a visit at their residence by a swab team worker or public health professional, such as a nurse, sanitarian, public health educator, or other public health professional. The swab team worker or public health professional shall inform the property owner, landlord, and the tenant of the health-related aspects of lead exposure; nutrition; safety measures to minimize exposure; methods to be followed before, during, and after the lead hazard reduction process; and community, legal, and housing resources. If a family moves to a temporary residence during the lead hazard reduction process, lead education services should be provided at the temporary residence whenever feasible.

Subd. 4. [Repealed, 2001 c 205 art 1 s 43]

Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment, shall order a property owner to perform lead hazard reduction on all lead sources that exceed a standard adopted according to section 144.9508. If lead risk assessments and lead orders are conducted at times when weather or soil conditions do not permit the lead risk assessment or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow.

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(b) If the paint standard under section 144.9508 is violated, but the paint is intact, the assessing agency shall not order the paint to be removed unless the intact paint is a known source of actual lead exposure to a specific person. Before the assessing agency may order the intact paint to be removed, a reasonable effort must be made to protect the child and preserve the intact paint by the use of guards or other protective devices and methods.

(c) Whenever windows and doors or other components covered with deteriorated lead-based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping or planed down to remove deteriorated lead-based paint, or covered with protective guards instead of being replaced, provided that such an activity is the least cost method. However, a property owner who has been ordered to perform lead hazard reduction may choose any method to address deteriorated lead-based paint on windows, doors, or other components, provided that the method is approved in rules adopted under section 144.9508 and that it is appropriate to the specific property.

(d) Lead orders must require that any source of damage, such as leaking roofs, plumbing, and windows, be repaired or replaced, as needed, to prevent damage to lead-containing interior surfaces.

(e) The assessing agency is not required to pay for lead hazard reduction. The assessing agency shall enforce the lead orders issued to a property owner under this section.

Subd. 6. **Swab team services.** After a lead risk assessment or after issuing lead orders, the assessing agency, within the limits of appropriations and availability, shall offer the property owner the services of a swab team free of charge and, if accepted, shall send a swab team within ten working days to the residence to perform swab team services as defined in section 144.9501. If the assessing agency provides swab team services after a lead risk assessment, but before the issuance of a lead order, swab team services do not need to be repeated after the issuance of the lead order if the swab team services fulfilled the lead order. Swab team services are not considered completed until the clearance inspection required under this section shows that the property is lead safe.

Subd. 7. **Relocation of residents.** (a) Within the limits of appropriations, the assessing agency shall ensure that residents are relocated from rooms or dwellings during a lead hazard reduction process that generates leaded dust, such as removal or disruption of lead-based paint or plaster that contains lead. Residents shall not remain in rooms or dwellings where the lead hazard reduction process is occurring. An assessing agency is not required to pay for relocation unless state or federal funding is available for this purpose. The assessing agency shall make an effort to assist the resident in locating resources that will provide assistance with relocation costs. Residents shall be allowed to return to the room or dwelling after completion of the lead hazard reduction process. An assessing agency shall use grant funds under section 144.9507 if available, in cooperation with local housing agencies, to pay for moving costs and rent for a temporary residence for any low-income resident temporarily relocated during lead hazard reduction. For purposes of this section, "low-income resident" means any resident whose gross household income is at or below 185 percent of federal poverty level.

(b) A resident of rental property who is notified by an assessing agency to vacate the premises during lead hazard reduction, notwithstanding any rental agreement or lease provisions:

(1) shall not be required to pay rent due the landlord for the period of time the tenant vacates the premises due to lead hazard reduction;

(2) may elect to immediately terminate the tenancy effective on the date the tenant vacates the premises due to lead hazard reduction; and

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(3) shall not, if the tenancy is terminated, be liable for any further rent or other charges due under the terms of the tenancy.

(c) A landlord of rental property whose tenants vacate the premises during lead hazard reduction shall:

(1) allow a tenant to return to the dwelling unit after lead hazard reduction and clearance inspection, required under this section, is completed, unless the tenant has elected to terminate the tenancy as provided for in paragraph (b); and

(2) return any security deposit due under section 504B.178 within five days of the date the tenant vacates the unit, to any tenant who terminates tenancy as provided for in paragraph (b).

Subd. 8. **Property owner notification responsibility.** If the property owner does not hire a person licensed by the commissioner under section 144.9505 for compliance with the lead orders, the property owner shall submit a notice as to when regulated lead work will begin, according to section 144.9505, subdivision 4, to the assessing agency within 30 days after receiving the orders.

Subd. 9. **Clearance inspection.** After completion of swab team services and compliance with the lead orders by the property owner, including any repairs ordered by a local housing or building inspector, the assessing agency shall conduct a clearance inspection by visual identification of deteriorated paint and bare soil and retest the dust lead concentration in the residence to assure that violations of the lead standards under section 144.9508 no longer exist. The assessing agency is not required to test a dwelling unit after lead hazard reduction that was not ordered by the assessing agency.

Subd. 10. **Case closure.** A lead risk assessment is completed and the responsibility of the assessing agency ends when all of the following conditions are met:

(1) lead orders are written on all known sources of violations of lead standards under section 144.9508;

(2) compliance with all lead orders has been completed; and

(3) clearance inspections demonstrate that no deteriorated lead paint, bare soil, or lead dust levels exist that exceed the standards adopted under section 144.9508.

Subd. 11. [Repealed, 2001 c 205 art 1 s 43]

Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner must revise clinical and case management guidelines to include recommendations for protective health actions and follow-up services when a child's blood lead level exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be implemented to the extent possible using available resources.

(b) In revising the clinical and case management guidelines for blood lead levels greater than five micrograms of lead per deciliter of blood under this subdivision, the commissioner of health must consult with a statewide organization representing physicians, the public health department of Minneapolis and other public health departments, one representative of the residential construction industry, and a nonprofit organization with expertise in lead abatement.

History: *1995 c 213 art 1 s 6; 1996 c 451 art 4 s 17-19; 1997 c 205 s 26; 1997 c 228 s 12; 1998 c 407 art 2 s 56-65; 1999 c 199 art 2 s 3; 2001 c 205 art 1 s 28-32; 1Sp2005 c 4 art 6 s 32; 2007 c 147 art 16 s 20; 1Sp2010 c 1 art 20 s 16; 2015 c 21 art 1 s 109*

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144.9505 CREDENTIALING OF LEAD FIRMS AND PROFESSIONALS.

Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this section shall be deposited into the state treasury and credited to the state government special revenue fund.

(b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers, renovation firms, or lead firms unless they have licenses or certificates issued by the commissioner under this section.

(c) The fees required in this section for inspectors, risk assessors, and certified lead firms are waived for state or local government employees performing services for or as an assessing agency.

(d) An individual who is the owner of property on which regulated lead work is to be performed or an adult individual who is related to the property owner, as defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and pay a fee according to this section.

(e) A person that employs individuals to perform regulated lead work outside of the person's property must obtain certification as a certified lead firm. An individual who performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments, clearance inspections, lead project designer services, lead sampling technician services, swab team services, and activities performed to comply with lead orders must be employed by a certified lead firm, unless the individual is a sole proprietor and does not employ any other individuals, the individual is employed by a person that does not perform regulated lead work outside of the person's property, or the individual is employed by an assessing agency.

Subd. 1a. **Lead worker license.** Before an individual performs regulated lead work as a worker, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of successfully completing a training course in lead hazard control. The commissioner shall specify the course of training and testing requirements and shall charge a $50 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1b. **Lead supervisor license.** Before an individual performs regulated lead work as a supervisor, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead hazard control. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $50 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1c. **Lead inspector license.** Before an individual performs lead inspection services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of successfully completing a training course in lead inspection. The commissioner shall specify the course of training and testing requirements and shall charge a $50 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1d. **Lead risk assessor license.** Before an individual performs lead risk assessor services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual

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shows evidence of experience and successful completion of a training course in lead risk assessment. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $100 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1e. **Lead project designer license.** Before an individual performs lead project designer services, the individual shall first obtain a license from the commissioner. No license shall be issued unless the individual shows evidence of experience and successful completion of a training course in lead project design. The commissioner shall specify the course of training, experience, and testing requirements and shall charge a $100 fee annually for the license. License fees are nonrefundable and must be submitted with each application. The license must be carried by the individual and be readily available for review by the commissioner and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1f. [Repealed by amendment, 2015 c 71 art 8 s 32]

Subd. 1g. **Certified lead firm.** A person who employs individuals to perform regulated lead work, with the exception of renovation, outside of the person's property must obtain certification as a lead firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A lead firm certificate is valid for one year. The certification fee is $100, is nonrefundable, and must be submitted with each application. The lead firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1h. **Certified renovation firm.** A person who employs individuals to perform renovation activities outside of the person's property must obtain certification as a renovation firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A renovation firm certificate is valid for two years. The certification fee is $100, is nonrefundable, and must be submitted with each application. The renovation firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Subd. 1i. **Lead training course.** Before a person provides training to lead workers, lead supervisors, lead inspectors, lead risk assessors, lead project designers, lead sampling technicians, and lead renovators, the person shall first obtain a permit from the commissioner. The permit must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A training course permit is valid for two years. Training course permit fees shall be nonrefundable and must be submitted with each application in the amount of $500 for an initial training course, $250 for renewal of a permit for an initial training course, $250 for a refresher training course, and $125 for renewal of a permit of a refresher training course.

Subd. 2. [Repealed, 2001 c 205 art 1 s 33,43]

Subd. 3. **Licensed building contractor; information.** The commissioner shall provide health and safety information on lead abatement and lead hazard reduction to all residential building contractors licensed under section 326B.805. The information must include the lead-safe practices and any other materials describing ways to protect the health and safety of both employees and residents.

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Subd. 4. **Notice of regulated lead work.** (a) At least five working days before starting work at each regulated lead worksite, the person performing the regulated lead work shall give written notice to the commissioner and the appropriate community health board.

(b) This provision does not apply to lead hazard screen, lead inspection, lead risk assessment, lead sampling technician, renovation, or lead project design activities.

Subd. 5. [Repealed, 2001 c 205 art 1 s 33,43]

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: *1995 c 213 art 1 s 7; 1996 c 451 art 4 s 20; 1998 c 407 art 2 s 66-68; 2001 c 205 art 1 s 33; 2007 c 140 art 8 s 30; art 13 s 4; 2007 c 147 art 16 s 20; 2009 c 79 art 10 s 12,13; 2015 c 21 art 1 s 109; 2015 c 71 art 8 s 32*

144.9506 [Repealed, 2001 c 205 art 1 s 43]

144.9507 LEAD-RELATED FUNDING.

Subdivision 1. **Lead education strategy contracts.** The commissioner shall, within available federal or state appropriations, contract with:

(1) community health boards to provide funds for lead education as provided for in sections 144.9503 and 144.9504; and

(2) swab team workers and community-based advocacy groups to provide funds for lead education for primary prevention of toxic lead exposure in areas at high risk for toxic lead exposure.

Subd. 2. **Lead risk assessment contracts.** The commissioner shall, within available federal or state appropriations, contract with community health boards to conduct lead risk assessments to determine sources of lead contamination and to issue and enforce lead orders according to section 144.9504.

Subd. 3. **Temporary lead-safe housing contracts.** The commissioner shall, within the limits of available appropriations, contract with community health boards for temporary housing, to be used in meeting relocation requirements in section 144.9504, and award grants to community health boards for the purposes of paying housing and relocation costs under section 144.9504. The commissioner may use up to 15 percent of the available appropriations to provide temporary lead-safe housing in areas of the state in which the commissioner has the duty under section 144.9504 to perform secondary prevention.

Subd. 4. [Repealed, 1999 c 245 art 2 s 45]

Subd. 5. **Federal lead-related funds.** To the extent practicable under federal guidelines, the commissioner of health may use federal funding to contract with community health boards for purposes specified in this section, but only to the extent that the federal funds do not replace existing funding for these lead services.

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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: *1995 c 213 art 1 s 9; 1998 c 407 art 2 s 71-73; 2001 c 205 art 1 s 34; 2007 c 147 art 16 s 8; 2015 c 21 art 1 s 109*

144.9508 RULES.

Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule, methods for:

(1) lead inspections, lead hazard screens, lead risk assessments, and clearance inspections;

(2) environmental surveys of lead in paint, soil, dust, and drinking water to determine areas at high risk for toxic lead exposure;

(3) soil sampling for soil used as replacement soil;

(4) drinking water sampling, which shall be done in accordance with lab certification requirements and analytical techniques specified by Code of Federal Regulations, title 40, section 141.89; and

(5) sampling to determine whether at least 25 percent of the soil samples collected from a census tract within a standard metropolitan statistical area contain lead in concentrations that exceed 100 parts per million.

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.

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(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.

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property where a child or pregnant female resides is conducted in a manner that protects health and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

Subd. 2a. **Lead standards for exterior surfaces and street dust.** The commissioner may, by rule, establish lead standards for exterior horizontal surfaces, concrete or other impervious surfaces, and street dust on residential property to protect the public health and the environment.

Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license lead supervisors, lead workers, lead project designers, lead inspectors, lead risk assessors, and lead sampling technicians. The commissioner shall also adopt rules requiring certification of firms that perform regulated lead work. The commissioner shall require periodic renewal of licenses and certificates and shall establish the renewal periods.

Subd. 4. **Lead training course.** The commissioner shall establish by rule requirements for training course providers and the renewal period for each lead-related training course required for certification or licensure. The commissioner shall establish criteria in rules for the content and presentation of training courses intended to qualify trainees for licensure under subdivision 3. The commissioner shall establish criteria in rules for the content and presentation of training courses for lead renovation and lead sampling technicians.

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Subd. 5. **Variances.** In adopting the rules required under this section, the commissioner shall provide variance procedures for any provision in rules adopted under this section, except for the numerical standards for the concentrations of lead in paint, dust, bare soil, and drinking water. A variance shall be considered only according to the procedures and criteria in Minnesota Rules, parts 4717.7000 to 4717.7050.

Subd. 6. [Repealed, 2001 c 205 art 1 s 43]

History: *1995 c 213 art 1 s 10; 1998 c 407 art 2 s 74-77; 2001 c 205 art 1 s 35-39; 2007 c 147 art 16 s 20; 2009 c 79 art 10 s 14-16; 2015 c 71 art 8 s 33*

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. Community health boards 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.

Subd. 3. **Enforcement and status report.** The commissioner shall examine compliance with Minnesota's existing lead standards and rules and report to the legislature biennially, beginning February 15, 1997, including an evaluation of current lead program activities by the state and community health boards, the need for any additional enforcement procedures, recommendations on developing a method to enforce compliance with lead standards, and cost estimates for any proposed enforcement procedure. The report shall also include a summary of lead surveillance data collected by the commissioner.

History: *1995 c 213 art 1 s 11; 1998 c 407 art 2 s 78; 2001 c 205 art 1 s 40,41; 2007 c 147 art 16 s 20; 2015 c 21 art 1 s 109*

144.951 [Repealed, 1976 c 173 s 64]

144.9511 [Repealed, 1999 c 245 art 2 s 45]

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 nonprofit organizations to train workers to provide lead screening, education, outreach, and swab team services for residential property. Projects that provide Americorps funding or positions, or leverage matching funds, as part of the delivery of the services must be given priority for the grant funds.

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:

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(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 ensure 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 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: *1Sp1995 c 3 art 16 s 13; 1998 c 273 s 10; 1999 c 86 art 1 s 30; 2001 c 79 s 1; 2002 c 379 art 1 s 41; 2003 c 130 s 12; 2004 c 206 s 27,52; 2005 c 98 art 1 s 24; 1Sp2005 c 5 art 8 s 1-4, 7; 2007 c 147 art 16 s 9; 2009 c 79 art 10 s 17*

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HEALTHY HOUSING PROGRAMS

144.9513 HEALTHY HOUSING GRANTS.

Subdivision 1. **Definitions.** For purposes of this section and sections 144.9501 to 144.9512, the following terms have the meanings given.

(a) "Housing" means a room or group of rooms located within a dwelling forming a single habitable unit with facilities used or intended to be used for living, sleeping, cooking, and eating.

(b) "Healthy housing" means housing that is sited, designed, built, renovated, and maintained in ways that supports the health of residents.

(c) "Housing-based health threat" means a chemical, biologic, or physical agent in the immediate housing environment, including toxic lead, mold, radon, and indoor allergens and contaminants in carpets, which constitutes a potential or actual hazard to human health at acute or chronic exposure levels.

(d) "Primary prevention" means preventing exposure to housing-based health threats before seeing clinical symptoms or a diagnosis.

(e) "Secondary prevention" means intervention to mitigate health effects on people with housing-based health threats.

Subd. 2. **Grants; administration.** Grant applicants shall submit applications to the commissioner as directed by a request for proposals. Grants must be competitively awarded and recipients of a grant under this section must prepare and submit a quarterly progress report to the commissioner beginning three months after receipt of the grant. The commissioner shall provide technical assistance and program support as needed to ensure that housing-based health threats are effectively identified, mitigated, and evaluated by grantees.

Subd. 3. **Healthy housing and implementation grants; eligible activities.** (a) Within the limits of available appropriations, the commissioner shall make grants to support implementation of healthy housing programs to community health boards, community action agencies under section 256E.31, and nonprofit organizations with expertise in providing outreach, education, and training on healthy housing subjects and in providing comprehensive healthy housing assessments and interventions.

(b) The grantee may conduct the following activities:

(1) implement and maintain primary prevention programs to reduce housing-based health threats that include the following:

(i) providing education materials to the general public and to property owners, contractors, code officials, health care providers, public health professionals, health educators, nonprofit organizations, and other persons and organizations engaged in housing and health issues;

(ii) promoting awareness of community, legal, and housing resources; and

(iii) promoting the use of hazard reduction measures in new housing construction and housing rehabilitation programs;

(2) provide training on identifying and addressing housing-based health threats;

(3) provide technical assistance on the implementation of mitigation measures;

(4) promote adoption of evidence-based best practices for mitigation of housing-based health threats;

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(5) develop work practices for addressing specific housing-based health threats;

(6) identify, characterize, and mitigate hazards in housing that contribute to adverse health outcomes;

(7) ensure screening services and other secondary prevention measures are provided to populations at high risk for housing-related health threats;

(8) promote compliance with Department of Health guidelines and other best practices, as identified by the commissioner, for preventing or reducing housing-based health threats;

(9) establish local or regional collaborative groups to ensure that resources for addressing housing-based health threats are coordinated; or

(10) develop model programs for addressing housing-based health threats.

History: *2014 c 312 art 23 s 4; 2015 c 21 art 1 s 109*

144.952 Subdivision 1. [Repealed, 1977 c 347 s 23]

Subd. 2. [Repealed, 1976 c 173 s 64]

Subd. 3. [Repealed, 1977 c 347 s 23]

144.953 [Repealed, 1976 c 173 s 64]

144.954 [Repealed, 1976 c 173 s 64]

144.955 [Repealed, 1976 c 173 s 64]

144.9555 [Repealed, 1976 c 173 s 64]

144.956 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

144.957 [Repealed, 1976 c 173 s 64]

144.958 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

144.959 [Repealed, 1976 c 173 s 64]

144.96 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

144.961 [Repealed, 1976 c 173 s 64]

144.962 [Repealed, 1976 c 173 s 64]

144.963 [Repealed, 1976 c 173 s 64]

144.964 [Repealed, 1976 c 173 s 64]

144.965 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

EARLY HEARING DETECTION AND INTERVENTION PROGRAM

144.966 EARLY HEARING DETECTION AND INTERVENTION PROGRAM.

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

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(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;

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(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 Commission of Deaf, DeafBlind and Hard-of-Hearing Minnesotans;

(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) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

(e) This subdivision expires June 30, 2019.

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 election as described under section 144.125, subdivision 4;

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(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. 3a. **Support services to families.** (a) The commissioner shall contract with a nonprofit organization to provide support and assistance to families with children who are deaf or have a hearing loss. The family support provided must include:

(1) direct hearing loss specific parent-to-parent assistance and unbiased information on communication, educational, and medical options; and

(2) individualized deaf or hard-of-hearing mentors who provide education, including instruction in American Sign Language as an available option.

The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state.

(b) Family participation in the support and assistance services is voluntary.

Subd. 4. **Notification and information; data retention and destruction.** (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 and information regarding the right of the parent or legal guardian to discontinue storage of the test results and require destruction under paragraph (d).

(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.

(d) The Department of Health may store hearing screening and rescreening test results for a period of time not to exceed 18 years from the infant's date of birth.

(e) Notwithstanding paragraph (d), a parent or legal guardian may instruct the Department of Health to discontinue storing hearing screening and rescreening test results by providing a signed and dated form

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requesting destruction of the test results. The Department of Health shall make necessary forms available on the department's Web site. If a parent or legal guardian instructs the Department of Health to discontinue storing hearing screening and rescreening test results, the Department of Health shall destroy the test results within one month of receipt of the instruction or within 25 months after it received the last test result, whichever is later.

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.

Subd. 8. **Construction.** Notwithstanding anything to the contrary, nothing in this section shall be construed as constituting newborn screening activities conducted under sections 144.125 to 144.128. Data collected by or submitted to the Department of Health pursuant to this section is not genetic information for purposes of section 13.386.

History: *2007 c 147 art 16 s 10; 2009 c 79 art 10 s 18; 2009 c 86 art 1 s 18; 2013 c 82 s 13-16; 2013 c 108 art 12 s 34,35*

ACCREDITATION OF ENVIRONMENTAL LABORATORIES

144.97 DEFINITIONS.

Subdivision 1. **Scope.** The definitions in this section apply to section 144.98.

Subd. 2. **Accreditation.** "Accreditation" means written acknowledgment that a laboratory has the policies, procedures, equipment, and practices to produce reliable data in the analysis of environmental samples.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Commercial laboratory.** "Commercial laboratory" means a laboratory that performs tests on samples on a contract or fee-for-service basis.

Subd. 5. **Environmental sample.** "Environmental sample" means a substance derived from a nonhuman source and collected for the purpose of analysis.

Subd. 5a. **Field of testing.** "Field of testing" means the combination of analyte, method, matrix, and test category for which a laboratory may hold accreditation.

Subd. 6. **Laboratory.** "Laboratory" means the state, a person, corporation, or other entity, including governmental, that examines, analyzes, or tests samples in a specified physical location.

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Subd. 7. **Sample.** "Sample" means a substance derived from a nonhuman source and collected for the purpose of analysis, or a tissue, blood, excretion, or other bodily fluid specimen obtained from a human for the detection of a chemical, etiologic agent, or histologic abnormality.

Subd. 8. **Test category.** "Test category" means the combination of program and category as provided by section 144.98, subdivisions 3, paragraph (b), clauses (1) to (10), and 3a, paragraph (a), clauses (1) to (5).

History: *1988 c 689 art 2 s 33; 2009 c 79 art 10 s 19-23*

144.98 ACCREDITATION OF ENVIRONMENTAL LABORATORIES.

Subdivision 1. **Authorization.** The commissioner of health shall accredit environmental laboratories according to national standards developed using a consensus process as established by Circular A-119, published by the United States Office of Management and Budget.

Subd. 2. **Rules and standards.** The commissioner may adopt rules to carry out the commissioner's responsibilities under the national standards specified in subdivisions 1 and 2a.

Subd. 2a. **Standards.** Notwithstanding the exemptions in subdivisions 8 and 9, the commissioner shall accredit laboratories according to the most current environmental laboratory accreditation standards under subdivision 1 and as accepted by the accreditation bodies recognized by the National Environmental Laboratory Accreditation Program (NELAP) of the NELAC Institute.

Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must be accompanied by the annual fees specified in this subdivision. The annual fees include:

(1) base accreditation fee, $600;

(2) sample preparation techniques fee, $200 per technique;

(3) an administrative fee for laboratories located outside this state, $2,000; and

(4) test category fees.

(b) For the programs in subdivision 3a, the commissioner may accredit laboratories for fields of testing under the categories listed in clauses (1) to (10) upon completion of the application requirements provided by subdivision 6 and receipt of the fees for each category under each program that accreditation is requested. The categories offered and related fees include:

(1) microbiology, $200;

(2) inorganics, $200;

(3) metals, $500;

(4) volatile organics, $1,000;

(5) other organics, $1,000;

(6) radiochemistry, $750;

(7) emerging contaminants, $1,000;

(8) agricultural contaminants, $1,000;

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(9) toxicity (bioassay), $500; and

(10) physical characterization, $250.

(c) The total annual fee includes the base fee, the sample preparation techniques fees, the test category fees per program, and, when applicable, an administrative fee for out-of-state laboratories.

Subd. 3a. **Available programs, categories, and analytes.** (a) The commissioner shall accredit laboratories that test samples under the following programs:

(1) the clean water program, such as compliance monitoring under the federal Clean Water Act, and ambient monitoring of surface and groundwater, or analysis of biological tissue;

(2) the safe drinking water program, including compliance monitoring under the federal Safe Drinking Water Act, and the state requirements for monitoring private wells;

(3) the resource conservation and recovery program, including federal and state requirements for monitoring solid and hazardous wastes, biological tissue, leachates, and groundwater monitoring wells not intended as drinking water sources;

(4) the underground storage tank program; and

(5) the clean air program, including air and emissions testing under the federal Clean Air Act, and state and federal requirements for vapor intrusion monitoring.

(b) The commissioner shall maintain and publish a list of analytes available for accreditation. The list must be reviewed at least once every six months and the changes published in the State Register and posted on the program's Web site. The commissioner shall publish the notification of changes and review comments on the changes no less than 30 days from the date the list is published.

Subd. 3b. **Additional fees.** (a) Laboratories located outside of this state that require an on-site assessment more frequent than once every two years must pay an additional assessed fee of $3,000 per assessment for each additional on-site assessment conducted. The laboratory must pay the fee within 15 business days of receiving the commissioner's notification that an on-site assessment is required. The commissioner may conduct additional on-site assessments to determine a laboratory's continued compliance with the standards provided in subdivision 2a.

(b) A late fee of $200 shall be added to the annual fee for accredited laboratories submitting renewal applications to the commissioner after November 1.

(c) A change fee shall be assessed if a laboratory requests additional fields of testing at any time other than when initially applying for or renewing its accreditation. A change fee does not apply for applications to add fields of testing for new analytes in response to the published notice under subdivision 3a, paragraph (b), if the laboratory holds valid accreditation for the changed test category and applies for additional analytes within the same test category. The change fee is equal to the applicable test category fee for the field of testing requested. An application that requests accreditation of multiple fields of testing within a test category requires a single payment of the applicable test category fee per application submitted.

(d) A variance fee shall be assessed if a laboratory requests a variance from a standard provided in subdivision 2a. The variance fee is $500 per variance.

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(e) The commissioner shall assess a fee for changes to laboratory information regarding ownership, name, address, or personnel. Laboratories must submit changes through the application process under subdivision 6. The information update fee is $250 per application.

(f) Fees must be set so that the total fees support the laboratory accreditation program. Direct costs of the accreditation service include program administration, assessments, the agency's general support costs, and attorney general costs attributable to the fee function.

Subd. 3c. **Refunds and nonpayment.** Refunds or credits shall not be made for applications received but not approved. Accreditation of a laboratory shall not be awarded until all fees are paid.

Subd. 4. **Fees for laboratory proficiency testing and technical training.** The commissioner of health may set fees for proficiency testing and technical training services under section 16A.1285. Fees must be set so that the total fees cover the direct costs of the proficiency testing and technical training services, including salaries, supplies and equipment, travel expenses, and attorney general costs attributable to the fee function.

Subd. 5. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 6. **Application.** (a) Laboratories seeking accreditation must apply on a form provided by the commissioner, include the laboratory's procedures and quality manual, and pay the applicable fees.

(b) Laboratories may be fixed-base or mobile. The commissioner shall accredit mobile laboratories individually and require a vehicle identification number, license plate number, or other uniquely identifying information in addition to the application requirements of paragraph (a).

(c) Laboratories maintained on separate properties, even though operated under the same management or ownership, must apply separately. Laboratories with more than one building on the same or adjoining properties do not need to submit a separate application.

(d) The commissioner may accredit laboratories located out of state. Accreditation for out-of-state laboratories may be obtained directly from the commissioner following the requirements in paragraph (a), or out-of-state laboratories may be accredited through a reciprocal agreement if the laboratory:

(1) is accredited by a NELAP-recognized accreditation body for those fields of testing in which the laboratory requests accreditation from the commissioner;

(2) submits an application and documentation according to this subdivision; and

(3) submits a current copy of the laboratory's unexpired accreditation from a NELAP-recognized accreditation body showing the fields of accreditation for which the laboratory is currently accredited.

(e) Under the conflict of interest determinations provided in section 43A.38, subdivision 6, clause (1), the commissioner shall not accredit governmental laboratories operated by agencies of the executive branch of the state. If accreditation is required, laboratories operated by agencies of the executive branch of the state must apply for accreditation through any other NELAP-recognized accreditation body.

Subd. 6a. **Implementation and effective date.** All laboratories must comply with standards under this section by July 1, 2009. Fees under subdivisions 3 and 3b apply to applications received and accreditations issued after June 30, 2009. Accreditations issued on or before June 30, 2009, shall expire upon their current expiration date.

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Subd. 7. **Initial accreditation and annual accreditation renewal.** (a) The commissioner shall issue or renew accreditation after receipt of the completed application and documentation required in this section, provided the laboratory maintains compliance with the standards specified in subdivision 2a, notwithstanding any exemptions under subdivisions 8 and 9, and attests to the compliance on the application form.

(b) The commissioner shall prorate the fees in subdivision 3 for laboratories applying for accreditation after December 31. The fees are prorated on a quarterly basis beginning with the quarter in which the commissioner receives the completed application from the laboratory.

(c) Applications for renewal of accreditation must be received by November 1 and no earlier than October 1 of each year. The commissioner shall send annual renewal notices to laboratories 90 days before expiration. Failure to receive a renewal notice does not exempt laboratories from meeting the annual November 1 renewal date.

(d) The commissioner shall issue all accreditations for the calendar year for which the application is made, and the accreditation shall expire on December 31 of that year.

(e) The accreditation of any laboratory that fails to submit a renewal application and fees to the commissioner expires automatically on December 31 without notice or further proceeding. Any person who operates a laboratory as accredited after expiration of accreditation or without having submitted an application and paid the fees is in violation of the provisions of this section and is subject to enforcement action under sections 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired accreditation may reapply under subdivision 6.

Subd. 8. **Exemption from national standards for quality control and personnel requirements.** Effective January 1, 2012, a laboratory that analyzes samples for compliance with a permit issued under section 115.03, subdivision 5, may request exemption from the personnel requirements and specific quality control provisions for microbiology and chemistry stated in the national standards as incorporated by reference in subdivision 2a. The commissioner shall grant the exemption if the laboratory:

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

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

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

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

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

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

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

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

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

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

Subd. 10. **Establishing a selection committee.** (a) The commissioner shall establish a selection committee for the purpose of recommending approval of qualified laboratory assessors and assessment bodies. Committee members shall demonstrate competence in assessment practices. The committee shall initially consist of seven members appointed by the commissioner as follows:

(1) one member from a municipal laboratory accredited by the commissioner;

(2) one member from an industrial treatment laboratory accredited by the commissioner;

(3) one member from a commercial laboratory located in this state and accredited by the commissioner;

(4) one member from a commercial laboratory located outside the state and accredited by the commissioner;

(5) one member from a nongovernmental client of environmental laboratories;

(6) one member from a professional organization with a demonstrated interest in environmental laboratory data and accreditation; and

(7) one employee of the laboratory accreditation program administered by the department.

(b) Committee appointments begin on January 1 and end on December 31 of the same year.

(c) The commissioner shall appoint persons to fill vacant committee positions, expand the total number of appointed positions, or change the designated positions upon the advice of the committee.

(d) The commissioner shall rescind the appointment of a selection committee member for sufficient cause as the commissioner determines, such as:

(1) neglect of duty;

(2) failure to notify the commissioner of a real or perceived conflict of interest;

(3) nonconformance with committee procedures;

(4) failure to demonstrate competence in assessment practices; or

(5) official misconduct.

(e) Members of the selection committee shall be compensated according to the provisions in section 15.059, subdivision 3.

(f) The selection committee expires June 30, 2018.

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Subd. 11. **Activities of the selection committee.** (a) The selection committee shall determine assessor and assessment organization application requirements, the frequency of application submittal, and the application review schedule. The commissioner shall publish the application requirements and procedures on the accreditation program Web site.

(b) In its selection process, the committee shall ensure its application requirements and review process:

(1) meet the standards implemented in subdivision 2a;

(2) ensure assessors have demonstrated competence in technical disciplines offered for accreditation by the commissioner; and

(3) consider any history of repeated nonconformance or complaints regarding assessors or assessment bodies.

(c) The selection committee shall consider an application received from qualified applicants and shall supply a list of recommended assessors and assessment bodies to the commissioner of health no later than 90 days after the commissioner notifies the committee of the need for review of applications.

Subd. 12. **Commissioner approval of assessors and scheduling of assessments.** (a) The commissioner shall approve assessors who:

(1) are employed by the commissioner for the purpose of accrediting laboratories and demonstrate competence in assessment practices for environmental laboratories; or

(2) are employed by a state or federal agency with established agreements for mutual assistance or recognition with the commissioner and demonstrate competence in assessment practices for environmental laboratories.

(b) The commissioner may approve other assessors or assessment organizations who are recommended by the selection committee according to subdivision 11, paragraph (c). The commissioner shall publish the list of assessors and assessment organizations approved from the recommendations.

(c) The commissioner shall rescind approval for an assessor or assessment organization for sufficient cause as the commissioner determines, such as:

(1) failure to meet the minimum qualifications for performing assessments;

(2) lack of availability;

(3) nonconformance with the applicable laws, rules, standards, policies, and procedures;

(4) misrepresentation of application information regarding qualifications and training; or

(5) excessive cost to perform the assessment activities.

Subd. 13. **Laboratory requirements for assessor selection and scheduling assessments.** (a) A laboratory accredited or seeking accreditation that requires an assessment by the commissioner must select an assessor, group of assessors, or assessment organization from the published list specified in subdivision 12, paragraph (b). An accredited laboratory must complete an assessment and make all corrective actions at least once every 24 months. Unless the commissioner grants interim accreditation, a laboratory seeking accreditation must complete an assessment and make all corrective actions prior to, but no earlier than, 18 months prior to the date the application is submitted to the commissioner.

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(b) A laboratory shall not select the same assessor more than twice in succession for assessments of the same facility unless the laboratory receives written approval from the commissioner for the selection. The laboratory must supply a written request to the commissioner for approval and must justify the reason for the request and provide the alternate options considered.

(c) A laboratory must select assessors appropriate to the size and scope of the laboratory's application or existing accreditation.

(d) A laboratory must enter into its own contract for direct payment of the assessors or assessment organization. The contract must authorize the assessor, assessment organization, or subcontractors to release all records to the commissioner regarding the assessment activity when the assessment is performed in compliance with this section.

(e) A laboratory must agree to permit other assessors as selected by the commissioner to participate in the assessment activities.

(f) If the laboratory determines no approved assessor is available to perform the assessment, the laboratory must notify the commissioner in writing and provide a justification for the determination. If the commissioner confirms no approved assessor is available, the commissioner may designate an alternate assessor from those approved in subdivision 12, paragraph (a), or the commissioner may delay the assessment until an assessor is available. If an approved alternate assessor performs the assessment, the commissioner may collect fees equivalent to the cost of performing the assessment activities.

(g) Fees collected under this section are deposited in a special account and are annually appropriated to the commissioner for the purpose of performing assessment activities.

History: *1988 c 689 art 2 s 34; 1Sp1993 c 1 art 9 s 52; 1995 c 165 s 4; 1995 c 233 art 2 s 50; 1996 c 305 art 3 s 21; 1999 c 250 art 3 s 21; 1Sp2001 c 9 art 1 s 38; 2002 c 379 art 1 s 113; 1Sp2005 c 4 art 6 s 33; 2009 c 79 art 10 s 24-33; 1Sp2011 c 9 art 2 s 15-18; 2013 c 108 art 12 s 36-41; 2014 c 286 art 7 s 2*

HEALTH ENFORCEMENT CONSOLIDATION ACT OF 1993

144.989 TITLE; CITATION.

Sections 144.989 to 144.993 may be cited as the "Health Enforcement Consolidation Act of 1993."

History: *1993 c 206 s 7*

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; 144.1215; 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; 144.97 to 144.98; 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.

Subd. 2. **Access to information and property.** The commissioner or an employee or agent authorized by the commissioner, upon presentation of credentials, may:

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(1) examine and copy any books, papers, records, memoranda, or data of any person subject to regulation under the statutes listed in subdivision 1; and

(2) enter upon any property, public or private, for the purpose of taking any action authorized under statutes, rules, or other actions listed in subdivision 1 including obtaining information from a person who has a duty to provide information under the statutes listed in subdivision 1, taking steps to remedy violations, or conducting surveys or investigations.

Subd. 3. **Correction orders.** (a) The commissioner may issue correction orders that require a person to correct a violation of the statutes, rules, and other actions listed in subdivision 1. The correction order must state the deficiencies that constitute the violation; the specific statute, rule, or other action; and the time by which the violation must be corrected.

(b) If the person believes that the information contained in the commissioner's correction order is in error, the person may ask the commissioner to reconsider the parts of the order that are alleged to be in error. The request must be in writing, delivered to the commissioner by certified mail within seven calendar days after receipt of the order, and:

(1) specify which parts of the order for corrective action are alleged to be in error;

(2) explain why they are in error; and

(3) provide documentation to support the allegation of error.

The commissioner must respond to requests made under this paragraph within 15 calendar days after receiving a request. A request for reconsideration does not stay the correction order; however, after reviewing the request for reconsideration, the commissioner may provide additional time to comply with the order if necessary. The commissioner's disposition of a request for reconsideration is final.

Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an order requiring violations to be corrected and administratively assessing monetary penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The procedures in section 144.991 must be followed when issuing administrative penalty orders. Except in the case of repeated or serious violations, the penalty assessed in the order must be forgiven if the person who is subject to the order demonstrates in writing to the commissioner before the 31st day after receiving the order that the person has corrected the violation or has developed a corrective plan acceptable to the commissioner. The maximum amount of an administrative penalty order is $10,000 for each violator for all violations by that violator identified in an inspection or review of compliance.

(b) Notwithstanding paragraph (a), the commissioner may issue to a large public water supply, serving a population of more than 10,000 persons, an administrative penalty order imposing a penalty of at least $1,000 per day per violation, not to exceed $10,000 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

(c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead firm or person performing regulated lead work, an administrative penalty order imposing a penalty of at least $5,000 per violation per day, not to exceed $10,000 for each violation of sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from monetary penalties in this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 5. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action for injunctive relief in the district court in Ramsey County or, at the commissioner's discretion,

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in the district court in the county in which a violation of the statutes, rules, or other actions listed in subdivision 1 has occurred to enjoin the violation.

Subd. 6. **Cease and desist.** The commissioner, or an employee of the department designated by the commissioner, may issue an order to cease an activity covered by subdivision 1 if continuation of the activity would result in an immediate risk to public health. An order issued under this paragraph is effective for a maximum of 72 hours. In conjunction with the issuance of the cease and desist order, the commissioner may post a sign to cease an activity until the cease and desist order is lifted and the sign is removed by the commissioner. The commissioner must seek an injunction or take other administrative action authorized by law to restrain activities for a period beyond 72 hours. The issuance of a cease and desist order does not preclude the commissioner from pursuing any other enforcement action available to the commissioner.

Subd. 7. **Plan for use of administrative penalties and cease and desist authority.** The commissioner of health shall prepare a plan for using the administrative penalty and cease and desist authority in this section. The commissioner shall provide a 30-day period for public comment on the plan. The plan must be finalized by December 1, 1993.

Subd. 8. **Denial or refusal to reissue permits, licenses, registrations, or certificates.** (a) The commissioner may deny or refuse to renew an application for a permit, license, registration, or certificate required under the statutes or rules cited in subdivision 1, if the applicant does not meet or fails to maintain the minimum qualifications for holding a permit, license, registration, or certificate or has any unresolved violations related to the activity for which the permit, license, registration, or certificate was issued.

(b) The commissioner may also deny or refuse to renew a permit, license, registration, or certificate required under the statutes or rules cited in subdivision 1 if the applicant has a persistent pattern of violations related to the permit, license, registration, or certificate, or if the applicant submitted false material information to the department in connection with the application.

(c) The commissioner may condition the grant or renewal of a permit, license, registration, or certificate on a demonstration by the applicant that actions needed to ensure compliance with the requirements of the statutes listed in subdivision 1 have been taken, or may place conditions on or issue a limited permit, license, registration, or certificate as a result of previous violations by the applicant.

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

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

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

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

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

Subd. 10. **Contested case hearings; license, certificate, registration.** If the commissioner proposes to deny, refuses to renew, suspends, or revokes a permit, license, registration, or certificate under subdivision 8 or 9, the commissioner must first notify, in writing, the person against whom the action is proposed to be taken and provide the person an opportunity to request a hearing under the contested case provisions of

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chapter 14. If the person does not request a hearing by notifying the commissioner within 20 days after receipt of the notice of proposed action, the commissioner may proceed with the action without a hearing. This subdivision does not apply to:

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

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

Subd. 11. **Misdemeanor penalties.** A person convicted of violating a statute or rule listed in subdivision 1 is guilty of a misdemeanor.

Subd. 12. **Securing radioactive materials.** (a) In the event of an emergency that poses a danger to the public health, the commissioner shall have the authority to impound radioactive materials and the associated shielding in the possession of a person who fails to abide by the provisions of the statutes, rules, and any other item listed in subdivision 1. If impounding the source of these materials is impractical, the commissioner shall have the authority to lock or otherwise secure a facility that contains the source of such materials, but only the portions of the facility as is necessary to protect the public health. An action taken under this paragraph is effective for up to 72 hours. The commissioner must seek an injunction or take other administrative action to secure radioactive materials beyond the initial 72-hour period.

(b) The commissioner may release impounded radioactive materials and the associated shielding to the owner of the radioactive materials and associated shielding, upon terms and conditions that are in accordance with the provisions of statutes, rules, and other items listed in subdivision 1. In the alternative, the commissioner may bring an action in a court of competent jurisdiction for an order directing the disposal of impounded radioactive materials and associated shielding or directing other disposition as necessary to protect the public health and safety and the environment. The costs of decontamination, transportation, burial, disposal, or other disposition shall be borne by the owner or licensee of the radioactive materials and shielding or by any other person who has used the radioactive materials and shielding for business purposes.

History: *1993 c 206 s 8; 1Sp1993 c 6 s 33; 1994 c 465 art 2 s 1; 1995 c 165 s 5-9; 1995 c 180 s 13; 1995 c 213 art 1 s 12; 1997 c 205 s 29,30; 1998 c 261 s 2; 1998 c 407 art 2 s 80; 1999 c 245 art 2 s 28,29; 2007 c 140 art 12 s 4; 2007 c 147 art 16 s 20; 2009 c 79 art 10 s 34; 2013 c 108 art 12 s 42; 1Sp2017 c 6 art 10 s 67*

144.991 ADMINISTRATIVE PENALTY ORDER PROCEDURE.

Subdivision 1. **Amount of penalty; considerations.** (a) In determining the amount of a penalty under section 144.99, subdivision 4, the commissioner may consider:

(1) the willfulness of the violation;

(2) the gravity of the violation, including damage to humans, animals, air, water, land, or other natural resources of the state;

(3) the history of past violations;

(4) the number of violations;

(5) the economic benefit gained by the person by allowing or committing the violation; and

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(6) other factors as justice may require, if the commissioner specifically identifies the additional factors in the commissioner's order.

(b) For a violation after an initial violation, the commissioner shall, in determining the amount of a penalty, consider the factors in paragraph (a) and the:

(1) similarity of the most recent previous violation and the violation to be penalized;

(2) time elapsed since the last violation;

(3) number of previous violations; and

(4) response of the person to the most recent previous violation identified.

Subd. 2. **Contents of order.** An order assessing an administrative penalty under section 144.99, subdivision 4, must include:

(1) a concise statement of the facts alleged to constitute a violation;

(2) a reference to the section of the statute, rule, variance, order, stipulation agreement, or term or condition of a permit that has been violated;

(3) a statement of the amount of the administrative penalty to be imposed and the factors upon which the penalty is based; and

(4) a statement of the person's right to review of the order.

Subd. 3. **Corrective order.** (a) The commissioner may issue an order assessing a penalty and requiring the violations cited in the order to be corrected within 30 calendar days from the date the order is received.

(b) The person to whom the order was issued shall provide information to the commissioner before the 31st day after the order was received demonstrating that the violation has been corrected or that the person has developed a corrective plan acceptable to the commissioner. The commissioner shall determine whether the violation has been corrected and notify the person subject to the order of the commissioner's determination.

Subd. 4. **Penalty.** (a) Except as provided in paragraph (b), if the commissioner determines that the violation has been corrected or the person to whom the order was issued has developed a corrective plan acceptable to the commissioner, the penalty must be forgiven. Unless the person requests review of the order under subdivision 5 before the penalty is due, the penalty in the order is due and payable:

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

(2) on the 20th day after the person receives the commissioner's determination under paragraph (b), if the person subject to the order has provided information to the commissioner that the commissioner determines is not sufficient to show the violation has been corrected or that appropriate steps have been taken toward correcting the violation.

(b) For repeated or serious violations, the commissioner may issue an order with a penalty that will not be forgiven after the corrective action is taken. The penalty is due by 31 days after the order was received unless review of the order under subdivision 5 has been sought.

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(c) Interest at the rate established in section 549.09 begins to accrue on penalties under this subdivision on the 31st day after the order with the penalty was received.

Subd. 5. **Expedited administrative hearing.** (a) Within 30 days after receiving an order or within 20 days after receiving notice that the commissioner has determined that a violation has not been corrected or appropriate steps have not been taken, the person subject to an order under this section may request an expedited hearing, using the procedures of Minnesota Rules, parts 1400.8510 to 1400.8612, to review the commissioner's action. The hearing request must specifically state the reasons for seeking review of the order. The person to whom the order is directed and the commissioner are the parties to the expedited hearing. The commissioner must notify the person to whom the order is directed of the time and place of the hearing at least 15 days before the hearing. The expedited hearing must be held within 30 days after a request for hearing has been filed with the commissioner unless the parties agree to a later date.

(b) All written arguments must be submitted within ten days following the close of the hearing. The hearing shall be conducted under Minnesota Rules, parts 1400.8510 to 1400.8612, as modified by this subdivision. The Office of Administrative Hearings may, in consultation with the agency, adopt rules specifically applicable to cases under this section.

(c) The administrative law judge shall issue a report making recommendations about the commissioner's action to the commissioner within 30 days following the close of the record. The administrative law judge may not recommend a change in the amount of the proposed penalty unless the administrative law judge determines that, based on the factors in subdivision 1, the amount of the penalty is unreasonable.

(d) If the administrative law judge makes a finding that the hearing was requested solely for purposes of delay or that the hearing request was frivolous, the commissioner may add to the amount of the penalty the costs charged to the agency by the Office of Administrative Hearings for the hearing.

(e) If a hearing has been held, the commissioner may not issue a final order until at least five days after receipt of the report of the administrative law judge. The person to whom an order is issued may, within those five days, comment to the commissioner on the recommendations and the commissioner will consider the comments. The final order may be appealed in the manner provided in sections 14.63 to 14.69.

(f) If a hearing has been held and a final order issued by the commissioner, the penalty shall be paid by 30 days after the date the final order is received unless review of the final order is requested under sections 14.63 to 14.69. If review is not requested or the order is reviewed and upheld, the amount due is the penalty, together with interest accruing from 31 days after the original order was received at the rate established in section 549.09.

Subd. 6. **Mediation.** In addition to review under subdivision 5, the commissioner is authorized to enter into mediation concerning an order issued under this section if the commissioner and the person to whom the order is issued both agree to mediation.

Subd. 7. **Enforcement.** (a) The attorney general may proceed on behalf of the state to enforce penalties that are due and payable under this section in any manner provided by law for the collection of debts.

(b) The attorney general may petition the district court to file the administrative order as an order of the court. At any court hearing, the only issues parties may contest are procedural and notice issues. Once entered, the administrative order may be enforced in the same manner as a final judgment of the district court.

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(c) If a person fails to pay the penalty, the attorney general may bring a civil action in district court seeking payment of the penalties, injunctive, or other appropriate relief including monetary damages, attorney fees, costs, and interest.

Subd. 8. **Revocation and suspension of permit, license, registration, or certificate.** If a person fails to pay a penalty owed under this section, the agency has grounds to revoke or refuse to reissue or renew a permit, license, registration, or certificate issued by the department.

Subd. 9. **Cumulative remedy.** The authority of the agency to issue a corrective order assessing penalties is in addition to other remedies available under statutory or common law, except that the state may not seek civil penalties under any other provision of law for the violations covered by the administrative penalty order. The payment of a penalty does not preclude the use of other enforcement provisions, under which penalties are not assessed, in connection with the violation for which the penalty was assessed.

History: *1993 c 206 s 9; 1994 c 465 art 1 s 18,19; 1995 c 165 s 10*

144.992 FALSE INFORMATION.

A person subject to any of the requirements listed in section 144.99, subdivision 1, may not make a false material statement, representation, or certification in; omit material information from; or alter, conceal, or fail to file or maintain a notice, application, record, report, plan, or other document required under the statutes, rules, or other actions listed in section 144.99, subdivision 1.

History: *1993 c 206 s 10*

144.993 RECOVERY OF LITIGATION COSTS AND EXPENSES.

In any judicial action brought by the attorney general for civil penalties, injunctive relief, or an action to compel performance pursuant to the authority cited in section 144.99, subdivision 1, if the state finally prevails, and if the proven violation was willful, the state, in addition to other penalties provided by law, may be allowed an amount determined by the court to be the reasonable value of all or part of the litigation expenses incurred by the state. In determining the amount of the litigation expenses to be allowed, the court shall give consideration to the economic circumstances of the defendant.

History: *1993 c 206 s 11*

144.994 [Repealed, 2001 c 171 s 14]

ENVIRONMENTAL HEALTH TRACKING

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.

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(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:

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(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*

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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

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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,

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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;

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(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; 2014 c 286 art 7 s 13*

144.999 EPINEPHRINE AUTO-INJECTOR.

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

(b) "Administer" means the direct application of an epinephrine auto-injector to the body of an individual.

(c) "Authorized entity" means entities that fall in the categories of recreation camps, colleges and universities, preschools and daycares, and any other category of entities or organizations that the commissioner authorizes to obtain and administer epinephrine auto-injectors without a prescription. This definition does not include a school covered under section 121A.2207.

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

(e) "Epinephrine auto-injector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(f) "Provide" means to supply one or more epinephrine auto-injectors to an individual or the individual's parent, legal guardian, or caretaker.

Subd. 2. **Commissioner duties.** The commissioner may identify additional categories of entities or organizations to be authorized entities if the commissioner determines that individuals may come in contact with allergens capable of causing anaphylaxis. Beginning July 1, 2016, the commissioner may annually review the categories of authorized entities and may authorize additional categories of authorized entities as the commissioner deems appropriate. The commissioner may contract with a vendor to perform the review and identification of authorized entities.

Subd. 3. **Obtaining and storing epinephrine auto-injectors.** (a) Notwithstanding section 151.37, an authorized entity may obtain and possess epinephrine auto-injectors to be provided or administered to an individual if, in good faith, an owner, manager, employee, or agent of an authorized entity believes that the individual is experiencing anaphylaxis regardless of whether the individual has a prescription for an

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epinephrine auto-injector. The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine.

(b) An authorized entity may obtain epinephrine auto-injectors from pharmacies licensed as wholesale drug distributors pursuant to section 151.47. Prior to obtaining an epinephrine auto-injector, an owner, manager, or authorized agent of the entity must present to the pharmacy a valid certificate of training obtained pursuant to subdivision 5.

(c) An authorized entity shall store epinephrine auto-injectors in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector's instructions for use and any additional requirements that may be established by the commissioner. An authorized entity shall designate employees or agents who have completed the training program required under subdivision 5 to be responsible for the storage, maintenance, and control of epinephrine auto-injectors obtained and possessed by the authorized entity.

Subd. 4. **Use of epinephrine auto-injectors.** (a) An owner, manager, employee, or agent of an authorized entity who has completed the training required under subdivision 5 may:

(1) provide an epinephrine auto-injector for immediate administration to an individual or the individual's parent, legal guardian, or caregiver if the owner, manager, employee, or agent believes, in good faith, the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy; or

(2) administer an epinephrine auto-injector to an individual who the owner, manager, employee, or agent believes, in good faith, is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(b) Nothing in this section shall be construed to require any authorized entity to maintain a stock of epinephrine auto-injectors.

Subd. 5. **Training.** (a) In order to use an epinephrine auto-injector as authorized under subdivision 4, an individual must complete, every two years, an anaphylaxis training program conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment, a statewide organization with experience providing training on allergies and anaphylaxis under the supervision of board-certified allergy medical advisors, or an entity or individual approved by the commissioner to provide an anaphylaxis training program. The commissioner may approve specific entities or individuals to conduct the training program or may approve categories of entities or individuals to conduct the training program. Training may be conducted online or in person and, at a minimum, must cover:

(1) how to recognize signs and symptoms of severe allergic reactions, including anaphylaxis;

(2) standards and procedures for the storage and administration of an epinephrine auto-injector; and

(3) emergency follow-up procedures.

(b) The entity or individual conducting the training shall issue a certificate to each person who successfully completes the anaphylaxis training program. The commissioner may develop, approve, and disseminate a standard certificate of completion. The certificate of completion shall be valid for two years from the date issued.

Subd. 6. **Good samaritan protections.** Any act or omission taken pursuant to this section by an authorized entity that possesses and makes available epinephrine auto-injectors and its employees or agents, a pharmacy

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or manufacturer that dispenses epinephrine auto-injectors to an authorized entity, or an individual or entity that conducts the training described in subdivision 5 is considered "emergency care, advice, or assistance" under section 604A.01.

History: *2015 c 71 art 8 s 34*

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