CHAPTER 144

DEPARTMENT OF HEALTH

144.0525 DATA FROM LABOR AND INDUSTRY AND JOBS AND TRAINING; EPIDEMIOLOGIC STUDIES.

All data collected by the commissioner of health under sections 176.234 and 268.12 shall be used only for the purposes of epidemiologic investigations and surveillance of occupational health and safety.

History: *1991 c 202 s 5*

144.1211 ENFORCEMENT.

Subdivision 1. **Cease and desist order.** (a) The commissioner of health may issue an order requiring a person to cease activities related to the use of X-ray equipment, accelerators, and any device that emits ionizing radiation if the commissioner of health determines:

(1) that any individual is in danger of harmful and unnecessary exposure to ionizing radiation resulting from:

(i) X-ray equipment not operated, or X-ray procedures not performed according to standards prescribed by the commissioner of health in rule to minimize unnecessary exposure;

(ii) protective structural shielding of an X-ray facility not meeting the standards prescribed by the commissioner of health in rule to minimize unnecessary exposure; and

(iii) X-ray equipment prohibited for diagnostic or therapeutic X-ray use by the commissioner of health in rule; or

(2) that any individual is in danger from X-ray equipment with observed mechanical or electrical defects.

(b) The order is effective immediately upon issuance. Following issuance of the cease and desist order, the commissioner shall provide opportunity for a hearing under the contested case provisions of chapter 14.

(c) The commissioner may assess an administrative penalty for each violation specified in the cease and desist order.

Subd. 2. **Correction order.** (a) The commissioner may issue correction orders for persons to correct violations of this section or other statutes and rules related to ionizing radiation, or for violation of a cease and desist order. The correction order shall state the deficiencies that constitute the violation; the specific statute, rule, or provision of a cease and desist order violated; and the time by which the violation must be corrected.

(b) If the person believes that the information contained in the commissioner's

correction order is in error, the person may ask the commissioner to reconsider the parts of the order that are alleged to be in error. The request must be in writing, must be delivered to the commissioner by certified mail within seven calendar days after receipt of the order, and must:

(1) specify which parts of the order for corrective action are alleged to be in error;

(2) explain why they are in error; and

(3) provide documentation to support the allegation of error.

The commissioner shall respond to requests made under this paragraph within 15 calendar days after receiving request. A request for reconsideration does not stay the correction order; however, after reviewing the request for reconsideration, the commissioner may provide additional time to comply with the order if necessary. The commissioner's disposition of a request for reconsideration is final.

Subd. 3. **Reinspections.** If upon reinspection it is found that any deficiency specified in the correction order or cease and desist order has not been corrected, a notice of noncompliance with a correction order shall be issued stating each deficiency not corrected and specifying any administrative penalty issued for each deficiency.

Subd. 4. **Administrative penalties.** (a) In the notice of noncompliance issued under subdivision 3, the commissioner of health may assess an administrative penalty under this section of not more than $10,000 for each deficiency found not corrected at the time of reinspection. In determining the amount of the penalty, the commissioner shall consider:

(1) the seriousness of the violation and the hazard or potential hazard created to the public health or safety;

(2) the amount necessary to deter future violations;

(3) the history of previous violations; and

(4) efforts to correct the violation.

For each day that the deficiency is not corrected after receipt of the notice of noncompliance, the penalty may be increased, but not more than $500 per day.

(b) A person subject to an administrative penalty may request a contested case hearing pursuant to chapter 14 within 20 days after mailing of the notice of noncompliance. If the administrative penalty is not contested within 20 days after mailing of the notice of noncompliance, the notice of noncompliance and the administrative penalty become final and the person may not contest the notice of noncompliance or the administrative penalty. Any administrative penalty not paid or contested within 60 days after mailing of the notice of noncompliance shall increase by not more than 25 percent of the original amount assessed and shall bear interest on any unpaid balance at the rate established in section 549.09.

(c) The commissioner may also establish by rule a schedule of penalties not to exceed $10,000.

Subd. 5. **Injunctive relief.** In the event of noncompliance with a cease and desist order issued under subdivision 1, the commissioner of health may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey county district court or, at the commissioner of health's discretion, in the district court in which the violation of the cease and desist order occurred.

Subd. 6. **Misdemeanor.** A person who violates the statutes and rules related to ionizing radiation shall be guilty of a misdemeanor for each violation.

History: *1991 c 202 s 6*

144.126 PHENYLKETONURIA TESTING PROGRAM.

The commissioner shall provide on a statewide basis without charge to the recipient, treatment control tests for which approved laboratory procedures are available for hemoglobinopathy, phenylketonuria, and other inborn errors of metabolism.

History: *1991 c 36 s 1*

144.128 TREATMENT FOR POSITIVE DIAGNOSIS, REGISTRY OF CASES.

The commissioner shall:

(1) make arrangements for the necessary treatment of diagnosed cases of hemoglobinopathy, phenylketonuria, and other inborn errors of metabolism when treatment is indicated and the family is uninsured and, because of a lack of available income, is unable to pay the cost of the treatment;

(2) maintain a registry of cases of hemoglobinopathy, phenylketonuria, and other inborn errors of metabolism for the purpose of follow-up services; and

(3) adopt rules to carry out section 144.126 and this section.

History: *1991 c 36 s 2*

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

[For text of subd 1, see M.S.1990]

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child, to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original certificate of birth and the certified copy, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate on the birth registration form whether data pertaining to the birth will be public data. Notwithstanding the designation of the data as confidential, it may be disclosed to a parent or guardian of the child, to the child when the child is 18 years of age or older, pursuant to a court order, or under paragraph (b).

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

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.1761; 144.218, subdivision 1; and 259.49. The birth and death records of the commissioner of health shall be open to inspection by the commissioner of human services and it shall not be necessary for the commissioner of human services to obtain an order of the court in order to inspect records or to secure certified copies of them.

[For text of subd 3, see M.S.1990]

Subd. 4. **Access to records for research purposes.** The state registrar may permit persons performing medical research access to the information restricted in subdivision 2 if those persons agree in writing not to disclose private or confidential data on individuals.

[For text of subd 5, see M.S.1990]

History: *1991 c 203 s 1,2*

144.335 ACCESS TO HEALTH RECORDS.

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

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

(b) "Provider" means (1) any person who furnishes health care services and is licensed to furnish the services pursuant to chapter 147, 148, 148B, 150A, 151, or 153; (2) a home care provider licensed under section 144A.46; (3) a health care facility licensed pursuant to this chapter or chapter 144A; and (4) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

[For text of subds 2 and 3, see M.S.1990]

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

(b) This subdivision does not prohibit the release of health records for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency.

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

(d) A patient's consent to the release of data on the date and type of immunizations administered to the patient is effective until the patient directs otherwise, if the consent was executed before August 1, 1991.

[For text of subd 4, see M.S.1990]

History: *1991 c 292 art 2 s 3; 1991 c 319 s 15*

COMMUNITY PREVENTION GRANTS

144.401 COMMUNITY PREVENTION GRANTS.

Subdivision 1. **Grants may be awarded to community health boards and Indian reservations.** Within the limits of funding provided by the legislature, the federal government, or public or private grants, the commissioner shall award grants to community health boards and the federally recognized Indian reservations to plan, develop, and implement community alcohol and drug use and abuse prevention programs. To be considered for a grant, a health board or Indian reservation must submit an application to the commissioner of health that includes a description of the planning process used, a description of community needs and existing resources, a description of the program activities to be implemented with grant money, and a list of the agencies and organizations with whom the board or Indian reservation intends to contract.

Subd. 2. **Local planning requirements.** To be eligible for a prevention grant, a community health board or Indian reservation must conduct a communitywide planning process that allows full participation of all agencies, organizations, and individuals interested in alcohol and drug use and abuse issues. This process must include at least an assessment of community needs, an inventory of existing resources, identification of prevention program activities that will be implemented, and a description of how the program will work collaboratively with programs in existence. A health board may comply with the planning requirements of this subdivision by expanding the community needs assessment process used to develop its community health plan under section 145A.10, subdivision 5.

Subd. 3. **Use of grant money.** Grant money may be used to plan, develop, and implement communitywide primary prevention programs relating to alcohol and other drug use and abuse. Programs may include specific components to address related health risk behaviors involving use of tobacco, poor nutrition, limited exercise or physi-

cal activity, and behaviors that create a risk of serious injury. Grantees may contract with other agencies and organizations to implement the program activities identified in the grant application. Special consideration for contracts must be given to local agencies and organizations with previous successful experience conducting alcohol and other drug prevention programs. Grant money must not be used for alcohol and other drug testing, treatment, or law enforcement activities. Grant money must not be used to supplant or replace funding provided from other sources.

Subd. 4. **Local match.** Prevention grant money provided by the commissioner must not exceed 75 percent of the estimated cost of the eligible prevention program activities for the fiscal year for which the grant is awarded. Local funding of the remainder of the costs may be provided from the sources specified in section 145A.13, subdivision 2, paragraph (a).

Subd. 5. **Transfer of funds.** Federal money provided to the commissioner of education for community prevention grants through the federal Drug Free Schools and Communities Act is transferred to the commissioner of health for prevention grants under this section.

History: *1991 c 292 art 2 s 4*

144.49 VIOLATIONS; PENALTIES.

[For text of subds 1 to 7, see M.S.1990]

Subd. 8. **False statements in reports.** Any person lawfully engaged in the practice of healing who willfully makes any false statement in any report required to be made pursuant to section 144.45 is guilty of a misdemeanor.

History: *1991 c 199 art 2 s 15*

144.50 HOSPITALS, LICENSES; DEFINITIONS.

[For text of subds 1 to 5, see M.S.1990]

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

(b) Class B supervised living facilities seeking medical assistance certification as an intermediate care facility for persons with mental retardation or related conditions shall be classified as follows for purposes of the state building code:

(1) Class B supervised living facilities for six or less persons must meet Group R, Division 3, occupancy requirements; and

(2) Class B supervised living facilities for seven to 16 persons must meet Group R, Division 1, occupancy requirements.

(c) Class B facilities classified under paragraph (b), clauses (1) and (2), must meet the fire protection provisions of chapter 21 of the 1985 life safety code, NFPA 101, for facilities housing persons with impractical evacuation capabilities, except that Class B facilities licensed prior to July 1, 1990, need only continue to meet institutional fire safety provisions. Class B supervised living facilities shall provide the necessary physical plant accommodations to meet the needs and functional disabilities of the residents. For Class B supervised living facilities licensed after July 1, 1990, and housing nonambulatory or nonmobile persons, the corridor access to bedrooms, common spaces, and other resident use spaces must be at least five feet in clear width, except that a waiver may be requested in accordance with Minnesota Rules, part 4665.0600.

(d) The commissioner may license as a Class A supervised living facility a residential program for chemically dependent individuals that allows children to reside with the parent receiving treatment in the facility. The licensee of the program shall be responsible for the health, safety, and welfare of the children residing in the facility. The facility in which the program is located must be provided with a sprinkler system

approved by the state fire marshal. The licensee shall also provide additional space and physical plant accommodations appropriate for the number and age of children residing in the facility. For purposes of license capacity, each child residing in the facility shall be considered to be a resident.

[For text of subd 7, see M.S.1990]

History: *1991 c 286 s 3*

144.653 RULES; PERIODIC INSPECTIONS; ENFORCEMENT.

[For text of subds 1 to 4, see M.S.1990]

Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state commissioner of health finds upon inspection of a facility required to be licensed under the provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, or 626.557, or the applicable rules promulgated under those sections, a correction order shall be issued to the licensee. The correction order shall state the deficiency, cite the specific rule violated, and specify the time allowed for correction.

[For text of subds 6 to 9, see M.S.1990]

History: *1991 c 286 s 4*

TRAUMATIC BRAIN AND SPINAL CORD INJURIES

144.661 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 144.661 to 144.665, the following terms have the meanings given them.

Subd. 2. **Traumatic brain injury.** "Traumatic brain injury" means a sudden insult or damage to the brain or its coverings caused by an external physical force which may produce a diminished or altered state of consciousness and which results in the following disabilities:

(1) impairment of cognitive or mental abilities;

(2) impairment of physical functioning; or

(3) disturbance of behavioral or emotional functioning.

These disabilities may be temporary or permanent and may result in partial or total loss of function. "Traumatic brain injury" does not include injuries of a degenerative or congenital nature.

Subd. 3. **Spinal cord injury.** "Spinal cord injury" means an injury that occurs as a result of trauma which may involve spinal vertebral fracture and where the injured person suffers an acute, traumatic lesion of neural elements in the spinal canal, resulting in any degree of temporary or permanent sensory deficit, motor deficit, or bladder or bowel dysfunction. "Spinal cord injury" does not include intervertebral disc disease.

History: *1991 c 292 art 2 s 5*

144.662 TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY REGISTRY; PURPOSE.

The commissioner of health shall establish and maintain a central registry of persons who sustain traumatic brain injury or spinal cord injury. The purpose of the registry is to:

(1) collect information to facilitate the development of injury prevention, treatment, and rehabilitation programs; and

(2) ensure the provision to persons with traumatic brain injury or spinal cord injury of information regarding appropriate public or private agencies that provide rehabilitative services so that injured persons may obtain needed services to alleviate

injuries and avoid secondary problems, such as mental illness and chemical dependency.

History: *1991 c 292 art 2 s 6*

144.663 DUTY TO REPORT.

Subdivision 1. **Establishment of reporting system.** The commissioner shall design and establish a reporting system which designates either the treating hospital, medical facility, or physician to report to the department within a reasonable period of time after the identification of a person with traumatic brain injury or spinal cord injury. The consent of the injured person is not required.

Subd. 2. **Information.** The report must be submitted on forms provided by the department and must include the following information:

(1) the name, age, and residence of the injured person;

(2) the date and cause of the injury;

(3) the initial diagnosis; and

(4) other information required by the commissioner.

Subd. 3. **Reporting without liability.** The furnishing of information required by the commissioner shall not subject any person or facility required to report to any action for damages or other relief, provided that the person or facility is acting in good faith.

History: *1991 c 292 art 2 s 7*

144.664 DUTIES OF COMMISSIONER.

Subdivision 1. **Studies.** The commissioner shall collect injury incidence information, analyze the information, and conduct special studies regarding traumatic brain injury and spinal cord injury.

Subd. 2. **Provision of data.** The commissioner shall provide summary registry data to public and private entities to conduct studies using data collected by the registry. The commissioner may charge a fee under section 13.03, subdivision 3, for all out-of-pocket expenses associated with the provision of data or data analysis.

Subd. 3. **Notification.** Within five days of receiving a report of traumatic brain injury or spinal cord injury, the commissioner shall notify the commissioner of jobs and training. The notification shall include the person's name and other identifying information.

Subd. 4. **Review committee.** The commissioner shall establish a committee to assist the commissioner in the adoption of rules under subdivision 5 and in the review of registry activities. The committee expires as provided in section 15.059, subdivision 5.

Subd. 5. **Rules.** The commissioner shall adopt rules to administer the registry, collect information, and distribute data. The rules must include, but are not limited to, the following:

(1) the specific ICD-9 procedure codes included in the definitions of "traumatic brain injury" and "spinal cord injury";

(2) the type of data to be reported;

(3) standards for reporting specific types of data;

(4) the persons and facilities required to report and the time period in which reports must be submitted;

(5) criteria relating to the use of registry data by public and private entities engaged in research; and

(6) specification of fees to be charged under section 13.03, subdivision 3, for out-of-pocket expenses.

History: *1991 c 292 art 2 s 8*

144.665 TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY DATA.

Data on individuals collected by the commissioner of health under sections 144.662 to 144.664 or provided to the commissioner of jobs and training under section 144.664 are private data on individuals as defined in section 13.02, subdivision 12, and may be used only for the purposes set forth in sections 144.662 to 144.664 in accordance with the rules adopted by the commissioner.

History: *1991 c 292 art 2 s 9*

144.698 REPORTING REQUIREMENTS.

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

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

(2) a detailed statement of income and expenses;

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

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

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

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

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

[For text of subds 2 to 5, see M.S.1990]

History: *1991 c 202 s 7*

144.70 BIENNIAL REPORT.

[For text of subd 1, see M.S.1990]

Subd. 2. **Interagency cooperation.** In completing the report required by subdivision 1, in fulfilling the requirements of sections 144.695 to 144.703, and in undertaking other initiatives concerning health care costs, access, or quality, the commissioner of health shall cooperate with and consider potential benefits to other state agencies that have a role in the market for health services or the market for health plans. Other agencies include the department of employee relations, as administrator of the state employee health benefits program; the department of human services, as administrator of health services entitlement programs; the department of commerce, in its regulation of health plans; the department of labor and industry, in its regulation of health service costs under workers' compensation.

History: *1991 c 345 art 2 s 37*

144.804 STANDARDS.

Subdivision 1. **Drivers and attendants.** No publicly or privately owned basic ambulance service shall be operated in the state unless its drivers and attendants possess a current emergency care course certificate authorized by rules adopted by the commissioner of health according to chapter 14. Until August 1, 1994, a licensee may substitute a person currently certified by the American Red Cross in advanced first aid and emergency care or a person who has successfully completed the United States Department of Transportation first responder curriculum, and who has also been trained to use basic life support equipment as required by rules adopted by the commissioner under section 144.804, subdivision 3, for one of the persons on a basic ambulance, provided that person will function as the driver while transporting a patient. The commissioner

may grant a variance to allow a licensed ambulance service to use attendants certified by the American Red Cross in advanced first aid and emergency care in order to ensure 24-hour emergency ambulance coverage. The commissioner shall study the roles and responsibilities of first responder units and report the findings by January 1, 1991. This study shall address at a minimum:

(1) education and training;

(2) appropriate equipment and its use;

(3) medical direction and supervision; and

(4) supervisory and regulatory requirements.

[For text of subds 2 to 7, see M.S.1990]

History: *1991 c 199 art 1 s 36*

144.8097 EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL.

[For text of subd 1, see M.S.1990]

Subd. 2. **Membership; terms; compensation.** (a) The council shall consist of 17 members. The members shall be appointed by the commissioner of health and shall consist of the following:

(1) a representative of each of the governing bodies of the eight regional emergency medical systems designated under section 144.8093;

(2) an emergency medical services physician;

(3) an emergency department nurse;

(4) an emergency medical technician (ambulance, intermediate, or paramedic);

(5) a representative of an emergency medical care training institution;

(6) a representative of a licensed ambulance service;

(7) a hospital administrator;

(8) a first responder;

(9) a member of a community health board; and

(10) a representative of the public at large.

(b) As nearly as possible, one-third of the initial members' terms must expire each year during the first three years of the council. Successors of the initial members shall be appointed for three-year terms. A person chosen to fill a vacancy shall be appointed only for the unexpired term of the board member whom the newly appointed member succeeds.

(c) Members of the council shall be compensated for expenses.

(d) The removal of all members and the expiration of the council shall be as provided in section 15.059.

History: *1991 c 199 art 1 s 37*

144.861 [Repealed, 1991 c 345 art 2 s 69]

144.871 DEFINITIONS.

[For text of subd 1, see M.S.1990]

Subd. 2. **Abatement.** "Abatement" means removal or encapsulation of paint, bare soil, dust, drinking water, or other materials that are readily accessible and pose an immediate threat of actual lead exposure to people. The abatement rules to be adopted under section 144.878, subdivision 2, shall apply as described in section 144.874.

[For text of subds 3 to 6, see M.S.1990]

Subd. 7. **Encapsulation.** "Encapsulation" means covering, sealing, painting, resurfacing to make smooth before repainting, or containment of a source of lead.

[For text of subd 8, see M.S.1990]

History: *1991 c 292 art 9 s 2,3*

144.8721 LEAD-RELATED CONTRACTS FOR FISCAL YEARS 1992 AND 1993.

For fiscal years 1992 and 1993, the commissioner shall conduct, or contract with boards of health to conduct, assessments to determine sources of lead contamination in the residences of children and pregnant women whose blood levels exceed ten micrograms per deciliter. For fiscal years 1992 and 1993, the commissioner shall also provide, or contract with boards of health to provide, education on ways of reducing the danger of lead contamination.

History: *1991 c 292 art 9 s 4*

144.873 REPORTING OF MEDICAL AND ENVIRONMENTAL SAMPLE ANALYSES.

Subdivision 1. **Report required.** Medical laboratories performing blood lead analyses must report to the commissioner confirmed blood lead results of at least five micrograms per deciliter. Boards of health must report to the commissioner the results of analyses from residential samples of paint, bare soil, dust, and drinking water that show lead in concentrations greater than or equal to the lead standards adopted by permanent rule under section 144.878. The commissioner shall require other related information from medical laboratories and boards of health as may be needed to monitor and evaluate blood lead levels in the public, including the date of the test and the address of the patient.

[For text of subds 2 and 3, see M.S.1990]

History: *1991 c 292 art 9 s 5*

144.874 ASSESSMENT AND ABATEMENT.

Subdivision 1. **Residence assessment.** (a) A board of health must conduct a timely assessment of a residence to determine sources of lead exposure if:

(1) a pregnant woman in the residence is identified as having a blood lead level of at least ten micrograms of lead per deciliter of whole blood; or

(2) a child in the residence is identified as having an elevated blood lead level. If a child regularly spends several hours per day at another residence, such as a residential child care facility, the board of health must also assess the other residence.

(b) The board of health must conduct the residential assessment according to rules adopted by the commissioner according to section 144.878.

Subd. 2. **Residential lead assessment guide.** (a) The commissioner of health shall develop or purchase a residential lead assessment guide that enables parents to assess the possible lead sources present and that suggests actions.

(b) A board of health must provide the residential lead assessment guide to:

(1) parents of children who are identified as having blood lead levels of at least ten micrograms per deciliter; and

(2) property owners and occupants who are issued housing code orders requiring disruption of lead sources.

(c) A board of health must provide the residential lead assessment guide on request to owners or tenants of residential property within the jurisdiction of the board of health.

Subd. 3. **Abatement orders.** A board of health must order a property owner to perform abatement on a lead source that exceeds a standard adopted according to section 144.878 at the residence of a child with an elevated blood lead level or a pregnant woman with a blood lead level of at least ten micrograms per deciliter. Abatement orders must require that any source of damage, such as leaking roofs, plumbing, and windows, must be repaired or replaced, as needed, to prevent damage to lead-

containing interior surfaces. With each abatement order, the board of health must provide a residential lead abatement guide. The guide must be developed or purchased by the commissioner and must provide information on safe abatement and disposal methods, sources of equipment, and telephone numbers for additional information to enable the property owner to either perform the abatement or to intelligently select an abatement contractor.

[For text of subds 4 to 6, see M.S.1990]

Subd. 7. [Repealed, 1991 c 345 art 2 s 69]

Subd. 8. **Authority of commissioner.** The commissioner may carry out the duties assigned to boards of health in subdivisions 1 to 6.

Subd. 9. **Primary prevention.** Although children who are found to already have elevated blood lead levels must have the highest priority for intervention, the commissioner shall pursue primary prevention of lead poisoning within the limits of appropriations.

Subd. 10. **Registered contractors.** State-subsidized lead abatement shall be conducted by registered lead abatement contractors.

Subd. 11. **Voluntary abatement.** The commissioner shall enforce the rules under section 144.878 in cases of voluntary lead abatement.

Subd. 12. **Enforcement report.** The commissioner shall examine compliance with Minnesota's existing lead standards and rules and report to the legislature by January 15, 1992, on an evaluation of current levels of compliance, the need for any additional enforcement procedures, recommendations on developing a method to enforce compliance with lead standards and cost estimates for any proposed enforcement procedure.

History: *1991 c 292 art 9 s 6-13*