CHAPTER 145

PUBLIC HEALTH PROVISIONS

145.075 INJUNCTIVE RELIEF BROUGHT BY COMMISSIONER.

ALZHEIMER'S AND OTHER DEMENTIA DISEASES

145.131 FINDINGS AND PURPOSE.

DEAD BODIES

145.135 UNIFORM DETERMINATION OF DEATH ACT.

145.161 DISSECTION; WHEN PERMITTED.

145.1621 DISPOSITION OF ABORTED OR MISCARRIED FETUSES.

145.1622 POLICY FOR NOTIFICATION OF DISPOSITION OPTIONS.

145.267 FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.

HOSPITAL RECORDS

145.30 SUPERINTENDENT OF HOSPITALS TO TRANSFER RECORDS.

145.31 COPIES TO BE USED AS EVIDENCE.

145.32 OLD RECORDS MAY BE DESTROYED.

145.33 CONSTRUCTION.

EXPOSURE TO DISEASE

145.36 EXPOSING PERSON WITH CONTAGIOUS DISEASE.

145.361 LONG COVID AND RELATED CONDITIONS; ASSESSMENT AND MONITORING.

145.365 TRAFFICKING IN SKUNKS.

INJURIOUS PRODUCTS

145.37 MANUFACTURE OF CERTAIN PRODUCTS WHICH MAY BE INJURIOUS.

145.409 REPRODUCTIVE HEALTH RIGHTS.

BLOOD DONATION

145.41 BLOOD DONATIONS, AGE OF DONOR.

ABORTION REGULATIONS

145.411 REGULATION OF ABORTIONS; DEFINITIONS.

145.4131 RECORDING AND REPORTING ABORTION DATA.

145.4134 COMMISSIONER'S PUBLIC REPORT.

145.414 ABORTION NOT MANDATORY.

145.42 ABORTIONS; NONLIABILITY FOR REFUSAL TO PERFORM.

USE OF HUMAN CONCEPTUS

145.421 HUMAN CONCEPTUS, LIVING; DEFINITIONS.

145.422 EXPERIMENTATION, RESEARCH OR SALE.

BORN ALIVE INFANTS PROTECTION ACT

145.423 RECOGNITION OF INFANT WHO IS BORN ALIVE.

145.424 PROHIBITION OF TORT ACTIONS.

REGULATION OF PAY TOILETS

145.425 PAY TOILETS IN PUBLIC PLACES; PROHIBITIONS; PENALTY.

PRENATAL TRISOMY DIAGNOSIS AWARENESS ACT

145.471 PRENATAL TRISOMY DIAGNOSIS AWARENESS ACT.

SEXUAL ASSAULT VICTIMS

145.4711 DEFINITIONS.

145.4712 EMERGENCY CARE TO SEXUAL ASSAULT VICTIMS.

145.4713 COMPLAINTS.

145.4715 REPORTING PREVALENCE OF SEXUAL VIOLENCE.

145.4716 SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.

145.4717 REGIONAL NAVIGATOR GRANTS.

145.4718 PROGRAM EVALUATION.

SUICIDE PREVENTION

145.56 SUICIDE PREVENTION.

145.561 988 SUICIDE AND CRISIS LIFELINE.

HEALTH CARE INFORMATION, REVIEW ORGANIZATIONS

145.61 DEFINITIONS.

145.62 PROVIDING INFORMATION TO REVIEW ORGANIZATION; IMMUNITY.

145.63 REVIEW ORGANIZATION; ADVISORY CAPACITY; IMMUNITY.

145.64 CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION.

145.65 GUIDELINES NOT ADMISSIBLE IN EVIDENCE.

145.66 PENALTY FOR VIOLATION.

145.67 PROTECTION OF PATIENT.

PEDIATRIC VACCINE ADMINISTRATION

145.671 PEDIATRIC VACCINE ADMINISTRATION.

145.672 HEALTHY CHILDREN THROUGH IMMUNIZATION.

MALPRACTICE ACTIONS; EXPERT REVIEW

145.682 CERTIFICATION OF EXPERT REVIEW; AFFIDAVIT.

145.685 COMMUNICATION AND RESOLUTION AFTER A HEALTH CARE ADVERSE INCIDENT.

DRUG DEPENDENT PERSONS; COMMITMENT

145.698 CONFINEMENT OF DRUG DEPENDENT PERSON.

OPHTHALMIC GOODS AND SERVICES

145.711 DEFINITIONS.

145.712 REQUIREMENTS FOR CONTACT LENSES PRESCRIPTIONS.

145.713 OPTOMETRIST AND PHYSICIAN PRACTICES.

145.7131 EXCEPTION TO EYEGLASS PRESCRIPTION EXPIRATION.

145.714 ENFORCEMENT.

UNIFORM DUTIES TO DISABLED PERSONS ACT

145.851 DEFINITIONS.

145.852 IDENTIFYING DEVICES FOR PERSONS HAVING CERTAIN CONDITIONS.
145.853 DUTY OF LAW ENFORCEMENT OFFICER.
145.854 DUTY OF MEDICAL PRACTITIONERS.
145.855 DUTY OF OTHERS.
145.856 FALSIFYING IDENTIFICATION OR MISREPRESENTING CONDITION; PENALTY.
145.857 OTHER DUTIES.
145.858 CITATION.

SPECIAL DIETS

145.867 PERSONS REQUIRING SPECIAL DIETS.
145.87 HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.

MATERNAL AND CHILD HEALTH

145.88 PURPOSE.
145.8811 MATERNAL AND CHILD HEALTH ADVISORY COMMITTEE.
145.882 MATERNAL AND CHILD HEALTH BLOCK GRANT DISTRIBUTION.
145.8821 ACCOUNTABILITY.
145.883 DEFINITIONS.
145.891 CITATION.
145.892 DEFINITIONS.
145.893 NUTRITIONAL SUPPLEMENT PROGRAM.
145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.
145.895 DEPARTMENT OF HUMAN SERVICES.
145.896 PROGRAM NOT A SUBSTITUTE OR REPLACEMENT.
145.897 FOOD BENEFITS.
145.898 SUDDEN INFANT DEATH.
145.899 WIC FOOD BENEFITS FOR ORGANICS.
145.901 MATERNAL DEATH STUDIES.
145.902 GIVE LIFE A CHANCE; SAFE PLACE FOR NEWBORNS DUTIES; IMMUNITY.
145.903 SCHOOL-BASED HEALTH CENTERS.
145.905 LOCATION FOR BREASTFEEDING.
145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.
145.907 MATERNAL DEPRESSION; DEFINITION.
145.908 GRANT PROGRAM; SCREENING AND TREATMENT FOR PRE- AND POSTPARTUM MOOD AND ANXIETY DISORDERS.

EPILEPSY AND RELATED SEIZURE DISORDERS

145.9231 EPILEPSY AND RELATED SEIZURE DISORDERS; DATA COLLECTION AND STATE COORDINATION PLAN.

HEALTH GRANTS

145.924 HIV PREVENTION GRANTS.
145.925 SEXUAL AND REPRODUCTIVE HEALTH SERVICES GRANTS.
145.9255 MINNESOTA EDUCATION NOW AND BABIES LATER; HEALTH.
145.9261 ABSTINENCE EDUCATION GRANT PROGRAM.
145.9265 FETAL ALCOHOL SYNDROME EFFECTS; DRUG-EXPOSED INFANT.
145.9266 FETAL ALCOHOL SYNDROME CAMPAIGN AND EDUCATION.
145.9268 COMMUNITY CLINIC GRANTS.
145.9269 FEDERALLY QUALIFIED HEALTH CENTERS.
145.9272 FEDERALLY QUALIFIED HEALTH CENTERS REGISTERED APPRENTICESHIP GRANT PROGRAM.
145.9273 TESTING FOR LEAD IN DRINKING WATER IN CHILD CARE SETTINGS.
145.9275 LEAD REMEDIATION IN SCHOOL AND CHILD CARE SETTINGS GRANT PROGRAM.
145.928 ELIMINATING HEALTH DISPARITIES.
145.9285 COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.
145.929 HEALTH CARE GRANTS FOR THE UNINSURED.

POISON CONTROL SYSTEM

145.93 MINNESOTA POISON INFORMATION CENTERS; ESTABLISHMENT.

HAZARDOUS SUBSTANCE EXPOSURE

145.94 EXPOSURE TO HAZARDOUS SUBSTANCE.
145.945 CERTAIN SALES OF CLEANING PRODUCTS PROHIBITED.

LONG-TERM DEVELOPMENT PROGRAM FOR CHILDREN

145.951 IMPLEMENTATION PLAN; STATEWIDE PROGRAM FOR FAMILIES.
145.952 DEFINITIONS.
145.953 PROGRAM STRUCTURE.
145.954 STANDARDS FOR PROGRAM.
145.955 DUTIES OF LOCAL ORGANIZATION.
145.956 TRAINING AND RECRUITMENT OF VOLUNTEERS.
145.957 ELIGIBILITY.
145.9571 HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.
145.9572 MINNESOTA PERINATAL QUALITY COLLABORATIVE.
145.9573 MINNESOTA PARTNERSHIP TO PREVENT INFANT MORTALITY.
145.9574 GRANTS.
145.9575 DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING WITH FOLLOW-UP.
145.9576 MODEL JAIL PRACTICES.

YOUTH VIOLENCE PREVENTION

145.958 YOUTH VIOLENCE PREVENTION.

HEALTH PROMOTION AND WELLNESS

145.985 HEALTH PROMOTION AND WELLNESS.
145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.
145.987 HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.
145.988 HELP ME CONNECT RESOURCE AND REFERRAL SYSTEM FOR CHILDREN.

145.01 [Repealed, 1987 c 309 s 27]

145.02 [Repealed, 1976 c 44 s 70]

145.03 [Repealed, 1987 c 309 s 27]

145.031 [Repealed, 1987 c 309 s 27]

145.04 [Repealed, 1987 c 309 s 27]

145.05 [Repealed, 1987 c 309 s 27]

145.06 [Repealed, 1987 c 309 s 27]

145.07 [Repealed, 1987 c 309 s 27]

145.071 MS 2006 [Renumbered 15.001]

145.075 INJUNCTIVE RELIEF BROUGHT BY COMMISSIONER.

In addition to any other remedy provided by law, the commissioner may in the commissioner's own name bring an action in the court of appropriate jurisdiction to enjoin any violation of a statute or rule which the commissioner is empowered to enforce or adopt, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health.

History: *1978 c 762 s 7; 1987 c 309 s 18*

145.08 [Repealed, 1987 c 309 s 27]

145.085 [Repealed, 1987 c 309 s 27]

145.09 [Repealed, 1965 c 45 s 73]

145.10 [Repealed, 1987 c 309 s 27]

145.11 [Repealed, 1987 c 309 s 27]

145.12 [Repealed, 1987 c 309 s 27]

145.123 [Repealed, 1987 c 309 s 27]

145.125 [Repealed, 1987 c 309 s 27]

145.13 [Repealed, 1980 c 357 s 22]

ALZHEIMER'S AND OTHER DEMENTIA DISEASES

145.131 FINDINGS AND PURPOSE.

The legislature finds that Alzheimer's and other dementia diseases occur in recipients of medical assistance. The costs the state pays in terms of human suffering, lost productivity, and medical assistance expenditures are enormous. The legislature also finds that research for the identification, cause, cure, and prevention of Alzheimer's and other dementia diseases requires autopsies and pathological studies of suspected victims. Expenses for autopsies and pathological studies are not provided for recipients of medical assistance.

History: *1Sp1985 c 9 art 2 s 14*

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

DEAD BODIES

145.135 UNIFORM DETERMINATION OF DEATH ACT.

Subdivision 1. **Citation.** This section may be cited as the "Uniform Determination of Death Act."

Subd. 2. **Determination of death.** An individual is dead if the individual sustains irreversible cessation of:

(1) circulatory and respiratory functions; or

(2) all functions of the entire brain, including the brain stem.

A determination of death must be made in accordance with generally accepted medical standards.

History: *1989 c 93 s 1*

145.14 [Repealed, 1997 c 215 s 47]

145.15 [Repealed, 1997 c 215 s 47]

145.16 [Repealed, 1997 c 215 s 47]

145.161 DISSECTION; WHEN PERMITTED.

The right to dissect the dead body of a human being shall be limited to: (a) cases specially provided by statute, or by the direction or will of the deceased; (b) cases where a coroner is authorized to hold an inquest upon the body, and then only so far as the coroner may authorize dissection; (c) cases where the spouse shall authorize dissection for the purpose of ascertaining the cause of death, and then only to the extent so authorized; and (d) cases where one of the next of kin, charged by law with the duty of burial, shall authorize dissection for the purpose of ascertaining the cause of death and then only to the extent so authorized, provided no dissection shall be performed pursuant to this clause if there is objection by anyone of such next of kin. Every person who shall make, cause or procure to be made, any dissection of the body of a human being, except as hereinbefore provided, shall be guilty of a gross misdemeanor.

History: *(10227) RL s 4975; 1967 c 220 s 1; 1986 c 444; 2024 c 101 art 3 s 2*

145.162 [Repealed, 1997 c 215 s 47]

145.1621 DISPOSITION OF ABORTED OR MISCARRIED FETUSES.

Subdivision 1. **Purpose.** The purpose of this section is to protect the public health and welfare by providing for the dignified and sanitary disposition of the remains of aborted or miscarried human fetuses in a uniform manner and to declare violations of this section to be a public nuisance.

Subd. 2. **Definition; remains of a human fetus.** For the purposes of this section, the term "remains of a human fetus" means the remains of the dead offspring of a human being that has reached a stage of development so that there are cartilaginous structures, fetal or skeletal parts after an abortion or miscarriage, whether or not the remains have been obtained by induced, spontaneous, or accidental means.

Subd. 3. **Regulation of disposal.** Remains of a human fetus resulting from an abortion or miscarriage, induced or occurring accidentally or spontaneously at a hospital, clinic, or medical facility must be deposited

or disposed of in this state only at the place and in the manner provided by this section or, if not possible, as directed by the commissioner of health.

Subd. 4. **Disposition; tests.** Hospitals, clinics, and medical facilities in which abortions are induced or occur spontaneously or accidentally and laboratories to which the remains of human fetuses are delivered must provide for the disposal of the remains by cremation, interment by burial, or in a manner directed by the commissioner of health. The hospital, clinic, medical facility, or laboratory may complete laboratory tests necessary for the health of the woman or her future offspring or for purposes of a criminal investigation or determination of parentage prior to disposing of the remains.

Subd. 5. **Violation; penalty.** Failure to comply with this section constitutes a public nuisance. A person, firm, or corporation failing to comply with this section is guilty of a misdemeanor.

Subd. 6. **Exclusions.** To comply with this section, a religious service or ceremony is not required as part of the disposition of the remains of a human fetus, and no discussion of the method of disposition is required with the woman obtaining an induced abortion.

History: *1987 c 238 s 1*

145.1622 POLICY FOR NOTIFICATION OF DISPOSITION OPTIONS.

Hospitals, clinics, and medical facilities must have in place by January 15, 2009, a policy for informing a woman of available options for fetal disposition when the woman experiences a miscarriage or is expected to experience a miscarriage.

History: *2008 c 326 art 1 s 4*

145.163 [Repealed, 1997 c 215 s 47]

145.17 [Repealed, 1987 c 309 s 27]

145.18 [Repealed, 1987 c 309 s 27]

145.19 [Repealed, 1987 c 309 s 27]

145.20 [Repealed, 1987 c 309 s 27]

145.21 [Repealed, 1987 c 309 s 27]

145.22 [Repealed, 1987 c 309 s 27]

145.23 [Repealed, 1987 c 309 s 27]

145.24 [Repealed, 1997 c 215 s 47]

145.267 FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.

(a) The commissioner of health shall award a grant to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The grant recipient must make subgrants to eligible regional collaboratives in rural and urban areas of the state for the purposes specified in paragraph (c).

(b) "Eligible regional collaboratives" means a partnership between at least one local government or Tribal government and at least one community-based organization and, where available, a family home

visiting program. For purposes of this paragraph, a local government includes a county or a multicounty organization, a county-based purchasing entity, or a community health board.

(c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to women with substance use disorder to increase positive birth outcomes.

(d) An eligible regional collaborative that receives a subgrant under this section must report to the grant recipient by January 15 of each year on the services and programs funded by the subgrant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxin-free babies born. The grant recipient must compile the information in the subgrant reports and submit a summary report to the commissioner of health by February 15 of each year.

History: *2022 c 98 art 1 s 61; art 4 s 51*

HOSPITAL RECORDS

145.30 SUPERINTENDENT OF HOSPITALS TO TRANSFER RECORDS.

The superintendent or other chief administrative officer of any public or private hospital, by and with the consent and approval of its board of directors or other governing body, is authorized to transfer and record, or cause to be transferred and recorded, upon photographic film, electronic image, or other state-of-the-art electronic preservation technology of convenient size for the preservation thereof as evidence, any or all of the original files and records of any such hospital dealing with the case history, physical examination, and daily hospital records of the individual patients thereof, including any miscellaneous documents, papers, and correspondence in connection therewith.

History: *1941 c 229 s 1; 2008 c 228 s 1*

145.31 COPIES TO BE USED AS EVIDENCE.

Upon the transferring and recording of any such original hospital files and records in the manner hereinbefore provided, such photographic film, electronic image, or other state-of-the-art electronic preservation technology records thereof shall have the same force and effect, when offered in evidence in any proceeding in this state, as the original records from which the same were so transferred and recorded, and any copy made therefrom, when duly certified in writing, attached thereto, by the officer or employee of such hospital in charge of the records, to be such correct and complete copy thereof, shall be admitted and received in evidence, without further foundation, in any proceeding in this state with the same force and effect as the original record of such hospital from which such copy was originally made, whether the original is in existence or not.

History: *1941 c 229 s 2; 1971 c 231 s 1; 2008 c 228 s 2*

145.32 OLD RECORDS MAY BE DESTROYED.

Subdivision 1. **Hospital records.** The superintendent or other chief administrative officer of any public or private hospital, by and with the consent and approval of the board of directors or other governing body of the hospital, may divest the files and records of that hospital of any individual case records and, with that consent and approval, may destroy the records. The records shall first have been transferred and recorded as authorized in section 145.30.

Portions of individual hospital medical records that comprise an individual permanent medical record, as defined by the commissioner of health, shall be retained as authorized in section 145.30. Other portions of the individual medical record, including any miscellaneous documents, papers, and correspondence in connection with them, may be divested and destroyed after seven years without transfer to photographic film, electronic image, or other state-of-the-art electronic preservation technology.

All portions of individual hospital medical records of minors shall be maintained for seven years or until the individual reaches the age of majority, whichever occurs last, at which time the individual may request that the patient's hospital records be destroyed, unless the hospital is required to retain the records as part of the individual's permanent medical record as defined in accordance with subdivision 2.

Nothing in this section shall be construed to prohibit the retention of hospital medical records beyond the periods described in this section. Nor shall anything in this section be construed to prohibit patient access to hospital medical records as provided in sections 144.291 to 144.298.

Subd. 2. **Individual permanent medical record.** (a) The commissioner of health shall define by rule the term "individual permanent medical record" by enumerating the specific types of records or other information that, at a minimum, must be maintained on a permanent basis by the hospital.

(b) "Individual permanent medical record" includes outpatient diagnostic and laboratory test results.

History: *1941 c 229 s 3; 1971 c 231 s 2; 1983 c 237 s 1; 1988 c 670 s 9; 2007 c 147 art 10 s 15; 2008 c 228 s 3; 1Sp2021 c 7 art 3 s 36*

145.33 CONSTRUCTION.

Sections 145.30 to 145.33 shall not be construed as requiring any such public or private hospital to retain among its files and records, during the period hereinbefore specified or otherwise, any such individual hospital case records, miscellaneous documents, papers, or correspondence, except as the preservation and retention thereof is otherwise required by law.

History: *1941 c 229 s 4*

145.34 [Repealed, 1991 c 202 s 42]

145.35 [Repealed, 1991 c 202 s 42]

EXPOSURE TO DISEASE

145.36 EXPOSING PERSON WITH CONTAGIOUS DISEASE.

Every person who shall willfully expose self or another affected with any contagious or infectious disease, in any public place or thoroughfare, except upon the person's necessary removal in a manner not dangerous to the public health, shall be guilty of a misdemeanor.

History: *(10270) RL s 5008; 1986 c 444*

145.361 LONG COVID AND RELATED CONDITIONS; ASSESSMENT AND MONITORING.

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

(b) "Long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post-COVID conditions, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

(c) "Related conditions" means conditions associated with or sequelae of long COVID, including but not limited to myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and dysautonomia, and postural orthostatic tachycardia syndrome (POTS).

Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct community assessments and epidemiologic investigations to monitor and address impacts of long COVID and related conditions. The purposes of these activities are to:

(1) monitor trends in: incidence, prevalence, mortality, and health outcomes; changes in disability status, employment, and quality of life; and service needs of individuals with long COVID or related conditions and to detect potential public health problems, predict risks, and assist in investigating long COVID and related conditions health inequities;

(2) more accurately target information and resources for communities and patients and their families;

(3) inform health professionals and citizens about risks and early detection;

(4) promote evidence-based practices around long COVID and related conditions prevention and management and to address public concerns and questions about long COVID and related conditions; and

(5) research and track related conditions.

Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health care professionals, the commissioner of human services, local public health entities, health insurers, employers, schools, survivors of long COVID or related conditions, and community organizations serving people at high risk of long COVID or related conditions, identify priority actions and activities to address the needs for communication, services, resources, tools, strategies, and policies to support survivors of long COVID or related conditions and their families.

Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions through community-based grants and contracts. The commissioner of health shall award grants and enter into contracts to organizations that serve communities disproportionately impacted by COVID-19, long COVID, or related conditions, including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino(a) communities, LGBTQ+ communities, and persons with living disabilities. Organizations may also address intersectionality within the groups. The commissioner shall award grants and award contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID or related conditions, including caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, and local and Tribal public health.

History: *2023 c 70 art 4 s 50*

145.365 TRAFFICKING IN SKUNKS.

Subdivision 1. **Prohibition.** In order to protect the public health and prevent human and domestic animal exposure to rabies, it shall be unlawful to:

(1) import into or export out of this state any live skunk, for sale, barter, exchange or gift for any purpose whatsoever;

(2) acquire, sell, barter, exchange, give, or purchase any live skunks.

Subd. 2. **Exception.** The provisions of subdivision 1 do not apply to the importation, acquisition, or exportation of a skunk by a publicly or privately owned zoological park or circus or any other show where a skunk is exhibited but is not in physical contact with the public, or by scientific or educational institutions for research or educational purposes.

Subd. 3. [Repealed, 1982 c 591 s 1]

Subd. 4. **Penalty.** Violation of subdivision 1 is a misdemeanor.

History: *1982 c 591 s 1; 2019 c 50 art 1 s 41*

INJURIOUS PRODUCTS

145.37 MANUFACTURE OF CERTAIN PRODUCTS WHICH MAY BE INJURIOUS.

Subdivision 1. **Cement; waterproofing or curing products.** It shall be unlawful for any person to manufacture for sale or distribution within the state any product to be used in waterproofing or curing cement which product may be injurious to the skin or eyes of the user unless there is specified on the container of such product the chemical composition thereof, a warning of possible injurious effect, and the antidote in the event of injury.

Subd. 2. **Penalty.** Violation of this section shall constitute a misdemeanor.

History: *1957 c 67 s 1*

145.38 [Repealed, 1992 c 485 s 3]

145.385 [Repealed, 1992 c 485 s 3]

145.39 [Repealed, 1992 c 485 s 3]

145.40 [Repealed, 1992 c 485 s 3]

145.406 [Repealed, 1997 c 239 art 3 s 25]

145.409 REPRODUCTIVE HEALTH RIGHTS.

Subdivision 1. **Short title.** This section may be cited as the "Protect Reproductive Options Act."

Subd. 2. **Definition.** For purposes of this section, "reproductive health care" means health care offered, arranged, or furnished for the purpose of preventing pregnancy, terminating a pregnancy, managing pregnancy loss, or improving maternal health and birth outcomes. Reproductive health care includes, but is not limited to, contraception; sterilization; preconception care; maternity care; abortion care; family planning and fertility services; and counseling regarding reproductive health care.

Subd. 3. **Reproductive freedom.** (a) Every individual has a fundamental right to make autonomous decisions about the individual's own reproductive health, including the fundamental right to use or refuse reproductive health care.

(b) Every individual who becomes pregnant has a fundamental right to continue the pregnancy and give birth, or obtain an abortion, and to make autonomous decisions about how to exercise this fundamental right.

Subd. 4. **Right to reproductive freedom recognized.** The Minnesota Constitution establishes the principles of individual liberty, personal privacy, and equality. Such principles ensure the fundamental right to reproductive freedom.

Subd. 5. **Local unit of government limitation.** A local unit of government may not regulate an individual's ability to freely exercise the fundamental rights set forth in this section in a manner that is more restrictive than that set forth in this section.

History: *2023 c 4 s 1*

BLOOD DONATION

145.41 BLOOD DONATIONS, AGE OF DONOR.

(a) Any person of the age of 17 years or over may donate blood in any voluntary and noncompensatory blood program without the necessity of obtaining parental permission or authorization.

(b) A person who is 16 years of age may donate blood in a voluntary and noncompensatory blood program if the person obtains written permission from the person's parent or guardian.

History: *1969 c 685 s 1; 1976 c 169 s 1; 2008 c 157 s 1*

ABORTION REGULATIONS

145.411 REGULATION OF ABORTIONS; DEFINITIONS.

Subdivision 1. **Terms.** As used in sections 145.411 to 145.415, the terms defined in this section have the meanings given to them.

Subd. 2. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 3. **Hospital.** "Hospital" means an institution licensed by the state commissioner of health; adequately and properly staffed and equipped; providing services, facilities and beds for the reception and care of one or more nonrelated persons for a continuous period longer than 24 hours for diagnosis, treatment or care of illness, injury or pregnancy; and regularly providing clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery, obstetrical care or other definitive medical treatment of similar extent. "Hospital" shall not include diagnostic or treatment centers, physicians' offices or clinics, or other facilities for the foster care of children licensed by the commissioner of human services.

Subd. 4. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument, medicine or drug which is supplied or prescribed for or administered to an individual with the intention of terminating, and which results in the termination of, pregnancy.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of health.

History: *1974 c 177 s 1; 1977 c 305 s 45; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1998 c 407 art 10 s 1; 2023 c 70 art 4 s 51,52*

145.412 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.413 Subdivision 1. [Repealed, 2003 c 14 art 2 s 2]

Subd. 2. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 3. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4131 RECORDING AND REPORTING ABORTION DATA.

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;

(6) the medical specialty of the physician performing the abortion; and

(7) if the abortion was performed via telehealth, the facility code for the patient and the facility code for the physician.

Subd. 2. **Submission.** A physician performing an abortion or a facility at which an abortion is performed shall complete and submit the form to the commissioner no later than September 30 for abortions performed in the previous calendar year. The annual report to the commissioner shall include the methods used to dispose of fetal tissue and remains.

Subd. 3. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortions.

History: *1998 c 407 art 10 s 2; 2015 c 71 art 8 s 43; 1Sp2017 c 6 art 10 s 95; 1Sp2021 c 7 art 6 s 28; 2023 c 70 art 4 s 53,54*

145.4132 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4133 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4134 COMMISSIONER'S PUBLIC REPORT.

(a) By December 31 of each year, the commissioner shall issue a public report providing statistics for the previous calendar year compiled from the data submitted under sections 145.4131 to 145.4133 and sections 145.4241 to 145.4249. Each report shall provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner shall ensure that none of the information included in the public reports can reasonably lead to identification of an individual having performed or having had an abortion. All data included on the forms under section 145.4131 must be included in the public report, except that the commissioner shall maintain as confidential, data which alone or in combination may constitute information from which an individual having performed or having had an abortion may be identified using epidemiologic principles.

(b) The commissioner may, by rules adopted under chapter 14, alter the submission dates established under section 145.4131 for administrative convenience, fiscal savings, or other valid reason, provided that physicians or facilities submit the required information once each year and the commissioner issues a report once each year.

History: *1998 c 407 art 10 s 5; 2003 c 14 art 2 s 1; 2022 c 98 art 14 s 8; 2023 c 70 art 4 s 55*

145.4135 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4136 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.414 ABORTION NOT MANDATORY.

(a) No person and no hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion for any reason.

(b) It is the policy of the state of Minnesota that no health plan company as defined under section 62Q.01, subdivision 4, or health care cooperative as defined under section 62R.04, subdivision 2, shall be required to provide or provide coverage for an abortion. No provision of this chapter; of chapter 62A, 62C, 62D, 62H, 62L, 62M, 62N, 62R, 62V, 64B, or of any other chapter; of Minnesota Rules; or of Laws 1995, chapter 234, shall be construed as requiring a health plan company as defined under section 62Q.01, subdivision 4, or a health care cooperative as defined under section 62R.04, subdivision 2, to provide or provide coverage for an abortion.

(c) This section supersedes any provision of Laws 1995, chapter 234, or any act enacted prior to enactment of Laws 1995, chapter 234, that in any way limits or is inconsistent with this section. No provision of any act enacted subsequent to Laws 1995, chapter 234 shall be construed as in any way limiting or being inconsistent with this section, unless the act amends this section or expressly provides that it is intended to limit or be inconsistent with this section.

History: *1974 c 177 s 4; 1995 c 234 art 2 s 30; 2013 c 84 art 1 s 92*

NOTE: This section was found unconstitutional as it applies to public hospitals or institutions under *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976), but see also *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2022).

145.415 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.416 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.42 ABORTIONS; NONLIABILITY FOR REFUSAL TO PERFORM.

Subdivision 1. **Damages.** No physician, nurse, or other person who refuses to perform or assist in the performance of an abortion, and no hospital that refuses to permit the performance of an abortion upon its premises, shall be liable to any person for damages allegedly arising from the refusal.

Subd. 2. **Related actions.** No physician, nurse, or other person who refuses to perform or assist in the performance of an abortion shall, because of that refusal, be dismissed, suspended, demoted, or otherwise prejudiced or damaged by a hospital with which the person is affiliated or by which the person is employed.

History: *1971 c 693 s 1,2; 1986 c 444*

USE OF HUMAN CONCEPTUS

145.421 HUMAN CONCEPTUS, LIVING; DEFINITIONS.

Subdivision 1. **Terms.** As used in this section and section 145.422, the terms defined in this section shall have the meanings given them.

Subd. 2. **Human conceptus.** "Human conceptus" means any human organism, conceived either in the human body or produced in an artificial environment other than the human body, from fertilization through the first 265 days thereafter.

Subd. 3. **Living.** "Living," as defined for the sole purpose of this section and section 145.422, means the presence of evidence of life, such as movement, heart or respiratory activity, the presence of electroencephalographic or electrocardiographic activity.

History: *1973 c 562 s 1*

145.422 EXPERIMENTATION, RESEARCH OR SALE.

Subdivision 1. **Penalty.** Whoever uses or permits the use of a living human conceptus for any type of scientific, laboratory research or other experimentation except to protect the life or health of the conceptus, or except as herein provided, shall be guilty of a gross misdemeanor.

Subd. 2. **Permitted acts.** The use of a living human conceptus for research or experimentation which verifiable scientific evidence has shown to be harmless to the conceptus shall be permitted.

Subd. 3. **Penalty; permitted payments.** Whoever buys or sells a living human conceptus or nonrenewable organ of the body is guilty of a gross misdemeanor. Nothing in this subdivision prohibits (1) the buying and selling of a cell culture line or lines taken from a nonliving human conceptus; (2) payments for reasonable expenses associated with the removal, storage, and transportation of a human organ, including payments made to or on behalf of a living organ donor for actual expenses such as medical costs, lost income, or travel

expenses that are incurred as a direct result of the donation of the nonrenewable organ; or (3) financial assistance payments provided under insurance and Medicare reimbursement programs.

History: *1973 c 562 s 2; 1984 c 475 s 1*

BORN ALIVE INFANTS PROTECTION ACT

145.423 RECOGNITION OF INFANT WHO IS BORN ALIVE.

Subdivision 1. **Recognition; care.** An infant who is born alive shall be fully recognized as a human person, and accorded immediate protection under the law. All reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, shall be taken by the responsible medical personnel to care for the infant who is born alive.

Subd. 2. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 3. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 4. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 5. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 6. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 7. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 8. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

Subd. 9. MS 2022 [Repealed, 2023 c 70 art 4 s 113]

History: *1976 c 170 s 1; 1997 c 215 s 4; 2015 c 71 art 8 s 44; 2023 c 70 art 4 s 56,112*

145.4235 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.424 PROHIBITION OF TORT ACTIONS.

Subdivision 1. **Wrongful life action prohibited.** No person shall maintain a cause of action or receive an award of damages on behalf of that person based on the claim that but for the negligent conduct of another, the person would have been aborted.

Subd. 2. **Wrongful birth action prohibited.** No person shall maintain a cause of action or receive an award of damages on the claim that but for the negligent conduct of another, a child would have been aborted.

Subd. 3. **Failure or refusal to prevent a live birth.** Nothing in this section shall be construed to preclude a cause of action for intentional or negligent malpractice or any other action arising in tort based on the failure of a contraceptive method or sterilization procedure or on a claim that, but for the negligent conduct of another, tests or treatment would have been provided or would have been provided properly which would have made possible the prevention, cure, or amelioration of any disease, defect, deficiency, or disability; provided, however, that abortion shall not have been deemed to prevent, cure, or ameliorate any disease, defect, deficiency, or disability. The failure or refusal of any person to perform or have an abortion shall

not be a defense in any action, nor shall that failure or refusal be considered in awarding damages or in imposing a penalty in any action.

History: *1982 c 521 s 1; 1986 c 444; 2005 c 56 s 1*

145.4241 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4242 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4243 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4244 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4245 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4246 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4247 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4248 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

145.4249 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

REGULATION OF PAY TOILETS

145.425 PAY TOILETS IN PUBLIC PLACES; PROHIBITIONS; PENALTY.

Pay toilets and urinals in public places, public conveyances or public buildings are prohibited.

History: *1975 c 215 s 1; 2001 c 205 art 2 s 1*

145.43 Subdivision 1. MS 1990 [Renumbered 153A.19, subdivision 1]

Subd. 1a. MS 1991 Supp [Renumbered 153A.19, subd 2]

Subd. 2. [Repealed, 1984 c 418 s 2]

Subd. 3. [Repealed, 1975 c 182 s 2]

Subd. 4. MS 1990 [Renumbered 153A.19, subd 3]

Subd. 5. MS 1990 [Renumbered 153A.19, subd 4]

145.44 [Repealed, 1984 c 418 s 2]

145.45 [Renumbered 153A.19 subds 5,6]

145.46 [Repealed, 1999 c 245 art 2 s 45]

145.47 [Repealed, 1987 c 309 s 27]

PRENATAL TRISOMY DIAGNOSIS AWARENESS ACT

145.471 PRENATAL TRISOMY DIAGNOSIS AWARENESS ACT.

Subdivision 1. **Short title.** This section shall be known and may be cited as the "Prenatal Trisomy Diagnosis Awareness Act."

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

(1) "commissioner" means the commissioner of health;

(2) "deliver" means providing information to an expectant parent and, if appropriate, other family members, in a written format;

(3) "health care practitioner" means a medical professional that provides prenatal or postnatal care and administers or requests administration of a diagnostic or screening test to a pregnant woman that detects for trisomy conditions; and

(4) "trisomy conditions" means trisomy 13, otherwise known as Patau syndrome; trisomy 18, otherwise known as Edwards syndrome; and trisomy 21, otherwise known as Down syndrome.

Subd. 3. **Health care practitioner duty.** A health care practitioner who orders tests for a pregnant woman to screen for trisomy conditions shall provide the information in subdivision 4 to the pregnant woman if the test reveals a positive result for any of the trisomy conditions.

Subd. 4. **Commissioner duties.** (a) The commissioner shall make the following information available to health care practitioners:

(1) up-to-date and evidence-based information about the trisomy conditions that has been reviewed by medical experts and national trisomy organizations. The information must be provided in a written or an alternative format and must include the following:

(i) expected physical, developmental, educational, and psychosocial outcomes;

(ii) life expectancy;

(iii) the clinical course description;

(iv) expected intellectual and functional development; and

(v) treatment options available for the particular syndrome for which the test was positive; and

(2) contact information for nonprofit organizations that provide information and support services for trisomy conditions.

(b) The commissioner shall post the information in paragraph (a) on the Department of Health website.

(c) The commissioner shall follow existing department practice to ensure that the information is culturally and linguistically appropriate for all recipients.

(d) Any local or national organization that provides education or services related to trisomy conditions may request that the commissioner include the organization's informational material and contact information

on the Department of Health website. Once a request is made, the commissioner may add the information to the website.

History: *2015 c 28 s 1*

SEXUAL ASSAULT VICTIMS

145.4711 DEFINITIONS.

Subdivision 1. **Application.** For purposes of sections 145.4711 to 145.4713, the following definitions apply.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Emergency care to sexual assault victims.** "Emergency care to sexual assault victims" means medical examinations, procedures, and services provided at a hospital to a sexual assault victim following an alleged sexual assault.

Subd. 4. **Emergency contraception.** "Emergency contraception" means a drug, drug regimen, or device approved by the federal Food and Drug Administration to prevent pregnancy when administered after sexual contact, including prescription and over-the-counter hormonal emergency contraception and intrauterine devices.

Subd. 5. **Sexual assault.** "Sexual assault" means criminal sexual conduct in the first degree under section 609.342, criminal sexual conduct in the second degree under section 609.343, criminal sexual conduct in the third degree under section 609.344, criminal sexual conduct in the fourth degree under section 609.345, sexual extortion under section 609.3458, or incest under section 609.365.

Subd. 6. **Sexual assault victim.** "Sexual assault victim" means a woman or man who alleges, or is alleged to have been, sexually assaulted and who presents at a hospital as a patient.

History: *2007 c 42 s 1; 1Sp2021 c 11 art 4 s 31*

145.4712 EMERGENCY CARE TO SEXUAL ASSAULT VICTIMS.

Subdivision 1. **Emergency care to female sexual assault victims.** (a) It shall be the standard of care for all hospitals and other health care providers that provide emergency care to, at a minimum:

(1) provide each female sexual assault victim with medically and factually accurate and unbiased written and oral information about emergency contraception from the American College of Obstetricians and Gynecologists and distributed to all hospitals by the Department of Health;

(2) orally inform each female sexual assault victim of the option of being provided with emergency contraception at the hospital or other health care facility; and

(3) immediately provide emergency contraception to each sexual assault victim who requests it provided it is not medically contraindicated and is ordered by a legal prescriber. Emergency contraception shall be administered in accordance with current medical protocols regarding timing and dosage necessary to complete the treatment.

(b) A hospital or health care provider may administer a pregnancy test. If the pregnancy test is positive, the hospital or health care provider does not have to comply with the provisions in paragraph (a).

Subd. 2. **Emergency care to male and female sexual assault victims.** It shall be the standard of care for all hospitals and health care providers that provide emergency care to, at a minimum:

(1) provide each sexual assault victim with factually accurate and unbiased written and oral medical information about prophylactic antibiotics for treatment of sexually transmitted infections;

(2) orally inform each sexual assault victim of the option of being provided prophylactic antibiotics for treatment of sexually transmitted infections at the hospital or other health care facility; and

(3) immediately provide prophylactic antibiotics for treatment of sexually transmitted infections to each sexual assault victim who requests it, provided it is not medically contraindicated and is ordered by a legal prescriber.

History: *2007 c 42 s 2; 2023 c 52 art 5 s 2*

145.4713 COMPLAINTS.

The commissioner shall accept and investigate complaints regarding hospital compliance with section 145.4712. The commissioner shall periodically determine whether hospitals are in compliance with section 145.4712. Failure to comply with section 145.4712 may be grounds for the suspension or revocation of a hospital's license under section 144.55, subdivision 6.

History: *2007 c 42 s 3*

145.4715 REPORTING PREVALENCE OF SEXUAL VIOLENCE.

The commissioner of health must routinely report to the public and to the legislature data on the prevalence and incidence of sexual violence in Minnesota, to the extent federal funding is available for this purpose. The commissioner must use existing data provided by the Centers for Disease Control and Prevention, or other source as identified by the commissioner.

History: *2012 c 247 art 2 s 11*

145.4716 SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.

Subdivision 1. **Director.** The commissioner of health shall establish a position for a director of child sex trafficking prevention.

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health website;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under sections 145.4716 to 145.4718; 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

(5) managing the request for proposals for grants for comprehensive services, including trauma-informed, culturally specific services;

(6) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

(7) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

(8) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

(9) developing a policy consistent with the requirements of chapter 13 for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Subd. 3. **Youth eligible for services.** Youth 24 years of age or younger are eligible for all services, support, and programs provided under this section and section 145.4717, and all shelter, housing beds, and services provided by the commissioner of human services to sexually exploited youth and youth at risk of sexual exploitation under section 256K.47.

History: *2013 c 108 art 12 s 43; 2014 c 312 art 23 s 6; 2016 c 189 art 15 s 1,2; 1Sp2017 c 6 art 10 s 96; 2023 c 70 art 11 s 1*

145.4717 REGIONAL NAVIGATOR GRANTS.

The commissioner of health, through its director of child sex trafficking prevention established in section 145.4716, shall provide grants to regional navigators serving six regions of the state to be determined by the commissioner. Each regional navigator must develop and annually submit a work plan to the director of child sex trafficking prevention. The work plans must include, but are not limited to, the following information:

(1) a needs statement specific to the region, including an examination of the population at risk;

(2) regional resources available to sexually exploited youth, as defined in section 260C.007, subdivision 31;

(3) grant goals and measurable outcomes; and

(4) grant activities including timelines.

History: *2013 c 108 art 12 s 44*

145.4718 PROGRAM EVALUATION.

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

(b) In conducting the evaluation, the director of child sex trafficking prevention must consider evaluation of outcomes, including whether the program increases identification of sexually exploited youth, coordination of investigations, access to services and housing available for sexually exploited youth, and improved effectiveness of services. The evaluation must also include examination of the ways in which penalties under

section 609.3241 are assessed, collected, and distributed to ensure funding for investigation, prosecution, and victim services to combat sexual exploitation of youth.

History: *2013 c 108 art 12 s 45; 2025 c 12 s 1*

145.475 [Repealed, 2002 c 220 art 16 s 3]

145.48 [Repealed, 1987 c 309 s 27]

145.49 [Repealed, 1987 c 309 s 27]

145.50 [Repealed, 1987 c 309 s 27]

145.51 [Repealed, 1987 c 309 s 27]

145.52 [Repealed, 1987 c 309 s 27]

145.53 [Repealed, 1987 c 309 s 27]

145.54 [Repealed, 1987 c 309 s 27]

145.55 [Repealed, 1987 c 309 s 27]

SUICIDE PREVENTION

145.56 SUICIDE PREVENTION.

Subdivision 1. **Suicide prevention plan.** The commissioner of health shall refine, coordinate, and implement the state's suicide prevention plan using an evidence-based, public health approach for a life span plan focused on awareness and prevention, in collaboration with the commissioner of human services; the commissioner of public safety; the commissioner of education; the chancellor of Minnesota State Colleges and Universities; the president of the University of Minnesota; and appropriate agencies, organizations, and institutions in the community.

Subd. 2. **Community-based programs.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources;

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12, and for students attending Minnesota colleges and universities;

(5) community-based programs to provide evidence-based suicide prevention and intervention to public school nurses, teachers, administrators, coaches, school social workers, peace officers, firefighters, emergency medical technicians, advanced emergency medical technicians, paramedics, primary care providers, and others; and

(6) community-based, evidence-based postvention training to mental health professionals and practitioners in order to provide technical assistance to communities after a suicide and to prevent suicide clusters and contagion.

Subd. 3. **Workplace and professional education.** (a) The commissioner shall promote the use of employee assistance and workplace programs to support employees with depression and other psychiatric illness and substance use disorder, and refer them to services. In promoting these programs, the commissioner shall collaborate with employer and professional associations, unions, and safety councils.

(b) The commissioner shall provide training and technical assistance to local public health and other community-based professionals to provide for integrated implementation of best practices for preventing suicides.

Subd. 4. **Collection and reporting suicide data.** (a) The commissioner shall coordinate with federal, regional, local, and other state agencies to collect, analyze, and annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

(b) The commissioner, in consultation with stakeholders, shall submit a detailed plan identifying proposed methods to improve the timeliness, usefulness, and quality of suicide-related data so that the data can help identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs. The report shall include how to improve external cause of injury coding, progress on implementing the Minnesota Violent Death Reporting System, how to obtain and release data in a timely manner, and how to support the use of psychological autopsies.

(c) The written report must be provided to the chairs and ranking minority members of the house of representatives and senate finance and policy divisions and committees with jurisdiction over health and human services by February 1, 2016.

Subd. 5. **Periodic evaluations; biennial reports.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. On July 1 of each even-numbered year, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house of representatives and senate with jurisdiction over health and human services issues.

History: *1Sp2001 c 9 art 1 s 45; 2002 c 379 art 1 s 113; 2003 c 130 s 12; 1Sp2005 c 4 art 6 s 36,37; 2009 c 159 s 11,12; 2015 c 71 art 2 s 6,7; 2022 c 98 art 4 s 51; 2026 c 127 art 1 s 31*

145.561 988 SUICIDE AND CRISIS LIFELINE.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following have the meanings given.

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

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

(d) "988" means the universal telephone number designated as the universal telephone number within the United States for the purpose of the national suicide prevention and mental health crisis hotline system

operating through the 988 Suicide and Crisis Lifeline, or its successor, maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

(e) "988 administrator" means the administrator of the national 988 Suicide and Crisis Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act.

(f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system within the United States via modalities offered including call, chat, or text.

(g) "988 Lifeline Center" means a state-identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(h) "988 Suicide and Crisis Lifeline" or "988 Lifeline" means the national suicide prevention and mental health crisis hotline system maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

(i) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary of Veterans Affairs under United States Code, title 38, section 170F(h).

Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the state 24 hours per day, seven days per week.

(b) The designated 988 Lifeline Center must:

(1) have an active agreement with the 988 Suicide and Crisis Lifeline program for participation in the network and the department;

(2) meet the 988 Lifeline program requirements and best practice guidelines for operational and clinical standards;

(3) provide data and reports, and participate in evaluations and related quality improvement activities as required by the 988 Lifeline program and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across mobile crisis and public safety answering points used in the state for the purpose of crisis care coordination;

(5) facilitate crisis and outgoing services, including mobile crisis teams in accordance with guidelines established by the 988 Lifeline program and the department;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers, local community mental health centers including certified community behavioral health clinics and community behavioral health centers, mobile crisis teams, and community based and hospital emergency departments;

(7) offer follow-up services to individuals accessing the 988 Lifeline Center that are consistent with guidance established by the 988 Lifeline program and the department; and

(8) meet the requirements set by the 988 Lifeline program and the department for serving at-risk and specialized populations.

(c) The commissioner shall adopt rules to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The commissioner, having primary oversight of suicide prevention, shall work with the 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the purpose of ensuring consistency of public messaging about 988 services.

(e) The commissioner shall work with representatives from 988 Lifeline Centers and public safety answering points, other public safety agencies, and the commissioner of public safety to facilitate the development of protocols and procedures for interactions between 988 and 911 services across Minnesota. Protocols and procedures shall be developed following available national standards and guidelines.

(f) The commissioner shall provide a biennial public report on 988 Lifeline usage by July 1 of each even-numbered year, including data on answer rates, abandoned calls, and referrals to 911 emergency response. The biennial report may be included as a section within the state suicide prevention report required under section 145.56.

Subd. 3. **988 special revenue account.** (a) A 988 special revenue account is established as a dedicated account in the special revenue fund to create and maintain a statewide 988 suicide and crisis lifeline system according to the National Suicide Hotline Designation Act of 2020, the Federal Communications Commission's report and order FCC 20-100 adopted July 16, 2020, and national guidelines for crisis care.

(b) The 988 special revenue account shall consist of:

(1) a 988 telecommunications fee imposed under subdivision 4;

(2) a prepaid wireless 988 fee imposed under section 403.161;

(3) transfers of state money into the account;

(4) grants and gifts intended for deposit in the account;

(5) interest, premiums, gains, and other earnings of the account; and

(6) money from any other source that is deposited in or transferred to the account.

(c) The account shall be administered by the commissioner. Money in the account shall only be used to offset costs that are or may reasonably be attributed to:

(1) implementing, maintaining, and improving the 988 suicide and crisis lifeline, including staff and technology infrastructure enhancements needed to achieve the operational standards and best practices set forth by the 988 administrator and the department;

(2) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(3) administration, oversight, and evaluation of the account.

(d) Money in the account:

(1) does not cancel at the end of any state fiscal year and is carried forward in subsequent state fiscal years;

(2) is not subject to transfer to any other account or fund or to transfer, assignment, or reassignment for any use or purpose other than the purposes specified in this subdivision; and

(3) is appropriated to the commissioner for the purposes specified in this subdivision.

(e) The commissioner shall submit an annual report to the legislature and to the Federal Communications Commission on deposits to and expenditures from the account. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide Hotline Designation Act of 2020, each subscriber of a wireline, wireless, or IP-enabled voice service must pay a monthly fee to provide for the robust creation, operation, and maintenance of a statewide 988 suicide prevention and crisis system.

(b) The amount of the 988 telecommunications fee is 12 cents per month for each consumer access line, including trunk equivalents as designated by the Public Utilities Commission pursuant to section 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

(c) Each wireline, wireless, and IP-enabled voice telecommunication service provider shall collect the 988 telecommunications fee and transfer the amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d).

(d) The commissioner of public safety shall deposit the money collected from the 988 telecommunications fee to the 988 special revenue account established in subdivision 3.

(e) All 988 telecommunications fee revenue must be used to supplement, and not supplant, federal, state, and local funding for suicide prevention.

(f) The 988 telecommunications fee amount shall be adjusted as needed to provide for continuous operation of the lifeline centers and 988 hotline, volume increases, and maintenance.

(g) The commissioner shall annually report to the Federal Communications Commission on revenue generated by the 988 telecommunications fee.

Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988 telecommunications fee established in subdivision 4 does not apply to prepaid wireless telecommunications services. Prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

(b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by sections 403.161 and 403.162.

Subd. 6. **988 Lifeline operating budget; data to legislature.** The commissioner shall provide a biennial report for maintaining the 988 system to the legislature as part of the biennial departmental earnings report process under section 16A.1285, subdivision 3. The report must include data on direct and indirect expenditures to maintain the 988 system, 988 fees collected, the balance in the 988 account, and the most recent forecast of revenues to and expenditures from the 988 account.

Subd. 7. **Waiver.** A wireless telecommunications service provider or wire-line telecommunications service provider may petition the commissioner for a waiver of all or portions of the requirements of this section. The commissioner may grant a waiver upon a demonstration by the petitioner that the requirement is economically infeasible.

History: *2023 c 70 art 4 s 57; 2024 c 127 art 59 s 44; 2026 c 127 art 1 s 32*

HEALTH CARE INFORMATION, REVIEW ORGANIZATIONS

145.61 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 145.61 to 145.67, the terms defined in this section have the meanings given them.

Subd. 2. **Professional.** "Professional" means a person licensed or registered to practice a healing art under chapter 147 or 148, to practice dentistry under chapter 150A, to practice as a pharmacist under chapter 151, or to practice podiatry under chapter 153.

Subd. 3. **Professional service.** "Professional service" means service rendered by a professional of the type such professional is licensed to perform.

Subd. 4. **Health care.** "Health care" means professional services rendered by a professional or an employee of a professional and services furnished by a hospital, sanitarium, nursing home or other institution for the hospitalization or care of human beings.

Subd. 4a. **Administrative staff.** "Administrative staff" means the staff of a hospital, clinic, nursing home, nonprofit health service plan corporation, or health maintenance organization.

Subd. 4b. **Consumer director.** "Consumer director" means a director of a health service plan corporation or health maintenance organization who is not a licensed or registered health care professional.

Subd. 4c. **Preferred provider organization.** "Preferred provider organization" means an organization that contracts with insurance carriers or other entities to arrange a network of health care providers whose services are offered to the insureds or other covered persons.

Subd. 5. **Review organization.** "Review organization" means a nonprofit organization acting according to clause (l), a committee as defined under section 144E.32, subdivision 2, or a committee whose membership is limited to professionals, administrative staff, and consumer directors, except where otherwise provided for by state or federal law, and which is established by one or more of the following: a hospital, a clinic, a nursing home, an ambulance service or first responder service regulated under chapter 144E, one or more state or local associations of professionals, an organization of professionals from a particular area or medical institution, a health maintenance organization as defined in chapter 62D, a community integrated service network as defined in chapter 62N, a nonprofit health service plan corporation as defined in chapter 62C, a preferred provider organization, a professional standards review organization established pursuant to United States Code, title 42, section 1320c-1 et seq., a medical review agent established to meet the requirements of section 256B.04, subdivision 15, the Department of Human Services, Direct Care and Treatment, or a nonprofit corporation that owns, operates, or is established by one or more of the above referenced entities, to gather and review information relating to the care and treatment of patients for the purposes of:

(a) evaluating and improving the quality of health care;

(b) reducing morbidity or mortality;

(c) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(d) developing and publishing guidelines showing the norms of health care in the area or medical institution or in the entity or organization that established the review organization;

(e) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;

(f) developing and publishing guidelines designed to improve the safety of care provided to individuals;

(g) reviewing the safety, quality, or cost of health care services provided to enrollees of health maintenance organizations, community integrated service networks, health service plans, preferred provider organizations, and insurance companies;

(h) acting as a professional standards review organization pursuant to United States Code, title 42, section 1320c-1 et seq.;

(i) determining whether a professional shall be granted staff privileges in a medical institution, membership in a state or local association of professionals, or participating status in a nonprofit health service plan corporation, health maintenance organization, community integrated service network, preferred provider organization, or insurance company, or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked;

(j) reviewing, ruling on, or advising on controversies, disputes or questions between:

(1) health insurance carriers, nonprofit health service plan corporations, health maintenance organizations, community integrated service networks, self-insurers and their insureds, subscribers, enrollees, or other covered persons;

(2) professional licensing boards and health providers licensed by them;

(3) professionals and their patients concerning diagnosis, treatment or care, or the charges or fees therefor;

(4) professionals and health insurance carriers, nonprofit health service plan corporations, health maintenance organizations, community integrated service networks, or self-insurers concerning a charge or fee for health care services provided to an insured, subscriber, enrollee, or other covered person;

(5) professionals or their patients and the federal, state, or local government, or agencies thereof;

(k) providing underwriting assistance in connection with professional liability insurance coverage applied for or obtained by dentists, or providing assistance to underwriters in evaluating claims against dentists;

(l) acting as a medical review agent under section 256B.04, subdivision 15;

(m) providing recommendations on the medical necessity of a health service, or the relevant prevailing community standard for a health service;

(n) providing quality assurance as required by United States Code, title 42, sections 1396r(b)(1)(b) and 1395i-3(b)(1)(b) of the Social Security Act;

(o) providing information to group purchasers of health care services when that information was originally generated within the review organization for a purpose specified by this subdivision;

(p) providing information to other, affiliated or nonaffiliated review organizations, when that information was originally generated within the review organization for a purpose specified by this subdivision, and as long as that information will further the purposes of a review organization as specified by this subdivision; or

(q) participating in a standardized incident reporting system, including Internet-based applications, to share information for the purpose of identifying and analyzing trends in medical error and iatrogenic injury.

History: *1971 c 283 s 1; 1974 c 295 s 1,2; 1975 c 73 s 1; 1976 c 173 s 49; 1982 c 424 s 133; 1982 c 546 s 1; 1985 c 184 s 1; 1989 c 282 art 3 s 30; 1991 c 137 s 1-3; 1992 c 400 s 1,2; 1992 c 549 art 7 s 6; 1993 c 345 art 3 s 18; 1994 c 497 s 1,2; 1996 c 305 art 1 s 37; 1996 c 451 art 4 s 24; 1999 c 51 s 2; 1999 c 84 s 2; 2001 c 7 s 33; 2001 c 120 s 1; 2016 c 158 art 2 s 37; 2024 c 125 art 5 s 13; 2024 c 127 art 50 s 13*

145.62 PROVIDING INFORMATION TO REVIEW ORGANIZATION; IMMUNITY.

No person, firm, or corporation providing information to a review organization shall be subject to any action for damages or other relief, by reason of having furnished such information, unless such information is false and the person providing such information knew, or had reason to believe, such information was false.

History: *1971 c 283 s 2*

145.63 REVIEW ORGANIZATION; ADVISORY CAPACITY; IMMUNITY.

Subdivision 1. **Members, directors, and officers.** No review organization and no person who is a member or employee, director, or officer of, who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization shall be liable for damages or other relief in any action brought by a person or persons whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance by the person of any duty, function, or activity of such review organization, unless the performance of such duty, function or activity was motivated by malice toward the person affected thereby. No review organization and no person shall be liable for damages or other relief in any action by reason of the performance of the review organization or person of any duty, function, or activity as a review organization or a member of a review committee or by reason of any recommendation or action of the review committee when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made, except that any corporation designated as a review organization under the Code of Federal Regulations, title 42, section 466 (1983) shall be subject to actions for damages or other relief by reason of any failure of a person, whose care or treatment is required to be scrutinized or reviewed by the review organization, to receive medical care or treatment as a result of a determination by the review organization that medical care was unnecessary or inappropriate.

The protections from liability provided in this subdivision shall also apply to the governing body of the review organization and shall not be waived as a result of referral of a matter from the review organization to the governing body or consideration by the governing body of decisions, recommendations, or documentation of the review organization.

Subd. 2. **Organizations.** No state or local association of professionals or organization of professionals from a particular area shall be liable for damages or other relief in any action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization established by the association or organization, unless the association or organization was motivated by malice towards the person affected by the review or scrutiny.

History: *1971 c 283 s 3; 1974 c 295 s 3; 1985 c 184 s 2; 1986 c 444; 1987 c 152 art 2 s 1; 1989 c 282 art 3 s 31; 1991 c 137 s 4*

145.64 CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION.

Subdivision 1. **Data and information.** (a) Except as provided in subdivision 4, data and information acquired by a review organization, in the exercise of its duties and functions, or by an individual or other entity acting at the direction of a review organization, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness cannot be asked about the witness' testimony before a review organization or opinions formed by the witness as a result of its hearings. For purposes of this subdivision, records of a review organization include Internet-based data derived from data shared for the purposes of the standardized incident reporting system described in section 145.61, subdivision 5, clause (q), and reports submitted electronically in compliance with sections 144.706 to 144.7069.

(b) Notwithstanding paragraph (a), a review organization may release non-patient-identified aggregate trend data on medical error and iatrogenic injury and a facility may file the reports, analyses, and plans required by sections 144.706 to 144.7069 without violating this section or being subjected to a penalty under section 145.66 and without compromising the protections provided under sections 145.61 to 145.67 to the reporter of such information; to the review organization, its sponsoring organizations, and members; and to the underlying data and reports.

(c) The confidentiality protection and protection from discovery or introduction into evidence provided in this subdivision shall also apply to the governing body of the review organization and shall not be waived as a result of referral of a matter from the review organization to the governing body or consideration by the governing body of decisions, recommendations, or documentation of the review organization.

(d) The governing body of a hospital, health maintenance organization, or community integrated service network, that is owned or operated by a governmental entity, may close a meeting to discuss decisions, recommendations, deliberations, or documentation of the review organization. A meeting may not be closed except by a majority vote of the governing body in a public meeting. The closed meeting must be tape recorded and the tape must be retained by the governing body for five years.

Subd. 2. **Provider data.** The restrictions in subdivision 1 shall not apply to professionals requesting or seeking through discovery, data, information, or records relating to their medical staff privileges, membership, or participation status. However, any data so disclosed in such proceedings shall not be admissible in any other judicial proceeding than those brought by the professional to challenge an action relating to the professional's medical staff privileges or participation status.

Subd. 3. **Hennepin County emergency medical services data.** Data collected, created, or maintained by the quality committee of the Hennepin County Emergency Medical Services Advisory Council when conducting a health care review activity of the emergency medical services function or services are private data on individuals or nonpublic data not on individuals, as defined in section 13.02.

Subd. 4. **Standardized incident reporting system data.** A review organization that is participating in a standardized incident reporting system described in section 145.61, subdivision 5, clause (q), may release data for purposes of the reporting system, provided that the data do not identify an individual and are not released in a manner in which an individual can be identified.

Subd. 5. **Commissioner of health.** Nothing in this section shall be construed to prohibit or restrict the right of the commissioner of health to access the original information, documents, or records acquired by a review organization as permitted by law.

History: *1971 c 283 s 4; 1974 c 295 s 4; 1975 c 73 s 2; 1986 c 444; 1991 c 137 s 5; 1992 c 549 art 7 s 7; 1994 c 497 s 3; 1994 c 625 art 8 s 47; 1996 c 440 art 1 s 37; 1997 c 225 art 2 s 62; 2001 c 120 s 2-4; 2003 c 99 s 6*

145.65 GUIDELINES NOT ADMISSIBLE IN EVIDENCE.

No guideline established by a review organization shall be admissible in evidence in any proceeding brought by or against a professional by a person to whom such professional has rendered professional services.

History: *1971 c 283 s 5*

145.66 PENALTY FOR VIOLATION.

Any disclosure other than that authorized by section 145.64, of data and information acquired by a review committee or of what transpired at a review meeting, is a misdemeanor.

History: *1971 c 283 s 6*

145.667 MS 2010 [Renumbered 145.671]

145.668 MS 2010 [Renumbered 145.672]

145.67 PROTECTION OF PATIENT.

Nothing contained in sections 145.61 to 145.67 shall be construed to relieve any person of any liability which the person has incurred or may incur to a patient as a result of furnishing health care to such patient.

History: *1971 c 283 s 7; 1986 c 444*

PEDIATRIC VACCINE ADMINISTRATION

145.671 PEDIATRIC VACCINE ADMINISTRATION.

The commissioner of health shall enroll a licensed pharmacy or individual pharmacist as a program-registered provider in the pediatric vaccine administration program under section 13631 of the federal Omnibus Budget Reconciliation Act of 1993, Public Law 103-66, based on the program's infrastructure capacity to enroll the additional pharmacy providers in the program.

History: *2009 c 157 art 1 s 1; 2012 c 187 s 74*

145.672 HEALTHY CHILDREN THROUGH IMMUNIZATION.

Pharmacies and pharmacists providing immunizations to children under private insurance or fee-for-service arrangements prior to June 1, 2009, that are not enrolled in the pediatric vaccine administration

program under section 13631 of the federal Omnibus Budget Reconciliation Act of 1993, Public Law 103-66, must discontinue immunization services to children under private insurance or fee-for-service arrangements after December 31, 2009.

History: *2009 c 157 art 1 s 2; 2012 c 187 s 74*

MALPRACTICE ACTIONS; EXPERT REVIEW

145.682 CERTIFICATION OF EXPERT REVIEW; AFFIDAVIT.

Subdivision 1. **Definition.** For purposes of this section, "health care provider" means a physician, surgeon, dentist, or other health care professional or hospital, including all persons or entities providing health care as defined in section 145.61, subdivisions 2 and 4, or a certified health care professional employed by or providing services as an independent contractor in a hospital.

Subd. 2. **Requirement.** In an action alleging malpractice, error, mistake, or failure to cure, whether based on contract or tort, against a health care provider which includes a cause of action as to which expert testimony is necessary to establish a prima facie case, the plaintiff must: (1) unless otherwise provided in subdivision 3, clause (2), serve upon defendant with the summons and complaint an affidavit as provided in subdivision 3; and (2) serve upon defendant within 180 days after commencement of discovery under the Rules of Civil Procedure, rule 26.04(a) an affidavit as provided by subdivision 4.

Subd. 3. **Affidavit of expert review.** The affidavit required by subdivision 2, clause (1), must be by the plaintiff's attorney and state that:

(1) the facts of the case have been reviewed by the plaintiff's attorney with an expert whose qualifications provide a reasonable expectation that the expert's opinions could be admissible at trial and that, in the opinion of this expert, one or more defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff; or

(2) the expert review required by clause (1) could not reasonably be obtained before the action was commenced because of the applicable statute of limitations. If an affidavit is executed pursuant to this paragraph, the affidavit in clause (1) must be served on defendant or the defendant's counsel within 90 days after service of the summons and complaint.

Subd. 4. **Identification of experts to be called.** (a) The affidavit required by subdivision 2, clause (2), must be signed by each expert listed in the affidavit and by the plaintiff's attorney and state the identity of each person whom plaintiff expects to call as an expert witness at trial to testify with respect to the issues of malpractice or causation, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. Answers to interrogatories that state the information required by this subdivision satisfy the requirements of this subdivision if they are signed by the plaintiff's attorney and by each expert listed in the answers to interrogatories and served upon the defendant within 180 days after commencement of discovery under the Rules of Civil Procedure, rule 26.04(a).

(b) The parties or the court for good cause shown, may by agreement, provide for extensions of the time limits specified in subdivision 2, 3, or this subdivision. Nothing in this subdivision may be construed to prevent either party from calling additional expert witnesses or substituting other expert witnesses.

(c) In any action alleging medical malpractice, all expert interrogatory answers must be signed by the attorney for the party responding to the interrogatory and by each expert listed in the answers. The court shall include in a scheduling order a deadline prior to the close of discovery for all parties to answer expert

interrogatories for all experts to be called at trial. No additional experts may be called by any party without agreement of the parties or by leave of the court for good cause shown.

Subd. 5. **Responsibilities of plaintiff as attorney.** If the plaintiff is acting pro se, the plaintiff shall sign the affidavit or answers to interrogatories referred to in this section and is bound by those provisions as if represented by an attorney.

Subd. 6. **Penalty for noncompliance.** (a) Failure to comply with subdivision 2, clause (1), within 60 days after demand for the affidavit results, upon motion, in mandatory dismissal with prejudice of each cause of action as to which expert testimony is necessary to establish a prima facie case.

(b) Failure to comply with subdivision 2, clause (2), results, upon motion, in mandatory dismissal with prejudice of each cause of action as to which expert testimony is necessary to establish a prima facie case.

(c) Failure to comply with subdivision 4 because of deficiencies in the affidavit or answers to interrogatories results, upon motion, in mandatory dismissal with prejudice of each action as to which expert testimony is necessary to establish a prima facie case, provided that:

(1) the motion to dismiss the action identifies the claimed deficiencies in the affidavit or answers to interrogatories;

(2) the time for hearing the motion is at least 45 days from the date of service of the motion; and

(3) before the hearing on the motion, the plaintiff does not serve upon the defendant an amended affidavit or answers to interrogatories that correct the claimed deficiencies.

Subd. 7. **Consequences of signing affidavit.** The signature of the plaintiff or the plaintiff's attorney constitutes a certification that the person has read the affidavit or answers to interrogatories, and that to the best of the person's knowledge, information, and belief formed after a reasonable inquiry, it is true, accurate, and made in good faith. A certification made in violation of this subdivision subjects the attorney or plaintiff responsible for such conduct to reasonable attorney's fees, costs, and disbursements.

History: *1986 c 455 s 60; 1992 c 549 art 8 s 1; 2002 c 403 s 1; 2014 c 153 s 1,2*

145.685 COMMUNICATION AND RESOLUTION AFTER A HEALTH CARE ADVERSE INCIDENT.

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

(b) "Health care adverse incident" means an objective and definable outcome arising from or related to patient care that results in the death or physical injury of a patient.

(c) "Health care provider" means a person who is licensed, certified, or registered, or otherwise permitted by state law, to administer health care in the ordinary course of business or in the practice of a profession and practices at a health facility.

(d) "Health facility" means a hospital or outpatient surgical center licensed under sections 144.50 to 144.56; a medical, dental, or health care clinic; a diagnostic laboratory; or a birthing center licensed under section 144.615. The definition of health facility includes any corporation, professional corporation, partnership, limited liability company, limited liability partnership, or other entity comprised of health facilities or health care providers.

(e) "Open discussion" means all communications that are made during an open discussion process under this section and includes memoranda, work product, documents, and other materials that are prepared for or submitted in the course of or in connection with communications made under this section. Open discussion does not include any communication, memoranda, work product, or other materials that would otherwise be subject to discovery and were not prepared specifically for use in an open discussion pursuant to this section.

(f) "Patient" means a person who receives health care from a health care provider. If the patient is under 18 years of age and is not an emancipated minor, the definition of patient includes the patient's legal guardian or parent. If the patient is deceased or incapacitated, the definition of patient includes the patient's legal representative.

Subd. 2. **Engaging in an open discussion.** (a) If a health care adverse incident occurs, a health care provider involved in the health care adverse incident, the health facility involved in the health care adverse incident, or both jointly may provide the patient with written notice of their desire to enter into an open discussion with the patient to discuss potential outcomes following a health care adverse incident in accordance with this section. A health facility may designate a person or class of persons who has the authority to provide the notice on behalf of the health facility. The patient involved in the health care adverse incident may provide oral notice to the health care provider, the health facility involved in the health care adverse incident, or both, of the patient's desire to enter into an open discussion with either the health care provider, or the health care provider and health facility jointly, to discuss potential outcomes following a health care adverse incident in accordance with this section.

(b) If a health care provider or health facility decides to enter into an open discussion as specified in this section, the written notice must be sent to the patient within 365 days from the date the health care provider or the health facility knew, or through the use of diligence should have known, of the health care adverse incident. The notice must include:

(1) the health care provider, health facility, or both jointly desire to pursue an open discussion in accordance with this section;

(2) the patient's right to receive a copy of the medical records related to the health care adverse incident and the patient's right to authorize the release of the patient's medical records related to the health care adverse incident to a third party;

(3) the patient's right to seek legal counsel and to have legal counsel present throughout the open discussion process;

(4) a copy of section 541.076 with notice that the time for a patient to bring a lawsuit is limited under section 541.076 and will not be extended by engaging in an open discussion under this section unless all parties agree in writing to an extension;

(5) that if the patient chooses to engage in an open discussion with the health care provider, health facility, or jointly with both, all communications made during the course of the open discussion process, including communications regarding the initiation of an open discussion are:

(i) privileged and confidential;

(ii) not subject to discovery, subpoena, or other means of legal compulsion for release; and

(iii) not admissible as evidence in a proceeding arising directly out of the health care adverse incident, including a judicial, administrative, or arbitration proceeding; and

(6) that any communications, memoranda, work product, documents, or other material that are otherwise subject to discovery and not prepared specifically for use in an open discussion under this section are not confidential.

(c) If the patient agrees to engage in an open discussion with a health care provider, health facility, or jointly with both, the agreement must be in writing and must state that the patient has received the notice described in paragraph (b).

(d) Upon agreement to engage in an open discussion, the patient, health care provider, or health facility may include other persons in the open discussion process. All other persons included in the open discussion must be advised of the parameters of communications made during the open discussion process specified under paragraph (b), clauses (5) and (6).

(e) If a health care provider or health facility decides to engage in an open discussion, the health care provider or health facility may:

(1) investigate how the health care adverse incident occurred, including gathering information regarding the medical care or treatment and disclose the results of the investigation to the patient;

(2) openly communicate to the patient the steps the health care provider or health facility will take to prevent future occurrences of the health care adverse incident; and

(3) determine that no offer of compensation for the health care adverse incident is warranted or that an offer of compensation for the health care adverse incident is warranted.

(f) If a health care provider or health facility determines that no offer of compensation is warranted, the health care provider or health facility shall orally communicate that decision to the patient.

(g) If a health care provider or a health facility determines that an offer of compensation is warranted, the health care provider or health facility shall provide the patient with a written offer of compensation. If an offer of compensation is made under this paragraph, and the patient is not represented by legal counsel, the health care provider or health facility shall:

(1) advise the patient of the patient's right to seek legal counsel regarding the offer of compensation and encourage the patient to seek legal counsel; and

(2) provide notice to the patient that the patient may be legally required to repay medical and other expenses that were paid by a third party on the patient's behalf, including private health insurance, Medicaid, or Medicare, along with an itemized statement from the health provider showing all charges and third-party payments.

(h) Except for an offer of compensation made under paragraph (g), open discussions between the health care provider or health facility and the patient about compensation shall not be in writing.

Subd. 3. **Confidentiality of open discussions and offers of compensation.** (a) Open discussion communications made under this section, including offers of compensation made under subdivision 2:

(1) do not constitute an admission of liability;

(2) are privileged and confidential and shall not be disclosed;

(3) are not admissible as evidence in any subsequent judicial, administrative, or arbitration proceeding arising directly out of the health care adverse incident, except as provided in paragraph (b);

(4) are not subject to discovery, subpoena, or other means of legal compulsion for release; and

(5) shall not be disclosed by any party in any subsequent judicial, administrative, or arbitration proceeding arising directly out of the health care adverse incident.

(b) A party may move the court or other decision maker in a subsequent proceeding to adjudicate the matter to admit as evidence a communication made during an open discussion that contradicts a statement made during the proceeding. The court or other decision maker shall allow a communication made during an open discussion that contradicts a statement made at a subsequent proceeding to adjudicate the matter into evidence only if the communication made during an open discussion is material to the claims presented in the subsequent proceeding.

(c) Communications, memoranda, work product, documents, and other materials that are otherwise subject to discovery and that were not prepared specifically for use in an open discussion under this section are not confidential.

(d) The limitation on disclosure imposed by this subdivision includes disclosure during any discovery conducted as part of a subsequent adjudicatory proceeding, and a court or other adjudicatory body shall not compel any person who engages in an open discussion under this section to disclose confidential communications or agreements made under this section.

(e) This subdivision does not affect any other law, rule, or requirement with respect to confidentiality.

Subd. 4. **Payment and resolution.** (a) If a patient accepts an offer of compensation made pursuant to this section, and payment of compensation is made to a patient as a result, the payment to the patient is not payment resulting from:

(1) a written claim or demand for payment;

(2) a final judgment, settlement, or arbitration award against a health care institution for medical malpractice purposes; or

(3) a malpractice claim settled or in which judgment is rendered against a health care professional for purposes of reporting by malpractice insurance companies under sections 146A.03, 147.111, 147A.14, 148.102, 148.263, 148B.381, 148F.205, 150A.13, and 153.24.

(b) A health care provider or health facility may require, as a condition of an offer of compensation made pursuant to this section, a patient to execute all documents and obtain any necessary court approval to resolve a health care adverse incident. The parties shall negotiate the form of the documents to be executed and obtain court approval as necessary.

Subd. 5. **Sunset.** This section sunsets on June 30, 2031.

Subd. 6. **Applicability.** This section applies only to health care adverse incidents that occur on or after August 1, 2023.

History: *2023 c 52 art 19 s 82*

DRUG DEPENDENT PERSONS; COMMITMENT

145.696 [Repealed, 1973 c 572 s 18]

145.697 [Repealed, 1973 c 572 s 18]

145.698 CONFINEMENT OF DRUG DEPENDENT PERSON.

Subdivision 1. **Authority.** When a person has been accused of violating any state or local law or ordinance in district court, and if it appears to the court that the defendant may be a drug dependent person, or by reason of the repeated use of drugs may not be responsible for that person's actions, the court may adjourn the proceedings and order the county attorney to file a petition for commitment of the defendant pursuant to chapter 253B, the Minnesota Commitment and Treatment Act, for confinement in a hospital, a mental health center, the Willmar Regional Treatment Center or other drug treatment facility until such time as the court feels that such person can be returned to the court.

Subd. 2. **Stay; commitment.** Upon conviction of a defendant for any crime, or following revocation of probation previously granted whether or not sentence has been imposed, if it appears to the court that the defendant may be a drug dependent person, or by reason of the repeated use of drugs may be in imminent danger of becoming addicted, the court may adjourn the proceedings or suspend imposition or execution of sentence and order the county attorney to file a petition for commitment of the defendant pursuant to chapter 253B until the court feels that the person is no longer in need of institutional care and treatment.

History: *1971 c 892 s 11; 1983 c 247 s 62; 1986 c 444; 1987 c 384 art 1 s 49; 1998 c 254 art 2 s 11; 2000 c 260 s 22*

145.699 [Repealed, 1973 c 572 s 18]

145.71 [Repealed, 1979 c 323 s 16]

OPHTHALMIC GOODS AND SERVICES

145.711 DEFINITIONS.

Subdivision 1. **Application.** For purposes of sections 145.711 to 145.714, the following definitions apply.

Subd. 2. **Dispensing.** "Dispensing" means the retail delivery of ophthalmic goods to a patient.

Subd. 3. **Fitting.** "Fitting" means the performance of mechanical procedures and measurements necessary to adapt and fit contact lenses after an eye examination and supervision of the trial wearing of the contact lenses, which may require revisions during the trial period.

Subd. 4. **Ophthalmic goods.** "Ophthalmic goods" means eyeglasses, one or more eyeglass components for which a prescription is required, or contact lenses.

Subd. 5. **Ophthalmic services.** "Ophthalmic services" means the measuring, fitting, adjusting, fabricating, or prescribing of ophthalmic goods after an eye examination.

Subd. 6. **Optometrist.** "Optometrist" means an individual licensed to practice optometry under sections 148.52 to 148.62.

Subd. 7. **Patient.** "Patient" means a person who has had an eye examination.

Subd. 8. **Prescription.** "Prescription" means a written directive from an optometrist or physician for contact lenses that must include the manufacturer's brand name, power, base curve, the name and telephone number of the prescribing optometrist or physician, patient's name, and the expiration date of the prescription. If applicable, the prescription may also include diameter, axis, add power, cylinder, peripheral curve, optical zone, or center thickness.

Subd. 9. **Physician.** "Physician" means an individual licensed to practice medicine under chapter 147.

History: *2002 c 259 s 1*

145.712 REQUIREMENTS FOR CONTACT LENSES PRESCRIPTIONS.

Subdivision 1. **Copy of prescription.** An optometrist or physician must provide a patient with a copy of the patient's prescription upon completion of the patient's eye examination and fitting. An optometrist or physician may refuse to give a patient a copy of the patient's prescription until after the patient has paid for the eye examination and fitting, but only if the optometrist or physician would have required immediate payment from that patient if the examination had revealed that no ophthalmic goods were required.

Subd. 2. **Prescription expiration date.** A prescription written by an optometrist or physician must expire two years after it is written, unless a different expiration date is warranted by the patient's ocular health. If the prescription is valid for less than two years, the optometrist or physician must note the medical reason for the prescription's expiration date in the patient's record and must orally explain to the patient at the time of the eye examination the reason for the prescription's expiration date.

Subd. 3. **Prescription verification.** An optometrist or physician must promptly respond to any request received from a physician, optometrist, optician, or contact lens retailer to verify a patient's prescription information in order for the person requesting the information to accurately dispense the contact lenses. Verification must be requested by telephone, fax, or through electronic communications during the prescriber's normal business hours. Consistently failing to respond to verification requests within a reasonable period of time is grounds for disciplinary action by the respective regulatory board.

Subd. 4. **Prohibited conduct.** When filling a contact lens prescription, no optometrist, physician, or contact lens retailer may:

(1) substitute or in any way dispense a different contact lens than the contact lens ordered on the prescription;

(2) dispense a contact lens for a period of time beyond the written expiration date; or

(3) dispense contact lenses that are not based on prescription parameters pursuant to a valid prescription.

Subd. 5. **Dispensing records.** A copy of the dispensing records must be kept on file at the dispensing location for a period of no less than two years.

History: *2002 c 259 s 2*

145.713 OPTOMETRIST AND PHYSICIAN PRACTICES.

Subdivision 1. **Prohibited conduct.** No optometrist or physician may:

(1) condition the availability of an eye examination or the release of a prescription to a patient on a requirement that the patient agree to purchase ophthalmic goods from the optometrist or physician who performed the eye examination or from another specified optometrist or physician;

(2) charge a patient a fee in addition to the optometrist's or physician's examination and fitting fees as a condition of releasing the prescription to the patient. An optometrist or physician may charge a reasonable additional fee for fitting ophthalmic goods dispensed by another practitioner if that fee is imposed at the time the fitting is performed; or

(3) prescribe a manufacturer's brand name contact lens that can only be dispensed through the prescribing physician or optometrist's office.

Subd. 2. **Contraindications for contact lenses.** If an optometrist or physician determines that a patient's ocular health presents a contraindication for contact lenses, the optometrist or physician must orally inform the patient of the contraindication and must document the contraindication in the patient's records. An optometrist or physician may exclude categories of contact lenses where clinically indicated.

Subd. 3. **Waivers of liability prohibited.** No optometrist or physician may place on a patient's prescription, require a patient to sign, or deliver to a patient a form or notice waiving liability or responsibility for the accuracy of the eye examination or the accuracy of the ophthalmic goods and ophthalmic services dispensed by another practitioner. Prohibiting waivers of liability under this subdivision does not impose liability on an optometrist or physician for the ophthalmic goods or ophthalmic services dispensed by another practitioner pursuant to the optometrist's or physician's prescription.

Subd. 4. **Provider-patient relationship required.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "contact lens" means any lens that is placed directly on the surface of the eye, whether or not the lens is intended to correct a visual defect, including any cosmetic, therapeutic, or corrective lens;

(2) "ophthalmic prescription" means a handwritten or electronic order of a provider that includes:

(i) in the case of contact lenses, all information required by the Fairness to Contact Lens Consumers Act, United States Code, title 15, section 7601, et seq.;

(ii) in the case of prescription eyeglasses, all information required by the Ophthalmic Practice Rule, also known as the Eyeglass Rule, Code of Federal Regulations, title 16, part 456; and

(iii) necessary and appropriate information for the dispensing of prescription eyeglasses or contact lenses for a patient, including, at a minimum, the provider's name, the physical address of the provider's practice, and the provider's telephone number; and

(3) "provider" means an optometrist or physician.

(b) For the purposes of a provider prescribing ophthalmic goods to a patient, the provider must establish a provider-patient relationship through an examination pursuant to paragraph (c).

(c) An examination meets the requirements of paragraph (b) if it takes place:

(1) in person;

(2) through face-to-face interactive, two-way, real-time communication; or

(3) through store-and-forward technologies when all of the following conditions are met:

(i) the provider obtains an updated medical history and makes a diagnosis at the time of prescribing;

(ii) the provider conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition;

(iii) the ophthalmic prescription is not determined solely by use of an online questionnaire;

(iv) the provider is licensed and authorized to issue an ophthalmic prescription in the state; and

(v) upon request, the provider provides patient records in a timely manner in accordance with state and federal requirements.

(d) This subdivision does not apply to the sale of over-the-counter eyeglasses, also known as readers, that are not designed to address the visual needs of the individual wearer.

History: *2002 c 259 s 3; 2019 c 31 s 1*

145.7131 EXCEPTION TO EYEGLASS PRESCRIPTION EXPIRATION.

Notwithstanding any practice to the contrary, in an emergency situation or in the case of lost glasses, an optometrist or physician may authorize a new pair of prescription eyeglasses using the prescription from the old lenses or the last prescription available.

History: *2014 c 291 art 10 s 1; 2017 c 59 s 4; 2018 c 170 s 4*

145.714 ENFORCEMENT.

Failure to comply with sections 145.711 to 145.713 shall be grounds for disciplinary action by the Board of Optometry or the Board of Medical Practice.

History: *2002 c 259 s 4*

145.72 [Repealed, 1979 c 323 s 16]

145.73 [Repealed, 1979 c 323 s 16]

145.74 [Repealed, 1979 c 323 s 16]

145.75 [Repealed, 1979 c 323 s 16]

145.751 [Repealed, 1979 c 323 s 16]

145.76 [Repealed, 1979 c 323 s 16]

145.761 [Repealed, 1979 c 323 s 16]

145.77 [Repealed, 1979 c 323 s 16]

145.78 [Repealed, 1979 c 323 s 16]

145.79 [Repealed, 1979 c 323 s 16]

145.80 [Repealed, 1979 c 323 s 16]

145.81 [Repealed, 1975 c 299 s 12]

145.811 [Repealed, 1979 c 323 s 16]

145.812 [Repealed, 1979 c 323 s 16]

145.82 [Repealed, 1979 c 323 s 16]

145.83 [Repealed, 1979 c 323 s 16]

145.831 [Repealed, 1979 c 323 s 16]

145.832 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.833 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.834 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.835 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.836 [Repealed, 1982 c 614 s 12, 1983 c 312 art 1 s 26]

145.837 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.838 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.839 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.84 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.841 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.842 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.843 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.844 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

145.845 [Repealed, 1982 c 614 s 12; 1983 c 312 art 1 s 26]

UNIFORM DUTIES TO DISABLED PERSONS ACT

145.851 DEFINITIONS.

In sections 145.851 to 145.858:

(1) "disabled condition" means the condition of being unconscious, semiconscious, incoherent, or otherwise incapacitated to communicate;

(2) "disabled person" means a person in a disabled condition;

(3) "the emergency symbol" means the caduceus inscribed within a six-barred cross used by the American Medical Association to denote emergency information;

(4) "identifying device" means an identifying bracelet, necklace, metal tag, or similar device bearing the emergency symbol and the information needed in an emergency;

(5) "medical practitioner" means a person licensed or authorized to practice medicine, osteopathic medicine, and the healing arts.

History: *1973 c 428 s 1; 2016 c 119 s 7*

145.852 IDENTIFYING DEVICES FOR PERSONS HAVING CERTAIN CONDITIONS.

Subdivision 1. **Authorization.** A person who suffers from epilepsy, diabetes, a cardiac condition, or any other type of illness that causes temporary blackouts, semiconscious periods, or complete unconsciousness, or who suffers from a condition requiring specific medication or medical treatment, is allergic to certain medications or items used in medical treatment, wears contact lenses, or is unable to communicate coherently or effectively in the English language, is authorized and encouraged to wear an identifying device.

Subd. 2. **Identification card.** Any person may carry an identification card bearing the person's name, type of medical condition, physician's name, and other medical information.

Subd. 3. **Consent.** By wearing an identifying device a person gives consent for any law enforcement officer or medical practitioner who finds the person in a disabled condition to make a reasonable search of the person's clothing or other effects for an identification card of the type described in subdivision 2.

History: *1973 c 428 s 2; 1986 c 444*

145.853 DUTY OF LAW ENFORCEMENT OFFICER.

Subdivision 1. **Diligent effort required.** A law enforcement officer shall make a diligent effort to determine whether any disabled person found is a person having epilepsy or a diabetic, or suffers from some other type of illness that would cause the condition. Whenever feasible, this effort shall be made before the person is charged with a crime or taken to a place of detention.

Subd. 2. **Search.** In seeking to determine whether a disabled person suffers from an illness, a law enforcement officer shall make a reasonable search for an identifying device and an identification card of the type described in section 145.852, subdivision 2, and examine them for emergency information. The law enforcement officer may not search for an identifying device or an identification card in a manner or to an extent that would appear to a reasonable person in the circumstances to cause an unreasonable risk of worsening the disabled person's condition. The law enforcement officer may not remove an identifying device or an identification card from the possession of a disabled person unless the removal is necessary for law enforcement purposes or to protect the safety of the disabled person.

Subd. 3. **Duty; absence of device.** A law enforcement officer who finds a disabled person without an identifying device or identification card is not relieved of the duty to that person to make a diligent effort to ascertain the existence of any illness causing the disabled condition.

Subd. 4. **Actions.** A cause of action against a law enforcement officer does not arise from the officer's making a reasonable search of the disabled person to locate an identifying device or identification card, even though the person is not wearing an identifying device or carrying an identification card.

Subd. 5. **Notification; medical care.** A law enforcement officer who determines or has reason to believe that a disabled person is suffering from an illness causing the person's condition shall promptly notify the person's physician, advanced practice registered nurse, or physician assistant, if practicable. If the officer is unable to ascertain the physician's, advanced practice registered nurse's, or physician assistant's identity or to communicate with the physician, advanced practice registered nurse, or physician assistant, the officer shall make a reasonable effort to cause the disabled person to be transported immediately to a medical practitioner or to a facility where medical treatment is available. If the officer believes it unduly dangerous

to move the disabled person, the officer shall make a reasonable effort to obtain the assistance of a medical practitioner.

History: *1973 c 428 s 3; 1983 c 10 s 1; 1986 c 444; 1988 c 689 art 2 s 44; 2020 c 115 art 4 s 64; 2022 c 58 s 75*

145.854 DUTY OF MEDICAL PRACTITIONERS.

Subdivision 1. **Search.** A medical practitioner, in discharging a duty to a disabled person whom the practitioner has undertaken to examine or treat, shall make a reasonable search for an identifying device or identification card of the type described in section 145.852, subdivision 2 and examine them for emergency information.

Subd. 2. **Actions.** A cause of action against a medical practitioner does not arise from the practitioner's making a reasonable search of a disabled person to locate an identifying device or identification card, even though the person is not wearing an identifying device or carrying an identification card.

History: *1973 c 428 s 4; 1986 c 444*

145.855 DUTY OF OTHERS.

Subdivision 1. **Notification; search.** A person, other than a law enforcement officer or medical practitioner, who finds a disabled person shall make a reasonable effort to notify a law enforcement officer. If a law enforcement officer or medical practitioner is not present, a person who finds a disabled person may (1) make a reasonable search for an identifying device, and (2) if the identifying device is found may make a reasonable search for an identification card of the type described in section 145.852, subdivision 2. If a device or card is located, the person making the search shall attempt promptly to bring its contents to the attention of a law enforcement officer or medical practitioner.

Subd. 2. **Actions.** A cause of action does not arise from a reasonable search to locate an identifying device or identification card as authorized by subdivision 1.

History: *1973 c 428 s 5*

145.856 FALSIFYING IDENTIFICATION OR MISREPRESENTING CONDITION; PENALTY.

A person who with intent to deceive provides, wears, uses, or possesses a false identifying device or identification card of the type described in section 145.852, subdivision 2 is guilty of a misdemeanor.

History: *1973 c 428 s 6*

145.857 OTHER DUTIES.

The duties imposed by sections 145.851 to 145.858 are in addition to, and not in limitation of, other duties existing under the law of this state.

History: *1973 c 428 s 7*

145.858 CITATION.

Sections 145.851 to 145.858 may be cited as the "Uniform Duties to Disabled Persons Act."

History: *1973 c 428 s 8*

145.861 [Repealed, 1976 c 222 s 209]

145.862 [Repealed, 1976 c 222 s 209]

145.863 [Repealed, 1976 c 222 s 209]

145.864 [Repealed, 1976 c 222 s 209]

145.865 Subdivision 1. [Repealed, 1976 c 222 s 209]

Subd. 2. [Repealed, 1975 c 315 s 26]

Subd. 3. [Repealed, 1976 c 222 s 209]

145.866 [Repealed, 1976 c 222 s 209]

SPECIAL DIETS

145.867 PERSONS REQUIRING SPECIAL DIETS.

Subdivision 1. **Public facility.** "Public facility" means an auditorium, concert hall, sports stadium, sports arena, or theater.

Subd. 2. **Identification card for individuals needing a special diet.** The commissioner of health shall make special diet identification cards available to physicians, advanced practice registered nurses, physician assistants, and persons with diabetes and other conditions requiring special diets. The identification card must contain spaces for: (1) the person's name, address, and signature; (2) the physician's, advanced practice registered nurse's, or physician assistant's name, telephone number, and signature; (3) a description of the person's medical condition; and (4) an expiration date. The card must also contain the following provision, in identical or substantially similar language: "The owner of this card is exempted by the commissioner of health from prohibitions on bringing outside food and drink into a public facility." Persons with medical conditions requiring a special diet may ask their physician, advanced practice registered nurse, or physician assistant to fill out and sign the card. The physician, advanced practice registered nurse, or physician assistant shall fill out and sign the card if, in the physician's, advanced practice registered nurse's, or physician assistant's medical judgment, the person has a medical condition that requires a special diet. Persons with diabetes shall be automatically assumed by physicians, advanced practice registered nurses, and physician assistants to require special diets. Special diet identification cards shall be valid for five years. Persons with a medical condition requiring a special diet may request a new card from their physician, advanced practice registered nurse, or physician assistant up to six months before the expiration date.

Subd. 3. **Exemption from food and drink prohibitions.** Persons with medical conditions requiring a special diet who present a valid special diet identification card to any employee of a public facility shall be allowed to bring in outside food and drink, subject to the limitations in subdivision 4. To be valid, the card must be filled out according to subdivision 2 and must be current. Persons with special diet identification cards must obey all other food and drink regulations established by a public facility including prohibitions on eating or drinking in certain areas of the public facility.

Subd. 4. **Limitation on exemption.** Public facilities may limit the amount of food and drink that may be brought into a public facility by a person with a special diet identification card to the amount that can reasonably be consumed by a single individual. Public facilities may also place limits on the size of any food or drink container carried in, if the container would be a safety hazard or interfere with other patrons

or customers. Public facilities may also require persons displaying a special diet identification card to show some other form of identification.

History: *1989 c 282 art 2 s 32; 2017 c 59 s 5*

145.87 HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and have the meanings given them.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either:

(i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or

(ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women or young children; and

(2) either:

(i) has an active evaluation of the program; or

(ii) has a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential and no individual is disadvantaged from achieving this potential.

(e) "Promising practice home visiting program" means a program that has shown improvement toward achieving positive outcomes for pregnant women or young children.

Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall award grants to community health boards, nonprofit organizations, and Tribal Nations to start up, sustain, or expand voluntary home visiting programs serving pregnant women or families with young children. Home visiting programs supported under this section shall provide voluntary home visits by early childhood professionals or health professionals, including but not limited to nurses, social workers, early childhood educators, and trained paraprofessionals. Grant money shall be used to:

(1) establish, sustain, or expand evidence-based, evidence-informed, or promising practice home visiting programs that address health equity and utilize community-driven health strategies;

(2) serve families with young children or pregnant women who have high needs or are high-risk, including but not limited to a family with low income, a parent or pregnant woman with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing housing instability or domestic abuse; and

(3) improve program outcomes in two or more of the following areas:

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

(iv) coordination and referral for other community resources and supports;

(v) reduction in child injuries, abuse, or neglect; or

(vi) reduction in crime or domestic violence.

(b) Grants awarded to evidence-informed and promising practice home visiting programs must include money to evaluate program outcomes for up to four of the areas listed in paragraph (a), clause (3).

Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give priority to community health boards, nonprofit organizations, and Tribal Nations seeking to expand home visiting services with community or regional partnerships.

(b) The commissioner shall allocate at least 75 percent of the grant money awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant money awarded each grant cycle to evidence-informed or promising practice home visiting programs that address health equity and utilize community-driven health strategies.

Subd. 4. **Administration.** The commissioner may provide training and technical assistance and administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to establishing, sustaining, or expanding evidence-based home visiting programs shall, for grants awarded on or after July 1, 2021, be awarded according to this section. This section shall not govern grant awards of federal funds for home visiting programs and shall not govern grant awards using state general fund appropriations dedicated to establishing or expanding nurse-family partnership home visiting programs.

History: *2021 c 30 art 3 s 21; 2023 c 70 art 4 s 58*

MATERNAL AND CHILD HEALTH

145.88 PURPOSE.

Federal money received by the Minnesota Department of Health, pursuant to United States Code, title 42, sections 701 to 709, shall be expended to:

(1) assure access to quality maternal and child health services for mothers and children, especially those of low income and with limited availability to health services and those children at risk of physical,

neurological, emotional, and developmental problems arising from chemical abuse by a mother during pregnancy;

(2) reduce infant mortality and the incidence of preventable diseases and disabling conditions among children;

(3) reduce the need for inpatient and long-term care services and to otherwise promote the health of mothers and children, especially by providing preventive and primary care services for low-income mothers and children and prenatal, delivery and postpartum care for low-income mothers;

(4) provide rehabilitative services for blind and disabled children under age 16 receiving benefits under title XVI of the Social Security Act; and

(5) provide and locate medical, surgical, corrective and other service for children with special health care needs.

History: *1982 c 431 s 1; 1990 c 542 s 3; 1Sp2003 c 14 art 8 s 2; 2005 c 56 s 1; 2013 c 62 s 5*

145.881 MS 2010 [Expired, 1Sp2003 c 14 art 7 s 45; 2007 c 85 s 4]

145.8811 MATERNAL AND CHILD HEALTH ADVISORY COMMITTEE.

Subdivision 1. **Composition of committee.** The commissioner shall establish and appoint a Maternal and Child Health Advisory Committee consisting of 15 members who will provide equal representation from:

(1) professionals with expertise in maternal and child health services;

(2) representatives of community health boards as defined in section 145A.02, subdivision 5; and

(3) consumer representatives interested in the health of mothers and children.

No members shall be employees of the Minnesota Department of Health. Section 15.059 governs the Maternal and Child Health Advisory Committee. Notwithstanding section 15.059, the Maternal and Child Health Advisory Committee does not expire.

Subd. 2. **Duties.** The advisory committee shall meet on a regular basis to perform the following duties:

(1) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(2) review and report on the type, frequency, and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(3) establish, review, and report to the commissioner a list of program guidelines and criteria the advisory committee considers essential to providing an effective maternal and child health care program to low-income populations and high-risk persons and fulfilling the purposes defined in section 145.88;

(4) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(5) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services:

(i) prenatal, delivery, and postpartum care;

(ii) comprehensive health care for children, especially from birth through five years of age;

(iii) adolescent health services;

(iv) family planning services;

(v) preventive dental care;

(vi) special services for chronically ill and disabled children; and

(vii) any other services that promote the health of mothers and children; and

(6) establish in consultation with the commissioner statewide outcomes that will improve the health status of mothers and children.

History: *2012 c 247 art 2 s 7; 2014 c 291 art 7 s 29; 2015 c 42 s 3; 1Sp2025 c 3 art 1 s 77*

145.882 MATERNAL AND CHILD HEALTH BLOCK GRANT DISTRIBUTION.

Subdivision 1. **Funding.** Any decrease in the amount of federal funding to the state for the maternal and child health block grant must be apportioned to reflect a proportional decrease for each recipient. Any increase in the amount of federal funding to the state must be distributed under subdivisions 2 and 3.

Subd. 2. **Allocation to commissioner of health.** Beginning January 1, 1986, up to one-third of the total maternal and child health block grant money may be retained by the commissioner of health to:

(1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report;

(2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year;

(3) provide technical assistance to community health boards in meeting statewide outcomes;

(4) evaluate the impact of maternal and child health activities on the health status of mothers and children;

(5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and

(6) perform other maternal and child health activities listed in section 145.88 and as deemed necessary by the commissioner.

Subd. 3. **Allocation to community health boards.** (a) The maternal and child health block grant money remaining after distributions made under subdivision 2 must be allocated according to the formula in section 145A.131, subdivision 2, for distribution to community health boards.

(b) A community health board that receives funding under this section shall provide at least a 50 percent match for funds received under United States Code, title 42, sections 701 to 709. Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other funds, donations, nonfederal grants, or state funds received under the local public health grant defined in section 145A.131, that are used for maternal and child health activities as described in subdivision 7.

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5a. **Nonparticipating community health boards.** If a community health board decides not to participate in maternal and child health block grant activities under subdivision 3 or the commissioner determines under section 145A.03, subdivision 7, not to fund the community health board, the commissioner is responsible for directing maternal and child health block grant activities in that community health board's geographic area. The commissioner may elect to directly provide public health activities to meet the statewide outcomes or to contract with other governmental units or nonprofit organizations.

Subd. 6. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 7. **Use of block grant money.** Maternal and child health block grant money allocated to a community health board under this section must be used for qualified programs for high risk and low-income individuals. Block grant money must be used for programs that:

(1) specifically address the highest risk populations, particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, including prepregnancy family planning services, calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;

(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

(3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;

(4) provide family planning and preventive medical care for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to decrease the occurrence of inappropriate pregnancy and minimize the risk of complications associated with pregnancy and childbirth;

(5) specifically address the frequency and severity of childhood and adolescent health issues, including injuries in high risk target populations by providing services calculated to produce measurable decreases in mortality and morbidity;

(6) specifically address preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visits under section 145A.17; or

(7) specifically address nutritional issues of women, infants, and young children through WIC clinic services.

Subd. 8. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 9. **Contracting and procurement.** The commissioner is exempt from the contract term limits in chapter 16C for issuance of benefits under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) through an electronic benefit transfer (EBT) system and related services and contracts. The contracts may have an initial term of up to five years, with extensions not to exceed a ten-year total contract duration.

Subd. 10. **Management information systems; contracting and procurement.** WIC is exempt from the contract term limits in chapter 16C for the management information systems used for issuance of supplemental nutrition benefits and the WIC EBT systems used for processing the redemptions of supplemental nutrition benefits. These contracts may have an initial term of up to five years, with extensions not to exceed a ten-year total contract duration.

History: *1982 c 431 s 3; 1983 c 312 art 4 s 2; 1Sp1985 c 14 art 19 s 18; 1987 c 209 s 33; 1987 c 309 s 24; 1989 c 282 art 2 s 33-35; 1990 c 542 s 4; 1Sp2003 c 14 art 8 s 4-8; 2014 c 291 art 7 s 29; 2026 c 88 art 1 s 65; 2026 c 127 art 1 s 33,34*

145.8821 ACCOUNTABILITY.

(a) Coordinating with accountability measures outlined in section 145A.131, subdivision 3, each community health board that receives money under section 145.882, subdivision 3, shall select by February 1, 2005, and every five years thereafter, up to two statewide maternal and child health outcomes.

(b) For the period January 1, 2004, to December 31, 2005, each community health board must work toward the Healthy People 2010 goal to reduce the state's percentage of low birth weight infants.

(c) The commissioner shall monitor and evaluate whether each community health board has made sufficient progress toward the selected outcomes established in paragraph (b).

(d) Community health boards shall provide the commissioner with annual information necessary to evaluate progress toward selected statewide outcomes and to meet federal reporting requirements.

History: *1Sp2003 c 14 art 8 s 9; 2014 c 275 art 1 s 27; 2014 c 291 art 7 s 29; 2026 c 88 art 1 s 66*

145.883 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 145.882 and 145.883, the terms defined in this section shall have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Qualified program.** "Qualified program" means a program with professional maternal and child health care staff which is established for the purpose of providing one or more essential services in maternal and child health care to target populations of low income and high risk persons. Nothing in this subdivision shall imply that every person served must take a means test.

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5. **Low income.** "Low income" means an individual or family income determined to be at or below 175 percent of the official poverty line established by the Office of Management and Budget and revised annually in accordance with United States Code, title 42, section 9902, as amended. With respect to an individual who is a high risk person, "low income" means that the income of the high risk person or the person's family is determined to be at or below 200 percent of the official poverty line established by the Office of Management and Budget and revised annually in accordance with United States Code, title 42, section 9902, as amended, or determined to meet the income eligibility requirements of medical assistance, MinnesotaCare, or the special supplemental food program for women, infants and children (WIC). The commissioner shall establish the low income level for eligibility for services to children with disabilities.

Subd. 6. **High risk person.** "High risk person" means a mother or child with a condition which significantly increases the probability of disease, injury, death, or other adverse health-related problem. Determination that a condition results in high risk shall be based on well-validated, scientific studies.

Subd. 7. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 8. **Maternal and child health block grant money.** "Maternal and child health block grant money" means the money received by the state from the federal maternal and child health block grant. The commissioner shall carry forward from state fiscal year 1985, and succeeding years, only sufficient money for qualified programs approved through the federal award period.

Subd. 9. **Community health board.** "Community health board" means a community health board established, operating, and eligible for a local public health grant under sections 145A.11 to 145A.131.

History: *1983 c 312 art 4 s 3; 1Sp1985 c 14 art 19 s 19,20; 1987 c 309 s 24-26; 1991 c 36 s 3; 1Sp1993 c 1 art 3 s 1; 1Sp2003 c 14 art 8 s 10,11; 2005 c 56 s 1; 2012 c 187 art 1 s 23; 2014 c 219 art 7 s 29; 2015 c 21 art 1 s 109*

145.884 Subdivision 1. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 2. [Repealed, 1Sp1985 c 14 art 19 s 38; 1Sp2003 c 14 art 8 s 32]

145.885 [Repealed, 1Sp2003 c 14 art 8 s 32]

145.886 [Repealed, 1Sp2003 c 14 art 8 s 32]

145.888 [Repealed, 1Sp2003 c 14 art 8 s 32]

145.889 [Repealed, 1Sp2003 c 14 art 8 s 32]

145.890 [Repealed, 1Sp2003 c 14 art 8 s 32]

145.891 CITATION.

Sections 145.891 to 145.897 shall be known as the "Maternal and Child Nutrition Act of 1975."

History: *1975 c 346 s 1*

145.892 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 145.891 to 145.897, the terms defined in this section have the meanings given them.

Subd. 2. **Local health agency.** "Local health agency" means the community health services agency or any public or private nonprofit organization which enters into a contract with the commissioner of health pursuant to sections 145.891 to 145.897.

Subd. 3. **Pregnant woman.** "Pregnant woman" means an individual determined by a licensed physician, advanced practice registered nurse, physician assistant, midwife, or appropriately trained registered nurse to have one or more fetuses in utero.

Subd. 4. **Lactating woman.** "Lactating woman" means any breast feeding individual who presents competent evidence of having been delivered of a surviving child within the 12 months immediately preceding the filing of an application for nutritional supplements.

Subd. 5. **Infant.** "Infant" means an individual under one year of age.

Subd. 6. **Child.** "Child" means an individual one to five years of age.

Subd. 7. **Nutritional risk.** "Nutritional risk" means individuals with any of the following characteristics:

(a) For pregnant and lactating women:

(i) Known inadequate nutritional patterns;

(ii) Anemia;

(iii) History of prematurity or miscarriage; or

(iv) Inadequate patterns of growth (underweight, obesity, or stunting).

(b) For infants and children:

(i) Low birth weight;

(ii) Deficient patterns of growth;

(iii) Anemia; or

(iv) Known inadequate nutritional patterns.

Subd. 8. **Low birth weight.** "Low birth weight" means a birth weight of less than 2,500 grams.

Subd. 9. **Nutritional supplements.** "Nutritional supplements" means any food authorized by the commissioner to be made available under this program.

Subd. 10. **Commissioner.** "Commissioner" means the commissioner of health or a representative.

History: *1975 c 346 s 2; 1977 c 305 s 45; 1978 c 762 s 4; 1986 c 404 s 7; 1986 c 444; 2020 c 115 art 4 s 65; 2022 c 58 s 76*

145.893 NUTRITIONAL SUPPLEMENT PROGRAM.

Subdivision 1. **Food benefits.** An eligible individual shall receive food benefits for the purchase of specified nutritional supplements in type and quantity approved by the commissioner. Alternate forms of delivery may be developed by the commissioner in appropriate cases.

Subd. 2. **Eligibility.** An individual shall be eligible for nutritional supplements who is not receiving a similar supplement under any federal, state, or local program and

(1) is pregnant or lactating; or

(2) is an infant or a child; and

(3) is eligible for or a recipient of any form of public assistance authorized by law and is certified by the local health agency to be a nutritional risk; or

(4) is certified by the local health agency to be a nutritional risk and is without sufficient resources to purchase necessary nutritional supplements.

Subd. 3. **Cessation.** Eligibility for nutritional supplements shall cease upon certification by the local health agency that the individual is no longer a nutritional risk, but in no case later than:

(1) for lactating women, 12 months after the birth of a surviving child; and

(2) for children, at five years of age.

History: *1975 c 346 s 3; 1977 c 305 s 45; 1978 c 762 s 5; 2021 c 30 art 3 s 22*

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

(1) develop a comprehensive state plan for the delivery of nutritional supplements to pregnant and lactating women, infants, and children;

(2) contract with existing local public or private nonprofit organizations for the administration of the nutritional supplement program;

(3) develop and implement a public education program promoting the provisions of sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition education and counseling at project sites. The education programs must include a campaign to promote breast feeding;

(4) develop in cooperation with other agencies and vendors a uniform state food benefit system for the delivery of nutritional supplements;

(5) authorize local health agencies to issue food benefits trimonthly to some or all eligible individuals served by the agency, provided the agency demonstrates that the federal minimum requirements for providing nutrition education will continue to be met and that the quality of nutrition education and health services provided by the agency will not be adversely impacted;

(6) investigate and implement a system to reduce the cost of nutritional supplements and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to maximize cost savings;

(7) develop, analyze, and evaluate the health aspects of the nutritional supplement program and establish nutritional guidelines for the program;

(8) apply for, administer, and annually expend at least 99 percent of available federal or private funds;

(9) aggressively market services to eligible individuals by conducting ongoing outreach activities and by coordinating with and providing marketing materials and technical assistance to local human services and community service agencies and nonprofit service providers;

(10) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC);

(11) promulgate all rules necessary to carry out the provisions of sections 145.891 to 145.897; and

(12) ensure that any state appropriation to supplement the federal program is spent consistent with federal requirements.

History: *1975 c 346 s 4; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 404 s 8; 1988 c 689 art 2 s 45; 1989 c 282 art 1 s 17; 1990 c 568 art 3 s 5; 1997 c 7 art 2 s 20; 2021 c 30 art 3 s 23*

145.895 DEPARTMENT OF HUMAN SERVICES.

The commissioner of human services shall cooperate with the commissioners of health and children, youth, and families in identifying eligible individuals. The commissioner of human services shall provide

a procedure for the notification of pregnant or lactating women, infants and children receiving any form of public assistance of eligibility for benefits under this program.

History: *1975 c 346 s 5; 1977 c 305 s 45; 1984 c 654 art 5 s 58; 2025 c 21 s 19*

145.896 PROGRAM NOT A SUBSTITUTE OR REPLACEMENT.

This program shall not be a replacement or substitute for any other local, state, or federal program administered through the Departments of Health or Human Services, nor shall the value of the nutritional supplements be included in eligibility determination for other assistance programs.

History: *1975 c 346 s 6; 1984 c 654 art 5 s 58*

145.897 FOOD BENEFITS.

Food benefits issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the United States Department of Agriculture to be desirable nutritional supplements for pregnant and lactating women, infants and children.

History: *1975 c 346 s 7; 1977 c 305 s 45; 2021 c 30 art 3 s 24*

145.898 SUDDEN INFANT DEATH.

The Department of Health shall develop uniform investigative guidelines and protocols for coroners and medical examiners conducting death investigations and autopsies of children under two years of age.

History: *1989 c 282 art 2 s 36*

145.899 WIC FOOD BENEFITS FOR ORGANICS.

Food benefits for the special supplemental nutrition program for women, infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable food. The commissioner of health shall regularly evaluate the list of WIC allowable food in accordance with federal requirements and shall add to the list any organic WIC allowable foods determined to be cost-neutral.

History: *2009 c 114 s 1; 2021 c 30 art 3 s 25*

145.90 [Repealed, 2001 c 211 s 4]

145.901 MATERNAL DEATH STUDIES.

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

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (c), without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to deaths that occur on or after July 1, 2000, including the names of the providers, clinics, or other health services such as family home

visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; and behavioral health services, where care was received before, during, or related to the pregnancy or death. The commissioner has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital discharge data, for the purpose of providing the name and location of any pre-pregnancy, prenatal, or other care received by the subject of the data up to one year after the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the parent, spouse, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from a coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, or other health services to the subject of the data.

(f) The commissioner may access Department of Human Services and Department of Children, Youth, and Families data to identify sources of care and services to assist with the evaluation of welfare systems, including housing, to reduce preventable maternal deaths.

(g) The commissioner may request and receive law enforcement reports or incident reports related to the subject of the data.

Subd. 3. **Management of records.** After the commissioner has collected all data about a subject of a maternal death study needed to perform the study, the data from source records obtained under subdivision 2, other than data identifying the subject, must be transferred to separate records to be maintained by the commissioner. Notwithstanding section 138.17, after the data have been transferred, all source records obtained under subdivision 2 possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal death studies.

(c) Summary data on maternal death studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services or the commissioner of children, youth, and families to the commissioner of health under this section retain the same classification the data held when

retained by the commissioner of human services or the commissioner of children, youth, and families, as required under section 13.03, subdivision 4, paragraph (c).

Subd. 5. **Maternal Mortality Review Committee.** (a) The commissioner of health shall convene a Maternal Mortality Review Committee to conduct maternal death study reviews, make recommendations, and publicly share summary information. The commissioner shall appoint members to the review committee, and membership may include but is not limited to medical examiners or coroners, representatives of health care institutions that provide care to pregnant women, obstetric and midwifery practitioners, Medicaid representatives, representatives of state agencies, individuals from communities with disparate rates of maternal mortality, and other subject matter experts as appropriate. Committee membership shall not exceed 25 members. The review committee shall review data from source records obtained under subdivision 2, other than data identifying the subject or the provider.

(b) A person attending a Maternal Mortality Review Committee meeting shall not disclose what transpired at the meeting, except as necessary to carry out the purposes of the review committee. The proceedings and records of the review committee are protected nonpublic data as defined in section 13.02, subdivision 13. Discovery and introduction into evidence in legal proceedings of case review committee proceedings and records, and testimony in legal proceedings by review committee members and persons presenting information to the review committee, shall occur in compliance with the requirements in section 142A.03, subdivision 7, paragraph (e).

History: *2001 c 211 s 3; 2007 c 147 art 10 s 15; 2020 c 83 art 2 s 4; 1Sp2021 c 7 art 3 s 37-39; 2024 c 80 art 1 s 96; 2024 c 115 art 16 s 34; 2025 c 21 s 20,21; 1Sp2025 c 3 art 6 s 3*

145.902 GIVE LIFE A CHANCE; SAFE PLACE FOR NEWBORNS DUTIES; IMMUNITY.

Subdivision 1. **General.** (a) For purposes of this section, a "safe place" means a hospital licensed under sections 144.50 to 144.56, a health care provider who provides urgent care medical services, or an ambulance service licensed under chapter 144E dispatched in response to a 911 call from a mother or a person with the mother's permission to relinquish a newborn infant.

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

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

(2) the newborn is left in an unharmed condition.

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

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

Subd. 2. **Reporting.** Within 24 hours of receiving a newborn under this section, the hospital must inform the responsible social service agency that a newborn has been left at the hospital, but must not do so in the presence of the mother or the person leaving the newborn. The hospital must provide necessary care to the newborn pending assumption of legal responsibility by the responsible social service agency pursuant to section 260C.139, subdivision 5.

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

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

History: *2000 c 421 s 1; 2012 c 216 art 2 s 1; art 6 s 13; 1Sp2020 c 2 art 8 s 29*

145.903 SCHOOL-BASED HEALTH CENTERS.

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, provided by licensed and qualified health professionals in accordance with federal, state, and local law. When not located on school property, the school-based health center must have an established relationship with one or more schools in the community and operate to primarily serve those student groups.

(c) "Sponsoring organization" means any of the following that operate a school-based health center:

(1) health care providers;

(2) community clinics;

(3) hospitals;

(4) federally qualified health centers and look-alikes as defined in section 145.9269;

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

(1) operate in partnership with a school or school district and with the permission of the school or school district board;

(2) provide health services through a sponsoring organization that meets the requirements in subdivision 1, paragraph (c); and

(3) provide health services to all students and youth within a school or school district, regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.

(c) The commissioner of health shall administer a grant to a nonprofit organization to facilitate a community of practice among school-based health centers to improve quality, equity, and sustainability of care delivered through school-based health centers; encourage cross-sharing among school-based health centers; support existing clinics; and expand school-based health centers in new communities in Minnesota.

(d) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

(e) The commissioners of health and of education shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote coordinated efforts.

Subd. 3. **School-based health center services.** (a) Services provided by a school-based health center may include but are not limited to:

(1) preventive health care;

(2) chronic medical condition management, including diabetes and asthma care;

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

(b) Services provided by a school-based health center must not replace the daily student support provided in the school by educational student service providers, including but not limited to licensed school nurses, educational psychologists, school social workers, and school counselors.

Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or school district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or school district and must identify the costs that are the responsibility

of the school or school district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health centers in order to maintain the financial sustainability of school-based health centers.

History: *2023 c 70 art 4 s 59*

145.905 LOCATION FOR BREASTFEEDING.

A mother may breastfeed in any location, public or private, where the mother and child are otherwise authorized to be, irrespective of whether the nipple of the mother's breast is uncovered during or incidental to the breastfeeding.

History: *1998 c 407 art 2 s 83*

145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.

(a) The commissioner of health shall work with health care facilities, licensed health and mental health care professionals, the women, infants, and children (WIC) program, mental health advocates, consumers, and families in the state to develop materials and information about postpartum depression, including treatment resources, and develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must have available to women and their families information about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources.

(d) Information about postpartum depression, including its symptoms, potential impact on families, and treatment resources, must be available at WIC sites.

(e) The commissioner of health, in collaboration with the commissioner of human services and to the extent authorized by the federal Centers for Disease Control and Prevention, shall review the materials and information related to postpartum depression to determine their effectiveness in transmitting the information in a way that reduces racial health disparities as reported in surveys of maternal attitudes and experiences before, during, and after pregnancy, including those conducted by the commissioner of health. The commissioner shall implement changes to reduce racial health disparities in the information reviewed, as needed, and ensure that women of color are receiving the information.

History: *1Sp2005 c 4 art 6 s 38; 2012 c 247 art 2 s 8; 2013 c 108 art 12 s 46*

145.907 MATERNAL DEPRESSION; DEFINITION.

"Maternal depression" means depression or other perinatal mood or anxiety disorder experienced by a woman during pregnancy or during the first year following the birth of her child.

History: *2013 c 108 art 12 s 47*

145.908 GRANT PROGRAM; SCREENING AND TREATMENT FOR PRE- AND POSTPARTUM MOOD AND ANXIETY DISORDERS.

Subdivision 1. **Grant program established.** Within the limits of available appropriations for this purpose, the commissioner of health shall establish a grant program to provide culturally competent programs

to screen and treat pregnant women and women who have given birth in the preceding 12 months for pre- and postpartum mood and anxiety disorders. Organizations may use grant funds to establish new screening or treatment programs, or expand or maintain existing screening or treatment programs. In establishing the grant program, the commissioner shall prioritize expanding or enhancing screening for pre- and postpartum mood and anxiety disorders in primary care settings. The commissioner shall determine the types of organizations eligible for grants.

Subd. 2. **Allowable uses of funds.** Grant funds awarded by the commissioner under this section:

(1) must be used to provide health care providers with appropriate training and relevant resources on screening, treatment, follow-up support, and links to community-based resources for pre- and postpartum mood and anxiety disorders; and

(2) may be used to:

(i) enable health care providers to provide or receive psychiatric consultations to treat eligible women for pre- and postpartum mood and anxiety disorders;

(ii) conduct a public awareness campaign;

(iii) fund start-up costs for telephone lines, websites, and other resources to collect and disseminate information about screening and treatment for pre- and postpartum mood and anxiety disorders; or

(iv) establish connections between community-based resources.

Subd. 3. **Federal funds.** The commissioner shall apply for any available grant funds from the federal Department of Health and Human Services for this program.

History: *2016 c 189 art 20 s 21; 1Sp2019 c 9 art 11 s 68*

145.911 [Repealed, 1987 c 309 s 27]

145.912 Subdivision 1. [Repealed, 1987 c 309 s 27]

Subd. 2. [Repealed, 1987 c 309 s 27]

Subd. 3. [Repealed, 1987 c 309 s 27]

Subd. 4. [Repealed, 1987 c 309 s 27]

Subd. 5. [Repealed, 1987 c 309 s 27]

Subd. 6. [Repealed, 1987 c 309 s 27]

Subd. 7. [Repealed, 1987 c 309 s 27]

Subd. 8. [Repealed, 1987 c 309 s 27]

Subd. 9. [Renumbered 145.925, subd 1a]

Subd. 10. [Repealed, 1987 c 309 s 27]

Subd. 11. [Repealed, 1987 c 309 s 27]

Subd. 12. [Repealed, 1987 c 309 s 27]

Subd. 13. [Repealed, 1987 c 309 s 27]

Subd. 14. [Repealed, 1987 c 309 s 27]

Subd. 15. [Repealed, 1987 c 309 s 27]

Subd. 16. [Repealed, 1Sp1985 c 9 art 2 s 104]

Subd. 17. [Repealed, 1Sp1985 c 9 art 2 s 104]

Subd. 18. [Repealed, 1Sp1985 c 9 art 2 s 104]

Subd. 19. [Repealed, 1987 c 309 s 27]

Subd. 20. [Repealed, 1987 c 309 s 27]

145.913 [Repealed, 1987 c 309 s 27]

145.914 [Repealed, 1987 c 309 s 27]

145.915 [Repealed, 1987 c 309 s 27]

145.916 [Repealed, 1987 c 309 s 27]

145.917 [Repealed, 1987 c 309 s 27]

145.918 [Repealed, 1987 c 309 s 27]

145.919 [Repealed, 1987 c 309 s 27]

145.92 [Repealed, 1987 c 309 s 27]

145.921 [Renumbered 145A.13]

145.922 [Repealed, 1987 c 309 s 27]

EPILEPSY AND RELATED SEIZURE DISORDERS

145.923 [Renumbered 145A.14, subd 3]

145.9231 EPILEPSY AND RELATED SEIZURE DISORDERS; DATA COLLECTION AND STATE COORDINATION PLAN.

Subdivision 1. **Data collection.** The commissioner of health must collect, analyze, and report data on epilepsy and related seizure disorders in Minnesota. The data must include the number of diagnoses, clinical outcomes, mortality rates, and related population health data for each calendar year. Deidentified data must be made publicly available.

Subd. 2. **State coordination plan.** The commissioner of health must use the data on epilepsy and seizure disorders to inform statewide efforts and build coordinated systems and partnerships to support community-led and culturally responsive strategies to ensure that Minnesotans at risk for or living with epilepsy and seizure disorders and their caregivers have equitable access to opportunities and resources to support their well-being and quality of life. The commissioner of health must use the data to identify areas of need and recommend strategies to address gaps.

History: *1Sp2025 c 3 art 1 s 78*

HEALTH GRANTS

145.924 HIV PREVENTION GRANTS.

(a) The commissioner may award grants to community health boards as defined in section 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, communities of color, adolescents, women, people who inject drugs, and gay, bisexual, and transgender individuals.

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including people who inject drugs and their partners, adolescents, women, and gay, bisexual, and transgender individuals. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policy makers representative of the targeted population; that have experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific Islander community.

(c) All state grants awarded under this section for programs targeted to adolescents shall include the promotion of abstinence from sexual activity and drug use.

(d) The commissioner shall administer a grant program to provide funds to organizations, including Tribal health agencies, to assist with HIV outbreaks.

History: *1987 c 309 s 24; 1988 c 689 art 2 s 46; 1991 c 292 art 2 s 31; 1999 c 245 art 2 s 31; 2015 c 21 art 1 s 109; 2023 c 70 art 4 s 60*

145.9245 [Repealed, 1Sp2001 c 9 art 3 s 76]

145.925 SEXUAL AND REPRODUCTIVE HEALTH SERVICES GRANTS.

Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase access to sexual and reproductive health services for people who experience barriers, whether geographic, cultural, financial, or other, in access to such services. The commissioner of health shall administer grants to facilitate access to sexual and reproductive health services for people of reproductive age, particularly those from populations that experience barriers to these services.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in sexual and reproductive health service promotion among people of reproductive age.

Subd. 1a. MS 2022 [Repealed by amendment, 2023 c 70 art 4 s 61]

Subd. 2. MS 2022 [Repealed by amendment, 2023 c 70 art 4 s 61]

Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section, "sexual and reproductive health services" means services that promote a state of complete physical, mental, and social well-being in relation to sexuality, reproduction, and the reproductive system and its functions and processes, and not merely the absence of disease or infirmity. These services must be provided in accord with nationally

recognized standards and include but are not limited to sexual and reproductive health counseling, voluntary and informed decision-making on sexual and reproductive health, information on and provision of contraceptive methods, sexual and reproductive health screenings and treatment, pregnancy testing and counseling, and other preconception services.

Subd. 3. **Grants authorized.** (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal communities in rural and metropolitan areas of the state to support, sustain, expand, or implement reproductive and sexual health programs for people of reproductive age to increase access to and availability of medically accurate sexual and reproductive health services.

(b) The commissioner of health shall establish application scoring criteria to use in the evaluation of applications submitted for award under this section. These criteria shall include but are not limited to the degree to which applicants' programming responds to demographic factors relevant to paragraph (f) and subdivision 1, paragraph (a).

(c) When determining whether to award a grant or the amount of a grant under this section, the commissioner of health may identify and stratify geographic regions based on the region's need for sexual and reproductive health services. In this stratification, the commissioner may consider data on the prevalence of poverty and other factors relevant to a geographic region's need for sexual and reproductive health services.

(d) The commissioner of health may consider geographic and Tribal communities' representation in the award of grants.

(e) Current recipients of funding under this section shall not be afforded priority over new applicants.

(f) Grant funds shall be used to support new or existing sexual and reproductive health programs that provide person-centered, accessible services; that are culturally and linguistically appropriate, inclusive of all people, and trauma-informed; that protect the dignity of the individual; and that ensure equitable, quality services consistent with nationally recognized standards of care. These services shall include:

(1) education and outreach on medically accurate sexual and reproductive health information;

(2) contraceptive counseling, provision of contraceptive methods, and follow-up;

(3) screening, testing, and treatment of sexually transmitted infections and other sexual or reproductive concerns; and

(4) referral and follow-up for medical, financial, mental health, and other services in accord with a service recipient's needs.

Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part from funds provided under this section who advises an abortion or sterilization to any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.

Subd. 5. MS 2022 [Repealed by amendment, 2023 c 70 art 4 s 61]

Subd. 6. **Public services; individual rights.** The request of any person for sexual and reproductive health services or the refusal to accept any service shall in no way affect the right of the person to receive public assistance, public health services, or any other public service. Nothing in this section shall abridge the right of the person to make decisions concerning sexual and reproductive health, nor shall any person be required to state a reason for refusing any offer of sexual and reproductive health services.

All information gathered by any agency, entity, or individual conducting programs in sexual and reproductive health is private data on individuals within the meaning of section 13.02, subdivision 12. For any person or entity meeting the definition of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and reproductive health services information provided to, gathered about, or received from a person under this section is also subject to the Minnesota Health Records Act, in sections 144.291 to 144.298.

Subd. 7. MS 2022 [Repealed by amendment, 2023 c 70 art 4 s 61]

Subd. 8. MS 2022 [Repealed by amendment, 2023 c 70 art 4 s 61]

Subd. 9. MS 2022 [Repealed by amendment, 2023 c 70 art 4 s 61]

History: *1976 c 9 s 2; 1977 c 305 s 45; 1978 c 775 s 1; 1981 c 311 s 39; 1981 c 356 s 176; 1982 c 545 s 24; 1983 c 289 s 115 subd 1; 1Sp1985 c 9 art 2 s 16; 1986 c 444; 1987 c 309 s 25; 1991 c 199 art 2 s 1; 1991 c 292 art 2 s 32; 1997 c 187 art 5 s 19; 1997 c 203 art 2 s 15; 2023 c 70 art 4 s 61*

145.9255 MINNESOTA EDUCATION NOW AND BABIES LATER; HEALTH.

Subdivision 1. **Establishment.** To the extent funds are available for the purposes of this subdivision, the commissioner of health, in consultation with a representative from Minnesota planning; the commissioner of human services; the commissioner of children, youth, and families; and the commissioner of education, shall develop and implement the Minnesota education now and babies later (MN ENABL) program, targeted to adolescents ages 12 to 14, with the goal of reducing the incidence of adolescent pregnancy in the state and promoting abstinence until marriage. The program must provide a multifaceted, primary prevention, community health promotion approach to educating and supporting adolescents in the decision to postpone sexual involvement modeled after the ENABL program in California. The commissioner of health shall consult with the chief of the health education section of the California Department of Health Services for general guidance in developing and implementing the program.

Subd. 2. **Definition.** "Community-based local contractor" or "contractor" includes community health boards under section 145A.02, nonprofit organizations, or school districts. The community-based local contractors may provide the education component of MN ENABL in a variety of settings including, but not limited to, schools, religious establishments, local community centers, and youth camps.

Subd. 3. **Duties of commissioner of health.** The commissioner shall:

(1) manage the grant process, including awarding and monitoring grants to community-based local contractors, and may contract with community-based local contractors that can demonstrate at least a 25 percent local match and agree to participate in the four MN ENABL program components under subdivision 4;

(2) provide technical assistance to the community-based local contractors as necessary under subdivision 4;

(3) develop and implement the evaluation component, and provide centralized coordination at the state level of the evaluation process; and

(4) explore and pursue the federal funding possibilities and specifically request funding from the United States Department of Health and Human Services to supplement the development and implementation of the program.

Subd. 4. **Program components.** (a) The program must include the following four major components:

(b) A community organization component in which the community-based local contractors shall include:

(1) use of a postponing sexual involvement education curriculum targeted to boys and girls ages 12 to 14 in schools and community settings;

(2) planning and implementing community organization strategies to convey and reinforce the MN ENABL message of postponing sexual involvement, including activities promoting awareness and involvement of parents and other primary caregivers/significant adults, schools, and community; and

(3) development of local media linkages.

(c) A statewide, comprehensive media and public relations campaign to promote changes in sexual attitudes and behaviors, and reinforce the message of postponing adolescent sexual involvement and promoting abstinence from sexual activity until marriage. Nothing in this paragraph shall be construed to prevent the commissioner from targeting populations that historically have had a high incidence of adolescent pregnancy with culturally appropriate messages on abstinence from sexual activity.

The commissioner of health, in consultation with the commissioner of education, shall develop and implement the media and public relations campaign. In developing the campaign, the commissioner of health shall coordinate and consult with representatives from ethnic and local communities to maximize effectiveness of the social marketing approach to health promotion among the culturally diverse population of the state. The commissioner may continue to use any campaign materials or media messages developed or produced prior to July 1, 1999.

The local community-based contractors shall collaborate and coordinate efforts with other community organizations and interested persons to provide school and community-wide promotional activities that support and reinforce the message of the MN ENABL curriculum.

(d) An evaluation component which evaluates the process and the impact of the program.

The "process evaluation" must provide information to the state on the breadth and scope of the program. The evaluation must identify program areas that might need modification and identify local MN ENABL contractor strategies and procedures which are particularly effective. Contractors must keep complete records on the demographics of clients served, number of direct education sessions delivered and other appropriate statistics, and must document exactly how the program was implemented. The commissioner may select contractor sites for more in-depth case studies.

The "impact evaluation" must provide information to the state on the impact of the different components of the MN ENABL program and an assessment of the impact of the program on adolescents' related sexual knowledge, attitudes, and risk-taking behavior.

The commissioner shall compare the MN ENABL evaluation information and data with similar evaluation data from other states pursuing a similar adolescent pregnancy prevention program modeled after ENABL and use the information to improve MN ENABL and build on aspects of the program that have demonstrated a delay in adolescent sexual involvement.

(e) A training component requiring the commissioner of health, in consultation with the commissioner of education, to provide comprehensive uniform training to the local MN ENABL community-based local contractors and the direct education program staff.

The local community-based contractors may use adolescent leaders slightly older than the adolescents in the program to impart the message to postpone sexual involvement provided:

(1) the contractor follows a protocol for adult mentors/leaders and older adolescent leaders established by the commissioner of health;

(2) the older adolescent leader is accompanied by an adult leader; and

(3) the contractor uses the curriculum as directed and required by the commissioner of the Department of Health to implement this part of the program. The commissioner of health shall provide technical assistance to community-based local contractors.

History: *1995 c 257 art 4 s 1; 1Sp1995 c 3 art 16 s 13; 1999 c 245 art 2 s 32,33; 2003 c 130 s 12; 2008 c 363 art 17 s 4; 2014 c 291 art 7 s 28; 2025 c 21 s 22*

145.9256 [Repealed, 1997 c 203 art 2 s 37]

145.926 [Repealed, 1993 c 224 art 4 s 45]

145.9261 ABSTINENCE EDUCATION GRANT PROGRAM.

The commissioner of health shall expend federal funds for abstinence education programs provided under United States Code, title 42, section 710, and state matching funds for abstinence education programs only to an abstinence education program that complies with the state plan that has been submitted to and approved by the federal Department of Health and Human Services.

History: *1998 c 407 art 2 s 84*

145.9265 FETAL ALCOHOL SYNDROME EFFECTS; DRUG-EXPOSED INFANT.

The commissioner of health, in coordination with the commissioner of education; the commissioner of children, youth, and families; and the commissioner of human services, shall design and implement a coordinated prevention effort to reduce the rates of fetal alcohol syndrome and fetal alcohol effects, and reduce the number of drug-exposed infants. The commissioner shall:

(1) conduct research to determine the most effective methods of preventing fetal alcohol syndrome, fetal alcohol effects, and drug-exposed infants and to determine the best methods for collecting information on the incidence and prevalence of these problems in Minnesota;

(2) provide training on effective prevention methods to health care professionals and human services workers; and

(3) operate a statewide media campaign focused on reducing the incidence of fetal alcohol syndrome and fetal alcohol effects and reducing the number of drug-exposed infants.

History: *1992 c 571 art 10 s 8; 1Sp1995 c 3 art 16 s 13; 2003 c 130 s 12; 2025 c 21 s 23*

145.9266 FETAL ALCOHOL SYNDROME CAMPAIGN AND EDUCATION.

Subdivision 1. **Public awareness and education.** The commissioner of health shall design and implement an ongoing statewide campaign to raise public awareness and educate the public about fetal alcohol syndrome and other effects of prenatal alcohol exposure. The campaign shall include messages directed to the general population as well as culturally specific and community-based messages. A toll-free resource and referral telephone line shall be included in the messages. The commissioner of health shall conduct an evaluation to determine the effectiveness of the campaign.

Subd. 2. **Statewide network of fetal alcohol syndrome diagnostic clinics.** A statewide network of regional fetal alcohol syndrome diagnostic clinics shall be developed between the Department of Health and the University of Minnesota. This collaboration shall be based on a statewide needs assessment and shall include involvement from consumers, providers, and payors. By the end of calendar year 1998, a plan shall be developed for the clinic network, and shall include a comprehensive evaluation component. Sites shall be established in calendar year 1999. The commissioner shall not access or collect individually identifiable data for the statewide network of regional fetal alcohol syndrome diagnostic clinics. Data collected at the clinics shall be maintained according to applicable data privacy laws, including sections 144.291 to 144.298.

Subd. 3. **Professional training and education about fetal alcohol syndrome.** (a) The commissioner of health, in collaboration with the Board of Medical Practice, the Board of Nursing, and other professional boards and state agencies, shall develop materials about fetal alcohol syndrome for professional training of health care providers, social service providers, educators, and judicial and corrections systems professionals. The training shall increase knowledge and develop practical skills of professionals to help them address the needs of at-risk pregnant women and the needs of individuals affected by fetal alcohol syndrome or fetal alcohol effects and their families.

(b) Training for health care providers shall focus on skill building for screening, counseling, referral, and follow-up for women using or at risk of using alcohol while pregnant. Training for health care professionals shall include methods for diagnosis and evaluation of fetal alcohol syndrome and fetal alcohol effects. Training for education, judicial, and corrections professionals shall involve effective education strategies, methods to identify the behaviors and learning styles of children with alcohol-related birth defects, and methods to identify available referral and community resources.

(c) Training and education for social service providers shall focus on resources for assessing, referring, and treating at-risk pregnant women, changes in the mandatory reporting and commitment laws, and resources for affected children and their families.

Subd. 4. **Fetal alcohol syndrome community grant education program.** The commissioner of health shall administer a grant education program to provide money to community organizations and coalitions to collaborate on fetal alcohol syndrome prevention and intervention strategies and activities. The commissioner shall disburse grant money through a request for proposal process or sole-source distribution where appropriate, and shall include at least one grant award for transitional skills and services for individuals with fetal alcohol syndrome or fetal alcohol effects.

Subd. 5. **School pilot programs.** (a) The commissioner of education shall award up to four grants to schools for pilot programs to identify and implement effective educational strategies for individuals with fetal alcohol syndrome and other alcohol-related birth defects.

(b) One grant shall be awarded in each of the following age categories:

(1) birth to three years;

(2) three to five years;

(3) six to 12 years; and

(4) 13 to 18 years.

(c) Grant proposals must include an evaluation plan, demonstrate evidence of a collaborative or multisystem approach, provide parent education and support, and show evidence of a child- and family-focused

approach consistent with research-based best educational practices and other guidelines developed by the Department of Education.

(d) Children participating in the pilot program sites may be identified through child find activities or a diagnostic clinic. No identification activity may be undertaken without the consent of a child's parent or guardian.

Subd. 6. [Repealed, 2007 c 133 art 2 s 13]

Subd. 7. [Repealed, 2007 c 133 art 2 s 13]

History: *1998 c 398 art 9 s 2; 1998 c 407 art 2 s 85; 2002 c 220 art 16 s 1; 2003 c 130 s 12; 2004 c 206 s 52; 2007 c 147 art 10 s 15*

145.9268 COMMUNITY CLINIC GRANTS.

Subdivision 1. **Definition.** For purposes of this section, "eligible community clinic" means:

(1) a nonprofit clinic that is established to provide health services to low income or rural population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay;

(2) a governmental entity or an Indian Tribal government or Indian health service unit that provides services and utilizes a sliding fee scale or other procedure as described under clause (1);

(3) a consortium of clinics comprised of entities under clause (1) or (2); or

(4) a nonprofit, Tribal, or governmental entity proposing the establishment of a clinic that will provide services and utilize a sliding fee scale or other procedure as described under clause (1).

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to eligible community clinics to plan, establish, or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. The commissioner shall award grants to community clinics in metropolitan and rural areas of the state, and shall ensure geographic representation in grant awards among all regions of the state.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community clinic 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. Community clinics may apply for and the commissioner may award grants for one-year or two-year periods.

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

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

(2) a description of the problem or problems the grant funds will be used to address;

(3) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(4) a process for documenting and evaluating results of the grant.

(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 according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base and the degree to which grant funds will be used to support services increasing or maintaining access to health care services. 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. The commissioner has discretion over the number of grants awarded.

(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations.

Subd. 3a. **Awarding grants.** (a) The commissioner may award grants for activities to:

(1) provide a direct offset to expenses incurred for services provided to the clinic's target population;

(2) establish, update, or improve information, data collection, or billing systems, including electronic health records systems;

(3) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;

(4) provide improvements for care delivery, such as increased translation and interpretation services;

(5) build a new clinic or expand an existing facility; or

(6) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

(b) A grant awarded to an eligible community clinic may not exceed $300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed $300,000 per clinic included in the consortium. The commissioner has discretion over the 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 reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on the needs of community clinics and provide any recommendations for adding or changing eligible activities.

History: *1Sp2001 c 9 art 1 s 47; 2002 c 379 art 1 s 113; 1Sp2005 c 4 art 6 s 39*

145.9269 FEDERALLY QUALIFIED HEALTH CENTERS.

Subdivision 1. **Definitions.** For purposes of this section, "federally qualified health center" means an entity that is receiving a grant under United States Code, title 42, section 254b, or, based on the

recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant.

Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute subsidies to federally qualified health centers operating in Minnesota to continue, expand, and improve federally qualified health center services to low-income populations. The commissioner shall distribute the funds appropriated under this section to federally qualified health centers operating in Minnesota as of January 1, 2007. The amount of each subsidy shall be in proportion to each federally qualified health center's amount of discounts granted to patients during the most recent calendar year as reported on the federal Uniform Data System report in conformance with the Bureau of Primary Health Care Program Expectations Policy Information Notice 98-23, except that each eligible federally qualified health center shall receive at least five percent but no more than 30 percent of the total amount of money available under this section.

History: *2007 c 147 art 10 s 12; 2008 c 292 s 1; 1Sp2025 c 3 art 1 s 79*

145.927 [Repealed, 1Sp2001 c 9 art 1 s 62]

145.9272 FEDERALLY QUALIFIED HEALTH CENTERS REGISTERED APPRENTICESHIP GRANT PROGRAM.

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

(b) "Apprentice" means an employee participating in a registered apprenticeship program.

(c) "Federally qualified health center" has the meaning given in section 145.9269, subdivision 1.

(d) "Nonprofit organization of community health centers" means a nonprofit organization, the membership of which consists of federally qualified health centers operating service delivery sites in Minnesota and that provides services to federally qualified health centers in Minnesota to promote the delivery of affordable, quality primary care services in the state.

(e) "Registered apprenticeship program" means an employer or organization registered with the Department of Labor and Industry under chapter 178.

Subd. 2. **Registered apprenticeship grant program.** The commissioner of health shall distribute a grant to a nonprofit organization of community health centers for registered apprenticeship programs in federally qualified health centers operating in Minnesota. Grant money must be used to establish new registered apprenticeship programs and fund ongoing costs for existing registered apprenticeship programs for medical assistants, dental assistants, and other health care occupations at federally qualified health center service delivery sites in Minnesota. Apprentices must be recruited from federally qualified health center staff and from the population in the geographic area served by the federally qualified health center.

History: *2023 c 70 art 5 s 11*

145.9273 TESTING FOR LEAD IN DRINKING WATER IN CHILD CARE SETTINGS.

Subdivision 1. **Requirement to test.** (a) By July 1, 2024, licensed or certified child care providers must develop a plan to accurately and efficiently test for the presence of lead in drinking water in child care facilities following either the Department of Health's document "Reducing Lead in Drinking Water: A Technical Guidance for Minnesota's School and Child Care Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action" guidance materials.

(b) For purposes of this section, "licensed or certified child care provider" means a child care center licensed under Minnesota Rules, chapter 9503, or a certified license-exempt child care center under chapter 142C.

Subd. 2. **Scope and frequency of testing.** The plan under subdivision 1 must include testing every building serving children and all water fixtures used for consumption of water, including water used in food preparation. All taps must be tested at least once every five years. A licensed or certified child care provider must begin testing in buildings by July 1, 2024, and complete testing in all buildings that serve students within five years.

Subd. 3. **Remediation of lead in drinking water.** The plan under subdivision 1 must include steps to remediate if lead is present in drinking water. A licensed or certified child care provider that finds lead at concentrations at or exceeding five parts per billion at a specific location providing water to children within its facilities must take action to reduce lead exposure following guidance and verify the success of remediation by retesting the location for lead. Remediation actions are actions that reduce lead levels from the drinking water fixture as demonstrated by testing. This includes using certified filters, implementing and documenting a building-wide flushing program, and replacing or removing fixtures with elevated lead levels.

Subd. 4. **Reporting results.** (a) A licensed or certified child care provider that tested its buildings for the presence of lead shall make the results of the testing and any remediation steps taken available to parents and staff and notify them of the availability of results. Reporting shall occur no later than 30 days from receipt of results and annually thereafter.

(b) Beginning July 1, 2024, a licensed or certified child care provider must report the provider's test results and remediation activities to the commissioner of health annually on or before July 1 of each year.

History: *2023 c 70 art 4 s 62; 2024 c 80 art 3 s 3*

145.9275 LEAD REMEDIATION IN SCHOOL AND CHILD CARE SETTINGS GRANT PROGRAM.

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of remediating identified sources of lead in drinking water in schools and licensed child care settings.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to schools and licensed child care settings. Priority shall be given to schools and licensed child care settings with higher levels of lead detected in water samples, evidence of lead service lines, or lead plumbing materials and school districts that serve disadvantaged communities.

Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead contamination in their facilities including but not limited to service connections and premise plumbing, and to implement best practices for water management within the building.

History: *2023 c 70 art 4 s 63*

145.928 ELIMINATING HEALTH DISPARITIES.

Subdivision 1. **Goal; establishment.** It is the goal of the state to decrease the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, access to and utilization of high-quality

prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Subd. 2. **State-community partnerships; plan.** The commissioner, in partnership with culturally based community organizations; the Indian Affairs Council under section 3.922; the Minnesota Council on Latino Affairs under section 15.0145; the Council for Minnesotans of African Heritage under section 15.0145; the Council on Asian-Pacific Minnesotans under section 15.0145; community health boards as defined in section 145A.02; and Tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3. **Measurable outcomes.** The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. **Statewide assessment.** The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. **Technical assistance.** The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6. **Process.** (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. **Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates;

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

(3) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, Tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 7a. **Minority-run health care professional associations.** The commissioner shall award grants to minority-run health care professional associations to achieve the following:

(1) provide collaborative mental health services to minority residents;

(2) provide collaborative, holistic, and culturally competent health care services in communities with high concentrations of minority residents; and

(3) collaborate on recruitment, training, and placement of minorities with health care providers.

Subd. 8. **Community grant program; other health disparities.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics.

Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact more than one priority area;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. **Health of foreign-born persons.** (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

(1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;

(2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;

(3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and

(4) $50 per foreign-born person in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. **Tribal governments.** The commissioner shall award grants to American Indian Tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the Tribal governments.

Subd. 11. **Coordination.** The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

Subd. 12. **Evaluation.** Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs, community health board activities, and Tribal government activities funded under this section. Grant recipients, Tribal governments, and

community health boards shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 13. **Reports.** (a) The commissioner shall submit a biennial report to the legislature on the local community projects, Tribal government, 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, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

(b) The commissioner shall release an annual report to the public on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the amount of each grant awarded to each agency or organization, an itemized list submitted to the commissioner by each agency or organization awarded a grant specifying all uses of grant funds and the amount expended for each use, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the previous fiscal year beginning January 15, 2016.

Subd. 14. **Supplantation of existing funds.** Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or Tribal expenditures.

Subd. 15. **Promising strategies.** For all grants awarded under this section, the commissioner shall consider applicants that present evidence of a promising strategy to accomplish the applicant's objective. A promising strategy shall be given the same weight as a research or evidence-based strategy based on potential value and measurable outcomes.

History: *1Sp2001 c 9 art 1 s 48; 2002 c 379 art 1 s 113; 2014 c 291 art 6 s 22; 2015 c 71 art 8 s 45,46; 2015 c 77 art 2 s 87; 1Sp2017 c 6 art 10 s 97; 1Sp2019 c 9 art 11 s 69,70; 2022 c 98 art 14 s 9*

145.9285 COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.

Subdivision 1. **Establishment.** The commissioner of health shall establish the community solutions for healthy child development grant program. The purpose of the program is to:

(1) improve child development outcomes as related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Services' early childhood systems reform effort for: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce racial disparities in children's health and development from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. **Commissioner's duties.** The commissioner shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the Community Solutions Advisory Council;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the Community Solutions Advisory Council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the state advisory council on early childhood education and care on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the Community Solutions Advisory Council, that is focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community Solutions Advisory Council; establishment; duties; compensation.** (a) The commissioner, in consultation with the three ethnic councils under section 15.0145 and the Indian Affairs Council under section 3.922, shall appoint a 13-member Community Solutions Advisory Council, as follows:

(1) three members representing Black Minnesotans of African heritage, one of whom is a parent with a child under the age of eight years at the time of the appointment;

(2) three members representing Latino and Latina Minnesotans with an ethnic heritage from Mexico, a country in Central or South America, Cuba, the Dominican Republic, or Puerto Rico, one of whom is a parent with a child under the age of eight years at the time of the appointment;

(3) three members representing Asian-Pacific Minnesotans with Asian-Pacific heritage, one of whom is a parent with a child under the age of eight years at the time of the appointment;

(4) three members representing the American Indian community, one of whom is a parent of a child under the age of eight years at the time of the appointment; and

(5) one member with research or academic expertise in racial equity and healthy child development.

(b) The commissioner must include representation from organizations with expertise in advocacy on behalf of communities of color and Indigenous communities in areas related to the grant program.

(c) At least three of the 13 members appointed under paragraph (a), clauses (1) to (4), of the advisory council must come from outside the seven-county metropolitan area.

(d) The Community Solutions Advisory Council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(e) Member terms, compensation, and removal shall be as provided in section 15.059, subdivisions 2 to 4.

(f) The commissioner must convene meetings of the advisory council at least four times per year.

(g) The advisory council shall expire upon expiration or repeal of the healthy childhood development program.

(h) The commissioner of health must provide meeting space and administrative support for the advisory council.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with communities of color and American Indian communities;

(2) Tribal Nations and Tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the Community Solutions Advisory Council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of color and American Indian children from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by people of color and serving communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including Tribal Nations and Tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to grade 3;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(c) The first round of grants must be awarded no later than April 15, 2024. Grants must be awarded annually thereafter. Grants are awarded for a period of three years.

Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant money is prioritized and awarded to organizations and entities that are within counties that have a higher proportion of people of color and American Indians than the state average, to the extent possible.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

History: *2023 c 70 art 12 s 18*

145.929 HEALTH CARE GRANTS FOR THE UNINSURED.

Subdivision 1. **Dental providers.** (a) A dental provider is eligible for a grant under this section if:

(1) the provider is a nonprofit organization not affiliated with a hospital or medical group that offers free or reduced-cost oral health care to low-income patients under the age of 21 with family incomes below 275 percent of the federal poverty guidelines who do not have insurance coverage for oral health care services;

(2) the provider is eligible for critical access dental provider payments under section 256B.76, subdivision 4; and

(3) more than 80 percent of the dental provider's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

(b) Grants shall be distributed by the commissioner of health to each eligible provider based on the proportion of that provider's number of low-income uninsured patients under the age of 21 served in the reporting year to the total number of low-income uninsured patients under the age of 21 served by all eligible providers, except that no single eligible provider shall receive less than two percent or more than 30 percent of the total appropriation provided under this subdivision. If the number of eligible providers is such that the minimum of two percent cannot be provided to each eligible provider, the commissioner shall limit eligibility for the subsidy to the top 20 eligible oral health providers.

Subd. 2. **Community mental health programs.** A community mental health program is eligible for a grant under this section if it is a community mental health center established under section 245.62, or a nonprofit community mental health clinic that is designated as an essential community provider under section 62Q.19, and the center or clinic offers free or reduced-cost mental health care to low-income patients under the age of 21 with family incomes below 275 percent of the federal poverty guidelines who do not have health insurance coverage. The grants shall be distributed by the commissioner of health to each eligible mental health center or clinic based on the proportion of that mental health center's or clinic's number of low-income uninsured patients under the age of 21 served in the reporting year to the total number of low-income uninsured patients under the age of 21 served by all mental health centers and clinics eligible for a grant under this subdivision, except that no single eligible provider shall receive less than two percent or more than 30 percent of the total appropriation provided under this subdivision.

Subd. 3. **Emergency medical assistance outlier grant program.** (a) The commissioner of health shall establish a grant program for hospitals for the purpose of defraying underpayments associated with the emergency medical assistance program. Grants shall be made for the services provided beginning July 1, 2014, to an individual who is enrolled in emergency medical assistance, and when an emergency medical assistance reimbursement claim is in excess of $50,000.

(b) Hospitals seeking a grant from this program must submit an application that includes the number and dollar amount of hospital claims for emergency medical assistance in excess of $50,000 to the commissioner in a form prescribed by the commissioner. Grant payments shall be in proportion to the total hospital emergency medical assistance claims submitted by all applicant hospitals each state fiscal year. Claims for inpatient hospital, outpatient services, and hospital emergency department services shall be considered when determining the value of the grants.

Subd. 4. **Grant process.** The commissioner of health may use data submitted by organizations seeking a grant under this section, without further verification, for purposes of determining eligibility for a grant and allocating grant money among eligible organizations. The chief executive or chief financial officer must certify that the data submitted is accurate and that no changes were made in the organization's accounting and record-keeping practices or policies for providing free or reduced-cost care to uninsured patients for the purpose of creating eligibility or increasing the organization's allocation. The commissioner may audit or verify the data submitted. Grant funds must be used to defray the organization's costs of providing care and services to uninsured patients as identified under subdivision 1, 2, or 3. An organization must not receive more than one grant under subdivision 1, 2, or 3, even though the organization is potentially eligible for a grant under two or more subdivisions. Organizations eligible for a grant under this section may join together to submit a combined application provided the data submitted is certified by each individual organization.

History: *2014 c 312 art 23 s 7*

POISON CONTROL SYSTEM

145.93 MINNESOTA POISON INFORMATION CENTERS; ESTABLISHMENT.

Subdivision 1. **Purpose.** The legislature finds that the needs of citizens of the state for information relating to the prompt identification and appropriate home management or referral of cases of human poisoning are best served by establishment of a single integrated poison control system, consisting of one or more regional poison information centers organized to provide statewide information and education services to the public and to health professionals.

Subd. 2. [Repealed, 1993 c 337 s 20]

Subd. 3. **Grant award; designation; payments under grant.** Every fifth year, the commissioner shall solicit applications for the poison information centers by giving reasonable public notice of the availability of money appropriated or otherwise available. The commissioner shall select from among the entities, whether profit or nonprofit, or units of government the applicants that best fulfill the criteria specified in subdivision 4. The grant shall be paid to the grantees quarterly beginning on July 1.

Subd. 4. **Selection criteria.** In selecting grantees under this section, the commissioner of health shall determine that the following criteria are met:

(1) whether the applicant can demonstrate the ability to provide appropriate and adequate telephone poison information services to the general public and to health professionals 24 hours a day at no direct cost

to users and in a manner that appropriately utilizes "911" emergency telephone services developed pursuant to chapter 403;

(2) whether the applicant can demonstrate the ability to provide adequate medical direction as well as the toxicological and related professional and technical resources needed for poison information services;

(3) whether the applicant can demonstrate the ability to provide appropriate public education and professional education services;

(4) whether the applicant can demonstrate the ability to provide poison information services in a financially sound and cost-effective manner; and

(5) whether the applicant can demonstrate the ability to cooperate with interested health professionals throughout the state to provide poison information in a coordinated fashion.

Subd. 5. [Repealed, 1985 c 223 s 5]

Subd. 6. **Reports; monitoring; termination.** The grantees selected shall report quarterly to the commissioner of health, on a form provided by the commissioner, information about fiscal performance and status. Grantees shall also report annually information about programmatic status and performance. All relevant records and the performance of the grantee shall be monitored by the commissioner for purposes of assuring that the grantee continues to fulfill the criteria specified in subdivision 4. Should the commissioner at any time find that a grantee is not continuing to fulfill the criteria specified in subdivision 4, the commissioner may terminate the grant upon 30 days' notice.

History: *1980 c 577 s 1; 1983 c 260 s 32,33; 1985 c 223 s 1-4; 1989 c 209 art 2 s 1; 1999 c 159 s 27; 2013 c 43 s 20*

HAZARDOUS SUBSTANCE EXPOSURE

145.94 EXPOSURE TO HAZARDOUS SUBSTANCE.

Subdivision 1. **Site inspection.** To determine hazardous substance exposure to the community, the commissioner of health may enter the premises of any employer as defined in section 182.651, subdivision 7, including the University of Minnesota, to investigate the actual, suspected, or potential release of a hazardous substance if there is evidence or risk of exposure to the community. Before entering the commissioner shall present to the employer a statement of the reason, nature, and scope of the investigation at a particular location. As part of the investigation, and upon request to the employer, the commissioner must be allowed access to information required under the Employee Right-To-Know Act to determine if there are existing or potential health hazards to the community from the release of any hazardous substance originating in the workplace of the employer.

Subd. 2. **Disclosure of information.** The commissioner may disclose to individuals or to the community, information including data made nonpublic by law, relating to the hazardous properties and health hazards of hazardous substances released from a workplace if the commissioner finds:

(1) evidence that a person requesting the information may have suffered or is likely to suffer illness or injury from exposure to a hazardous substance; or

(2) evidence of a community health risk and if the commissioner seeks to have the employer cease an activity which results in release of a hazardous substance.

Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage according to established standards to prevent unauthorized use or disclosure. If the nonpublic data is required for the diagnosis, treatment, or prevention of illness or injury, a personal physician, advanced practice registered nurse, or physician assistant may be provided with this information if the physician, advanced practice registered nurse, or physician assistant agrees to preserve the confidentiality of the information, except for patient health records subject to sections 144.291 to 144.298. After the disclosure of any hazardous substance information relating to a particular workplace, the commissioner shall advise the employer of the information disclosed, the date of the disclosure, and the person who received the information.

History: *1986 c 456 s 1; 1Sp1986 c 3 art 2 s 9; 2007 c 147 art 10 s 15; 2020 c 115 art 4 s 66; 2022 c 58 s 77*

145.945 CERTAIN SALES OF CLEANING PRODUCTS PROHIBITED.

Subdivision 1. **Prohibition.** In order to prevent the spread of infectious disease and avoidable infections and to promote best practices in sanitation, no person shall offer for retail sale in Minnesota any cleaning product that contains triclosan and is used by consumers for sanitizing or hand and body cleansing.

Subd. 2. **Exception.** The prohibition in subdivision 1 shall not apply to individual products for which specific United States Food and Drug Administration approval for consumer use has been secured.

History: *2014 c 277 s 8*

145.95 MS 1980 [Expired]

LONG-TERM DEVELOPMENT PROGRAM FOR CHILDREN

145.951 IMPLEMENTATION PLAN; STATEWIDE PROGRAM FOR FAMILIES.

The commissioner of health, in consultation with the commissioners of education; corrections; public safety; and human services, and with the director of the Council on Disability and the councils and commission under sections 3.922, 3.9221, and 15.0145, may develop an implementation plan for the establishment of a statewide program to assist families in developing the full potential of their children. The program must be designed to strengthen the family, to reduce the risk of abuse to children, and to promote the long-term development of children in their home environments. The program must also be designed to use volunteers to provide support to parents, and to link parents with existing public health, education, and social services as appropriate.

History: *1996 c 451 art 4 s 25; 2003 c 130 s 12; 2015 c 77 art 2 s 87; 2023 c 62 art 2 s 95*

145.952 DEFINITIONS.

Subdivision 1. **Scope.** The definitions in this section apply to sections 145.951 to 145.957.

Subd. 2. **Abuse.** "Abuse" means physical abuse, sexual abuse, neglect, mental injury, and threatened injury, as those terms are defined in chapter 260E.

Subd. 3. **CHILD program or program.** "CHILD program" or "program" means the children helped in long-term development program that the commissioner shall plan to be implemented under sections 145.951 to 145.957.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 5. **Local organization.** "Local organization" means an organization that contracts with the commissioner under section 145.953, subdivision 1, to administer the CHILD program on a local level.

History: *1996 c 451 art 4 s 26; 1Sp2020 c 2 art 8 s 30*

145.953 PROGRAM STRUCTURE.

Subdivision 1. **Local administration of program.** The implementation plan must require the commissioner to contract with appropriate private nonprofit and governmental organizations to administer the CHILD program on a local level. The local organization, in collaboration and coordination with the Department of Health, shall be responsible for recruiting, screening training, and overseeing volunteers for the program.

Subd. 2. **Volunteer component.** The implementation plan must provide that a volunteer will be matched with a family to provide ongoing support in parenting. The volunteer shall provide the family with information on the CHILD program and other social services available. Through home visits and frequent contact, the volunteer shall provide support and guidance on raising the child and coping with stresses that may increase the risk of abuse. The volunteer shall also assist the family in obtaining other needed services from existing social services programs.

History: *1996 c 451 art 4 s 27*

145.954 STANDARDS FOR PROGRAM.

In planning for the implementation of the program, the commissioner shall:

(1) establish mechanisms to encourage families to participate in the CHILD program;

(2) establish mechanisms to identify families who may wish to participate in the CHILD program and to match volunteers with these families either before or as soon as possible after a child is born;

(3) ensure that local organizations coordinate with services already provided by the Departments of Health, Human Services, and Education to ensure that participating families receive a continuum of care;

(4) coordinate with local social services agencies, local health boards, and community health boards;

(5) ensure that services provided through the program are community-based and that the special needs of minority communities are addressed;

(6) develop and implement appropriate systems to gather data on participating families and to monitor and evaluate their progress; and

(7) evaluate the program's effectiveness.

History: *1996 c 451 art 4 s 28; 2003 c 130 s 12*

145.955 DUTIES OF LOCAL ORGANIZATION.

The implementation plan shall require the local organizations to:

(1) recruit and train volunteers to serve families under the program, according to section 145.956;

(2) provide ongoing supervision and consultation to volunteers; and

(3) develop resource and referral booklets that volunteers can distribute to families served by the program. The booklets shall contain comprehensive information on the spectrum of services available to assist the family and to reduce the risk of abuse.

History: *1996 c 451 art 4 s 29*

145.956 TRAINING AND RECRUITMENT OF VOLUNTEERS.

Subdivision 1. **Training requirements.** (a) The implementation plan shall require the local organization to carefully screen and train volunteers to provide program services. Training must prepare volunteers to:

(1) identify signs of abuse or other indications that a child may be at risk of abuse;

(2) help families develop communications skills;

(3) teach and reinforce healthy discipline techniques;

(4) provide other support a family needs to cope with stresses that increase the risk of abuse; and

(5) refer the family to other appropriate public health, education, and social services.

(b) The implementation plan shall also include procedures whereby the local agency will provide ongoing support, supervision, and training for all volunteers. Training must be culturally appropriate and community-based, and must incorporate input from parents who will be using the program's services.

Subd. 2. **Recruitment of volunteers.** The implementation plan must require that the local organization recruit minority volunteers to serve communities of color.

History: *1996 c 451 art 4 s 30*

145.957 ELIGIBILITY.

The implementation plan must ensure that all residents of Minnesota are eligible for services under the program. The plan must make services available on a sliding fee basis. The commissioner shall develop a sliding fee scale for the program.

History: *1996 c 451 art 4 s 31*

145.9571 HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.

Sections 145.9571 to 145.9576 are the Healthy Beginnings, Healthy Families Act.

History: *2023 c 70 art 4 s 64*

145.9572 MINNESOTA PERINATAL QUALITY COLLABORATIVE.

Subdivision 1. **Duties.** The Minnesota perinatal quality collaborative is established to improve pregnancy outcomes for pregnant people and newborns through efforts to:

(1) advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives that enable equitable outcomes;

(2) review current data, trends, and research on best practices to inform and prioritize quality improvement initiatives;

(3) identify methods that incorporate antiracism into individual practice and organizational guidelines in the delivery of perinatal health services;

(4) support quality improvement initiatives to address substance use disorders in pregnant people and infants with neonatal abstinence syndrome or other effects of substance use;

(5) provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes;

(6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

(7) support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Subd. 2. **Grants authorized.** The commissioner of health must, within available appropriations, award one grant to a nonprofit organization to support efforts that improve maternal and infant health outcomes aligned with the purpose outlined in subdivision 1. The commissioner must give preference to a nonprofit organization that has the ability to provide these services throughout the state. The commissioner must provide content expertise to the grant recipient to further the accomplishment of the purpose.

History: *2023 c 70 art 4 s 65*

145.9573 MINNESOTA PARTNERSHIP TO PREVENT INFANT MORTALITY.

(a) The commissioner of health must establish the Minnesota partnership to prevent infant mortality program that is a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

(b) The goal of the Minnesota partnership to prevent infant mortality program is to:

(1) build a statewide multisectoral partnership including the state government, local public health agencies, Tribes, private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, other nonwhite communities, and rural populations;

(2) address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and

(3) promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes.

History: *2023 c 70 art 4 s 66*

145.9574 GRANTS.

Subdivision 1. **Improving pregnancy and infant outcomes grant.** The commissioner of health must, within available appropriations, make a grant to a nonprofit organization to create or sustain a multidisciplinary network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives.

Subd. 2. **Improving infant health grants.** (a) The commissioner of health must award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally relevant activities to improve infant health by reducing preterm birth, sleep-related infant deaths, and congenital malformations and address social and environmental determinants of health. Eligible entities include community nonprofit organizations, Tribal governments, and community health boards. In accordance with available funding, the commissioner may award grants on a noncompetitive basis to the 11 sovereign Tribal governments if their respective proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and meet other requirements of this section. An eligible applicant must submit a complete application to the commissioner of health by the deadline established by the commissioner. The commissioner must award all other grants competitively to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

(b) Grantee activities must:

(1) address the leading cause or causes of infant mortality;

(2) be based on community input;

(3) focus on policy, systems, and environmental changes that support infant health; and

(4) address the health disparities and inequities that are experienced in the grantee's community.

(c) The commissioner must 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 according to this subdivision, the commissioner must establish criteria including but not limited to: the eligibility of the applicant's project under this section; the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; a description of the applicant's proposed project; the project's likelihood to achieve the grant's purposes as described in this section; a description of the population demographics and service area of the proposed project; and evidence of efficiencies and effectiveness gained through collaborative efforts.

(d) Grant recipients must report their activities to the commissioner in a format and at a time specified by the commissioner.

History: *2023 c 70 art 4 s 67*

145.9575 DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING WITH FOLLOW-UP.

Subdivision 1. **Developmental and social-emotional screening with follow-up.** The goal of the developmental and social-emotional screening is to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and young children to appropriate community-based resources and programs. The commissioner of health must work with the commissioners of human services and education to implement this section and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

Subd. 2. **Duties.** The commissioner must:

(1) increase the awareness of developmental and social-emotional screening with follow-up in coordination with community and state partners;

(2) expand existing electronic screening systems to administer developmental and social-emotional screening to children from birth to kindergarten entrance;

(3) provide screening for developmental and social-emotional delays based on current recommended best practices;

(4) review and share the results of the screening with the parent or guardian and support families in their role as caregivers by providing anticipatory guidance around typical growth and development;

(5) refer and connect children and families with appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

(6) establish performance measures and collect, analyze, and share program data regarding population-level outcomes of developmental and social-emotional screening, referrals to community-based services, and follow-up services.

Subd. 3. **Grants.** The commissioner must award grants to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. Grants may also be awarded to train and utilize cultural liaisons to help families navigate the screening and follow-up process in a culturally and linguistically responsive manner. Eligible grantees include community-based organizations, community health boards, and Tribal Nations. The commissioner must provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

History: *2023 c 70 art 4 s 68*

145.9576 MODEL JAIL PRACTICES.

Subdivision 1. **Model jail practices for incarcerated parents.** (a) The commissioner of health may make grants to counties and groups of counties to implement model jail practices and to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) "Model jail practices" means a set of practices that correctional administrators can implement to remove barriers that may prevent children from cultivating or maintaining relationships with their incarcerated parents during and immediately after incarceration without compromising the safety or security of the correctional facility.

Subd. 2. **Grants authorized; model jail practices.** (a) The commissioner of health may award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) Grantee activities include but are not limited to:

(1) parenting classes or groups;

(2) family-centered intake and assessment of inmate programs;

(3) family notification, information, and communication strategies;

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

(c) Grant recipients must report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 3. **Technical assistance and oversight; model jail practices.** (a) The commissioner may provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 2, including for administrative purposes, the commissioner may award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

(3) evaluation of process and outcomes of model jail practices; and

(4) expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

History: *2023 c 70 art 4 s 69*

YOUTH VIOLENCE PREVENTION

145.958 YOUTH VIOLENCE PREVENTION.

Subdivision 1. **Definition.** For purposes of this section, "at-risk youth" means adolescents and teenagers who are likely to be a threat to the health and well-being of themselves or others through gang involvement, alcohol and drug use, unsafe sexual activity, dropping out of school, or through violence and other criminal activity.

Subd. 2. **Violence prevention programs for at-risk youth.** (a) Community-based violence prevention programs may apply to the commissioner of health for technical assistance. The programs must be community-based efforts serving at-risk youth and must work in collaboration with local schools, law enforcement agencies, faith communities, and community groups to provide a comprehensive approach to reducing youth violence by addressing the needs of at-risk youth.

(b) The programs must:

(1) ensure that there are trusted adults serving as role models and mentors for at-risk youth;

(2) intervene at the first signs that a youth may be at risk and strive to rehabilitate youth who are already involved in violence;

(3) work to strengthen families;

(4) work with schools in order to keep students engaged and help them prepare for higher education or job training; and

(5) teach self-respect and respect of others so that unsafe and unhealthy behaviors may be avoided.

(c) Violence prevention programs may include, but are not limited to:

(1) mentorship;

(2) job placement and support;

(3) youth violence prevention training;

(4) parent and family intervention and teaching parenting skills;

(5) school-related initiative involving police liaison officers, youth leadership, peer mediation systems, after-school activities, and intervention in truancy cases;

(6) substance use disorder and mental health intervention, screening, and assessment;

(7) assisting juvenile offenders in reconnecting with families and reintegrating into the community;

(8) working with youth to prevent sexual violence;

(9) working with youth to prevent pregnancy and sexually transmitted infections; and

(10) a youth helpline and street outreach workers to connect youth with needed services.

Subd. 3. **Coordination of prevention and intervention for programs for at-risk youth.** (a) The commissioner of health, in collaboration with the commissioners of public safety, human services, and education, shall identify five community-based violence prevention programs that meet the criteria described in this section. One of these programs identified must be serving the youth in Minneapolis, one program must be serving the youth in St. Paul, and the remaining three programs must be serving youth in outstate communities.

(b) The commissioner of health shall provide technical support to these community programs including, but not limited to, assistance in seeking and applying for federal grants and private foundation funding.

(c) The commissioner of health shall monitor the progress of these programs in terms of the impact on public health and reducing juvenile violent crime and shall identify the effective aspects of each program in order to assist other programs in replicating these successful aspects.

(d) The commissioner of health shall apply for private, state, or federal funding to support the activities described in this subdivision. This subdivision is effective upon the availability of funding to support these activities.

History: *2009 c 156 s 1; 2022 c 98 art 4 s 51*

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

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

Subd. 2. [Repealed, 1983 c 260 s 68]

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

Subd. 4. [Repealed, 1983 c 260 s 68]

HEALTH PROMOTION AND WELLNESS

145.985 HEALTH PROMOTION AND WELLNESS.

Community health boards as defined in section 145A.02, subdivision 5, may work with schools, health care providers, and others to coordinate health and wellness programs in their communities. In order to meet the requirements of this section, community health boards may:

(1) provide instruction, technical assistance, and recommendations on how to evaluate project outcomes;

(2) assist with on-site health and wellness programs utilizing volunteers and others addressing health and wellness topics including smoking, nutrition, obesity, and others; and

(3) encourage health and wellness programs consistent with the Centers for Disease Control and Prevention's Community Guide and goals consistent with the Centers for Disease Control and Prevention's Healthy People 2010 initiative.

History: *2007 c 147 art 15 s 14*

145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.

Subdivision 1. **Purpose.** The purpose of the statewide health improvement program is to:

(1) address the leading preventable causes of illness and death such as tobacco use or exposure, poor diet, and lack of regular physical activity, and other issues as determined by the commissioner through the statewide health assessment;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Subd. 1a. **Grants to local communities.** (a) The commissioner of health shall award competitive grants to community health boards and Tribal governments to convene, coordinate, and implement proven-effective strategies, promising practice strategies, or theory-based strategies that can be evaluated using experimental or quasi-experimental design. Grants shall be awarded to all community health boards and Tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and other requirements of this section. In each grant cycle, the commissioner may award up to 100 percent of Tribal grants and up to 25 percent of the grants awarded to community health boards to theory-based strategies that are culturally or ethnically focused.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, work site, and health care settings;

(5) be focused on policy, systems, and environmental changes that support healthy behaviors; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and Tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and Tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

(f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

(g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(h) For purposes of this subdivision, "proven-effective" means a strategy or practice that offers a high level of research on effectiveness for at least one outcome of interest; "promising practice" means a practice or activity that is supported by research demonstrating effectiveness for at least one outcome of interest; and "theory-based" means a strategy or activity that has no research on effectiveness but has a well-constructed logical model or theory of change.

Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

(c) For grants awarded on or after July 1, 2016, the commissioner, in coordination with each grant recipient under section 145.986, must identify:

(1) each geographic area or population to be targeted;

(2) the policy, systems, or environmental strategy to be used to address one or more of the health indicators listed in section 62U.10, subdivision 6; and

(3) the selected outcomes and evaluation measures for the grant, related to one or more of the health indicators listed in section 62U.10, subdivision 6, within the geographic area or among the population targeted.

Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on evidence-based strategies, including those based on populations and types of communities served. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 2 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

(b) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) community engagement and capacity building;

(2) Tribal support;

(3) community asset building and risk behavior reduction;

(4) legal;

(5) communications;

(6) community, school, health care, work site, and other site-specific strategies; and

(7) health equity.

Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program grants funded under this section. The evaluation must use the most appropriate experimental or quasi-experimental design suitable for the grant activity or project. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation, including information on any impact on the health indicators listed in section 62U.10, subdivision 6, within the geographic area or among the population targeted.

(b) Grant recipients will collect, monitor, and submit to the Department of Health baseline and annual data and provide information to improve the quality and impact of community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems. The commissioner shall consult with the commissioner of management and budget to ensure that the evaluation process is using experimental or quasi-experimental design.

(d) Contracts awarded under paragraph (c) may be used to:

(1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;

(2) manage, analyze, and report program evaluation data results; and

(3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

(e) For purposes of this subdivision, "experimental design" means a method of evaluating the impact of a strategy that uses random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated; and "quasi-experimental design" means a method of evaluating the impact of a strategy that uses an approach other than random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated.

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. The report must include information on each grant recipient, including the activities that were conducted by the grantee using grant funds, the grantee's progress toward achieving the measurable outcomes established under subdivision 2, and the data provided to the commissioner by the grantee to measure these outcomes for grant activities. The commissioner shall provide information on grants in which a corrective action plan was required under subdivision 1a, the types of plan action, and the progress that has been made toward meeting the measurable outcomes. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. In the reports due beginning January 15, 2020, the commissioner shall include a description of the contracts awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems that were designed and implemented under these contracts.

Subd. 6. **Supplantation of existing funds.** Community health boards and Tribal governments must use funds received under this section to develop new programs, expand current programs, or replace discontinued state or federal funds. Funds must not be used to supplant current state or local funding to community health boards or Tribal governments.

History: *2008 c 358 art 1 s 1; 2013 c 108 art 12 s 48; 2014 c 291 art 7 s 29; 2015 c 71 art 8 s 47-49; 1Sp2017 c 6 art 10 s 98; 1Sp2019 c 9 art 11 s 71-75*

145.987 HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.

Subdivision 1. **Establishment; composition of advisory council.** The health equity advisory and leadership (HEAL) council consists of 18 members appointed by the commissioner of health, including but not limited to members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** (a) Terms, compensation, and removal of members of the advisory council shall be as provided in section 15.059, subdivisions 2 to 4, except that terms for advisory council members shall be for two years. Members may be reappointed to serve up to two additional terms. Notwithstanding section 15.059, subdivision 6, the advisory council shall not expire.

(b) The commissioner must convene meetings at least quarterly and must provide meeting space and administrative support to the advisory council. Subcommittees may be convened as necessary. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting in specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Subd. 5. **Annual report.** By January 15 each year, the commissioner or a designee, in collaboration with the advisory council, must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance summarizing the work of the advisory council over the previous year and setting goals for the upcoming year.

History: *2023 c 70 art 4 s 70; 1Sp2025 c 3 art 2 s 31,32*

145.988 HELP ME CONNECT RESOURCE AND REFERRAL SYSTEM FOR CHILDREN.

Subdivision 1. **Establishment; purpose.** The commissioner shall establish the Help Me Connect resource and referral system for children as a comprehensive, collaborative resource and referral system for children from the prenatal stage through age eight, and their families. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this section.

Subd. 2. **Duties.** (a) The Help Me Connect system shall facilitate collaboration across sectors, including child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support knowledge of and access to local resources that provide early detection and intervention services;

(2) identifying and providing access to early childhood and family support navigation specialists that can support families and their children's needs; and

(3) linking children and families to appropriate community-based services.

(b) The Help Me Connect system shall provide community outreach that includes support for, and participation in, the Help Me Connect system, including disseminating information on the system and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health services and resources, and other appropriate early childhood information.

(c) The Help Me Connect system shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) The Help Me Connect system shall collect data to increase understanding of the current and ongoing system of support and resources for expectant families and children through age eight and their families,

including identification of gaps in service, barriers to finding and receiving appropriate services, and lack of resources.

History: *2023 c 70 art 4 s 71*