Health

CHAPTER 144

DEPARTMENT OF HEALTH

STATE COMMISSIONER OF HEALTH

144.01 [Repealed, 1977 c 305 s 46]

144.011 DEPARTMENT OF HEALTH.

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

Subd. 2. **State health advisory task force.** The commissioner of health may appoint a state health advisory task force. If appointed, members of the task force shall be broadly representative of the licensed health professions and shall also include public members as defined by section 214.02. The task force shall expire, and the terms, compensation, and removal of members shall be as provided in section 15.059.

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

144.02 [Repealed, 1977 c 305 s 46]

144.03 [Repealed, 1977 c 305 s 46]

144.04 [Repealed, 1977 c 305 s 46]

144.05 GENERAL DUTIES OF COMMISSIONER; REPORTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) include specific objectives in the performance report required under section 15.91 to increase the efficiency of agency operations, when appropriate; and

(7) recommend to the legislature, in the performance report of the department required under section 15.91, appropriate changes in law necessary to carry out the mission of the department.

History: *(5339) RL s 2130; 1973 c 356 s 2; 1977 c 305 s 45; 1986 c 444; 1995 c 248 art 11 s 11*

144.0505 COOPERATION WITH COMMISSIONER OF HUMAN SERVICES.

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

History: *1992 c 513 art 7 s 1*

144.051 DATA RELATING TO LICENSED AND REGISTERED PERSONS.

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

Subd. 2. **Information system.** The commissioner of health shall establish a system for the collection, analysis and reporting of data on individuals licensed or registered by the commissioner or the health–related licensing boards as defined in section 214.01, subdivision 2. Individuals licensed or registered by the commissioner or the health–related licensing boards shall provide information to the commissioner of health that the commissioner may,

pursuant to section 144.052, require. The commissioner shall publish at least biennially, a report which indicates the type of information available and methods for requesting the information.

History: *1978 c 759 s 1; 1986 c 444*

144.052 USE OF DATA.

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

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

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

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

All data collected by the commissioner of health under sections 176.234, 268.12, and 270B.14, subdivision 11, shall be used only for the purposes of epidemiologic investigations, notification of persons exposed to health hazards as a result of employment, and surveillance of occupational health and safety.

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

144.053 RESEARCH STUDIES CONFIDENTIAL.

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

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

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

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

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

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

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

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

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

144.0535 ENTRY FOR INSPECTION.

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

History: *1989 c 282 art 2 s 7*

144.054 SUBPOENA POWER.

Subdivision 1. **Generally.** The commissioner may, as part of an investigation to determine whether a serious health threat exists or to locate persons who may have been exposed to an agent which can seriously affect their health, issue subpoenas to require the attendance and testimony of witnesses and production of books, records, correspondence, and other information relevant to any matter involved in the investigation. The commissioner or the commissioner's designee may administer oaths to witnesses or take their affirmation. The subpoenas may be served upon any person named therein anywhere in the state by any person authorized to serve subpoenas or other processes in civil actions of the district courts. If a person to whom a subpoena is issued does not comply with the subpoena, the commissioner may apply to the district court in any district and the court shall order the person to comply with the subpoena. Failure to obey the order of the court may be punished by the court as contempt of court. Except as provided in subdivision 2, no person may be compelled to disclose privileged information as described in section 595.02, subdivision 1. All information pertaining to individual medical records obtained under this section shall be considered health data under section 13.38. The fees for the service of a subpoena must be paid in the same manner as prescribed by law for a service of process issued out of a district court. Witnesses must receive the same fees and mileage as in civil actions.

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

History: *1988 c 579 s 1; 1992 c 559 art 1 s 1*

144.055 HOME SAFETY PROGRAMS.

Subdivision 1. **Preventing home accidents; working with local boards.** The state commissioner of health is authorized to develop and conduct by exhibit, demonstration and by health education or public health engineering activity, or by any other means or methods which the commissioner may determine to be suitable and practicable for the purpose, a pro-

gram in home safety designed to prevent accidents and fatalities resulting therefrom. The commissioner shall cooperate with boards of health as defined in section 145A.02, subdivision 2, the Minnesota safety council, and other interested voluntary groups in its conduct of such programs.

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

History: *1957 c 290 s 1; 1977 c 305 s 45; 1987 c 309 s 24*

144.056 PLAIN LANGUAGE IN WRITTEN MATERIALS.

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

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

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

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

(e) The commissioner shall report annually to the chairs of the health and human services divisions of the senate finance committee and the house of representatives appropriations committee on the number and outcome of cases that raise the issue of the commissioner's compliance with this section.

History: *1988 c 689 art 2 s 30*

144.057 BACKGROUND STUDIES ON LICENSEES.

Subdivision 1. **Background studies required.** The commissioner of health shall contract with the commissioner of human services to conduct background studies of individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17.

If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of

health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. **Responsibilities of the department of human services.** The department of human services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The department of human services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. If an individual is disqualified, the department of human services shall notify the facility and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the department of health.

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action.

Subd. 4. **Responsibilities of facilities.** Facilities described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, shall apply to these facilities. The provision of section 245A.04, subdivision 3, paragraph (e), shall apply to applicants, licensees, or an individual's refusal to cooperate with the completion of the background studies.

History: *1995 c 229 art 3 s 4; 1996 c 305 art 1 s 35; 1996 c 408 art 10 s 1–3*

144.06 STATE COMMISSIONER OF HEALTH TO PROVIDE INSTRUCTION.

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

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

144.062 VACCINE COST REDUCTION PROGRAM.

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

History: *1990 c 568 art 2 s 5*

144.065 VENEREAL DISEASE TREATMENT CENTERS.

The state commissioner of health shall assist local health agencies and organizations throughout the state with the development and maintenance of services for the detection and treatment of venereal diseases. These services shall provide for diagnosis, treatment, case finding, investigation, and the dissemination of appropriate educational information. The state commissioner of health shall promulgate rules relative to the composition of such services and shall establish a method of providing funds to local health agencies and organizations which offer such services. The state commissioner of health shall provide technical assistance to such agencies and organizations in accordance with the needs of the local area.

History: *1974 c 575 s 6; 1977 c 305 s 45; 1985 c 248 s 70*

144.07 POWERS OF COMMISSIONER.

The commissioner may:

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

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

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

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

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

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

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

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

144.071 MERIT SYSTEM FOR LOCAL EMPLOYEES.

The commissioner may establish a merit system for employees of county or municipal health departments or public health nursing services or health districts, and may promulgate rules governing the administration and operation thereof. In the establishment and administration of the merit system authorized by this section, the commissioner may utilize facilities and personnel of any state department or agency with the consent of such department or agency. The commissioner may also, by rule, cooperate with the federal government in any manner necessary to qualify for federal aid.

History: *1969 c 1073 s 1; 1977 c 305 s 45; 1985 c 248 s 70*

144.072 IMPLEMENTATION OF SOCIAL SECURITY AMENDMENTS OF 1972.

Subdivision 1. **Rules.** The state commissioner of health shall implement by rule, pursuant to the administrative procedure act, those provisions of the social security amendments of 1972 (Public Law Number 92–603) required of state health agencies, including rules which:

(a) establish a plan, consistent with regulations prescribed by the secretary of health, education, and welfare, for the review by appropriate professional health personnel, of the appropriateness and quality of care and services furnished to recipients of medical assistance; and

(b) provide for the determination as to whether institutions and agencies meet the requirements for participation in the medical assistance program, and the certification that those requirements, including utilization review, are being met.

Subd. 2. **Existing procedures.** The policies and procedures, including survey forms, reporting forms, and other documents developed by the commissioner of health for the purpose of conducting the inspections of care required under Code of Federal Regulations, title

42, sections 456.600 to 456.614, in effect on March 1, 1984, have the force and effect of law and shall remain in effect and govern inspections of care until June 30, 1987, unless otherwise superseded by rules adopted by the commissioner of health.

History: *1973 c 717 s 1; 1977 c 305 s 45; 1984 c 641 s 10; 1986 c 316 s 1*

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** The commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396–1396p. These assessments shall be conducted in accordance with section 144.072, with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

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

(1) under section 13.05;

(2) under a valid court order;

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

(4) to the commissioner of human services; or

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

Subd. 3. **Level of care criteria; modifications.** The commissioner shall seek appropriate federal waivers to implement this subdivision. Notwithstanding any laws or rules to the contrary, effective July 1, 1996, Minnesota's level of care criteria for admission of any person to a nursing facility licensed under chapter 144A, or a boarding care home licensed under sections 144.50 to 144.56, are modified as follows:

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

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

(3) applicants in clause (2) who are eligible for assistance as determined under sections 256B.055 and 256B.056 or meet eligibility criteria for section 256B.0913 are eligible for a service allowance under section 256B.0913, subdivision 15, and are not eligible for services under sections 256B.0913, subdivisions 1 to 14, and 256B.0915. Applicants in clause (2) shall have the option of receiving personal care assistant and home health aide services under section 256B.0625, if otherwise eligible, or of receiving the service allowance option, but not both. Applicants in clause (2) shall have the option of residing in community settings under sections 256I.01 to 256I.06, if otherwise eligible, or receiving the services allowance option under section 256B.0913, subdivision 15, but not both;

(4) residents of a certified nursing facility or certified boarding care home who were admitted before July 1, 1996, or individuals receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915, before July 1, 1996, are not subject to the new level of care criteria unless the resident is discharged home or to another service setting other than a certified nursing facility or certified boarding care home and applies for admission to a certified nursing facility or certified boarding care home after June 30, 1996;

(5) the local screening teams under section 256B.0911 shall make preliminary determinations concerning the existence of extraordinary circumstances and may authorize an admission for a short–term stay at a certified nursing facility or certified boarding care home in accordance with a treatment and discharge plan for up to 30 days per year; and

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

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

Subd. 3a. **Exception.** Subdivision 3 does not apply to a facility whose rates are subject to section 256I.05, subdivision 2.

History: *1984 c 641 s 11; 1984 c 654 art 5 s 58; 1995 c 207 art 6 s 1,2; 1995 c 259 art 1 s 31*

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS; PROCEDURES FOR RECONSIDERATION.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under sections 144.072 and 144.0721, or under rules established by the commissioner of human services under sections 256B.41 to 256B.48. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of resident classification must be sent by first–class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident. The nursing home or boarding care home is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notices from the department.

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

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

Subd. 3a. **Access to information.** Upon written request, the nursing home or boarding care home must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home or boarding care home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a

correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues. For the purposes of this section, "representative" includes the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

Subd. 3b. **Facility's request for reconsideration.** In addition to the information required in subdivision 3, a reconsideration request from a nursing home or boarding care home must contain the following information: the date the resident reimbursement classification notices were received by the facility; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the department and the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

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

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

History: *1Sp1985 c 3 s 1; 1987 c 209 s 2; 1996 c 451 art 5 s 3*

144.0723 CLIENT REIMBURSEMENT CLASSIFICATIONS; PROCEDURES FOR RECONSIDERATION.

Subdivision 1. **Client classifications.** The commissioner of health shall establish classifications based upon the assessment of each client in intermediate care facilities for the mentally retarded conducted after December 31, 1992, under section 256B.501, subdivision 3g. The classifications established by the commissioner must conform to section 256B.501, subdivision 3g, and subsequent rules established by the commissioner of human services to set payment rates for intermediate care facilities for the mentally retarded.

Subd. 2. **Notice of client classification.** The commissioner of health shall notify each intermediate care facility for the mentally retarded of the classifications established under subdivision 1 for each client residing in the facility. The notice must inform the intermediate care facility for the mentally retarded of the classifications that are assigned and the opportunity to request a reconsideration of any classifications assigned. The notice of classification must be sent by first–class mail.

Subd. 3. **Request for reconsideration.** The intermediate care facility for the mentally retarded may request that the commissioner reconsider the assigned classification. The re-

quest for reconsideration must be submitted in writing to the commissioner within 30 days after the receipt of the notice of client classification. The request for reconsideration must include the name of the client, the name and address of the facility in which the client resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the client and services provided to the client at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 4. **Access to information.** Annually, at the interdisciplinary team meeting, the intermediate care facility for the mentally retarded shall inform the client or the client's representative and case manager of the client's most recent classification as determined by the department of health. Upon written request, the intermediate care facility for the mentally retarded must give the client's case manager, the client, or the client's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings.

Subd. 5. [Repealed, 1995 c 207 art 7 s 43]

Subd. 6. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. Within 15 working days after receiving the request for reconsideration, the commissioner shall affirm or modify the original client classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The intermediate care facility for the mentally retarded shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 7. **Audit authority.** The department of health may audit assessments of clients in intermediate care facilities for the mentally retarded. The audits may be conducted at the facility, and the department may conduct the audits on an unannounced basis.

Subd. 8. **Rulemaking.** The commissioner of health shall adopt rules necessary to implement these provisions.

History: *1989 c 282 art 3 s 3; 1995 c 207 art 7 s 1–5*

144.073 USE OF DUPLICATING EQUIPMENT.

The state commissioner of health is authorized to maintain and operate mimeograph or similar type of stencil duplicating equipment in the Minneapolis office to expedite the issuance of communicable disease bulletins and public health information circulars to agents of a board of health as authorized under section 145A.02 and other public health workers.

History: *1957 c 274 s 1; 1977 c 305 s 45; 1987 c 309 s 24*

144.074 FUNDS RECEIVED FROM OTHER SOURCES.

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

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

144.0741 MS 1980 [Expired]

144.0742 CONTRACTS FOR PROVISION OF PUBLIC HEALTH SERVICES.

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

specified in the contracts. All such contractual agreements shall be processed in accordance with the provisions of chapter 16B.

History: *1981 c 360 art 1 s 15; 1984 c 544 s 89*

144.075 [Repealed, 1984 c 503 s 6]

144.076 MOBILE HEALTH CLINIC.

The state commissioner of health may establish, equip, and staff with the commissioner's own members or volunteers from the healing arts, or may contract with a public or private nonprofit agency or organization to establish, equip, and staff a mobile unit, or units to travel in and around poverty stricken areas and Indian reservations of the state on a prescribed course and schedule for diagnostic and general health counseling, including counseling on and distribution of dietary information, to persons residing in such areas. For this purpose the state commissioner of health may purchase and equip suitable motor vehicles, and furnish a driver and such other personnel as the department deems necessary to effectively carry out the purposes for which these mobile units were established or may contract with a public or private nonprofit agency or organization to provide the service.

History: *1971 c 940 s 1; 1975 c 310 s 3; 1977 c 305 s 45; 1986 c 444*

144.077 MOBILE HEALTH CARE PROVIDERS.

Subdivision 1. **Definition.** "Mobile health evaluation and screening provider" means any provider who is transported in a vehicle mounted unit, either motorized or trailered, and readily movable without disassembling, and who regularly provides evaluation and screening services in more than one geographic location. "Mobile health evaluation and screening provider" does not include any ambulance medical transportation type services or any mobile health service provider affiliated, owned and operated, or under contract with a licensed health care facility or provider, managed care entity licensed under chapter 62D or 62N or Minnesota licensed physician or dentist, nor does it include fixed location providers who transfer or move during the calendar year. All mobile health evaluation and screening providers must be directly supervised by a physician licensed under chapter 147.

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

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

History: *1995 c 135 s 1*

144.08 POWERS AND DUTIES OF HOTEL INSPECTORS AND AGENTS; INSPECTIONS AND REPORTS.

The department of health shall have and exercise all of the authority and perform all the duties imposed upon and vested in the state hotel inspector. With the advice and consent of the department of administration, the department of health shall appoint and fix the compensation of a hotel inspector and such other inspectors and agents as may be required for the efficient conduct of the duties hereby imposed. These inspectors, by order of the department of administration, may be required to inspect any or all food products subject to inspection by the department of agriculture and to investigate and report to such department violations of the pure food laws and the rules of the department of agriculture pertaining thereto. The reports of these inspectors to the department of agriculture shall have the force and effect of reports made or required to be made by the inspectors of such department.

History: *(53–34) 1925 c 426 art 9 s 2; 1961 c 113 s 1; 1985 c 248 s 70*

144.09 COOPERATION WITH FEDERAL AUTHORITIES.

The state of Minnesota, through its legislative authority:

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

(2) Empowers and directs the commissioner to cooperate with the federal children's bureau to carry out the purposes of such acts; and

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

History: *(5344) 1921 c 392 s 5; 1977 c 305 s 45*

144.092 COORDINATED NUTRITION DATA COLLECTION.

The commissioner of health may develop and coordinate a reporting system to improve the state's ability to document inadequate nutrient and food intake of Minnesota's children and adults and to identify problems and determine the most appropriate strategies for improving inadequate nutritional status. The board on aging may develop a method to evaluate the nutritional status and requirements of the elderly in Minnesota. The commissioner of health and the board on aging may report to the legislature on each July 1, beginning in 1988, on the results of their investigation and their recommendations on the nutritional needs of Minnesotans.

History: *1986 c 404 s 6; 1987 c 209 s 3*

144.10 FEDERAL AID FOR MATERNAL AND CHILD WELFARE SERVICES; CUSTODIAN OF FUND; PLAN OF OPERATION; LOCAL APPROPRIATIONS.

The state treasurer is hereby appointed as the custodian of all moneys received, or which may hereafter be received, by the state by reason of any federal aid granted for maternal and child welfare service and for public health services, including the purposes as declared in Public Law Number 725 enacted by the 79th Congress of the United States, Chapter 958–2d Session and all amendments thereto, which moneys shall be expended in accordance with the purposes expressed in the acts of Congress granting such aid and solely in accordance with plans to be prepared by the state commissioner. The plans so to be prepared by the commissioner for maternal and child health service shall be approved by the United States Children's Bureau; and the plans of the commissioner for public health service shall be approved by the United States Public Health Service. Such plans shall include the training of personnel for both state and local health work and conform with all the requirements governing federal aid for these purposes. Such plans shall be designed to secure for the state the maximum amount of federal aid which is possible to be secured on the basis of the available state, county, and local appropriations for such purposes. The commissioner shall make reports, which shall be in such form and contain such information as may be required by the United States Children's Bureau or the United States Public Health Service, as the case may be; and comply with all the provisions, rules, and regulations which may be prescribed by these federal authorities in order to secure the correction and verification of such reports.

History: *(5391–1) Ex1936 c 70 s 1; 1947 c 485 s 1; 1977 c 305 s 45*

144.11 RULES.

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

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

144.12 REGULATION, ENFORCEMENT, LICENSES, FEES.

Subdivision 1. **Rules.** The commissioner may adopt reasonable rules pursuant to chapter 14 for the preservation of the public health. The rules shall not conflict with the charter or ordinance of a city of the first class upon the same subject. The commissioner may control, by

rule, by requiring the taking out of licenses or permits, or by other appropriate means, any of the following matters:

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

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

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

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

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

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

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

Neither the commissioner nor any board of health as defined in section 145A.02, subdivision 2, nor director of public health may adopt any rule or regulation for the treatment in any penal or correctional institution of any person suffering from any communicable disease or venereal disease or infection, which requires the involuntary detention of any person after the expiration of the period of sentence to the penal or correctional institution, or after the expiration of the period to which the sentence may be reduced by good time allowance or by the lawful order of any judge or the department of corrections;

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

(9) The furnishing of vaccine matter; the assembling, during epidemics of smallpox, with other persons not vaccinated, but no rule of the board or of any public board or officer shall at any time compel the vaccination of a child, or exclude, except during epidemics of smallpox and when approved by the local board of education, a child from the public schools for the reason that the child has not been vaccinated; any person required to be vaccinated may select for that purpose any licensed physician and no rule shall require the vaccination of any child whose physician certifies that by reason of the child's physical condition vaccination would be dangerous;

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

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

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

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

(14) Atmospheric pollution which may be injurious or detrimental to public health;

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

(16) The establishment, operation and maintenance of all clinical laboratories not owned, or functioning as a component of a licensed hospital. These laboratories shall not include laboratories owned or operated by five or less licensed practitioners of the healing arts, unless otherwise provided by federal law or regulation, and in which these practitioners per-

form tests or procedures solely in connection with the treatment of their patients. Rules promulgated under the authority of this clause, which shall not take effect until federal legislation relating to the regulation and improvement of clinical laboratories has been enacted, may relate at least to minimum requirements for external and internal quality control, equipment, facility environment, personnel, administration and records. These rules may include the establishment of a fee schedule for clinical laboratory inspections. The provisions of this clause shall expire 30 days after the conclusion of any fiscal year in which the federal government pays for less than 45 percent of the cost of regulating clinical laboratories.

Subd. 2. **Mass gatherings.** The commissioner may regulate the general sanitation of mass gatherings by promulgation of rules in respect to, but not limited to, the following areas: water supply, disposal of sewage, garbage and other wastes, the prevention and control of communicable diseases, the furnishing of suitable and adequate sanitary accommodations, and all other reasonable and necessary precautions to protect and insure the health, comfort and safety of those in attendance. No permit, license, or other prior approval shall be required of the commissioner for a mass gathering. A "mass gathering" shall mean an actual or reasonably anticipated assembly of more than 1,500 persons which will continue, or may reasonably be expected to continue, for a period of more than ten consecutive hours and which is held in an open space or temporary structure especially constructed, erected or assembled for the gathering. For purposes of this subdivision, "mass gatherings" shall not include public gatherings sponsored by a political subdivision or a nonprofit organization.

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

History: *(5345) RL s 2131; 1917 c 345 s 1; 1923 c 227 s 1; 1951 c 537 s 1; 1953 c 134 s 1; 1957 c 361 s 1; 1975 c 310 s 4; 1975 c 351 s 1; 1977 c 66 s 10; 1977 c 305 s 45; 1977 c 406 s 1; 1983 c 359 s 9; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24*

144.121 X–RAY MACHINES AND FACILITIES USING RADIUM.

Subdivision 1. **Registration; fees.** The fee for the registration for X–ray machines and radium required to be registered under rules adopted by the state commissioner of health pursuant to section 144.12, shall be in an amount prescribed by the commissioner pursuant to section 144.122. The first fee for registration shall be due on January 1, 1975. The registration shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122.

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

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

Subd. 4. **Radiation monitoring.** Whenever involved in radiation procedures, practitioners of veterinary medicine and staff shall wear film–based radiation monitoring badges to monitor individual exposure. The badges must be submitted periodically to a dosimetry service for individual exposure determination.

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

criteria for the approval of examinations required for an individual operating an X–ray machine in Minnesota.

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

Subd. 7. **Advisory committee.** The commissioner of health shall establish an advisory committee for advice on the examination required under subdivision 5. The committee shall consist of 15 members including, but not limited to, a representative of each of the following associations and licensing boards: medical, dental, chiropractic, podiatric, nursing, and hospital, and a representative of registered radiologic technologists and laboratory technicians. The committee shall expire March 31, 1996.

History: *1974 c 81 s 1; 1975 c 310 s 35; 1977 c 305 s 45; 1985 c 248 s 70; 1993 c 188 s 1,2; 1995 c 146 s 1–3*

144.1211 [Repealed, 1993 c 206 s 25]

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner, for fiscal years 1996 and beyond, shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals)	$1,017
Non–JCAHO hospitals	$762 plus $34 per bed
Nursing home	$78 plus $19 per bed

For fiscal years 1996 and beyond, the commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	$517
Boarding care homes	$78 plus $19 per bed
Supervised living facilities	$78 plus $19 per bed.

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

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

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

History: *1974 c 471 s 1; 1975 c 310 s 36; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1987 c 403 art 2 s 7; 1989 c 209 art 1 s 14; 1989 c 282 art 1 s 16; 1992 c 513 art 6 s 1; 1Sp1993 c 1 art 9 s 18; 1995 c 207 art 9 s 4; 1996 c 451 art 4 s 5*

144.1222 PUBLIC POOLS; ENCLOSED SPORTS ARENAS.

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

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

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

History: *1995 c 165 s 1*

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subdivision 1. **Who must pay.** Except for the limitation contained in this section, the commissioner of health shall charge a handling fee for each specimen submitted to the department of health for analysis for diagnostic purposes by any hospital, private laboratory, private clinic, or physician. No fee shall be charged to any entity which receives direct or indirect financial assistance from state or federal funds administered by the department of health, including any public health department, nonprofit community clinic, venereal disease clinic, family planning clinic, or similar entity. The commissioner of health may establish by rule other exceptions to the handling fee as may be necessary to gather information for epidemiologic purposes. All fees collected pursuant to this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 2. **Rules for fee amounts.** The commissioner of health shall promulgate rules, in accordance with chapter 14, which shall specify the amount of the handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be $15 per specimen until the commissioner promulgates rules pursuant to this subdivision.

History: *1979 c 49 s 1; 1982 c 424 s 130; 1987 c 403 art 2 s 8; 1992 c 513 art 6 s 2; 1Sp1993 c 1 art 9 s 19*

144.125 TESTS OF INFANTS FOR INBORN METABOLIC ERRORS.

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

History: *1965 c 205 s 1; 1977 c 305 s 45; 1Sp1981 c 4 art 1 s 75; 1985 c 248 s 70; 1986 c 444; 1988 c 689 art 2 s 31; 1994 c 636 art 2 s 2*

144.126 INBORN METABOLISM ERROR TESTING PROGRAMS.

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: *1Sp1985 c 9 art 2 s 9; 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: *1Sp1985 c 9 art 2 s 10; 1991 c 36 s 2*

144.13 RULES, NOTICE PUBLISHED.

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

History: *(5346) RL s 2132; 1977 c 305 s 45; 1985 c 248 s 70*

144.14 QUARANTINE OF INTERSTATE CARRIERS.

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

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

144.145 FLUORIDATION OF MUNICIPAL WATER SUPPLIES.

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

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

144.146 TREATMENT OF CYSTIC FIBROSIS.

Subdivision 1. **Program.** The commissioner of health shall develop and conduct a program including medical care and hospital treatment for persons aged 21 or over who are suffering from cystic fibrosis.

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

History: *1975 c 409 s 1,2; 1977 c 305 s 45*

SUMMER HEALTH CARE INTERNS

144.1464 SUMMER HEALTH CARE INTERNS.

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

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

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

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

(3) pay one–half the costs of employing the secondary and post–secondary summer health care intern, based on an overall hourly wage that is at least the minimum wage but does not exceed $6 an hour;

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

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

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

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

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

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

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

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

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

(3) provide the facility with a letter of recommendation from a health occupations or science educator.

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

Subd. 3. **Grants.** The commissioner, through the organization under contract, shall award separate grants to hospitals and clinics meeting the requirements of subdivision 2. The grants must be used to pay one–half of the costs of employing secondary and post–secondary pupils in a hospital or clinic during the course of the program. No more than 50 percent of the participants may be post–secondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary or post–secondary institution to participate in the program and no more than one–half of the number of pupils selected may be from the seven–county metropolitan area.

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

History: *1992 c 499 art 7 s 9; 1993 c 345 art 11 s 1; 1993 c 366 s 28,29; 1994 c 625 art 12 s 2; 1995 c 234 art 8 s 29–31*

RURAL HOSPITAL GRANTS

144.1465 FINDING AND PURPOSE.

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

History: *1990 c 568 art 2 s 6*

144.147 RURAL HOSPITAL PLANNING AND TRANSITION GRANT PROGRAM. .

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

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 5,000, according to United States Census Bureau statistics, outside the seven–county metropolitan area;

(2) has 100 or fewer beds;

(3) is not for profit; and

(4) has not been awarded a grant under the federal rural health transition grant program, which would be received concurrently with any portion of the grant period for this program.

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

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

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

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

(3) an implementation plan.

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

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

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

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

(2) changes in service populations;

(3) demand for ambulatory and emergency services;

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

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

(6) the involvement and extent of support of the community and local health care providers; and

(7) the financial condition of the hospital.

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

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

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

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

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

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

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

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

(f) A grant to a hospital, including hospitals that submit applications as consortia, may not exceed $37,500 a year and may not exceed a term of two years. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one–half of the amount, which may include in–kind services, is available for the same purposes from nonstate sources. A hospital receiving a grant under this section may use the grant for any expenses incurred in the development of strategic plans or the implementation of transition projects with respect to which the grant is made. Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

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

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

History: *1990 c 568 art 2 s 7; 1992 c 549 art 5 s 4–6; 1993 c 247 art 5 s 11; 1993 c 345 art 10 s 1; 1995 c 234 art 8 s 32*

RURAL HEALTH

144.1481 RURAL HEALTH ADVISORY COMMITTEE.

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

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

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

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

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

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

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

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

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

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

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

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

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

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

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

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

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

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

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

History: *1992 c 549 art 5 s 7; 1993 c 247 art 5 s 12*

144.1482 OFFICE OF RURAL HEALTH.

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

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

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

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

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

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

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

History: *1992 c 549 art 5 s 8*

144.1483 RURAL HEALTH INITIATIVES.

The commissioner of health, through the office of rural health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the higher education services office, and other state agencies, shall:

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

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;

(3) administer the program of financial assistance established under section 144.1484 for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support;

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

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

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

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

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

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

(10) coordinate the development of a statewide plan for emergency medical services, in cooperation with the emergency medical services advisory council; and

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

History: *1992 c 549 art 5 s 9; 1995 c 212 art 3 s 59*

144.1484 RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.

Subdivision 1. **Sole community hospital financial assistance grants.** The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92 or be located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short–term services; (2) have experienced net income losses in the two most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of 40 or fewer licensed beds; and (4) demonstrate to the commissioner that it has obtained local support for the hospital and that any state support awarded under this program will not be used to supplant local support for the hospital. The commissioner shall review audited financial statements of the hospital to assess the extent of local support. Evidence of local support may include bonds issued by a local government entity such as a city, county, or hospital district for the purpose of financing

hospital projects; and loans, grants, or donations to the hospital from local government entities, private organizations, or individuals. The commissioner shall determine the amount of the award to be given to each eligible hospital based on the hospital's operating loss margin (total operating losses as a percentage of total operating revenue) for the two most recent consecutive fiscal years for which audited financial information is available and the total amount of funding available. One hundred percent of the available funds will be disbursed proportionately based on the operating loss margins of the eligible hospitals.

Subd. 2. **Grants to at-risk rural hospitals to offset the impact of the hospital tax.** (a) The commissioner of health shall award financial assistance grants to rural hospitals that would otherwise close as a direct result of the hospital tax in section 295.52. To be eligible for a grant, a hospital must have 50 or fewer beds and must not be located in a city of the first class. To receive a grant, the hospital must demonstrate to the satisfaction of the commissioner of health that the hospital will close in the absence of state assistance under this subdivision and that the hospital tax is the principal reason for the closure.

(b) At a minimum the hospital must demonstrate that:

(1) it has had a net margin of minus ten percent or below in at least one of the last two years or a net margin of less than zero percent in at least three of the last four years. For purposes of this subdivision, "net margin" means the ratio of net income from all hospital sources to total revenues generated by the hospital;

(2) it has had a negative cash flow in at least three of the last four years. For purposes of this subdivision, "cash flow" means the total of net income plus depreciation; and

(3) its fund balance has declined by at least 25 percent over the last two years, and its fund balance at the end of its last fiscal year was equal to or less than its accumulated net loss during the last two years. For purposes of this subdivision, "fund balance" means the excess of assets of the hospital's fund over its liabilities and reserves.

(c) A hospital seeking a grant shall submit the following with its application:

(1) a statement of the projected dollar amount of tax liability for the current fiscal year, projected monthly disbursements, and projected net patient revenue base for the current fiscal year, broken down by payer categories including Medicare, medical assistance, MinnesotaCare, general assistance medical care, and others. The figures must be certified by the hospital administrator;

(2) a statement of all rate increases, listing the date and percentage of each increase during the last three years and the date and percentage of any increases for the current fiscal year. The statement must be certified by the hospital administrator and must include a narrative explaining whether or not the rate increase incorporates a pass-through of the hospital tax;

(3) a statement certified by the chair or equivalent of the hospital board, and by an independent auditor, that the hospital will close within the next 12 months as a result of the hospital tax unless it receives a grant; and

(4) a statement certified by the chair or equivalent of the hospital board that the hospital will not close for financial reasons within the next 12 months if it receives a grant.

The amount of the grant must not exceed the amount of the tax the hospital would pay under section 295.52, based on the previous year's hospital revenues. A hospital that closes within 12 months after receiving a grant under this subdivision must refund the amount of the grant to the commissioner of health.

History: *1992 c 549 art 5 s 10; 1993 c 345 art 10 s 2,3; 1995 c 234 art 8 s 33*

144.1485 DATABASE ON HEALTH PERSONNEL.

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

(b) Health professionals who report their practice or place of employment address to the commissioner of health under section 144.052 may request in writing that their practice or

place of employment address be classified as private data on individuals, as defined in section 13.02, subdivision 12. The commissioner shall grant the classification upon receipt of a signed statement by the health professional that the classification is required for the safety of the health professional, if the statement also provides a valid, existing address where the health professional consents to receive service of process. The commissioner shall use the mailing address in place of the practice or place of employment address in all documents available to the general public. The practice or place of employment address and any information provided in the classification request, other than the mailing address, are private data on individuals and may be provided to other state agencies. The practice or place of employment address may be used to develop summary reports that show in aggregate the distribution of health care providers in Minnesota.

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

144.1486 RURAL COMMUNITY HEALTH CENTERS.

Subdivision 1. **Community health center.** "Community health center" means a community owned and operated primary and preventive health care practice that meets the unique, essential health care needs of a specified population.

Subd. 2. **Program goals.** The Minnesota community health center program shall increase health care access for residents of rural Minnesota by creating new community health centers in areas where they are needed and maintaining essential rural health care services. The program is not intended to duplicate the work of current health care providers.

Subd. 3. **Grants.** (a) The commissioner shall provide grants to communities for planning and establishing community health centers through the Minnesota community health center program. Grant recipients shall develop and implement a strategy that allows them to become self–sufficient and qualify for other supplemental funding and enhanced reimbursement. The commissioner shall coordinate the grant program with the federal rural health clinic, federally qualified health center, and migrant and community health center programs to encourage federal certification. The commissioner may award planning, project, and initial operating expense grants, as provided in paragraphs (b) to (d).

(b) Planning grants may be awarded to communities to plan and develop state funded community health centers, federally qualified health centers, or migrant and community health centers.

(c) Project grants may be awarded to communities for community health center start–up or expansion, and the conversion of existing practices to community health centers. Start–up grants may be used for facilities, capital equipment, moving expenses, initial staffing, and setup. Communities must provide reasonable assurance of their ability to obtain health care providers and effectively utilize existing health care provider resources. Funded community health center projects must become operational before funding expires. Communities may obtain funding for conversion of existing health care practices to community health centers. Communities with existing community health centers may apply for grants to add sites in underserved areas. Governing boards must include representatives of new service areas.

(d) Centers may apply for grants for up to two years to subsidize initial operating expenses. Applicants for initial operating expense grants must demonstrate that expenses exceed revenues by a minimum of ten percent or demonstrate other extreme need that cannot be met using organizational reserves.

Subd. 4. **Eligibility requirements.** In order to qualify for community health center program funding, a project must:

(1) be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area. "Rural" means an area of the state outside the seven–county Twin Cities metropolitan area and outside of the Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester, and LaCrosse census defined urbanized areas;

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental entity. Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period. With the exception of governmental entities, all applicants must sub-

mit application for nonprofit incorporation and 501(c)(3) tax–exempt status within six months of accepting community health center grant funds;

(3) result in a locally owned and operated community health center that provides primary and preventive health care services, and incorporates quality assurance, regular reviews of clinical performance, and peer review;

(4) seek to employ midlevel professionals, where appropriate;

(5) demonstrate community and popular support and provide a 20 percent local match of state funding; and

(6) propose to serve an area that is not currently served or was not served prior to establishment of a state–funded community health center by a federally certified medical organization.

Subd. 5. **Review process, rating criteria, and point allocation.** (a) The commissioner shall establish grant application guidelines and procedures that allow the commissioner to assess relative need and the applicant's ability to plan and manage a health care project. Program documentation must communicate program objectives, philosophy, expectations, and other conditions of funding to potential applicants.

The commissioner shall establish an impartial review process to objectively evaluate grant applications. Proposals must be categorized, ranked, and funded using a 100–point rating scale. Fifty–two points shall be assigned to relative need and 48 points to project merit.

(b) The scoring of relative need must be based on proposed service area factors, including but not limited to:

(1) population below 200 percent of poverty;

(2) geographic barriers based on average travel time and distance to the next nearest source of primary care that is accessible to Medicaid and Medicare recipients and uninsured low–income individuals;

(3) a shortage of primary care health professionals, based on the ratio of the population in the service area to the number of full–time equivalent primary care physicians in the service area; and

(4) other community health issues including a high unemployment rate, high percentage of uninsured population, high growth rate of minority and special populations, high teenage pregnancy rate, high morbidity rates due to specific diseases, late entry into prenatal care, high percentage geriatric population, high infant mortality rate, high percentage of low birth weight, cultural and language barriers, high percentage minority population, excessive average travel time and distance to next nearest source of subsidized primary care.

(c) Project merit shall be determined based on expected benefit from the project, organizational capability to develop and manage the project, and probability of success, including but not limited to the following factors:

(1) proposed scope of health services;

(2) clinical management plan;

(3) governance;

(4) financial and administrative management; and

(5) community support, integration, collaboration, resources, and innovation.

The commissioner may elect not to award any of the community health center grants if applications fail to meet criteria or lack merit. The commissioner's decision on an application is final.

Subd. 6. **Eligible expenditures.** Grant recipients may use grant funds for the following types of expenditures:

(1) salaries and benefits for employees, to the extent they are involved in project planning and implementation;

(2) purchase, repair, and maintenance of necessary medical and dental equipment and furnishings;

(3) purchase of office, medical, and dental supplies;

(4) in–state travel to obtain training or improve coordination;

(5) initial operating expenses of community health centers;

(6) programs or plans to improve the coordination, effectiveness, or efficiency of the primary health care delivery system;

(7) facilities;

(8) necessary consultant fees; and

(9) reimbursement to rural–based primary care practitioners for equipment, supplies, and furnishings that are transferred to community health centers. Up to 65 percent of the grant funds may be used to reimburse owners of rural practices for the reasonable market value of usable facilities, equipment, furnishings, supplies, and other resources that the community health center chooses to purchase.

Grant funds shall not be used to reimburse applicants for preexisting debt amortization, entertainment, and lobbying expenses.

Subd. 7. **Special consideration.** The commissioner, through the office of rural health, shall make special efforts to identify areas of the state where need is the greatest, notify representatives of those areas about grant opportunities, and encourage them to submit applications.

Subd. 8. **Requirements.** The commissioner shall develop a list of requirements for community health centers and a tracking and reporting system to assess benefits realized from the program to ensure that projects are on schedule and effectively utilizing state funds.

The commissioner shall require community health centers established through the grant program to:

(1) abide by all federal and state laws, rules, regulations, and executive orders;

(2) establish policies, procedures, and services equivalent to those required for federally certified rural health clinics or federally qualified health centers. Written policies are required for description of services, medical management, drugs, biologicals, and review of policies;

(3) become a Minnesota nonprofit corporation and apply for 501(c)(3) tax–exempt status within six months of accepting state funding. Local governmental or tribal entities are exempt from this requirement;

(4) establish a governing board composed of nine to 25 members who are residents of the area served and representative of the social, economic, linguistic, ethnic, and racial target population. At least 35 percent of the board must represent consumers;

(5) establish corporate bylaws that reflect all functions and responsibilities of the board;

(6) develop an appropriate management and organizational structure with clear lines of authority and responsibility to the board;

(7) provide for adequate patient management and continuity of care on site and from referral sources;

(8) establish quality assurance and risk management programs, policies, and procedures;

(9) develop a strategic staffing plan to acquire an appropriate mix of primary care providers and clinical support staff;

(10) establish billing policies and procedures to maximize patient collections, except where federal regulations or contractual obligations prohibit the use of these measures;

(11) develop and implement policies and procedures, including a sliding scale fee schedule, that assure that no person will be denied services because of inability to pay;

(12) establish an accounting and internal control system in accordance with sound financial management principles;

(13) provide a local match equal to 20 percent of the grant amount;

(14) work cooperatively with the local community and other health care organizations, other grant recipients, and the office of rural health;

(15) obtain an independent annual audit and submit audit results to the office of rural health;

(16) maintain detailed records and, upon request, make these records available to the commissioner for examination; and

(17) pursue supplemental funding sources, when practical, for implementation and initial operating expenses.

Subd. 9. **Precautions.** The commissioner may withhold, delay, or cancel grant funding if a grant recipient does not comply with program requirements and objectives.

Subd. 10. **Technical assistance.** The commissioner may provide, contract for, or provide supplemental funding for technical assistance to community health centers in the areas of clinical operations, medical practice management, community development, and program management.

History: *1992 c 549 art 5 s 12; 1993 c 247 art 5 s 13; 1994 c 625 art 8 s 40; 1995 c 234 art 8 s 34*

NATIONAL HEALTH SERVICES CORPS STATE LOAN REPAYMENT PROGRAM

144.1487 LOAN REPAYMENT PROGRAM FOR HEALTH PROFESSIONALS.

Subdivision 1. **Definition.** (a) For purposes of sections 144.1487 to 144.1492, the following definition applies.

(b) "Health professional shortage area" means an area designated as such by the federal Secretary of Health and Human Services, as provided under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E.

Subd. 2. **Establishment and purpose.** The commissioner shall establish a National Health Services Corps state loan repayment program authorized by section 388I of the Public Health Service Act, United States Code, title 42, section 254q–1, as amended by Public Law Number 101–597. The purpose of the program is to assist communities with the recruitment and retention of health professionals in federally designated health professional shortage areas.

History: *1993 c 345 art 11 s 16; 1995 c 212 art 3 s 44; 1995 c 234 art 8 s 35*

144.1488 PROGRAM ADMINISTRATION AND ELIGIBILITY.

Subdivision 1. **Duties of the commissioner of health.** The commissioner shall administer the state loan repayment program. The commissioner shall:

(1) ensure that federal funds are used in accordance with program requirements established by the federal National Health Services Corps;

(2) notify potentially eligible loan repayment sites about the program;

(3) develop and disseminate application materials to sites;

(4) review and rank applications using the scoring criteria approved by the federal Department of Health and Human Services as part of the Minnesota department of health's National Health Services Corps state loan repayment program application;

(5) select sites that qualify for loan repayment based upon the availability of federal and state funding;

(6) carry out other activities necessary to implement and administer sections 144.1487 to 144.1492;

(7) verify the eligibility of program participants;

(8) sign a contract with each participant that specifies the obligations of the participant and the state;

(9) arrange for the payment of qualifying educational loans for program participants;

(10) monitor the obligated service of program participants;

(11) waive or suspend service or payment obligations of participants in appropriate situations;

(12) place participants who fail to meet their obligations in default; and

(13) enforce penalties for default.

Subd. 2. [Repealed, 1995 c 212 art 3 s 60; 1995 c 234 art 8 s 57]

Subd. 3. **Eligible loan repayment sites.** Private, nonprofit, and public entities located in and providing health care services in federally designated primary care health professional

shortage areas are eligible to apply for the program. The commissioner shall develop a list of Minnesota health professional shortage areas in greatest need of health care professionals and shall select loan repayment sites from that list. The commissioner shall ensure, to the greatest extent possible, that the geographic distribution of sites within the state reflects the percentage of the population living in rural and urban health professional shortage areas.

Subd. 4. **Eligible health professionals.** (a) To be eligible to apply to the commissioner for the loan repayment program, health professionals must be citizens or nationals of the United States, must not have any unserved obligations for service to a federal, state, or local government, or other entity, and must be ready to begin full–time clinical practice upon signing a contract for obligated service.

(b) In selecting physicians for participation, the commissioner shall give priority to physicians who are board certified or have completed a residency in family practice, osteopathic general practice, obstetrics and gynecology, internal medicine, or pediatrics. A physician selected for participation is not eligible for loan repayment until the physician has an employment agreement or contract with an eligible loan repayment site and has signed a contract for obligated service with the commissioner.

History: *1993 c 345 art 11 s 17; 1995 c 212 art 3 s 45,46; 1995 c 234 art 8 s 36,37*

144.1489 OBLIGATIONS OF PARTICIPANTS.

Subdivision 1. **Contract required.** Before starting the period of obligated service, a participant must sign a contract with the commissioner that specifies the obligations of the participant and the commissioner.

Subd. 2. **Obligated service.** A participant shall agree in the contract to fulfill the period of obligated service by providing primary health care services in full–time clinical practice. The service must be provided in a private, nonprofit, or public entity that is located in and providing services to a federally designated health professional shortage area and that has been designated as an eligible site by the commissioner under the state loan repayment program.

Subd. 3. **Length of service.** Participants must agree to provide obligated service for a minimum of two years. A participant may extend a contract to provide obligated service for a third and fourth year, subject to approval by the commissioner and the availability of federal and state funding.

Subd. 4. **Affidavit of service required.** Within 30 days of the start of obligated service, and by February 1 of each succeeding calendar year, a participant shall submit an affidavit to the commissioner stating that the participant is providing the obligated service and which is signed by a representative of the organizational entity in which the service is provided. Participants must provide written notice to the commissioner within 30 days of: a change in name or address, a decision not to fulfill a service obligation, or cessation of clinical practice.

Subd. 5. **Tax responsibility.** The participant is responsible for reporting on federal income tax returns any amount paid by the state on designated loans, if required to do so under federal law.

Subd. 6. **Nondiscrimination requirements.** Participants are prohibited from charging a higher rate for professional services than the usual and customary rate prevailing in the area where the services are provided. If a patient is unable to pay this charge, a participant shall charge the patient a reduced rate or not charge the patient. Participants must agree not to discriminate on the basis of ability to pay or status as a Medicare or medical assistance enrollee. Participants must agree to accept assignment under the Medicare program and to serve as an enrolled provider under medical assistance.

History: *1993 c 345 art 11 s 18; 1995 c 212 art 3 s 47–49; 1995 c 234 art 8 s 38–40*

144.1490 RESPONSIBILITIES OF THE LOAN REPAYMENT PROGRAM.

Subdivision 1. **Loan repayment.** Subject to the availability of federal and state funds for the loan repayment program, the commissioner shall pay all or part of the qualifying education loans up to $20,000 annually for each primary care physician participant that fulfills the required service obligation. For purposes of this provision, "qualifying educational

loans" are government and commercial loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

Subd. 2. **Procedure for loan repayment.** Program participants, at the time of signing a contract, shall designate the qualifying loan or loans for which the commissioner is to make payments. The participant shall submit to the commissioner all payment books for the designated loan or loans or all monthly billings for the designated loan or loans within five days of receipt. The commissioner shall make payments in accordance with the terms and conditions of the designated loans, in an amount not to exceed $20,000 when annualized. If the amount paid by the commissioner is less than $20,000 during a 12–month period, the commissioner shall pay during the 12th month an additional amount towards a loan or loans designated by the participant, to bring the total paid to $20,000. The total amount paid by the commissioner must not exceed the amount of principal and accrued interest of the designated loans.

History: *1993 c 345 art 11 s 19; 1995 c 212 art 3 s 50; 1995 c 234 art 8 s 41*

144.1491 FAILURE TO COMPLETE OBLIGATED SERVICE.

Subdivision 1. **Penalties for breach of contract.** A program participant who fails to complete two years of obligated service shall repay the amount paid, as well as a financial penalty based upon the length of the service obligation not fulfilled. If the participant has served at least one year, the financial penalty is the number of unserved months multiplied by $1,000. If the participant has served less than one year, the financial penalty is the total number of obligated months multiplied by $1,000.

Subd. 2. **Suspension or waiver of obligation.** Payment or service obligations cancel in the event of a participant's death. The commissioner may waive or suspend payment or service obligations in case of total and permanent disability or long–term temporary disability lasting for more than two years. The commissioner shall evaluate all other requests for suspension or waivers on a case–by–case basis.

History: *1993 c 345 art 11 s 20; 1995 c 212 art 3 s 51; 1995 c 234 art 8 s 42*

144.1492 STATE RURAL HEALTH NETWORK REFORM INITIATIVE.

Subdivision 1. **Purpose and matching funds.** The commissioner of health shall apply for federal grant funding under the state rural health network reform initiative, a health care financing administration program to provide grant funds to states to encourage innovations in rural health financing and delivery systems. The commissioner may use state funds appropriated to the department of health for the provision of technical assistance for community integrated service network development as matching funds for the federal grant.

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

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

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

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

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

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

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

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

History: *1994 c 625 art 8 s 41*

144.1493 NURSING GRANT PROGRAM.

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

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

(1) an employee of a health care facility located in Minnesota, whom the facility has recommended to the metropolitan healthcare foundation's project LINC for consideration;

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

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

(4) a resident of the state of Minnesota.

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

Subd. 3. **Responsibility of commissioner.** The commissioner shall distribute money each year to the metropolitan healthcare foundation's project LINC to be used to award grants under this section, provided that the commissioner shall not distribute the money unless the metropolitan healthcare foundation's project LINC matches the money with an equal amount from nonstate sources. The metropolitan healthcare foundation's project LINC shall expend nonstate money prior to expending state money and shall return to the commissioner all state money not used each year for nursing program grants to be redistributed under this section. The metropolitan healthcare foundation's project LINC shall report to the commissioner on its program activity as requested by the commissioner.

History: *1995 c 234 art 8 s 43*

144.15 [Repealed, 1945 c 512 s 37]

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

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

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

Subd. 4. [Repealed, 1978 c 699 s 17]
Subd. 5. [Repealed, 1978 c 699 s 17]
Subd. 6. [Repealed, 1978 c 699 s 17]
Subd. 7. [Repealed, 1978 c 699 s 17]
Subd. 8. [Repealed, 1978 c 699 s 17; 1978 c 790 s 4]
Subd. 9. [Repealed, 1978 c 699 s 17; 1978 c 790 s 4]

144.152 [Repealed, 1978 c 699 s 17]

144.153 [Repealed, 1978 c 699 s 17]

144.154 [Repealed, 1978 c 699 s 17]

144.155 [Repealed, 1978 c 699 s 17]

144.156 [Repealed, 1978 c 699 s 17]

144.157 [Repealed, 1978 c 699 s 17]

144.158 [Repealed, 1978 c 699 s 17]

144.159 [Repealed, 1978 c 699 s 17]

144.16 [Repealed, 1945 c 512 s 37]

144.161 [Repealed, 1978 c 699 s 17]

144.162 [Repealed, 1978 c 699 s 17]

144.163 [Repealed, 1978 c 699 s 17]

144.164 [Repealed, 1978 c 699 s 17]

144.165 [Repealed, 1978 c 699 s 17]

144.166 [Repealed, 1978 c 699 s 17]

144.167 [Repealed, 1978 c 699 s 17]

144.168 [Repealed, 1978 c 699 s 17]

144.169 [Repealed, 1978 c 699 s 17]

144.17 [Repealed, 1945 c 512 s 37]

144.171 [Repealed, 1978 c 699 s 17]

144.172 [Repealed, 1978 c 699 s 17]

144.173 [Repealed, 1978 c 699 s 17]

144.174 [Repealed, 1978 c 699 s 17]

144.175 Subdivision 1. [Repealed, 1978 c 699 s 17]
Subd. 2. [Repealed, 1978 c 699 s 17; 1978 c 790 s 4]
Subd. 3. [Repealed, 1947 c 517 s 8; 1978 c 699 s 17]
Subd. 4. [Repealed, 1978 c 699 s 17]
Subd. 5. [Repealed, 1978 c 699 s 17]

144.176 [Repealed, 1978 c 699 s 17]

144.1761 ACCESS TO ADOPTION RECORDS.

Subdivision 1. **Request.** Whenever an adopted person requests the state registrar to disclose the information on the adopted person's original birth certificate, the state registrar shall act in accordance with the provisions of section 259.89.

Subd. 2. [Repealed, 1982 c 584 s 6]

Subd. 3. [Repealed, 1982 c 584 s 6]

Subd. 4. [Repealed, 1982 c 584 s 6]

Subd. 5. [Repealed, 1982 c 584 s 6]

History: *1977 c 181 s 3; 1982 c 584 s 1; 1994 c 631 s 31*

144.177 [Repealed, 1978 c 699 s 17]

144.178 [Repealed, 1978 c 699 s 17]

144.18 [Repealed, 1945 c 512 s 37]

144.181 [Repealed, 1978 c 699 s 17]

144.182 [Repealed, 1978 c 699 s 17]

144.183 [Repealed, 1978 c 699 s 17]

144.19 [Repealed, 1945 c 512 s 37]

144.191 [Repealed, 1978 c 699 s 17]

144.20 [Repealed, 1945 c 512 s 37]

144.201 [Repealed, 1978 c 699 s 17]

144.202 [Repealed, 1978 c 699 s 17]

144.203 [Repealed, 1978 c 699 s 17]

144.204 [Repealed, 1978 c 699 s 17]

144.205 [Repealed, 1978 c 699 s 17]

144.21 [Repealed, 1945 c 512 s 37]

VITAL STATISTICS

144.211 CITATION.

Sections 144.211 to 144.227 may be cited as the "vital statistics act."

History: *1978 c 699 s 1*

144.212 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 144.211 to 144.227, the following terms have the meanings given:

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

Subd. 3. **File.** "File" means to present a vital record for registration.

Subd. 4. **Final disposition.** "Final disposition" means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or dead fetus.

Subd. 5. **Registration.** "Registration" means the acceptance of a vital record for filing by a registrar of vital statistics.

Subd. 6. **State registrar.** "State registrar" means the commissioner of health or a designee.

Subd. 7. **System of vital statistics.** "System of vital statistics" includes the registration, collection, preservation, amendment and certification of vital records, the collection of other reports required by sections 144.211 to 144.227, and related activities including the tabulation, analysis and publication of vital statistics.

Subd. 8. **Vital record.** "Vital record" means certificates or reports of birth, death, marriage, dissolution and annulment, and data related thereto.

Subd. 9. **Vital statistics.** "Vital statistics" means the data derived from certificates and reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment, and related reports.

Subd. 10. **Local registrar.** "Local registrar" means an individual designated under section 144.214, subdivision 1, to perform the duties of a local registrar.

Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed with the state registrar which sets forth the following information:

(a) The current name and address of the affiant;

(b) Any previous name by which the affiant was known;

(c) The original and adopted names, if known, of the adopted child whose original birth certificate is to be disclosed;

(d) The place and date of birth of the adopted child;

(e) The biological relationship of the affiant to the adopted child; and

(f) The affiant's consent to disclosure of the original unaltered birth certificate of the adopted child.

History: *1978 c 699 s 2; 1986 c 444*

144.213 OFFICE OF VITAL STATISTICS.

Subdivision 1. **Creation; state registrar.** The commissioner shall establish an office of vital statistics under the supervision of the state registrar. The commissioner shall furnish to local registrars the forms necessary for correct reporting of vital statistics, and shall instruct the local registrars in the collection and compilation of the data. The commissioner shall promulgate rules for the collection, filing, and registering of vital statistics information by state and local registrars, physicians, morticians, and others. Except as otherwise provided in sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to the collection, filing and registering of vital statistics shall remain in effect until repealed, modified or superseded by a rule promulgated by the commissioner.

Subd. 2. **General duties.** The state registrar shall coordinate the work of local registrars to maintain a statewide system of vital statistics. The state registrar is responsible for the administration and enforcement of sections 144.211 to 144.227, and shall supervise local registrars in the enforcement of sections 144.211 to 144.227 and the rules promulgated thereunder.

Subd. 3. **Record keeping.** To preserve vital records the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and files in the office of vital statistics. The reproductions when certified by the state or local registrar shall be accepted as the original records.

History: *1978 c 699 s 3*

144.214 LOCAL REGISTRARS OF VITAL STATISTICS.

Subdivision 1. **Districts.** Each county of the state, and the city of St. Paul, shall constitute the 88 registration districts of the state. The local registrar in each county shall be the court administrator of district court in that county. The local registrar in any city which maintains local registration of vital statistics shall be the agent of a board of health as authorized under section 145A.04. In addition, the state registrar may establish registration districts on United States government reservations, and may appoint a local registrar for each registration district so established.

Subd. 2. **Failure of duty.** A local registrar who neglects or fails to discharge duties as provided by sections 144.211 to 144.227 may be relieved of the duties as local registrar by the state registrar after notice and hearing. The state registrar may appoint a successor to serve as local registrar. If a local registrar fails to file or transmit birth or death certificates the state registrar shall obtain them by other means.

Subd. 3. **Duties.** The local registrar shall examine each certificate of birth and death received pursuant to the rules of the commissioner. If the certificate is complete it shall be registered. The local registrar shall enforce the provisions of sections 144.211 to 144.227 and the rules promulgated thereunder within the registration district, and shall promptly report violations of the laws or rules to the state registrar.

Subd. 4. **Designated morticians.** The state registrar may designate licensed morticians to receive for filing certificates of death, to issue burial permits, and to issue permits for the

transportation of dead bodies or dead fetuses within designated territory. The designated morticians shall perform duties as prescribed by rule of the commissioner.

History: *1978 c 699 s 4; 1986 c 444; 1986 c 473 s 1; 1Sp1986 c 3 art 1 s 82; 1987 c 309 s 24*

144.215 BIRTH REGISTRATION.

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

Subd. 2. **Rules governing birth registration.** The commissioner shall establish by rule an orderly mechanism for the registration of births including at least a designation for who must file the birth certificate, a procedure for registering births which occur in moving conveyances, and a provision governing the names of the parent or parents to be entered on the birth certificate.

Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is determined by a court of competent jurisdiction, a declaration of parentage is executed under section 257.34, or a recognition of parentage is executed under section 257.75, the name of the father shall be entered on the birth certificate. If the order of the court declares the name of the child, it shall also be entered on the birth certificate. If the order of the court does not declare the name of the child, or there is no court order, then upon the request of both parents in writing, the surname of the child shall be that of the father.

Subd. 4. **Social security number registration.** (a) Parents of a child born within this state shall give their social security numbers to the office of vital statistics at the time of filing the birth certificate, but the numbers shall not appear on the certificate.

(b) The social security numbers are classified as private data, as defined in section 13.02, subdivision 12, on individuals, but the office of vital statistics shall provide the social security number to the public authority responsible for child support services upon request by the public authority for use in the establishment of parentage and the enforcement of child support obligations.

History: *1978 c 699 s 5; 1980 c 589 s 28; 1Sp1993 c 1 art 6 s 1,2*

144.216 FOUNDLING REGISTRATION.

Subdivision 1. **Reporting a foundling.** Whoever finds a live born infant of unknown parentage shall report within five days to the office of vital statistics such information as the commissioner may by rule require to identify the foundling.

Subd. 2. **Status of foundling reports.** A report registered under subdivision 1 shall constitute the certificate of birth for the child. If the child is identified and a certificate of birth is found or obtained, the report registered under subdivision 1 shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

History: *1978 c 699 s 6; 1981 c 311 s 39; 1982 c 545 s 24*

144.217 DELAYED CERTIFICATES OF BIRTH.

Subdivision 1. **Evidence required for filing.** Before a delayed certificate of birth is registered, the person presenting the delayed certificate for registration shall offer evidence of the facts contained in the certificate, as required by the rules of the commissioner. In the absence of the evidence required, the delayed certificate shall not be registered.

Subd. 2. **Court petition.** If a delayed certificate of birth is rejected under subdivision 1, a person may petition the appropriate court for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered. The petition shall state:

(a) That the person for whom a delayed certificate of birth is sought was born in this state;

(b) That no certificate of birth can be found in the office of the state or local registrar;

(c) That diligent efforts by the petitioner have failed to obtain the evidence required in subdivision 1;

(d) That the state registrar has refused to register a delayed certificate of birth; and

(e) Other information as may be required by the court.

Subd. 3. **Court order.** The court shall fix a time and place for a hearing on the petition and shall give the state registrar ten days notice of the hearing. The state registrar may appear and testify in the proceeding. If the court is satisfied from the evidence received at the hearing of the truth of the statements in the petition, the court shall order the registration of the delayed certificate.

Subd. 4. **Filing the order.** A certified copy of the order shall be filed with the state registrar, who shall forward a copy to the local registrar in the district of birth. Certified copies of the order shall be evidence of the truth of their contents and be admissible as birth certificates.

History: *1978 c 699 s 7*

144.218 NEW CERTIFICATES OF BIRTH.

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

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

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

Subd. 4. **Incomplete, incorrect, and modified certificates.** If a court finds that a birth certificate is incomplete, inaccurate or false, or if it is being issued pursuant to section 259.10, subdivision 2, it may order the registration of a new certificate, and, if necessary, set forth the correct information in the order. Upon receipt of the order the state registrar shall register a new certificate containing the findings of the court, and the prior certificate shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

History: *1978 c 699 s 8; 1980 c 561 s 1; 1981 c 311 s 24; 1982 c 545 s 24; 1984 c 654 art 5 s 58; 1994 c 465 art 1 s 62; 1994 c 631 s 31; 1995 c 259 art 1 s 32*

144.219 AMENDMENT OF VITAL RECORDS.

Upon the order of a court of this state, upon the request of a court of another state, or upon the filing of a declaration of parentage under section 257.34 with the state registrar or the appropriate court, a new birth certificate shall be registered consistent with the findings of the court or with the declaration of parentage.

History: *1978 c 699 s 9; 1987 c 403 art 3 s 1*

144.22 [Repealed, 1945 c 512 s 37]

144.221 DEATH REGISTRATION.

Subdivision 1. **When and where to file.** A death certificate for each death which occurs in the state shall be filed with the local registrar of the district in which the death occurred or with a mortician appointed pursuant to section 144.214, subdivision 4, within five days after death and prior to final disposition.

Subd. 2. **Rules governing death registration.** The commissioner of health shall establish in rule an orderly mechanism for the registration of deaths including at least a designation for who must file the death certificate, a procedure for the registration of deaths in moving conveyances, and provision to include cause and certification of death and assurance of registration prior to final disposition.

Subd. 3. **When no body is found.** When circumstances suggest that a death has occurred although a dead body cannot be produced to confirm the fact of death, a death certificate shall not be registered until a court has adjudicated the fact of death. A certified copy of the court finding shall be attached to the death certificate when it is registered.

History: *1978 c 699 s 10*

144.2215 BIRTH DEFECTS REGISTRY SYSTEM.

The commissioner of health shall develop a statewide birth defects registry system to provide for the collection, analysis, and dissemination of birth defects information. The commissioner shall consult with representatives and experts in epidemiology, medicine, insurance, health maintenance organizations, genetics, consumers, and voluntary organizations in developing the system and may phase in the implementation of the system.

History: *1996 c 451 art 4 s 6*

144.222 REPORTS OF FETAL OR INFANT DEATH.

Subdivision 1. **Fetal death.** Each fetal death which occurs in this state shall be reported within five days to the state registrar as prescribed by rule by the commissioner.

Subd. 2. **Sudden infant death.** Each infant death which is diagnosed as sudden infant death syndrome shall be reported promptly to the state registrar.

History: *1978 c 699 s 11; 1984 c 637 s 2*

144.223 REPORT OF MARRIAGE.

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

A. Personal information on bride and groom:

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

B. Information concerning the marriage:

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

History: *1977 c 305 s 45; 1978 c 699 s 12*

144.224 REPORTS OF DISSOLUTION AND ANNULMENT OF MARRIAGE.

Each month the court administrator shall forward to the commissioner of health the statistical report forms collected pursuant to section 518.147 during the preceding month. The report form shall include only the following information:

(a) name, date of birth, birthplace, residence, race, and educational attainment of the husband and wife;

(b) county of decree;

(c) date and type of decree;

(d) place and date of marriage;

(e) date of separation;

(f) number and ages of children of marriage;

(g) amount and status of maintenance and child support;

(h) custody of children, including whether joint legal or physical custody was awarded;

(i) income of the parties;

(j) length of separation and length of marriage; and

(k) number of previous marriages and reasons for ending the previous marriages (death, dissolution, or annulment).

The commissioner may publish data collected under this section in summary form only. The statistical report form shall contain a statement that neither the report form, nor information contained in the form, shall be admissible in evidence in this or any subsequent proceeding.

History: *1978 c 699 s 13; 1984 c 534 s 1; 1Sp1986 c 3 art 1 s 20,82; 1990 c 574 s 1*

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

Subdivision 1. **Public information; access to records.** Except as otherwise provided for in this section and section 144.1761, information contained in vital records shall be public information. Physical access to vital records shall be subject to the supervision and regulation of state and local registrars and their employees pursuant to rules promulgated by the commissioner in order to protect vital records from loss, mutilation or destruction and to prevent improper disclosure of records which are confidential or private data on individuals, as defined in section 13.02, subdivisions 3 and 12.

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child, to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original 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 259.89. The birth and death records of the commissioner of health shall be open to inspection by the commissioner of human services and it shall not be necessary for the commissioner of human services to obtain an order of the court in order to inspect records or to secure certified copies of them.

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

Subd. 2a. **Health data associated with birth registration.** Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is private data as defined in section 13.02, subdivision 12. The commissioner may disclose to a local board of health, as defined in section 145A.02, subdivision 2, health data associated with birth registration which identifies a mother or child at high risk for serious disease, dis-

ability, or developmental delay in order to assure access to appropriate health, social, or educational services.

Subd. 3. **Laws and rules for preparing certificates.** No person shall prepare or issue any certificate which purports to be an original, certified copy, or copy of a vital record except as authorized in sections 144.211 to 144.227 or the rules of the commissioner.

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

Subd. 5. **Residents of other states.** When a resident of another state is born or dies in this state, the state registrar shall send a report of the birth or death to the state of residence.

Subd. 6. **Group purchaser identity; nonpublic data; disclosure.** (a) Except as otherwise provided in this subdivision, the named identity of a group purchaser as defined in section 62J.03, subdivision 6, collected in association with birth registration is nonpublic data as defined in section 13.02.

(b) The commissioner may publish, or by other means release to the public, the named identity of a group purchaser as part of an analysis of information collected from the birth registration process. Analysis means the identification of trends in prenatal care and birth outcomes associated with group purchasers. The commissioner may not reveal the named identity of the group purchaser until the group purchaser has had 21 days after receipt of the analysis to review the analysis and comment on it. In releasing data under this subdivision, the commissioner shall include comments received from the group purchaser related to the scientific soundness and statistical validity of the methods used in the analysis. This subdivision does not authorize the commissioner to make public any individual identifying data except as permitted by law.

(c) A group purchaser may contest whether an analysis made public under paragraph (b) is based on scientifically sound and statistically valid methods in a contested case proceeding under sections 14.57 to 14.62, subject to appeal under sections 14.63 to 14.68. To obtain a contested case hearing, the group purchaser must present a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the group purchaser must demonstrate by clear and convincing evidence the group purchaser's likelihood of succeeding on the merits. If the judge determines that the group purchaser has made this demonstration, the data may not be released during the contested case proceeding and through appeal. If the judge finds that the group purchaser has not made this demonstration, the commissioner may immediately publish, or otherwise make public, the nonpublic group purchaser data, with comments received as set forth in paragraph (b).

(d) The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

History: *1978 c 699 s 14; 1980 c 509 s 42; 1980 c 561 s 2; 1981 c 311 s 39; 1982 c 545 s 24; 1983 c 7 s 2; 1983 c 243 s 5 subd 2; 1984 c 654 art 5 s 58; 1986 c 444; 1991 c 203 s 1,2; 1994 c 631 s 31; 1995 c 259 art 1 s 33; 1996 c 440 art 1 s 34,35*

144.226 FEES.

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

(a) The issuance of a certified copy or certification of a vital record, or a certification that the record cannot be found;

(b) The replacement of a birth certificate;

(c) The filing of a delayed registration of birth or death;

(d) The alteration, correction, or completion of any vital record, provided that no fee shall be charged for an alteration, correction, or completion requested within one year after the filing of the certificate; and

(e) The verification of information from or noncertified copies of vital records. Fees charged shall approximate the costs incurred in searching and copying the records. The fee shall be payable at time of application.

Subd. 2. **Fees to state government special revenue fund.** Fees collected under this section by the state registrar shall be deposited to the state government special revenue fund.

Subd. 3. **Birth certificate copy surcharge.** In addition to any fee prescribed under subdivision 1, there shall be a surcharge of $3 for each certified copy of a birth certificate. The local or state registrar shall forward this amount to the commissioner of finance for deposit into the account for the children's trust fund for the prevention of child abuse established under section 119A.12. This surcharge shall not be charged under those circumstances in which no fee for a certified copy of a birth certificate is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of finance that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.

History: *1977 c 305 s 45; 1978 c 699 s 15; 1984 c 654 art 5 s 58; 1986 c 423 s 8; 1986 c 444; 1987 c 358 s 108; 1991 c 292 art 8 s 25; 1Sp1993 c 1 art 9 s 20; 1995 c 207 art 9 s 5*

144.227 PENALTIES.

Subdivision 1. **False statements.** Whoever intentionally makes any false statement in a certificate, record, or report required to be filed under sections 144.211 to 144.214 or 144.216 to 144.227, or in an application for an amendment thereof, or in an application for a certified copy of a vital record, or who supplies false information intending that the information be used in the preparation of any report, record, certificate, or amendment thereof, is guilty of a misdemeanor.

Subd. 2. **Fraud.** Any person who, without lawful authority and with the intent to deceive, willfully and knowingly makes, counterfeits, alters, obtains, possesses, uses or sells any certificate, record or report required to be filed under sections 144.211 to 144.227, or a certified copy of a certificate, record or report, is guilty of a gross misdemeanor.

Subd. 3. **Birth registration.** Whoever intentionally makes a false statement in a registration required under section 144.215 or in an application for an amendment to such a registration, or intentionally supplies false information intending that the information be used in the preparation of a registration under section 144.215 is guilty of a gross misdemeanor. This offense shall be prosecuted by the county attorney.

History: *1978 c 699 s 16; 1994 c 631 s 1,2*

144.23–144.28 [Repealed, 1945 c 512 s 37]

HEALTH RECORDS AND REPORTS

144.29 HEALTH RECORDS; CHILDREN OF SCHOOL AGE.

It shall be the duty of every school nurse, school physician, school attendance officer, superintendent of schools, principal, teacher, and of the persons charged with the duty of compiling and keeping the school census records, to cause a permanent public health record to be kept for each child of school age. Such record shall be kept in such form that it may be transferred with the child to any school which the child shall attend within the state and transferred to the commissioner when the child ceases to attend school. It shall contain a record of such health matters as shall be prescribed by the commissioner, and of all mental and physical defects and handicaps which might permanently cripple or handicap the child. Nothing in sections 144.29 to 144.32 shall be construed to require any child whose parent or guardian objects in writing thereto to undergo a physical or medical examination or treatment. A copy shall be forwarded to the proper department of any state to which the child shall remove. Each district shall assign a teacher, school nurse, or other professional person to review, at the beginning of each school year, the health record of all pupils under the assignee's direction. Growth, results of vision and hearing screening, and findings obtained from health assessments must be entered periodically on the pupil's health record.

History: *(5356–1) 1929 c 277 s 1; 1977 c 305 s 45; 1993 c 224 art 12 s 30*

144.30 COPIES OF RECORDS EVIDENCE IN JUVENILE COURT.

When any child shall be brought into juvenile court the court shall request, and the custodian of the record shall furnish, a complete certified copy of such record to the court, which

copy shall be received as evidence in the case; and no decision or disposition of the pending matter shall be finally made until such record, if existing, shall be considered.

History: *(5356–2) 1929 c 277 s 2*

144.31 [Repealed, 1969 c 1082 s 2]

144.32 FALSE STATEMENTS TO BE CAUSE FOR DISCHARGE.

Any intentionally false statement in such certificate and any act or omission of a superintendent or superior officer to connive at or permit the same shall be deemed good cause for summary discharge of the person at fault regardless of any contract.

History: *(5356–4) 1929 c 277 s 4*

144.33 [Repealed, 1961 c 27 s 1]

144.335 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; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

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

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

(b) Except as provided in paragraph (e), upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient (1) copies of the patient's health record, including but not limited to laboratory reports, X–rays, prescriptions, and other technical information used in assessing the patient's health condition, or (2) the pertinent portion of the record relating to a condition specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

(c) If a provider, as defined in subdivision 1, clause (b)(1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in subdivision 1, clause (b)(1). The other provider or third party may release the information to the patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3b. **Release of records to commissioner of health or health data institute.** Subdivision 3a does not apply to the release of health records to the commissioner of health or the health data institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 3c. **Independent medical examination.** This section applies to the subject and provider of an independent medical examination requested by or paid for by a third party. Notwithstanding subdivision 3a, a provider may release health records created as part of an independent medical examination to the third party who requested or paid for the examination.

Subd. 4. **Additional patient rights.** The rights set forth in this section are in addition to the rights set forth in sections 144.651 and 144.652 and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 5. **Costs.** When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee. When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to X–rays. The provider may charge a patient no more than the actual cost of reproducing X–rays, plus no more than $10 for the time spent retrieving and copying the X–rays.

The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the consumer price index for all urban consumers, Minneapolis–St. Paul (CPI–U), published by the department of labor.

Subd. 5a. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

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

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

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

Subd. 6. **Violation.** A violation of this section may be grounds for disciplinary action against a provider by the appropriate licensing board or agency.

History: *1977 c 380 s 1; 1985 c 298 s 40; 1986 c 444; 1987 c 347 art 1 s 18; 1987 c 378 s 1; 1988 c 670 s 8; 1989 c 64 s 1,2; 1989 c 175 s 3; 1989 c 209 art 1 s 15; 1990 c 573 s 20; 1991 c 292 art 2 s 3; 1991 c 319 s 15; 1992 c 569 s 8–11; 1993 c 345 art 12 s 7; 1993 c 351 s 24,25; 1994 c 618 art 1 s 19; 1994 c 625 art 8 s 42,43; 1995 c 205 art 2 s 3; 1995 c 234 art 5 s 23; 1995 c 259 art 1 s 34; art 4 s 5; 1996 c 440 art 1 s 36*

144.3351 IMMUNIZATION DATA.

Providers as defined in section 144.335, subdivision 1, group purchasers as defined in section 62J.03, subdivision 6, elementary or secondary schools or child care facilities as defined in section 123.70, subdivision 9, public or private post–secondary educational institutions as defined in section 135A.14, subdivision 1, paragraph (b), a board of health as defined in section 145A.02, subdivision 2, community action agencies as defined in section 268.53, subdivision 1, and the commissioner of health may exchange immunization data with one another, without the patient's consent, if the person requesting access provides services on behalf of the patient. For purposes of this section immunization data includes:

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

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

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

History: *1992 c 569 s 12; 1995 c 259 art 1 s 35*

144.3352 HEPATITIS B MATERNAL CARRIER DATA; INFANT IMMUNIZATION.

The commissioner of health or a local board of health may inform the physician attending a newborn of the hepatitis B infection status of the biological mother.

History: *1994 c 618 art 1 s 20*

144.336 REGISTRY OF PERSONS TYPED FOR HUMAN LEUKOCYTE ANTIGENS.

Subdivision 1. **Release restricted.** No person, including the state, a state agency, or a political subdivision, that maintains or operates a registry of the names of persons, their human leukocyte antigen types, and their willingness to be a tissue donor shall reveal the identity of the person or the person's human leukocyte antigen type without the person's consent. If the data are maintained by a governmental entity, the data are classified as private data on individuals as defined in section 13.02, subdivision 12.

Subd. 2. **Duties.** Persons that maintain or operate a registry described in subdivision 1 have no responsibility for any search beyond their own records to identify potential donors for the benefit of any person seeking a tissue transplant and have no duty to encourage potential donors to assist persons seeking a tissue transplant, and are not liable for their failure to do so.

History: *1984 c 436 s 33; 1986 c 444*

144.34 INVESTIGATION AND CONTROL OF OCCUPATIONAL DISEASES.

Any physician having under professional care any person whom the physician believes to be suffering from poisoning from lead, phosphorus, arsenic, brass, silica dust, carbon monoxide gas, wood alcohol, or mercury, or their compounds, or from anthrax or from compressed–air illness or any other disease contracted as a result of the nature of the employment of such person shall within five days mail to the department of health a report stating the name, address, and occupation of such patient, the name, address, and business of the patient's employer, the nature of the disease, and such other information as may reasonably be

required by the department. The department shall prepare and furnish the physicians of this state suitable blanks for the reports herein required. No report made pursuant to the provisions of this section shall be admissible as evidence of the facts therein stated in any action at law or in any action under the workers' compensation act against any employer of such diseased person. The department of health is authorized to investigate and to make recommendations for the elimination or prevention of occupational diseases which have been reported to it, or which shall be reported to it, in accordance with the provisions of this section. The department is also authorized to study and provide advice in regard to conditions that may be suspected of causing occupational diseases. Information obtained upon investigations made in accordance with the provisions of this section shall not be admissible as evidence in any action at law to recover damages for personal injury or in any action under the workers' compensation act. Nothing herein contained shall be construed to interfere with or limit the powers of the department of labor and industry to make inspections of places of employment or issue orders for the protection of the health of the persons therein employed. When upon investigation the commissioner of health reaches a conclusion that a condition exists which is dangerous to the life and health of the workers in any industry or factory or other industrial institutions the commissioner shall file a report thereon with the department of labor and industry.

History: *(4327–1) 1939 c 322; 1975 c 359 s 23; 1977 c 305 s 45; 1986 c 444*

CONSENT OF MINORS FOR HEALTH SERVICES

144.341 LIVING APART FROM PARENTS AND MANAGING FINANCIAL AFFAIRS, CONSENT FOR SELF.

Notwithstanding any other provision of law, any minor who is living separate and apart from parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required.

History: *1971 c 544 s 1; 1986 c 444*

144.342 MARRIAGE OR GIVING BIRTH, CONSENT FOR HEALTH SERVICE FOR SELF OR CHILD.

Any minor who has been married or has borne a child may give effective consent to personal medical, mental, dental and other health services, or to services for the minor's child, and the consent of no other person is required.

History: *1971 c 544 s 2; 1986 c 444*

144.343 PREGNANCY, VENEREAL DISEASE, ALCOHOL OR DRUG ABUSE, ABORTION.

Subdivision 1. **Minor's consent valid.** Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

Subd. 2. **Notification concerning abortion.** Notwithstanding the provisions of section 13.02, subdivision 8, no abortion operation shall be performed upon an unemancipated minor or upon a woman for whom a guardian or conservator has been appointed pursuant to sections 525.54 to 525.551 because of a finding of incompetency, until at least 48 hours after written notice of the pending operation has been delivered in the manner specified in subdivisions 2 to 4.

(a) The notice shall be addressed to the parent at the usual place of abode of the parent and delivered personally to the parent by the physician or an agent.

(b) In lieu of the delivery required by clause (a), notice shall be made by certified mail addressed to the parent at the usual place of abode of the parent with return receipt requested and restricted delivery to the addressee which means postal employee can only deliver the mail to the authorized addressee. Time of delivery shall be deemed to occur at 12 o'clock noon on the next day on which regular mail delivery takes place, subsequent to mailing.

Subd. 3. **Parent, abortion; definitions.** For purposes of this section, "parent" means both parents of the pregnant woman if they are both living, one parent of the pregnant woman if only one is living or if the second one cannot be located through reasonably diligent effort, or the guardian or conservator if the pregnant woman has one.

For purposes of this section, "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the fetus and "fetus" means any individual human organism from fertilization until birth.

Subd. 4. **Limitations.** No notice shall be required under this section if:

(a) The attending physician certifies in the pregnant woman's medical record that the abortion is necessary to prevent the woman's death and there is insufficient time to provide the required notice; or

(b) The abortion is authorized in writing by the person or persons who are entitled to notice; or

(c) The pregnant minor woman declares that she is a victim of sexual abuse, neglect, or physical abuse as defined in section 626.556. Notice of that declaration shall be made to the proper authorities as provided in section 626.556, subdivision 3.

Subd. 5. **Penalty.** Performance of an abortion in violation of this section shall be a misdemeanor and shall be grounds for a civil action by a person wrongfully denied notification. A person shall not be held liable under this section if the person establishes by written evidence that the person relied upon evidence sufficient to convince a careful and prudent person that the representations of the pregnant woman regarding information necessary to comply with this section are bona fide and true, or if the person has attempted with reasonable diligence to deliver notice, but has been unable to do so.

Subd. 6. **Substitute notification provisions.** If subdivision 2 of this law is ever temporarily or permanently restrained or enjoined by judicial order, subdivision 2 shall be enforced as though the following paragraph were incorporated as paragraph (c) of that subdivision; provided, however, that if such temporary or permanent restraining order or injunction is ever stayed or dissolved, or otherwise ceases to have effect, subdivision 2 shall have full force and effect, without being modified by the addition of the following substitute paragraph which shall have no force or effect until or unless an injunction or restraining order is again in effect.

(c)(i) If such a pregnant woman elects not to allow the notification of one or both of her parents or guardian or conservator, any judge of a court of competent jurisdiction shall, upon petition, or motion, and after an appropriate hearing, authorize a physician to perform the abortion if said judge determines that the pregnant woman is mature and capable of giving informed consent to the proposed abortion. If said judge determines that the pregnant woman is not mature, or if the pregnant woman does not claim to be mature, the judge shall determine whether the performance of an abortion upon her without notification of her parents, guardian, or conservator would be in her best interests and shall authorize a physician to perform the abortion without such notification if said judge concludes that the pregnant woman's best interests would be served thereby.

(ii) Such a pregnant woman may participate in proceedings in the court on her own behalf, and the court may appoint a guardian ad litem for her. The court shall, however, advise her that she has a right to court appointed counsel, and shall, upon her request, provide her with such counsel.

(iii) Proceedings in the court under this section shall be confidential and shall be given such precedence over other pending matters so that the court may reach a decision promptly and without delay so as to serve the best interests of the pregnant woman. A judge of the court who conducts proceedings under this section shall make in writing specific factual findings

and legal conclusions supporting the decision and shall order a record of the evidence to be maintained including the judge's own findings and conclusions.

(iv) An expedited confidential appeal shall be available to any such pregnant woman for whom the court denies an order authorizing an abortion without notification. An order authorizing an abortion without notification shall not be subject to appeal. No filing fees shall be required of any such pregnant woman at either the trial or the appellate level. Access to the trial court for the purposes of such a petition or motion, and access to the appellate courts for purposes of making an appeal from denial of the same, shall be afforded such a pregnant woman 24 hours a day, seven days a week.

Subd. 7. **Severability.** If any provision, word, phrase or clause of this section or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions, words, phrases, clauses or application of this section which can be given effect without the invalid provision, word, phrase, clause, or application, and to this end the provisions, words, phrases, and clauses of this section are declared to be severable.

History: *1971 c 544 s 3; 1981 c 228 s 1; 1981 c 311 s 39; 1982 c 545 s 24; 1986 c 444*

144.344 EMERGENCY TREATMENT.

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

History: *1971 c 544 s 4*

144.3441 HEPATITIS B VACCINATION.

A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

History: *1993 c 167 s 1*

144.345 REPRESENTATIONS TO PERSONS RENDERING SERVICE.

The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

History: *1971 c 544 s 5; 1986 c 444*

144.346 INFORMATION TO PARENTS.

The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

History: *1971 c 544 s 6*

144.347 FINANCIAL RESPONSIBILITY.

A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services.

History: *1971 c 544 s 7*

WATER POLLUTION

144.35 POLLUTION OF WATER.

No sewage or other matter that will impair the healthfulness of water shall be deposited where it will fall or drain into any pond or stream used as a source of water supply for domes-

tic use. The commissioner shall have general charge of all springs, wells, ponds, and streams so used and take all necessary and proper steps to preserve the same from such pollution as may endanger the public health. In case of violation of any of the provisions of this section, the commissioner may, with or without a hearing, order any person to desist from causing such pollution and to comply with such direction as the commissioner may deem proper and expedient in the premises. Such order shall be served forthwith upon the person found to have violated such provisions.

History: *(5375) RL s 2147; 1977 c 305 s 45; 1986 c 444*

144.36 APPEAL TO DISTRICT COURT.

Within five days after service of the order, any person aggrieved thereby may appeal to the district court of the county in which such polluted source of water supply is situated. During the pendency of the appeal the pollution against which the order has been issued shall not be continued and, upon violation of such order, the appeal shall forthwith be dismissed.

History: *(5376) RL s 2148; 1987 c 309 s 16*

144.37 OTHER REMEDIES PRESERVED.

Nothing in section 144.36 shall curtail the power of the courts to administer the usual legal and equitable remedies in cases of nuisances or of improper interference with private rights.

History: *(5377) RL s 2149; 1987 c 309 s 17*

144.371 [Renumbered 115.01]

144.372 [Renumbered 115.02]

144.373 [Renumbered 115.03]

144.374 [Renumbered 115.04]

144.375 [Renumbered 115.05]

144.376 [Renumbered 115.06]

144.377 [Renumbered 115.07]

144.378 [Renumbered 115.08]

144.379 [Renumbered 115.09]

144.38 [Repealed, 1967 c 882 s 11]

SAFE DRINKING WATER ACT

144.381 CITATION.

Sections 144.381 to 144.387 may be cited as the "safe drinking water act of 1977."

History: *1977 c 66 s 1*

144.382 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144.381 to 144.387, the following terms have the meanings given.

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

Subd. 3. **Federal regulations.** "Federal regulations" means rules promulgated by the federal environmental protection agency, or its successor agencies.

Subd. 4. **Public water supply.** "Public water supply" means a system providing piped water for human consumption, and either containing a minimum of 15 service connections or 15 living units, or serving an average of 25 persons daily for 60 days of the year. "Public water supply" includes a collection, treatment, storage, and distribution facility under control of

an operator and used primarily in connection with the system, and a collection or pretreatment storage facility used primarily in connection with the system but not under control of an operator.

Subd. 5. **Supplier.** "Supplier" means a person who owns, manages or operates a public water supply.

History: *1977 c 66 s 2; 1977 c 305 s 45*

144.383 AUTHORITY OF COMMISSIONER.

In order to insure safe drinking water in all public water supplies, the commissioner has the following powers:

(a) To approve the site, design, and construction and alteration of public water supply;

(b) To enter the premises of a public water supply, or part thereof, to inspect the facilities and records kept pursuant to rules promulgated by the commissioner, to conduct sanitary surveys and investigate the standard of operation and service delivered by public water supplies;

(c) To contract with boards of health as defined in section 145A.02, subdivision 2, created pursuant to section 145A.09, for routine surveys, inspections, and testing of public water supply quality;

(d) To develop an emergency plan to protect the public when a decline in water quality or quantity creates a serious health risk, and to issue emergency orders if a health risk is imminent;

(e) To promulgate rules, pursuant to chapter 14 but no less stringent than federal regulation, which may include the granting of variances and exemptions.

History: *1977 c 66 s 3; 1977 c 305 s 45; 1982 c 424 s 130; 1987 c 309 s 24; 1989 c 209 art 2 s 1*

144.3831 FEES.

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of $5.21 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

Subd. 2. **Collection and payment of fee.** The public water supply described in subdivision 1 shall:

(1) collect the fees assessed on its service connections;

(2) pay the department of revenue an amount equivalent to the fees based on the total number of service connections. The service connections for each public water supply described in subdivision 1 shall be verified every four years by the department of health; and

(3) pay one–fourth of the total yearly fee to the department of revenue each calendar quarter. The first quarterly payment is due on or before September 30, 1992. In lieu of quarterly payments, a public water supply described in subdivision 1 with fewer than 50 service connections may make a single annual payment by June 30 each year, starting in 1993. The fees payable to the department of revenue shall be deposited in the state treasury as nondedicated state government special revenue fund revenues.

Subd. 3. **Late fee.** The public water supply described in subdivision 1 shall pay a late fee in the amount of five percent of the amount of the fees due from the public water supply if the fees due from the public water supply are not paid within 30 days of the payment dates in subdivision 2, clause (3). The late fee that the public water supply shall pay shall be assessed only on the actual amount collected by the public water supply through fees on service connections.

History: *1992 c 513 art 6 s 3; 1Sp1993 c 1 art 9 s 21; 1995 c 186 s 42*

144.384 NOTICE OF VIOLATION.

Upon discovery of a violation of a maximum contaminant level or treatment technique, the commissioner shall promptly notify the supplier of the violation, state the rule violated,

and state a date by which the violation must be corrected or by which a request for variance or exemption must be submitted.

History: *1977 c 66 s 4; 1977 c 305 s 45*

144.385 PUBLIC NOTICE.

If a public water system has violated a rule of the commissioner, has a variance or exemption granted, or fails to comply with the terms of the variance or exemption, the supplier shall provide public notice of the fact pursuant to the rules of the commissioner.

History: *1977 c 66 s 5; 1977 c 305 s 45*

144.386 PENALTIES.

Subdivision 1. **Basic fine.** A person who violates a rule of the commissioner, fails to comply with the terms of a variance or exemption, or fails to request a variance or exemption by the date specified in the notice from the commissioner, may be fined up to $1,000 for each day the offense continues, in a civil action brought by the commissioner in district court. All fines shall be deposited in the general fund of the state treasury.

Subd. 2. **Gross misdemeanor fine.** A person who intentionally or repeatedly violates a rule of the commissioner, or fails to comply with an emergency order of the commissioner, is guilty of a gross misdemeanor, and may be fined not more than $10,000, imprisoned not more than one year, or both.

Subd. 3. **Drinking water notice; fine.** A supplier who fails to comply with the provisions of section 144.385, or disseminates false or misleading information relating to the notice required in section 144.385, is subject to the penalties described in subdivision 2.

Subd. 4. [Repealed, 1993 c 206 s 25]

History: *1977 c 66 s 6; 1977 c 305 s 45; 1984 c 628 art 3 s 11*

144.387 COSTS.

If the state prevails in any civil action under section 144.386, the court may award reasonable costs and expenses to the state.

History: *1977 c 66 s 7*

144.3871 [Repealed, 1996 c 418 s 18]

FEMALE GENITAL MUTILATION; EDUCATION AND OUTREACH

144.3872 FEMALE GENITAL MUTILATION; EDUCATION AND OUTREACH.

The commissioner of health shall carry out appropriate education, prevention, and outreach activities in communities that traditionally practice female circumcision, excision, or infibulation to inform people in those communities about the health risks and emotional trauma inflicted by those practices and to inform them and the medical community of the criminal penalties contained in section 609.2245. The commissioner shall work with culturally appropriate groups to obtain private funds to help finance these prevention and outreach activities.

History: *1994 c 636 art 9 s 9*

144.388 [Repealed, 1988 c 689 art 2 s 269]

144.39 [Repealed, 1967 c 882 s 11]

PROMOTION OF NONSMOKING

144.391 PUBLIC POLICY.

The legislature finds that:

(1) smoking causes premature death, disability, and chronic disease, including cancer and heart disease, and lung disease;

(2) smoking related diseases result in excess medical care costs; and

(3) smoking initiation occurs primarily in adolescence.

The legislature desires to prevent young people from starting to smoke, to encourage and assist smokers to quit, and to promote clean indoor air.

History: *1Sp1985 c 14 art 19 s 13*

144.392 DUTIES OF THE COMMISSIONER.

The commissioner of health shall:

(1) provide assistance to workplaces to develop policies that promote nonsmoking and are consistent with the Minnesota clean indoor air act;

(2) provide technical assistance, including design and evaluation methods, materials, and training to local health departments, communities, and other organizations that undertake community programs for the promotion of nonsmoking;

(3) collect and disseminate information and materials for smoking prevention;

(4) evaluate new and existing nonsmoking programs on a statewide and regional basis using scientific evaluation methods;

(5) conduct surveys in school–based populations regarding the epidemiology of smoking behavior, knowledge, and attitudes related to smoking, and the penetration of statewide smoking control programs; and

(6) report to the legislature each biennium on activities undertaken, smoking rates in the population and subgroups of the total population, evaluation activities and results of those activities, and recommendations for further action.

History: *1Sp1985 c 14 art 19 s 14*

144.393 PUBLIC COMMUNICATIONS PROGRAM.

The commissioner may conduct a long–term coordinated public information program that includes public service announcements, public education forums, mass media, and written materials. The program must promote nonsmoking and include background survey research and evaluation. The program must be designed to run over at least five years, subject to the availability of money.

History: *1Sp1985 c 14 art 19 s 15*

144.394 SMOKING PREVENTION.

The commissioner may sell at market value, all nonsmoking or tobacco use prevention advertising materials. Proceeds from the sale of the advertising materials are appropriated to the department of health for its nonsmoking program.

History: *1995 c 207 art 9 s 6*

144.40 [Repealed, 1967 c 882 s 11]

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 physical 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 children, families, and learning 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; 1Sp1995 c 3 art 16 s 13*

144.41 [Repealed, 1967 c 882 s 11]

CLEAN INDOOR AIR ACT

144.411 CITATION.

Sections 144.411 to 144.417 may be cited as the Minnesota clean indoor air act.

History: *1975 c 211 s 1*

144.412 PUBLIC POLICY.

The purpose of sections 144.411 to 144.417 is to protect the public health, comfort and environment by prohibiting smoking in areas where children or ill or injured persons are present, and by limiting smoking in public places and at public meetings to designated smoking areas.

History: *1975 c 211 s 2; 1987 c 399 s 1*

144.413 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 144.411 to 144.416, the terms defined in this section have the meanings given them.

Subd. 2. **Public place.** "Public place" means any enclosed, indoor area used by the general public or serving as a place of work, including, but not limited to, restaurants, retail stores, offices and other commercial establishments, public conveyances, educational facilities other than public schools, as defined in section 120.05, subdivision 2, hospitals, nursing homes, auditoriums, arenas, meeting rooms, and common areas of rental apartment build-

ings, but excluding private, enclosed offices occupied exclusively by smokers even though such offices may be visited by nonsmokers.

Subd. 3. **Public meeting.** "Public meeting" includes all meetings open to the public pursuant to section 471.705, subdivision 1.

Subd. 4. **Smoking.** "Smoking" includes carrying a lighted cigar, cigarette, pipe, or any other lighted smoking equipment.

History: *1975 c 211 s 3; 1992 c 576 s 1; 1994 c 520 s 1*

144.414 PROHIBITIONS.

Subdivision 1. **Public places.** No person shall smoke in a public place or at a public meeting except in designated smoking areas. This prohibition does not apply in cases in which an entire room or hall is used for a private social function and seating arrangements are under the control of the sponsor of the function and not of the proprietor or person in charge of the place. Furthermore, this prohibition shall not apply to factories, warehouses, and similar places of work not usually frequented by the general public, except that the state commissioner of health shall establish rules to restrict or prohibit smoking in those places of work where the close proximity of workers or the inadequacy of ventilation causes smoke pollution detrimental to the health and comfort of nonsmoking employees.

Subd. 2. **Day care premises.** Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation.

Subd. 3. **Health care facilities and clinics.** (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, or other health care–related facility, other than a nursing home, boarding care facility, or licensed residential facility, except as allowed in this subdivision.

(b) Smoking by patients in a chemical dependency treatment program or mental health program may be allowed in a separated well–ventilated area pursuant to a policy established by the administrator of the program that identifies circumstances in which prohibiting smoking would interfere with the treatment of persons recovering from chemical dependency or mental illness.

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

History: *1975 c 211 s 4; 1977 c 305 s 45; 1984 c 654 art 2 s 113; 1987 c 399 s 2; 1992 c 576 s 2; 1993 c 14 s 1; 1995 c 165 s 2*

144.415 DESIGNATION OF SMOKING AREAS.

Smoking areas may be designated by proprietors or other persons in charge of public places, except in places in which smoking is prohibited by the fire marshal or by other law, ordinance or rule.

Where smoking areas are designated, existing physical barriers and ventilation systems shall be used to minimize the toxic effect of smoke in adjacent nonsmoking areas. In the case of public places consisting of a single room, the provisions of this law shall be considered met if one side of the room is reserved and posted as a no smoking area. No public place other than a bar shall be designated as a smoking area in its entirety. If a bar is designated as a smoking area in its entirety, this designation shall be posted conspicuously on all entrances normally used by the public.

History: *1975 c 211 s 5; 1985 c 248 s 70*

144.416 RESPONSIBILITIES OF PROPRIETORS.

The proprietor or other person in charge of a public place shall make reasonable efforts to prevent smoking in the public place by

(a) posting appropriate signs;

(b) arranging seating to provide a smoke–free area;

(c) asking smokers to refrain from smoking upon request of a client or employee suffering discomfort from the smoke; or

(d) any other means which may be appropriate.

History: *1975 c 211 s 6*

144.4165 TOBACCO PRODUCTS PROHIBITED IN PUBLIC SCHOOLS.

No person shall at any time smoke, chew, or otherwise ingest tobacco or a tobacco product in a public school, as defined in section 120.05, subdivision 2. This prohibition extends to all facilities, whether owned, rented, or leased, and all vehicles that a school district owns, leases, rents, contracts for, or controls. Nothing in this section shall prohibit the lighting of tobacco by an adult as a part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 257.351, subdivision 9.

History: *1992 c 576 s 3; 1993 c 224 art 9 s 42; 1996 c 412 art 13 s 30*

144.417 COMMISSIONER OF HEALTH, ENFORCEMENT, PENALTIES.

Subdivision 1. **Rules.** The state commissioner of health shall adopt rules necessary and reasonable to implement the provisions of sections 144.411 to 144.417, except as provided for in section 144.414.

Subd. 2. **Penalties.** Any person who violates section 144.414 or 144.4165 is guilty of a petty misdemeanor.

Subd. 3. **Injunction.** The state commissioner of health, a board of health as defined in section 145A.02, subdivision 2, or any affected party may institute an action in any court with jurisdiction to enjoin repeated violations of section 144.416 or 144.4165.

History: *1975 c 211 s 7; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24; 1992 c 576 s 4,5; 1995 c 165 s 3*

HEALTH THREAT PROCEDURES

144.4171 SCOPE.

Subdivision 1. **Authority.** Under the powers and duties assigned to the commissioner in sections 144.05 and 144.12, the commissioner shall proceed according to sections 144.4171 to 144.4186 with respect to persons who pose a health threat to others or who engage in noncompliant behavior.

Subd. 2. **Preemption.** Sections 144.4171 to 144.4186 preempt and supersede any local ordinance or rule concerning persons who pose a health threat to others or who engage in noncompliant behavior.

History: *1987 c 209 s 4*

144.4172 DEFINITIONS.

Subdivision 1. **Carrier.** "Carrier" means a person who serves as a potential source of infection and who harbors or who the commissioner reasonably believes to be harboring a specific infectious agent whether or not there is present discernible clinical disease. In the absence of a medically accepted test, the commissioner may reasonably believe an individual to be a carrier only when a determination based upon specific facts justifies an inference that the individual harbors a specific infectious agent.

Subd. 2. **Communicable disease.** "Communicable disease" means a disease or condition that causes serious illness, serious disability, or death, the infectious agent of which may pass or be carried, directly or indirectly, from the body of one person to the body of another.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Contact notification program.** "Contact notification program" means an ongoing program established by the commissioner to encourage carriers of a communicable

disease whose primary route of transmission is through an exchange of blood, semen, or vaginal secretions, such as treponema pallidum, neisseria gonorrhea, chlamydia trachomatis, and human immunodeficiency virus, to identify others who may be at risk by virtue of contact with the carrier.

Subd. 5. **Directly transmitted.** "Directly transmitted" means predominately:

(1) sexually transmitted;

(2) blood–borne; or

(3) transmitted through direct or intimate skin contact.

Subd. 6. **Health directive.** "Health directive" means a written statement, or, in urgent circumstances, an oral statement followed by a written statement within three days, from the commissioner, or board of health as defined in section 145A.02, subdivision 2, with delegated authority from the commissioner, issued to a carrier who constitutes a health threat to others. A health directive must be individual, specific, and cannot be issued to a class of persons. The directive may require a carrier to cooperate with health authorities in efforts to prevent or control transmission of communicable disease, including participation in education, counseling, or treatment programs, and undergoing medical tests necessary to verify the person's carrier status. The written directive shall be served in the same manner as a summons and complaint under the Minnesota Rules of Civil Procedure.

Subd. 7. **Licensed health professional.** "Licensed health professional" means a person licensed in Minnesota to practice those professions described in section 214.01, subdivision 2.

Subd. 8. **Health threat to others.** "Health threat to others" means that a carrier demonstrates an inability or unwillingness to act in such a manner as to not place others at risk of exposure to infection that causes serious illness, serious disability, or death. It includes one or more of the following:

(1) with respect to an indirectly transmitted communicable disease:

(a) behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others; or

(b) a substantial likelihood that a carrier will transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention.

(2) With respect to a directly transmitted communicable disease:

(a) repeated behavior by a carrier which has been demonstrated epidemiologically to transmit or which evidences a careless disregard for the transmission of the disease to others;

(b) a substantial likelihood that a carrier will repeatedly transmit a communicable disease to others as is evidenced by a carrier's past behavior, or by statements of a carrier that are credible indicators of a carrier's intention;

(c) affirmative misrepresentation by a carrier of the carrier's status prior to engaging in any behavior which has been demonstrated epidemiologically to transmit the disease; or

(d) the activities referenced in clause (1) if the person whom the carrier places at risk is: (i) a minor, (ii) of diminished capacity by reason of mood altering chemicals, including alcohol, (iii) has been diagnosed as having significantly subaverage intellectual functioning, (iv) has an organic disorder of the brain or a psychiatric disorder of thought, mood, perception, orientation, or memory which substantially impairs judgment, behavior, reasoning, or understanding; (v) adjudicated as an incompetent; or (vi) a vulnerable adult as defined in section 626.5572.

(3) Violation by a carrier of any part of a court order issued pursuant to this chapter.

Subd. 9. **Indirectly transmitted.** "Indirectly transmitted" means any transmission not defined by subdivision 5.

Subd. 10. **Noncompliant behavior.** "Noncompliant behavior" means a failure or refusal by a carrier to comply with a health directive.

Subd. 11. **Respondent.** "Respondent" means any person against whom an action is commenced under sections 144.4171 to 144.4186.

History: *1986 c 444; 1987 c 209 s 5; 1987 c 309 s 24; 1995 c 229 art 4 s 4*

144.4173 CAUSE OF ACTION.

Subdivision 1. **Compliance with directive.** Failure or refusal of a carrier to comply with a health directive is grounds for proceeding under subdivision 2.

Subd. 2. **Commencement of action.** The commissioner, or a board of health as defined in section 145A.02, subdivision 2, with express delegated authority from the commissioner, may commence legal action against a carrier who is a health threat to others and, unless a court order is sought under section 144.4182, who engages in noncompliant behavior, by filing with the district court in the county in which respondent resides, and serving upon respondent, a petition for relief and notice of hearing.

History: *1987 c 209 s 6; 1987 c 309 s 24*

144.4174 STANDING.

Only the commissioner, or a board of health as defined in section 145A.02, subdivision 2, with express delegated authority from the commissioner, may commence an action under sections 144.4171 to 144.4186.

History: *1987 c 209 s 7; 1987 c 309 s 24*

144.4175 REPORTING.

Subdivision 1. **Voluntary reporting.** Any licensed health professional or other human services professional regulated by the state who has knowledge or reasonable cause to believe that a person is a health threat to others or has engaged in noncompliant behavior, as defined in section 144.4172, may report that information to the commissioner.

Subd. 2. **Liability for reporting.** A licensed health professional or other human services professional regulated by the state who has knowledge or reasonable cause to believe that a person is a health threat to others or has engaged in noncompliant behavior, and who makes a report in good faith under subdivision 1, is not subject to liability for reporting in any civil, administrative, disciplinary, or criminal action.

Subd. 3. **Falsified reports.** Any person who knowingly or recklessly makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury.

Subd. 4. **Waiver of privilege.** Any privilege otherwise created in section 595.02, clauses (d), (e), (g), and (j), with respect to persons who make a report under subdivision 1, is waived regarding any information about a carrier as a health threat to others or about a carrier's noncompliant behavior in any investigation or action under sections 144.4171 to 144.4186.

History: *1987 c 209 s 8*

144.4176 PETITION; NOTICE.

Subdivision 1. **Petition.** The petition must set forth the following:

(1) the grounds and underlying facts that demonstrate that the respondent is a health threat to others and, unless an emergency court order is sought under section 144.4182, has engaged in noncompliant behavior;

(2) the petitioner's efforts to alleviate the health threat to others prior to the issuance of a health directive, unless an emergency court order is sought under section 144.4182;

(3) the petitioner's efforts to issue the health directive to the respondent in person, unless an emergency court order is sought under section 144.4182;

(4) the type of relief sought; and

(5) a request for a court hearing on the allegations contained in the petition.

Subd. 2. **Hearing notice.** The notice must contain the following information:

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

(2) respondent's right to appear at the hearing;

(3) respondent's right to present and cross-examine witnesses; and

(4) respondent's right to counsel, including the right, if indigent, to representation by counsel designated by the court or county of venue.

History: *1987 c 209 s 9*

144.4177 TIME OF HEARING AND DUTIES OF COUNSEL.

Subdivision 1. **Time of hearing.** A hearing on the petition must be held before the district court in the county in which respondent resides as soon as possible, but no later than 14 days from service of the petition and hearing notice.

Subd. 2. **Duties of counsel.** In all proceedings under this section, counsel for the respondent shall (1) consult with the person prior to any hearing; (2) be given adequate time to prepare for all hearings; (3) continue to represent the person throughout any proceedings under this charge unless released as counsel by the court; and (4) be a vigorous advocate on behalf of the client.

History: *1987 c 209 s 10*

144.4178 CRIMINAL IMMUNITY.

In accordance with section 609.09, subdivision 2, no person shall be excused in an action under sections 144.4171 to 144.4186 from giving testimony or producing any documents, books, records, or correspondence, tending to be self–incriminating; but the testimony or evidence, or other testimony or evidence derived from it, must not be used against the person in any criminal case, except for perjury committed in the testimony.

History: *1987 c 209 s 11*

144.4179 STANDARD OF PROOF; EVIDENCE.

Subdivision 1. **Clear and convincing.** The commissioner must prove the allegations in the petition by clear and convincing evidence.

Subd. 2. **All relevant evidence.** The court shall admit all reliable relevant evidence. Medical and epidemiologic data must be admitted if it otherwise comports with section 145.30, chapter 600, Minnesota Rules of Evidence 803(6), or other statutes or rules that permit reliable evidence to be admitted in civil cases.

Subd. 3. **Carrier status.** Upon a finding by the court that the commissioner's suspicion of carrier status is reasonable as established by presentation of facts justifying an inference that the respondent harbors a specific infectious agent, there shall exist a rebuttable presumption that the respondent is a carrier. This presumption may be rebutted if the respondent demonstrates noncarrier status after undergoing medically accepted tests.

Subd. 4. **Failure to appear.** If a party fails to appear at the hearing without prior court approval, the hearing may proceed without the absent party and the court may make its determination on the basis of all reliable evidence submitted at the hearing.

Subd. 5. **Records.** The court shall take and preserve an accurate stenographic record of the proceedings.

History: *1987 c 209 s 12*

144.4180 REMEDIES.

Subdivision 1. **Remedies available.** Upon a finding by the court that the commissioner has proven the allegations set forth in the petition, the court may order that the respondent must:

(1) participate in a designated education program;

(2) participate in a designated counseling program;

(3) participate in a designated treatment program;

(4) undergo medically accepted tests to verify carrier status or for diagnosis, or undergo treatment that is consistent with standard medical practice as necessary to make respondent noninfectious;

(5) notify or appear before designated health officials for verification of status, testing, or other purposes consistent with monitoring;

(6) cease and desist the conduct which constitutes a health threat to others;

(7) live part time or full time in a supervised setting for the period and under the conditions set by the court;

(8) subject to the provisions of subdivision 2, be committed to an appropriate institutional facility for the period and under the conditions set by the court, but not longer than six months, until the respondent is made noninfectious, or until the respondent completes a course of treatment prescribed by the court, whichever occurs first, unless the commissioner shows good cause for continued commitment; and

(9) comply with any combination of the remedies in clauses (1) to (8), or other remedies considered just by the court. In no case may a respondent be committed to a correctional facility.

Subd. 2. **Commitment review panel.** The court may not order the remedy specified in subdivision 1, clause (8), unless it first considers the recommendation of a commitment review panel appointed by the commissioner to review the need for commitment of the respondent to an institutional facility.

The duties of the commitment review panel shall be to:

(1) review the record of the proceeding;

(2) interview the respondent. If the respondent is not interviewed, the reasons must be documented; and

(3) identify, explore, and list the reasons for rejecting or recommending alternatives to commitment.

Subd. 3. **Construction.** This section shall be construed so that the least restrictive alternative is used to achieve the desired purpose of preventing or controlling communicable disease.

Subd. 4. **Additional requirements.** If commitment or supervised living is ordered, the court shall require the head of the institutional facility or the person in charge of supervision to submit: (a) a plan of treatment within ten days of initiation of commitment or supervised living; and (b) a written report, with a copy to both the commissioner and the respondent, at least 60 days, but not more than 90 days, from the start of respondent's commitment or supervised living arrangement, setting forth the following:

(1) the types of support or therapy groups, if any, respondent is attending and how often respondent attends;

(2) the type of care or treatment respondent is receiving, and what future care or treatment is necessary;

(3) whether respondent has been cured or made noninfectious, or otherwise no longer poses a threat to public health;

(4) whether continued commitment or supervised living is necessary; and

(5) other information the court considers necessary.

History: *1987 c 209 s 13*

144.4181 APPEAL.

The petitioner or respondent may appeal the decision of the district court. The court of appeals shall hear the appeal within 30 days after service of the notice of appeal. However, respondent's status as determined by the district court remains unchanged, and any remedy ordered by the district court remains in effect while the appeal is pending.

History: *1987 c 209 s 14*

144.4182 TEMPORARY EMERGENCY HOLD.

Subdivision 1. **Apprehend and hold.** To protect the public health in an emergency, the court may order an agent of a board of health as authorized under section 145A.04 or peace officer to take a person into custody and transport the person to an appropriate emergency care or treatment facility for observation, examination, testing, diagnosis, care, treatment, and, if necessary, temporary detention. If the person is already institutionalized, the court may order the institutional facility to hold the person. These orders may be issued in an ex

parte proceeding upon an affidavit of the commissioner or a designee of the commissioner. An order shall issue upon a determination by the court that reasonable cause exists to believe that the person is: (a) for indirectly transmitted diseases, an imminent health threat to others; or (b) for directly transmitted diseases, a substantial likelihood of an imminent health threat to others.

The affidavit must set forth the specific facts upon which the order is sought and must be served on the person immediately upon apprehension or detention. An order under this section may be executed on any day and at any time.

Subd. 2. **Duration of hold.** No person may be held under subdivision 1 longer than 72 hours, exclusive of Saturdays, Sundays, and legal holidays, without a court hearing to determine if the emergency hold should continue.

History: *1987 c 209 s 15; 1987 c 309 s 24*

144.4183 EMERGENCY HOLD HEARING.

Subdivision 1. **Time of notice.** Notice of the emergency hold hearing must be served upon the person held under section 144.4182, subdivision 1, at least 24 hours before the hearing.

Subd. 2. **Contents of notice.** The notice must contain the following information:

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

(2) the grounds and underlying facts upon which continued detention is sought;

(3) the person's right to appear at the hearing;

(4) the person's right to present and cross–examine witnesses; and

(5) the person's right to counsel, including the right, if indigent, to representation by counsel designated by the court or county of venue.

Subd. 3. **Order for continued emergency hold.** The court may order the continued holding of the person if it finds, by a preponderance of the evidence, that the person would pose an imminent health threat to others if released. However, in no case may the emergency hold continue longer than five days, unless a petition is filed under section 144.4173. If a petition is filed, the emergency hold must continue until a hearing on the petition is held under section 144.4177. That hearing must occur within five days of the filing of the petition, exclusive of Saturdays, Sundays, and legal holidays.

History: *1987 c 209 s 16*

144.4184 CONTACT DATA.

Identifying information voluntarily given to the commissioner, or an agent of the commissioner, by a carrier through a contact notification program must not be used as evidence in a court proceeding to determine noncompliant behavior.

History: *1987 c 209 s 17*

144.4185 COSTS.

Subdivision 1. **Costs of care.** The court shall determine what part of the cost of care or treatment ordered by the court, if any, the respondent can pay. The respondent shall provide the court documents and other information necessary to determine financial ability. If the respondent cannot pay the full cost of care, the rest must be paid by the county in which respondent resides. If the respondent provides inaccurate or misleading information, or later becomes able to pay the full cost of care, the respondent becomes liable to the county for costs paid by the county.

Subd. 2. **Court–appointed counsel.** If the court appoints counsel to represent respondent free of charge, counsel must be compensated by the county in which respondent resides, except to the extent that the court finds that the respondent is financially able to pay for counsel's services. In these situations, the rate of compensation for counsel shall be determined by the court.

Subd. 3. **Report.** The commissioner shall report any recommendations for appropriate changes in the modes of financing of services provided under subdivision 1 by January 15, 1988.

History: *1987 c 209 s 18*

144.4186 DATA PRIVACY.

Subdivision 1. **Nonpublic data.** Data contained in a health directive are classified as protected nonpublic data under section 13.02, subdivision 13, in the case of data not on individuals, and private under section 13.02, subdivision 12, in the case of data on individuals. Investigative data shall have the classification accorded it under section 13.39.

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

Subd. 3. **Records retention.** A records retention schedule for records developed under sections 144.4171 to 144.4186 shall be established pursuant to section 138.17, subdivision 7.

History: *1987 c 209 s 19*

TUBERCULOSIS

144.42 [Repealed, 1980 c 357 s 22]

144.421 [Repealed, 1980 c 357 s 22]

144.422 [Repealed, 1987 c 209 s 40]

144.423 [Repealed, 1951 c 314 s 8]

144.424 [Repealed, 1987 c 209 s 40]

144.425 [Repealed, 1987 c 209 s 40]

144.426 [Repealed, 1951 c 314 s 8]

144.427 [Repealed, 1980 c 357 s 22]

144.428 [Repealed, 1980 c 357 s 22]

144.429 [Repealed, 1980 c 357 s 22]

144.43 [Repealed, 1980 c 357 s 22]

144.44 [Renumbered 144.423]

144.441 TUBERCULOSIS SCREENING IN SCHOOLS.

Subdivision 1. **Definitions.** As used in sections 144.441 to 144.444, the following terms have the meanings given them:

(a) "Person employed by a school or school district" means a person employed by a school, school district, or by a service cooperative as a member of the instructional, supervisory, or support staff including, but not limited to, superintendents, principals, supervisors, teachers, librarians, counselors, school psychologists, school nurses, school social workers, audiovisual directors or coordinators, recreation personnel, media generalists or supervisors, speech therapists, athletic coaches, teachers' aids, clerical workers, custodians, school bus drivers, and food service workers.

(b) "Person enrolled in a school" means a person enrolled in grades kindergarten through 12 and a handicapped child receiving special instruction and services in a school.

(c) "School" includes any public elementary, middle, secondary, or vocational center school as defined in section 120.05, or nonpublic school, church, or religious organization in which a child is provided instruction in compliance with sections 120.101 and 120.102.

Subd. 2. **Designation of schools.** Based on the occurrence of active tuberculosis or evidence of a higher than expected prevalence of tuberculosis infection in the population attending or employed by one or more schools in a school district, the commissioner of health may designate schools or a school district in which screening of some or all persons enrolled in or employed by the school or school district for tuberculosis is a necessary public health measure. In making the designation, the commissioner shall also determine the frequency with which proof of screening must be submitted. In determining whether the population attend-

ing or employed by a school or school district has a higher than expected prevalence of tuberculosis infection, the commissioner shall consider factors such as race or ethnicity, age, and the geographic location of residence of the student population; the expected background prevalence of tuberculosis infection in the community; and currently accepted public health standards pertaining to the control of tuberculosis.

Subd. 3. **Screening of students.** As determined by the commissioner under subdivision 2, no person may enroll or remain enrolled in any school which the commissioner has designated under subdivision 2 until the person has submitted to the administrator or other person having general control and supervision of the school, one of the following statements:

(1) a statement from a physician or public clinic stating that the person has had a negative Mantoux test reaction within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(2) a statement from a physician or public clinic stating that a person who has a positive Mantoux test reaction has had a negative chest roentgenogram (X–ray) for tuberculosis within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(3) a statement from a physician or public health clinic stating that the person (i) has a history of adequately treated active tuberculosis; (ii) is currently receiving tuberculosis preventive therapy; (iii) is currently undergoing therapy for active tuberculosis and the person's presence in a school building will not endanger the health of other people; or (iv) has completed a course of tuberculosis preventive therapy or was intolerant to preventive therapy, provided the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; or

(4) a notarized statement signed by the minor child's parent or guardian or by the emancipated person stating that the person has not submitted the proof of tuberculosis screening as required by this subdivision because of the conscientiously held beliefs of the parent or guardian of the minor child or of the emancipated person. This statement must be forwarded to the commissioner.

Subd. 4. **Screening of employees.** As determined by the commissioner under subdivision 2, a person employed by the designated school or school district shall submit to the administrator or other person having general control and supervision of the school one of the following:

(1) a statement from a physician or public clinic stating that the person has had a negative Mantoux test reaction within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(2) a statement from a physician or public clinic stating that a person who has a positive Mantoux test reaction has had a negative chest roentgenogram (X–ray) for tuberculosis within the past year, provided that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis;

(3) a statement from a physician or public health clinic stating that the person (i) has a history of adequately treated active tuberculosis; (ii) is currently receiving tuberculosis preventive therapy; (iii) is currently undergoing therapy for active tuberculosis and the person's presence in a school building will not endanger the health of other people; or (iv) has completed a course of preventive therapy or was intolerant to preventive therapy, provided the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; or

(4) a notarized statement signed by the person stating that the person has not submitted the proof of tuberculosis screening as required by this subdivision because of conscientiously held beliefs. This statement must be forwarded to the commissioner of health.

Subd. 5. **Exceptions.** Subdivisions 3 and 4 do not apply to:

(1) a person with a history of either a past positive Mantoux test reaction or active tuberculosis who has a documented history of completing a course of tuberculosis therapy or preventive therapy when the school or school district holds a statement from a physician or public health clinic indicating that such therapy was provided to the person and that the person has no symptoms suggestive of tuberculosis or evidence of a new exposure to active tuberculosis; and

(2) a person with a history of a past positive Mantoux test reaction who has not completed a course of preventive therapy. This determination shall be made by the commissioner based on currently accepted public health standards and the person's health status.

Subd. 6. **Programs using school facilities.** The commissioner may require the statements described in subdivisions 3 and 4 to be submitted by participants or staff of a program or activity that uses the facilities of a school or school district on a regular and ongoing basis, if the commissioner has determined that tuberculosis screening is necessary.

Subd. 7. **Implementation.** The administrator or other person having general control and supervision of the school or school district designated by the commissioner under subdivision 2 shall take the measures that are necessary, including the exclusion of persons from the premises of a school, to obtain the proof of screening required by subdivisions 3 and 4.

Subd. 8. **Access to records.** The commissioner shall have access to any school or school district records, including health records of persons enrolled in or employed by a school or school district, that are needed to determine whether a tuberculosis screening program is necessary, or to administer a screening program.

Subd. 9. **Reports.** The administrator or other person having general control and supervision of a school or school district that the commissioner has designated under subdivision 2 shall provide the commissioner with any reports determined by the commissioner to be necessary to implement a screening or control program or to evaluate the need for further tuberculosis screening or control efforts in a school.

Subd. 10. **Waiver.** The commissioner may waive any portion of the requirements of subdivisions 3 to 9 if the commissioner determines that it is not necessary in order to protect the public health.

History: *1993 c 167 s 2; 1996 c 305 a 1 s 138*

144.442 TESTING IN SCHOOL CLINICS.

Subdivision 1. **Administration; notification.** In the event that the commissioner designates a school or school district under section 144.441, subdivision 2, the school or school district or board of health may administer Mantoux screening tests to some or all persons enrolled in or employed by the designated school or school district. Any Mantoux screening provided under this section shall be under the direction of a licensed physician.

Prior to administering the Mantoux test to such persons, the school or school district or board of health shall inform in writing such persons and parents or guardians of minor children to whom the test may be administered, of the following:

(1) that there has been an occurrence of active tuberculosis or evidence of a higher than expected prevalence of tuberculosis infection in that school or school district;

(2) that screening is necessary to avoid the spread of tuberculosis;

(3) the manner by which tuberculosis is transmitted;

(4) the risks and possible side effects of the Mantoux test;

(5) the risks from untreated tuberculosis to the infected person and others;

(6) the ordinary course of further diagnosis and treatment if the Mantoux test is positive;

(7) that screening has been scheduled; and

(8) that no person will be required to submit to the screening if the person submits a statement of objection due to the conscientiously held beliefs of the person employed or of the parent or guardian of a minor child.

Subd. 2. **Consent of minors.** Minors may give consent for testing as set forth in sections 144.341 to 144.347.

Subd. 3. **Screening of minors.** Prior to administering a Mantoux test to a minor, the school or school district or board of health shall prepare a form for signature in which the parent or guardian shall consent or submit a statement of objection to the test. The parent or guardian of a minor child shall return a signed form to the school or school district or board of health which is conducting the screening indicating receipt of the notice and consent or objection to the administration of the test. In the event that the form with a signed consent or objection is not returned, the school or school district or board of health may undertake such

steps as are reasonable to secure such consent or objection. If after such steps the school or school district or board of health chooses to screen the minor without consent, it shall send a notice of intent to test by certified mail, restricted delivery with return receipt, to the address given to the school or school district by the parent or guardian for emergency contact of the parent or guardian. The accuracy of the address shall be checked with the person enrolled, if possible. Placing notice as specified in this subdivision shall constitute service. Reasonable efforts shall be made to provide this notice in a language understood by the parent or guardian. If this notice cannot be delivered or a form with a signed consent or objection is not returned, the school or school district or board of health shall check the permanent medical record required by section 144.29 to determine if the parent or guardian previously withheld consent to immunizations or other medical treatment because of conscientiously held beliefs. If there is such a statement on file or if the school district otherwise has notice of such a statement, the school or school district or board of health shall not administer the Mantoux test unless the consent of the parent or guardian is obtained. If there is no such statement in the permanent medical record or known to exist otherwise, the school or school district or board of health may administer the Mantoux test at the time and place specified in the notice unless medically contraindicated. The school or school district or board of health shall document in the permanent medical record its efforts to notify the parent or guardian of the minor child, and its efforts to check the permanent medical records.

Subd. 4. **Consent for subsequent testing or treatment.** In the event the Mantoux test is positive, no further diagnosis of or treatment for tuberculosis in a minor child shall be undertaken without the signed consent of the parent or guardian of the minor child.

History: *1986 c 444; 1993 c 167 s 3*

144.443 TUBERCULOSIS HEALTH THREAT TO OTHERS.

A "health threat to others" as defined in section 144.4172, subdivision 8, includes a person who, although not currently infectious, has failed to complete a previously prescribed course of tuberculosis therapy, demonstrates an inability or unwillingness to initiate or complete, or shows an intent to fail to complete, a prescribed course of tuberculosis drug therapy, if that failure could lead to future infectiousness.

History: *1993 c 167 s 4*

144.444 TUBERCULOSIS EMERGENCY HOLD.

A temporary emergency hold under section 144.4182 may be placed on a person who is a health threat to others when there is reasonable cause to believe that the person may be unlocatable for the purposes of applying the procedures described in sections 144.4171 to 144.4186, or when medical or epidemiologic evidence suggests that the person is or may become infectious before the conclusion of court proceedings and appeals.

History: *1993 c 167 s 5*

144.445 TUBERCULOSIS SCREENING IN CORRECTIONAL INSTITUTIONS AND FACILITIES.

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

Subd. 2. **Screening of employees.** All employees of facilities operated, licensed, or inspected by the department of corrections shall be screened for tuberculosis before employment in the facility and annually thereafter, with either a Mantoux test or a chest roentgenogram (X–ray) as consistent with screening and follow–up practices recommended by the United States Public Health Service or the department of health, as determined by the commissioner of health.

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

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

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

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

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

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

(6) an employee with a positive or significant Mantoux test reaction in preemployment screening who does not complete a course of preventive therapy may be exempt from annual Mantoux testing or other screening. This determination shall be made by the commissioner of health based on currently accepted public health standards and the person's health status; and

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

Subd. 4. **Reports.** The administrator or other person having general control and supervision of a facility operated, licensed, or inspected by the department of corrections shall provide the commissioner with any reports determined by the commissioner of health to be necessary to evaluate the need for further tuberculosis screening or control efforts in a facility or facilities.

Subd. 5. **Waiver.** The commissioner may waive any portion of the requirements of subdivisions 1 to 4 if the commissioner of health determines that it is not necessary to protect the public health or if the screening may have a detrimental effect on a person's health status.

History: *1993 c 167 s 6*

144.45 TUBERCULOSIS IN SCHOOLS; CERTIFICATE.

No person with active tuberculosis shall remain in or near a school building unless the person has a certificate issued by a physician stating that the person's presence in a school building will not endanger the health of other people.

History: *(5384) 1913 c 434 s 4; 1949 c 471 s 10; 1980 c 357 s 9*

144.46 [Repealed, 1980 c 357 s 22]

144.47 [Repealed, 1980 c 357 s 22]

144.471 [Repealed, 1987 c 209 s 40]

144.48 [Renumbered 144.427]

144.49 VIOLATIONS; PENALTIES.

Subdivision 1. **Violating rules or board directions.** Any person violating any rule of the commissioner or any lawful direction of a board of health as defined in section 145A.02, subdivision 2, or an agent of a board of health as authorized under section 145A.04 is guilty of a misdemeanor.

Subd. 2. [Repealed, 1979 c 50 s 14]

Subd. 3. [Repealed, 1979 c 50 s 14]

Subd. 4. [Repealed, 1979 c 50 s 14]

Subd. 5. [Repealed, 1987 c 209 s 40]

Subd. 6. **Operating without license.** Any person, partnership, association, or corporation establishing, conducting, managing, or operating any hospital, sanitarium, or other institution in accordance with the provisions of sections 144.50 to 144.56, without first obtaining a license therefor is guilty of a misdemeanor.

Subd. 7. **Operating outside law or rules.** Any person, partnership, association, or corporation which establishes, conducts, manages or operates any hospital, sanitarium or other institution required to be licensed under sections 144.50 to 144.56, in violation of any provision of sections 144.50 to 144.56 or any rule established thereunder, is guilty of a misdemeanor.

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

History: *(5346, 5356, 5367, 5388) RL s 2132; 1913 c 434 s 8; 1913 c 579; 1917 c 220 s 6; 1939 c 89 s 1; 1941 c 549 s 10; 1943 c 649 s 1; 1945 c 512 s 35,37; 1949 c 471 s 14; 1976 c 173 s 32,33; 1977 c 305 s 45; 1980 c 357 s 11,12; 1985 c 248 s 70; 1986 c 444; 1987 c 309 s 24; 1987 c 384 art 2 s 1; 1991 c 199 art 2 s 15*

LEAD ABSORPTION

144.491 COMMISSIONER'S DUTIES RELATING TO LEAD ABSORPTION.

The commissioner of health shall:

(1) provide coordination and advice to community programs that test children for lead in their blood to assure that these testing services are conducted in a safe and appropriate manner, are targeted to children throughout the state at risk to lead contamination or absorption, and generate data that may be analyzed on a statewide basis;

(2) provide coordination and advice of local lead absorption testing programs, to assure adequate skill and efficiency, to the laboratories within the state that conduct Erythrocyte Protoporphorin testing, confirmatory blood lead testing, and testing of paint chips and other environmental lead sources;

(3) provide public and professional education concerning lead contamination or absorption and its health effects on children;

(4) review state and local housing codes and advise the governing bodies and administrative departments adopting or administering the codes to insure that the hazard of absorp-

tion and contamination from leaded paint is adequately addressed and considered, and provide technical support for enforcement of the codes by local health departments and local building inspection departments; and

(5) study and determine the extent of exposure to lead in drinking water caused by plumbing and develop recommendations and techniques for reducing this exposure.

History: *1Sp1985 c 14 art 19 s 16*

FORMALDEHYDE GASES IN BUILDING MATERIALS

144.495 FORMALDEHYDE RULES.

The legislature finds that building materials containing urea formaldehyde may emit unsafe levels of formaldehyde in newly constructed housing units. The product standards prescribed in section 325F.181 are intended to provide indoor air levels of formaldehyde that do not exceed 0.4 parts per million. If the commissioner of health determines that the standards prescribed in section 325F.181 result in indoor air levels of formaldehyde that exceed 0.4 parts per million, the commissioner may adopt different building materials product standards to ensure that the 0.4 parts per million level is not exceeded. The commissioner may adopt rules under chapter 14 to establish product standards as provided in this section. The rules of the commissioner governing ambient air levels of formaldehyde, Minnesota Rules, parts 4620.1600 to 4620.2100, are repealed, except that the rule of the commissioner relating to new installations of urea formaldehyde foam insulation in residential housing units remains in effect.

History: *1980 c 594 s 1; 1982 c 424 s 130; 1985 c 216 s 1*

HOSPITALIZATION

144.50 HOSPITALS, LICENSES; DEFINITIONS.

Subdivision 1. **License required.** (a) No person, partnership, association, or corporation, nor any state, county, or local governmental units, nor any division, department, board, or agency thereof, shall establish, operate, conduct, or maintain in the state any hospital, sanitarium or other institution for the hospitalization or care of human beings without first obtaining a license therefor in the manner provided in sections 144.50 to 144.56. No person or entity shall advertise a facility providing services required to be licensed under sections 144.50 to 144.56 without first obtaining a license.

(b) A violation of this subdivision is a misdemeanor punishable by a fine of not more than $300. The commissioner may seek an injunction in the district court against the continuing operation of the unlicensed institution. Proceedings for securing an injunction may be brought by the attorney general or by the appropriate county attorney.

(c) The sanctions in this subdivision do not restrict other available sanctions.

Subd. 2. **Hospital, sanitarium, other institution; definition.** Hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which any accommodation is maintained, furnished, or offered for five or more persons for: the hospitalization of the sick or injured; the provision of care in a swing bed authorized under section 144.562; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings. Nothing in sections 144.50 to 144.56 shall apply to a clinic, a physician's office or to hotels or other similar places that furnish only board and room, or either, to their guests.

Subd. 3. **Hospitalization.** "Hospitalization" means the reception and care of persons for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of such persons.

Subd. 4. [Repealed, 1980 c 357 s 22]

Subd. 5. **Separate licensing for healing; medicine.** Nothing in sections 144.50 to 144.56 shall authorize any person, partnership, association, or corporation, nor any state, county, or local governmental units, nor any division, department, board, or agency thereof, to engage, in any manner, in the practice of healing, or the practice of medicine, as defined by law.

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

(b) Class B supervised living facilities shall be classified as follows for purposes of the state building code:

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

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

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

(d) The commissioner may license as a Class A supervised living facility a residential program for chemically dependent individuals that allows children to reside with the parent receiving treatment in the facility. The licensee of the program shall be responsible for the health, safety, and welfare of the children residing in the facility. The facility in which the program is located must be provided with a sprinkler system approved by the state fire marshal. The licensee shall also provide additional space and physical plant accommodations appropriate for the number and age of children residing in the facility. For purposes of license capacity, each child residing in the facility shall be considered to be a resident.

Subd. 7. **Residents with aids or hepatitis.** Boarding care homes and supervised living facilities licensed by the commissioner of health must accept as a resident a person who is infected with the human immunodeficiency virus or the hepatitis B virus unless the facility cannot meet the needs of the person under Minnesota Rules, part 4665.0200, subpart 5, or 4655.1500, subpart 2, or the person is otherwise not eligible for admission to the facility under state laws or rules.

History: *1941 c 549 s 1; 1943 c 649 s 1; 1951 c 304 s 1; 1969 c 358 s 1; 1976 c 173 s 34; 1977 c 218 s 1; 1981 c 95 s 1; 1Sp1985 c 3 s 2; 1987 c 209 s 20,21; 1988 c 689 art 2 s 32; 1989 c 282 art 2 s 8; art 3 s 4; 1990 c 568 art 3 s 3; 1991 c 286 s 3; 1992 c 513 art 6 s 4*

144.51 LICENSE APPLICATIONS.

Before a license shall be issued under sections 144.50 to 144.56, the person applying shall submit evidence satisfactory to the state commissioner of health that the person is not less than 18 years of age and of reputable and responsible character; in the event the applicant is an association or corporation or governmental unit like evidence shall be submitted as to the members thereof and the persons in charge. All applicants shall, in addition, submit satisfactory evidence of their ability to comply with the provisions of sections 144.50 to 144.56 and all rules and minimum standards adopted thereunder.

History: *1941 c 549 s 2; 1943 c 649 s 2; 1951 c 304 s 2; 1973 c 725 s 7; 1976 c 173 s 35; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444*

144.52 APPLICATION.

Any person, partnership, association, or corporation, including state, county, or local governmental units, or any division, department, board, or agency thereof, desiring a license under sections 144.50 to 144.56 shall file with the state commissioner of health a verified application containing the name of the applicant desiring said license; whether such persons so applying are 18 years of age; the type of institution to be operated; the location thereof; the name of the person in charge thereof, and such other information pertinent thereto as the state commissioner of health by rule may require. Application on behalf of a corporation or association or other governmental unit shall be made by any two officers thereof or by its managing agents.

History: *1941 c 549 s 3; 1943 c 649 s 3; 1951 c 304 s 3; 1973 c 725 s 8; 1977 c 305 s 45; 1985 c 248 s 70*

144.53 FEES.

Each application for a license, or renewal thereof, to operate a hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56, except applications by the Minnesota veterans home, the commissioner of human services for the licensing of state institutions or by the administrator for the licensing of the university of Minnesota hospitals, shall be accompanied by a fee to be prescribed by the state commissioner of health pursuant to section 144.122. No fee shall be refunded. Licenses shall expire and shall be renewed as prescribed by the commissioner of health pursuant to section 144.122.

No license granted hereunder shall be assignable or transferable.

History: *1941 c 549 s 4; 1945 c 192 s 1; 1951 c 304 s 4; 1959 c 466 s 1; 1974 c 471 s 3; 1975 c 63 s 1; 1975 c 310 s 5; 1976 c 173 s 36; 1976 c 239 s 69; 1977 c 305 s 45; 1984 c 654 art 5 s 58*

144.54 INSPECTIONS.

Every building, institution, or establishment for which a license has been issued shall be periodically inspected by a duly appointed representative of the state commissioner of health under the rules to be established by the state commissioner of health. No institution of any kind licensed pursuant to the provisions of sections 144.50 to 144.56 shall be required to be licensed or inspected under the laws of this state relating to hotels, restaurants, lodging houses, boarding houses, and places of refreshment.

History: *1941 c 549 s 5; 1951 c 304 s 5; 1977 c 305 s 45; 1985 c 248 s 70*

144.55 LICENSES; ISSUANCE, SUSPENSION AND REVOCATION BY COMMISSIONER.

Subdivision 1. **Issuance.** The state commissioner of health is hereby authorized to issue licenses to operate hospitals, sanitariums or other institutions for the hospitalization or care of human beings, which are found to comply with the provisions of sections 144.50 to 144.56 and any reasonable rules promulgated by the commissioner. All decisions of the commissioner thereunder may be reviewed in the district court in the county in which the institution is located or contemplated.

Subd. 2. **Definition.** For the purposes of this section, "joint commission" means the joint commission on accreditation of hospitals.

Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56, for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations promulgated pursuant to Title XVIII of the Social Security Act, United States Code, title 42, section 1395, et. seq. The commissioner may use as minimum standards changes in the federal hospital certification regulations promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably necessary to protect public health and safety. The commissioner shall also promulgate in rules additional minimum standards for new construction.

(b) Each hospital shall establish policies and procedures to prevent the transmission of human immunodeficiency virus and hepatitis B virus to patients and within the health care

setting. The policies and procedures shall be developed in conformance with the most recent recommendations issued by the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control. The commissioner of health shall evaluate a hospital's compliance with the policies and procedures according to subdivision 4.

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of the joint commission that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by the joint commission, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from the joint commission. Nothing in this subdivision shall be construed to limit the investigative powers of the office of health facility complaints as established in sections 144A.51 to 144A.54.

Subd. 5. **Coordination of inspections.** Prior to conducting routine inspections of hospitals, a state agency shall notify the commissioner of its intention to inspect. The commissioner shall then determine whether the inspection is necessary in light of any previous inspections conducted by the commissioner, any other state agency, or the joint commission. The commissioner shall notify the agency of the determination and may authorize the agency to conduct the inspection. No state agency may routinely inspect any hospital without the authorization of the commissioner. The commissioner shall coordinate, insofar as is possible, routine inspections conducted by state agencies, so as to minimize the number of inspections to which hospitals are subject.

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) Violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto;

(2) Permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) Conduct or practices detrimental to the welfare of the patient; or

(4) Obtaining or attempting to obtain a license by fraud or misrepresentation.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

Subd. 7. **Hearing.** Prior to any suspension, revocation or refusal to renew a license, the licensee shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. At each hearing, the commissioner shall have the burden of establishing that a violation described in subdivision 6 has occurred.

If a license is revoked, suspended, or not renewed, a new application for license may be considered by the commissioner if the conditions upon which revocation, suspension, or refusal to renew was based have been corrected and evidence of this fact has been satisfactorily furnished. A new license may then be granted after proper inspection has been made and all provisions of sections 144.50 to 144.56 and any rules promulgated thereunder have been complied with and recommendation has been made by the inspector as an agent of the commissioner.

Subd. 8. **Rules.** The commissioner may promulgate rules necessary to implement the provisions of this section, except that the standards described in subdivision 3 shall constitute the sole minimum quality standards for licensure of hospitals.

Subd. 9. **Expiration of presently valid licenses.** All licenses presently in effect shall remain valid following May 7, 1981 and shall expire on the dates specified on the licenses unless suspended or revoked.

Subd. 10. **Evaluation report.** On November 15, 1983, the commissioner shall provide the legislature and the governor with a written report evaluating the utilization of the accreditation program, paying particular attention to its effect upon the public health and safety.

Subd. 11. **State hospitals not affected.** Subdivisions 3, 4 and 5 do not apply to state hospitals and other facilities operated under the direction of the commissioner of human services.

History: *1941 c 549 s 6; 1951 c 304 s 6; 1976 c 173 s 37; 1977 c 305 s 45; 1978 c 674 s 60; 1981 c 95 s 2; 1982 c 424 s 130; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1987 c 384 art 2 s 1; 1987 c 403 art 4 s 1; 1992 c 559 art 1 s 2*

144.551 HOSPITAL CONSTRUCTION MORATORIUM.

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis–St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric–orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric–orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice county that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus; or

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds.

Subd. 2. **Emergency waiver.** The commissioner shall grant an emergency waiver from the provisions of this section if the need for the project is a result of fire, tornado, flood, storm damage, or other similar disaster, if adequate health care facilities are not available for the people who previously used the applicant facility, and if the request for an emergency waiver is limited in nature and scope only to those repairs necessitated by the natural disaster.

Subd. 3. **Enforcement.** The district court in Ramsey county has jurisdiction to enjoin an alleged violation of subdivision 1. At the request of the commissioner of health, the attorney general may bring an action to enjoin an alleged violation. The commissioner of health shall not issue a license for any portion of a hospital in violation of subdivision 1. No hospital in violation of subdivision 1 may apply for or receive public funds under chapters 245 to 256B, or from any other source.

Subd. 4. **Definitions.** Except as indicated in this subdivision, the terms used in this section have the meanings given them under Minnesota Statutes 1982, sections 145.832 to 145.845, and the rules adopted under those sections.

The term "hospital" has the meaning given it in section 144.50.

History: *1990 c 500 s 1; 1990 c 568 art 2 s 8; 1993 c 243 s 1*

144.555 HOSPITAL CLOSINGS; PATIENT RELOCATIONS.

Subdivision 1. **Notice of closing or curtailing service.** If a facility licensed under sections 144.50 to 144.56 voluntarily plans to cease operations or to curtail operations to the extent that patients or residents must be relocated, the controlling persons of the facility must notify the commissioner of health at least 90 days before the scheduled cessation or curtailment. The commissioner shall cooperate with the controlling persons and advise them about relocating the patients or residents.

Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 may result in issuance of a correction order under section 144.653, subdivision 5.

History: *1987 c 209 s 22*

144.56 STANDARDS.

Subdivision 1. **Commissioner's powers.** The state commissioner of health shall, in the manner prescribed by law, adopt and enforce reasonable rules and standards under sections 144.50 to 144.56 which the commissioner finds to be necessary and in the public interests and may rescind or modify them from time to time as may be in the public interest, insofar as such action is not in conflict with any provision thereof.

Subd. 2. **Content of rules and standards.** In the public interest the commissioner of health, by such rules and standards, may regulate and establish minimum standards as to the construction, equipment, maintenance, and operation of the institutions insofar as they relate to sanitation and safety of the buildings and to the health, treatment, comfort, safety, and well–being of the persons accommodated for care. Construction as used in this subdivision

means the erection of new buildings or the alterations of or additions to existing buildings commenced after the passage of this act.

Subd. 2a. **Double beds in boarding care homes.** The commissioner shall not adopt any rule which unconditionally prohibits double beds in a boarding care home. The commissioner may adopt rules setting criteria for when double beds will be allowed.

Subd. 2b. **Boarding care homes.** The commissioner shall not adopt or enforce any rule that limits a certified boarding care home from providing nursing services in accordance with the home's Medicaid certification.

Subd. 3. **Maternity patients.** The commissioner of health shall, with the advice of the commissioner of human services, prescribe such general rules for the conduct of all institutions receiving maternity patients as shall be necessary to effect the purposes of all laws of the state relating to maternity patients and newborn infants so far as the same are applicable.

Subd. 4. **Classes of institutions.** The commissioner of health may classify the institutions licensed under sections 144.50 to 144.56 on the basis of the type of care provided and may prescribe separate rules and minimum standards for each class.

History: *1941 c 549 s 7; 1943 c 649 s 7; 1951 c 304 s 7; 1977 c 305 s 45; 1981 c 23 s 2; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1995 c 207 art 7 s 6*

144.561 RESTRICTION OF NAME AND DESCRIPTION OF CERTAIN MEDICAL FACILITIES.

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

(a) "Person" means an individual, partnership, association, corporation, state, county or local governmental unit or a division, department, board or agency of a governmental unit.

(b) "Medical facility" means an institution, office, clinic, or building, not attached to a licensed hospital, where medical services for the diagnosis or treatment of illness or injury or the maintenance of health are offered in an outpatient or ambulatory setting.

Subd. 2. **Prohibition.** No person shall use the words "emergency," "emergent," "trauma," "critical," or any form of these words which suggest, offer, or imply the availability of immediate care for any medical condition likely to cause death, disability or serious illness in the name of any medical facilities, or in advertising, publications or signs identifying the medical facility unless the facility is licensed under the provisions of section 144.50.

History: *1984 c 534 s 2*

144.562 SWING BED APPROVAL; ISSUANCE OF LICENSE CONDITIONS; VIOLATIONS.

Subdivision 1. **Definition.** For the purposes of this section, "swing bed" means a hospital bed licensed under sections 144.50 to 144.56 that has been granted a license condition under this section and which has been certified to participate in the federal Medicare program under United States Code, title 42, section 1395 (tt).

Subd. 2. **Eligibility for license condition.** A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the department of health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66. Eligible hospitals are allowed a total of 1,460 days of swing bed use per year, provided that no more than ten hospital beds are used as swing beds at any one time. The commissioner of health must approve swing bed use beyond 1,460 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital.

Subd. 3. **Approval of license condition.** The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision:

(a) The hospital must meet the eligibility criteria in subdivision 2.

(b) The hospital must be in compliance with the Medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 482.66.

(c) The hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of Medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(d) The hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

(e) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(f) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, Medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

Subd. 4. **Issuance of license condition; renewals.** The commissioner of health shall issue a license condition to a hospital that complies with subdivisions 2 and 3. The license condition must be granted when the license is first issued, when it is renewed, or during the hospital's licensure year. The condition is valid for the hospital's licensure year. The license condition can be renewed at the time of the hospital's license renewal if the hospital complies with subdivisions 2 and 3.

Subd. 5. **Inspections.** Notwithstanding section 144.55, subdivision 4, the commissioner of health may conduct inspections of a hospital granted a condition under this section to assess compliance with this section.

Subd. 6. **Violations.** Notwithstanding section 144.55, subdivision 4, if the hospital fails to comply with subdivision 2 or 3, the commissioner of health shall issue a correction order and penalty assessment under section 144.653 or may suspend, revoke, or refuse to renew the license condition under section 144.55, subdivision 6. The penalty assessment for a violation of subdivision 2 or 3 is $500.

Subd. 7. **Effective date.** Hospitals participating in the Medicare swing bed program on June 25, 1985 shall comply with this section by January 1, 1986, or at the time of the renewal of the Medicare swing bed approval, whichever is earlier.

History: *1Sp1985 c 3 s 3; 1986 c 420 s 1; 1989 c 282 art 2 s 9,10; 1995 c 207 art 7 s 7*

144.563 NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.

A hospital that has been granted a license condition under section 144.562 must not provide to patients not reimbursed by medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or medicare as services of a skilled nursing facility or intermediate care facility for more than 42

days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

History: *1Sp1985 c 3 s 4*

144.564 MONITORING OF SUBACUTE OR TRANSITIONAL CARE SERVICES.

Subdivision 1. **Hospital data.** The commissioner of health shall monitor the provision of subacute or transitional care services provided in hospitals. All hospitals providing these services must report statistical data on the extent and utilization of these services on forms supplied by the commissioner. The data must include the following information: the number of admissions to and discharges from subacute or transitional care beds, charges for services in these beds, the length of stay and total patient days, admission origin and discharge destination, and other information required by the commissioner to assess the utilization of these services. For purposes of this subdivision, subacute or transitional care services is care provided in a hospital bed to patients who have been hospitalized and no longer meet established acute care criteria, and care provided to patients who are admitted for respite care.

Subd. 2. **Nursing home data.** Nursing homes which provide services to individuals whose length of stay in the facility is less than 42 days shall report the data required by subdivision 1 on forms supplied by the commissioner of health.

Subd. 3. **Annual report.** The commissioner shall monitor the provision of services described in this section and shall report annually to the legislature concerning these services, including recommendations on the need for legislation.

History: *1986 c 420 s 2*

144.57 [Repealed, 1951 c 304 s 8]

144.571 [Repealed, 1983 c 260 s 68]

144.572 INSTITUTIONS EXCEPTED.

No rule nor requirement shall be made, nor standard established under sections 144.50 to 144.56 for any sanitarium conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and treatment for those who select and depend upon spiritual means through prayer alone, in lieu of medical care, for healing, except as to the sanitary and safe condition of the premises, cleanliness of operation, and its physical equipment.

History: *1951 c 304 s 10; 1976 c 173 s 39; 1985 c 248 s 70; 1996 c 451 art 4 s 7*

144.573 PETS IN CERTAIN INSTITUTIONS.

Facilities for the institutional care of human beings licensed under section 144.50, may keep pet animals on the premises subject to reasonable rules as to the care, type and maintenance of the pet.

History: *1979 c 38 s 2*

144.58 INFORMATION, CONFIDENTIAL.

Information of a confidential nature received by the state commissioner of health through inspections and authorized under sections 144.50 to 144.56 shall not be disclosed except in a proceeding involving the question of licensure.

History: *1941 c 549 s 9; 1951 c 304 s 11; 1977 c 305 s 45*

144.581 HOSPITAL AUTHORITIES.

Subdivision 1. **Nonprofit corporation powers.** A municipality, political subdivision, state agency, or other governmental entity that owns or operates a hospital authorized, organized, or operated under chapters 158, 250, 376, and 397, or under sections 246A.01 to 246A.27, 412.221, 447.05 to 447.13, 447.31, or 471.59, or under any special law authorizing or establishing a hospital or hospital district shall, relative to the delivery of health care ser-

vices, have, in addition to any authority vested by law, the authority and legal capacity of a nonprofit corporation under chapter 317A, including authority to

(a) enter shared service and other cooperative ventures,

(b) join or sponsor membership in organizations intended to benefit the hospital or hospitals in general,

(c) enter partnerships,

(d) incorporate other corporations,

(e) have members of its governing authority or its officers or administrators serve as directors, officers, or employees of the ventures, associations, or corporations,

(f) own shares of stock in business corporations,

(g) offer, directly or indirectly, products and services of the hospital, organization, association, partnership, or corporation to the general public, and

(h) expend funds, including public funds in any form, or devote the resources of the hospital or hospital district to recruit or retain physicians whose services are necessary or desirable for meeting the health care needs of the population, and for successful performance of the hospital or hospital district's public purpose of the promotion of health. Allowable uses of funds and resources include the retirement of medical education debt, payment of one–time amounts in consideration of services rendered or to be rendered, payment of recruitment expenses, payment of moving expenses, and the provision of other financial assistance necessary for the recruitment and retention of physicians, provided that the expenditures in whatever form are reasonable under the facts and circumstances of the situation.

Subd. 2. **Use of hospital funds for corporate projects.** In the event that the municipality, political subdivision, state agency, or other governmental entity provides direct financial subsidy to the hospital from tax revenue at the time an undertaking authorized under subdivision 1, clauses (a) to (g), is established or funded, the hospital may not contribute funds to the undertaking for more than three years and thereafter all funds must be repaid, with interest in no more than ten years.

Subd. 3. **Converting public funds for individual benefit.** The conversion of public funds for the benefit of any individual shall constitute grounds for review and action by the attorney general or the county attorney under section 609.54.

Subd. 4. **Other laws governing hospital board.** The execution of the functions of the board of directors of a hospital by an organization established under this section shall be subject to the public purchasing requirements of section 471.345, the open meeting law, section 471.705, and the data practices act, chapter 13.

Subd. 5. **Closed meetings; recording.** (a) Notwithstanding subdivision 4 or section 471.705, a public hospital or an organization established under this section may hold a closed meeting to discuss specific marketing activity and contracts that might be entered into pursuant to the marketing activity in cases where the hospital or organization is in competition with health care providers that offer similar goods or services, and where disclosure of information pertaining to those matters would cause harm to the competitive position of the hospital or organization, provided that the goods or services do not require a tax levy. No contracts referred to in this paragraph may be entered into earlier than 15 days after the proposed contract has been described at a public meeting and the description entered in the minutes, except for contracts for consulting services or with individuals for personal services.

(b) A meeting may not be closed under paragraph (a) except by a majority vote of the board of directors in a public meeting. The time and place of the closed meeting must be announced at the public meeting. A written roll of members present at the closed meeting must be available to the public after the closed meeting. The proceedings of a closed meeting must be tape–recorded and preserved by the board of directors for two years. The data on the tape are nonpublic data under section 13.02, subdivision 9. However, the data become public data under section 13.02, subdivision 14, two years after the meeting, or when the hospital or organization takes action on matters referred to in paragraph (a), except for contracts for consulting services. In the case of personal service contracts, the data become public when the contract is signed. For entities subject to section 471.345, a contract entered into by the board is subject to the requirements of section 471.345.

(c) The board of directors may not discuss a tax levy, bond issuance, or other expenditure of money unless the expenditure is directly related to specific marketing activities and contracts described in paragraph (a) at a closed meeting.

History: *1984 c 554 s 1; 1984 c 655 art 2 s 15 subd 1; 1987 c 384 art 2 s 1; 1989 c 304 s 137; 1989 c 351 s 15; 1990 c 568 art 2 s 9; 1992 c 549 art 5 s 13; 1994 c 618 art 1 s 21; 1994 c 625 art 8 s 44*

144.583 [Repealed, 1973 c 139 s 2]

144.584 [Repealed, 1976 c 173 s 64]

144.59 [Repealed, 1980 c 567 s 2]

144.60 [Repealed, 1980 c 567 s 2]

144.61 [Repealed, 1980 c 567 s 2]

144.62 [Repealed, 1980 c 567 s 2]

144.63 [Repealed, 1980 c 567 s 2]

144.64 [Repealed, 1980 c 567 s 2]

144.65 [Repealed, 1980 c 567 s 2]

NURSING HOME ADMISSION CONTRACTS

144.6501 NURSING HOME ADMISSION CONTRACTS.

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

(a) "Facility" means a nursing home licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.58.

(b) "Contract of admission," "admission contract," or "admission agreement," includes, but is not limited to, all documents that a resident or resident's representative must sign at the time of, or as a condition of, admission to the facility. Oral representations and statements between the facility and the resident or resident's representative are not part of the contract of admission unless expressly contained in writing in those documents. The contract of admission must specify the obligations of the resident or the responsible party.

(c) "Legal representative" means an attorney–in–fact under a valid power of attorney executed by the prospective resident, or a conservator or guardian of the person or of the estate, or a representative payee appointed for the prospective resident, or other agent of limited powers.

(d) "Responsible party" means a person who has access to the resident's income and assets and who agrees to apply the resident's income and assets to pay for the resident's care or who agrees to make and complete an application for medical assistance on behalf of the resident.

Subd. 2. **Waivers of liability prohibited.** An admission contract must not include a waiver of facility liability for the health and safety or personal property of a resident while the resident is under the facility's supervision. An admission contract must not include a provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor any provision that requires or implies a lesser standard of care or responsibility than is required by law.

Subd. 3. **Contracts of admission.** (a) A facility shall make complete unsigned copies of its admission contract available to potential applicants and to the state or local long–term care ombudsman immediately upon request.

(b) A facility shall post conspicuously within the facility, in a location accessible to public view, either a complete copy of its admission contract or notice of its availability from the facility.

(c) An admission contract must be printed in black type of at least ten–point type size. The facility shall give a complete copy of the admission contract to the resident or the resi-

dent's legal representative promptly after it has been signed by the resident or legal representative.

(d) An admission contract is a consumer contract under sections 325G.29 to 325G.37.

(e) All admission contracts must state in bold capital letters the following notice to applicants for admission: "NOTICE TO APPLICANTS FOR ADMISSION. READ YOUR ADMISSION CONTRACT. ORAL STATEMENTS OR COMMENTS MADE BY THE FACILITY OR YOU OR YOUR REPRESENTATIVE ARE NOT PART OF YOUR ADMISSION CONTRACT UNLESS THEY ARE ALSO IN WRITING. DO NOT RELY ON ORAL STATEMENTS OR COMMENTS THAT ARE NOT INCLUDED IN THE WRITTEN ADMISSION CONTRACT."

Subd. 4. **Resident and facility obligations.** (a) Before or at the time of admission, the facility shall make reasonable efforts to communicate the content of the admission contract to, and obtain on the admission contract the signature of, the person who is to be admitted to the facility and the responsible party. The admission contract must be signed by the prospective resident unless the resident is legally incompetent or cannot understand or sign the admission contract because of the resident's medical condition.

(b) If the resident cannot sign the admission contract, the reason must be documented in the resident's medical record by the admitting physician.

(c) If the determination under paragraph (b) has been made, the facility may request the signature of another person on behalf of the applicant, subject to the provisions of paragraph (d). The facility must not require the person to disclose any information regarding the person's personal financial assets, liabilities, or income, unless the person voluntarily chooses to become financially responsible for the resident's care. The facility must issue timely billing, respond to questions, and monitor timely payment.

(d) A person who desires to assume financial responsibility for the resident's care may contract with the facility to do so. A person other than the resident or a financially responsible spouse who signs an admission contract must not be required by the facility to assume personal financial liability for the resident's care. However, if the responsible party has signed the admission contract and fails to make timely payment of the facility obligation, or knowingly fails to spenddown the resident's assets appropriately for the purpose of obtaining medical assistance, then the responsible party shall be liable to the facility for the resident's costs of care which are not paid for by medical assistance. A responsible party shall be personally liable only to the extent the resident's income or assets were misapplied.

(e) The admission contract must include written notice in the signature block, in bold capital letters, that a person other than the resident or financially responsible spouse may not be required by the facility to assume personal financial liability for the resident's care.

(f) This subdivision does not preclude the facility from obtaining the signature of a legal representative, if applicable.

Subd. 5. **Public benefits eligibility.** An admission contract must clearly and explicitly state whether the facility participates in the Medicare, medical assistance, or Veterans Administration programs. If the facility's participation in any of those programs is limited for any reason, the admission contract must clearly state the limitation and whether the facility is eligible to receive payment from the program for the person who is considering admission or who has been admitted to the facility.

Subd. 6. **Medical assistance payment.** (a) An admission contract for a facility that is certified for participation in the medical assistance program must state that neither the prospective resident, nor anyone on the resident's behalf, is required to pay privately any amount for which the resident's care at the facility has been approved for payment by medical assistance or to make any kind of donation, voluntary or otherwise. An admission contract must state that the facility does not require as a condition of admission, either in its admission contract or by oral promise before signing the admission contract, that residents remain in private pay status for any period of time.

(b) The admission contract must state that upon presentation of proof of eligibility, the facility will submit a medical assistance claim for reimbursement and will return any and all payments made by the resident, or by any person on the resident's behalf, for services covered by medical assistance, upon receipt of medical assistance payment.

(c) A facility that participates in the medical assistance program shall not charge for the day of the resident's discharge from the facility or subsequent days.

(d) If a facility's charges incurred by the resident are delinquent for 30 days, and no person has agreed to apply for medical assistance for the resident, the facility may petition the court under chapter 525 to appoint a representative for the resident in order to apply for medical assistance for the resident.

(e) The remedy provided in this subdivision does not preclude a facility from seeking any other remedy available under other laws of this state.

Subd. 7. **Consent to treatment.** An admission contract must not include a clause requiring a resident to sign a consent to all treatment ordered by any physician. An admission contract may require consent only for routine nursing care or emergency care. An admission contract must contain a clause that informs the resident of the right to refuse treatment.

Subd. 8. **Written acknowledgment.** An admission contract must contain a written acknowledgment that the resident has been informed of the patient's bill of rights, as required in section 144.652.

Subd. 9. **Violations; penalties.** (a) Violation of this section is grounds for issuance of a correction order, and if uncorrected, a penalty assessment issued by the commissioner of health, under section 144A.10. The civil fine for noncompliance with a correction order issued under this section is $250 per day.

(b) Unless otherwise expressly provided, the remedies or penalties provided by this subdivision do not preclude a resident from seeking any other remedy and penalty available under other laws of this state.

Subd. 10. **Applicability.** This section applies to new admissions to facilities on and after October 1, 1989. This section does not require the execution of a new admission contract for a resident who was residing in a facility before June 1, 1989. However, provisions of the admission contract that are inconsistent with or in conflict with this section are voidable at the sole option of the resident. Residents must be given notice of the changes in admission contracts according to this section and must be given the opportunity to execute a new admission contract that conforms to this section.

History: *1989 c 285 s 2; 1990 c 426 art 1 s 19; 1995 c 136 s 1,2*

SUBACUTE CARE WAIVERS

144.6505 SUBACUTE CARE WAIVERS.

Subdivision 1. **Subacute care; waiver from state and federal rules and regulations.** The commissioners of health and human services shall work with providers to examine state and federal rules and regulations governing the provision of care in nursing facilities and apply for federal waivers and pursue state law changes to any impediments to the provision of subacute care in skilled nursing facilities.

Subd. 2. **Definition of subacute care.** (a) For the purpose of this section, "subacute care" means comprehensive inpatient care, as further defined in this subdivision, designed for persons who:

(1) have or have had an acute illness or accident, or an acute exacerbation of a chronic illness, and who require a moderate level of service intensity;

(2) do not require, or no longer require, technologically intensive diagnosis or management;

(3) have concurrent medical, nursing, and discharge and/or nondischarge oriented rehabilitation objectives that are expected to be achieved within a specified time; and

(4) require interdisciplinary management.

(b) Subacute care includes goal–oriented treatment rendered immediately after, or as an appropriate alternative to, acute hospitalization with the goal of transitioning patients towards increased independence or lower acuity level in a cost–effective environment, to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a patient's underlying long–term conditions and overall situation.

(c) Subacute care does not generally depend heavily on high technology monitoring or complex diagnostic procedures.

(d) Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures.

(e) Subacute care is provided as part of a specifically defined program.

(f) Subacute care includes more intensive care than traditional nursing facility care and less intensive care than acute care and may be provided at a variety of sites, including hospitals and skilled nursing facilities.

(g) Subacute care requires recurrent patient assessment on a daily to weekly basis and review of the clinical course and treatment plan for a limited time period ranging from several days to several months, until the condition is stabilized or a predetermined treatment course is completed.

History: *1995 c 207 art 7 s 8; 1995 c 263 s 14*

PATIENTS BILL OF RIGHTS

144.651 PATIENTS AND RESIDENTS OF HEALTH CARE FACILITIES; BILL OF RIGHTS.

Subdivision 1. **Legislative intent.** It is the intent of the legislature and the purpose of this section to promote the interests and well being of the patients and residents of health care facilities. No health care facility may require a patient or resident to waive these rights as a condition of admission to the facility. Any guardian or conservator of a patient or resident or, in the absence of a guardian or conservator, an interested person, may seek enforcement of these rights on behalf of a patient or resident. An interested person may also seek enforcement of these rights on behalf of a patient or resident who has a guardian or conservator through administrative agencies or in district court or county court having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community–based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

Subd. 3. **Public policy declaration.** It is declared to be the public policy of this state that the interests of each patient and resident be protected by a declaration of a patients' bill of rights which shall include but not be limited to the rights specified in this section.

Subd. 4. **Information about rights.** Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in

an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the data practices act, and section 626.557, relating to vulnerable adults.

Subd. 5. **Courteous treatment.** Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

Subd. 6. **Appropriate health care.** Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.

Subd. 7. **Physician's identity.** Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

Subd. 8. **Relationship with other health services.** Patients and residents who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Residents shall be informed, in writing, of any health care services which are provided to those residents by individuals, corporations, or organizations other than their facility. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative.

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

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

Subd. 10. **Participation in planning treatment; notification of family members.** (a) Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative. In the event that the patient or resi-

dent cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences.

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

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

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

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

(4) inquiring of the physician to whom the patient or resident normally goes for care, if known, whether the patient or resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient or resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

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

Subd. 11. **Continuity of care.** Patients and residents shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

Subd. 12. **Right to refuse care.** Competent patients and residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a patient or resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's or resident's medical record.

Subd. 13. **Experimental research.** Written, informed consent must be obtained prior to a patient's or resident's participation in experimental research. Patients and residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record.

Subd. 14. **Freedom from maltreatment.** Patients and residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means con-

duct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient and resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's or resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self–injury or injury to others.

Subd. 15. **Treatment privacy.** Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

Subd. 16. **Confidentiality of records.** Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the department of health, where required by third party payment contracts, or where otherwise provided by law.

Subd. 17. **Disclosure of services available.** Patients and residents shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients and residents in obtaining information regarding whether the medicare or medical assistance program will pay for any or all of the aforementioned services.

Subd. 18. **Responsive service.** Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.

Subd. 19. **Personal privacy.** Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well–being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable.

Subd. 20. **Grievances.** Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the office of health facility complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital–based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

Subd. 21. **Communication privacy.** Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minne-

sota Commitment Act, leave the facility as they choose. Patients and residents shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients and residents can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' or residents' calls. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility. This right is limited where medically inadvisable, as documented by the attending physician in a patient's or resident's care record. Where programmatically limited by a facility abuse prevention plan pursuant to section 626.557, subdivision 14, paragraph (b), this right shall also be limited accordingly.

Subd. 22. **Personal property.** Patients and residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

Subd. 23. **Services for the facility.** Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal–related in their individual medical record.

Subd. 24. **Choice of supplier.** Residents may purchase or rent goods or services not included in the per diem rate from a supplier of their choice unless otherwise provided by law. The supplier shall ensure that these purchases are sufficient to meet the medical or treatment needs of the residents.

Subd. 25. **Financial affairs.** Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

Subd. 26. **Right to associate.** Residents may meet with visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes the right to join with other individuals within and outside the facility to work for improvements in long–term care. Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

Subd. 27. **Advisory councils.** Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

Subd. 28. **Married residents.** Residents, if married, shall be assured privacy for visits by their spouses and, if both spouses are residents of the facility, they shall be permitted to

share a room, unless medically contraindicated and documented by their physicians in the medical records.

Subd. 29. **Transfers and discharges.** Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly–admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.

Subd. 30. **Protection and advocacy services.** Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

Subd. 31. **Isolation and restraints.** A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

Subd. 32. **Treatment plan.** A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to a written treatment plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow–up treatment measures and services, if appropriate. To the degree possible, the minor patient and the minor patient's parents or guardian shall be involved in the development of the treatment and discharge plan.

History: *1973 c 688 s 1; 1976 c 274 s 1; 1982 c 504 s 1; 1983 c 248 s 1; 1984 c 654 art 5 s 8; 1984 c 657 s 1; 1986 c 326 s 1–6; 1986 c 444; 1989 c 186 s 1; 1989 c 282 art 3 s 5; 1991 c 255 s 19; 1993 c 54 s 1–3; 1995 c 136 s 3,4; 1995 c 189 s 8; 1995 c 229 art 4 s 5,6; 1996 c 277 s 1*

144.652 BILL OF RIGHTS NOTICE TO PATIENT OR RESIDENT; VIOLATION.

Subdivision 1. **Distribution; posting.** Except as provided below, section 144.651 shall be posted conspicuously in a public place in all facilities licensed under the provisions of sections 144.50 to 144.58, or 144A.02. Copies of the law shall be furnished the patient or resident and the patient or resident's guardian or conservator upon admittance to the facility. Facilities providing services to patients may delete section 144.651, subdivisions 24 to 29, and those portions of other subdivisions that apply only to residents, from copies posted or distributed to patients with appropriate notation that residents have additional rights under law. The policy statement shall include the address and telephone number of the board of medical practice and/or the name and phone number of the person within the facility to whom inquiries about the medical care received may be directed. The notice shall include a brief statement describing how to file a complaint with the office of health facility complaints established pursuant to section 144A.52 concerning a violation of section 144.651 or any other state statute or rule. This notice shall include the address and phone number of the office of health facility complaints.

Subd. 2. **Correction order; emergencies.** A substantial violation of the rights of any patient or resident as defined in section 144.651, shall be grounds for issuance of a correction order pursuant to section 144.653 or 144A.10. The issuance or nonissuance of a correction order shall not preclude, diminish, enlarge, or otherwise alter private action by or on behalf of a patient or resident to enforce any unreasonable violation of the patient's or resident's rights. Compliance with the provisions of section 144.651 shall not be required whenever emergency conditions, as documented by the attending physician in a patient's medical record or a resident's care record, indicate immediate medical treatment, including but not limited to surgical procedures, is necessary and it is impossible or impractical to comply with the provisions of section 144.651 because delay would endanger the patient's or resident's life, health, or safety.

History: *1973 c 688 s 2; 1976 c 173 s 41; 1976 c 222 s 28; 1976 c 274 s 2; 1977 c 326 s 1; 1983 c 248 s 2; 1986 c 444; 1991 c 106 s 6*

144.653 RULES; PERIODIC INSPECTIONS; ENFORCEMENT.

Subdivision 1. **Rules.** The state commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under the provisions of sections 144.50 to 144.58. The state commissioner of health shall enforce its rules subject only to the authority of the department of public safety respecting the enforcement of fire and safety standards in licensed health care facilities and the responsibility of the commissioner of human services pursuant to sections 245A.01 to 245A.16 and 252.28.

Subd. 2. **Periodic inspection.** All facilities required to be licensed under the provisions of sections 144.50 to 144.58 shall be periodically inspected by the state commissioner of health to ensure compliance with rules and standards. Inspections shall occur at different times throughout the calendar year. The commissioner of health may enter into agreements with political subdivisions providing for the inspection of such facilities by locally employed inspectors.

The commissioner of health shall conduct inspections and reinspections of facilities licensed under the provisions of sections 144.50 to 144.56 with a frequency and in a manner calculated to produce the greatest benefit to residents within the limits of the resources available to the commissioner. In performing this function, the commissioner may devote proportionately more resources to the inspection of those facilities in which conditions present the most serious concerns with respect to resident health, treatment, comfort, safety, and well–being.

These conditions include but are not limited to: change in ownership; frequent change in administration in excess of normal turnover rates; complaints about care, safety, or rights; where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; and, where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity. Any health care facility that has none of the above conditions or any other condition established by the commissioner that poses a risk to resident care, safety, or rights shall be inspected once every two years.

Subd. 3. **Enforcement.** With the exception of the department of public safety which has the exclusive jurisdiction to enforce state fire and safety standards, the state commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting facilities required to be licensed under the provisions of sections 144.50 to 144.58 and enforcing the rules and standards prescribed by it.

The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a licensed facility if the commissioner considers them necessary for the discharge of responsibilities. For the purposes of inspections and securing information to determine compliance with the licensure laws and rules, the commissioner need not present a release, waiver, or consent of the individual. The identities of patients or residents must be kept private as defined by section 13.02, subdivision 12.

Subd. 4. **Without notice.** One or more unannounced inspections of each facility required to be licensed under the provisions of sections 144.50 to 144.58 shall be made annually.

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

Subd. 6. **Reinspections; fines.** If upon reinspection it is found that the licensee of a facility required to be licensed under the provisions of sections 144.50 to 144.58 has not corrected deficiencies specified in the correction order, a notice of noncompliance with a correction order shall be issued stating all deficiencies not corrected. Unless a hearing is requested under subdivision 8, the licensee shall forfeit to the state within 15 days after receipt by the licensee of such notice of noncompliance with a correction order up to $1,000 for each deficiency not corrected. For each subsequent reinspection, the licensee may be fined an additional amount for each deficiency which has not been corrected. All forfeitures shall be paid into the general fund. The commissioner of health shall promulgate by rule a schedule of fines applicable for each type of uncorrected deficiency.

Subd. 7. **Recovery.** Any unpaid forfeitures may be recovered by the attorney general.

Subd. 8. **Hearings.** A licensee of a facility required to be licensed under the provisions of sections 144.50 to 144.58 is entitled to a hearing on any notice of noncompliance with a correction order issued to the licensee as a result of a reinspection, provided that the licensee makes a written request therefor within 15 days of receipt by the licensee of the notice of noncompliance with a correction order. Failure to request a hearing shall result in the forfeiture of a penalty as determined by the commissioner of health in accordance with subdivision 6. A request for a hearing shall operate as a stay during the hearing and review process of the payment of any forfeiture provided for in this section. Upon receipt of the request for a hearing, a hearing officer, who shall not be an employee of the state commissioner of health, shall be appointed by the state commissioner of health, and the hearing officer shall promptly schedule a hearing on the matter, giving at least ten days notice of the date, time, and place of the hearing to the licensee. Upon determining that the licensee of a facility required to be licensed under sections 144.50 to 144.58 has not corrected the deficiency specified in the correction order, the hearing officer shall impose a penalty as determined by the commissioner of health in accordance with subdivision 6. The hearing and review thereof shall be in accordance with the relevant provisions of the administrative procedure act.

Subd. 9. **Nonlimiting.** Nothing in this section shall be construed to limit the powers granted to the state commissioner of health in section 144.55.

History: *1973 c 688 s 3; 1975 c 310 s 6,7,37; 1976 c 173 s 42; 1977 c 305 s 45; 1Sp1981 c 4 art 1 s 76; 1983 c 312 art 1 s 16; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1987 c 209 s 23; 1989 c 209 art 2 s 1; 1991 c 286 s 4*

144.654 EXPERTS MAY BE EMPLOYED.

The state commissioner of health may employ experts in the field of health care to assist the staffs of facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, in programming and providing adequate care of the patients and residents of the facility. Alternate methods of care for patients and residents of the facilities shall be researched by the state commissioner of health using the knowledge and experience of experts employed therefor.

History: *1973 c 688 s 4; 1976 c 173 s 43; 1977 c 305 s 45*

144.655 PROGRAM FOR VOLUNTARY MEDICAL AID.

Licensed physicians may visit a facility required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, and examine patients and residents thereof under a program which shall be established by the state commissioner of health and regulated and governed by rules promulgated by the state commissioner of health pursuant to the administrative procedure act. The rules shall protect the privacy of patients and residents of facilities. No patient or resident of any facility shall be required to submit to an examination under the

program. The state commissioner of health shall consult with medical schools and other experts for the purpose of establishing the program. The state commissioner of health shall encourage the active participation of all licensed physicians on a voluntary basis in the program.

History: *1973 c 688 s 5; 1976 c 173 s 44; 1977 c 305 s 45*

144.656 EMPLOYEES TO BE COMPENSATED.

All employees of facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, participating in orientation programs or in in–service training provided by the facility shall be compensated therefor at their regular rate of pay, provided, however, that this section will be effective only to the extent that facilities are reimbursed for the compensation by the commissioner of human services in the proportion of welfare to total residents and patients in the facility.

History: *1973 c 688 s 6; 1976 c 173 s 45; 1984 c 654 art 5 s 58*

144.657 VOLUNTEER EFFORTS ENCOURAGED.

The state commissioner of health, through the dissemination of information to appropriate organizations, shall encourage citizens to promote improved care in facilities required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, throughout the state.

History: *1973 c 688 s 7; 1976 c 173 s 46; 1977 c 305 s 45*

144.658 EPIDEMIOLOGIC DATA DISCOVERY.

Notwithstanding any law to the contrary, health data on an individual collected by public health officials conducting an epidemiologic investigation to reduce morbidity or mortality is not subject to discovery in a legal action.

History: *1985 c 298 s 41*

144.6581 DETERMINATION OF WHETHER DATA IDENTIFIES INDIVIDUALS.

The commissioner of health may: (1) withhold access to health or epidemiologic data if the commissioner determines the data are data on an individual, as defined in section 13.02, subdivision 5; or (2) grant access to health or epidemiologic data, if the commissioner determines the data are summary data as defined in section 13.02, subdivision 19. In the exercise of this discretion, the commissioner shall consider whether the data requested, alone or in combination, may constitute information from which an individual subject of data may be identified using epidemiologic methods. In making this determination, the commissioner shall consider disease incidence, associated risk factors for illness, and similar factors unique to the data by which it could be linked to a specific subject of the data. This discretion is limited to health or epidemiologic data maintained by the commissioner of health or a board of health, as defined in section 145A.02.

History: *1993 c 351 s 26*

144.659 [Repealed, 1982 c 419 s 2]

144.66 [Repealed, 1987 c 403 art 2 s 164]

TRAUMATIC BRAIN AND SPINAL CORD INJURIES

144.661 DEFINITIONS.

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

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

(1) impairment of cognitive or mental abilities;

(2) impairment of physical functioning; or

(3) disturbance of behavioral or emotional functioning.

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

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

History: *1991 c 292 art 2 s 5*

144.662 TRAUMATIC BRAIN INJURY AND SPINAL CORD INJURY REGISTRY; 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 economic security. 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; 1994 c 483 s 1*

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 economic security 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; 1994 c 483 s 1*

144.67 [Repealed, 1987 c 403 art 2 s 164]

CANCER SURVEILLANCE SYSTEM

144.671 CANCER SURVEILLANCE SYSTEM; PURPOSE.

The commissioner of health shall establish a statewide population–based cancer surveillance system. The purpose of this system is to:

(1) monitor incidence trends of cancer to detect potential public health problems, predict risks, and assist in investigating cancer clusters;

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

(3) inform health professionals and citizens about risks, early detection, and treatment of cancers known to be elevated in their communities; and

(4) promote high quality research to provide better information for cancer control and to address public concerns and questions about cancer.

History: *1987 c 403 art 2 s 9*

144.672 DUTIES OF COMMISSIONER; RULES.

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

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

(1) the type of data to be reported;

(2) standards for reporting specific types of data;

(3) payments allowed to hospitals, pathologists, and registry systems to defray their costs in providing information to the system;

(4) criteria relating to contracts made with outside entities to conduct studies using data collected by the system. The criteria may include requirements for a written protocol outlining the purpose and public benefit of the study, the description, methods, and projected results of the study, peer review by other scientists, the methods and facilities to protect the privacy of the data, and the qualifications of the researcher proposing to undertake the study;

(5) specification of fees to be charged under section 13.03, subdivision 3, for all out-of-pocket expenses for data summaries or specific analyses of data requested by public and private agencies, organizations, and individuals, and which are not otherwise included in the commissioner's annual summary reports. Fees collected are appropriated to the commissioner to offset the cost of providing the data; and

(6) establishment of a committee to assist the commissioner in the review of system activities. The committee expires as provided in section 15.059, subdivision 5.

Subd. 2. **Biennial report required.** The commissioner of health shall prepare and transmit to the governor and to members of the legislature under section 3.195, a biennial report on the incidence of cancer in Minnesota and a compilation of summaries and reports from special studies and investigations performed to determine the potential public health significance of an increase in cancer incidence, together with any findings and recommendations. The first report shall be delivered by February 1989, with subsequent reports due in February of each of the following odd-numbered years.

History: *1987 c 403 art 2 s 10; 1988 c 629 s 37; 1994 c 411 s 1*

144.68 RECORDS AND REPORTS REQUIRED.

Subdivision 1. **Person practicing healing arts.** Every person licensed to practice the healing arts in any form, upon request of the commissioner of health, shall prepare and forward to the commissioner, in the manner and at such times as the commissioner designates, a detailed record of each case of cancer treated or seen by the person professionally.

Subd. 2. **Hospitals and similar institutions.** Every hospital, medical clinic, medical laboratory, or other institution for the hospitalization, clinical or laboratory diagnosis, or care of human beings, upon request of the commissioner of health, shall prepare and forward to the commissioner, in the manner and at the times designated by the commissioner, a detailed record of each case of cancer.

Subd. 3. **Reporting without liability.** The furnishing of the information required under subdivisions 1 and 2 shall not subject the person, hospital, medical clinic, medical laboratory, or other institution furnishing the information, to any action for damages or other relief.

History: *1949 c 350 s 3; 1976 c 173 s 47,48; 1977 c 305 s 45; 1986 c 444; 1987 c 403 art 2 s 11*

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected on individuals by the cancer surveillance system, including the names and personal identifiers of persons required in section 144.68 to report, shall be private and may only be used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure other than is provided for in this section and sections 144.671, 144.672, and 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by rule, and as part of an epidemiologic investigation, an officer or employee of the commissioner of health may interview patients named in any such report, or relatives of any such patient, only after the consent of the attending physician or surgeon is obtained.

History: *1949 c 350 s 4; 1987 c 403 art 2 s 12*

144.691 GRIEVANCE PROCEDURES.

Subdivision 1. **Facilities.** Every hospital licensed as such pursuant to sections 144.50 to 144.56, and every outpatient surgery center shall establish a grievance or complaint mechanism designed to process and resolve promptly and effectively grievances by patients or their representatives related to billing, inadequacies of treatment, and other factors which may have an impact on the incidence of malpractice claims and suits.

For the purposes of sections 144.691 to 144.693, "outpatient surgery center" shall mean a free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined prediagnosed low risk patients. Services provided at an outpatient surgery center shall be limited to surgical procedures which utilize local or general anesthesia and which do not require overnight inpatient care. "Outpatient surgery center" does not mean emergency medical services, or physician or dentist offices.

Subd. 2. **Patient notice.** Each patient receiving treatment at a hospital or an outpatient surgery center shall be notified of the grievance or complaint mechanism which is available to the patient.

Subd. 3. **Rules.** The state commissioner of health shall, by January 1, 1977, establish by rule promulgated pursuant to chapter 15:

(a) Minimum standards and procedural requirements for grievance and complaint mechanism;

(b) A list of patient complaints which may be processed through a complaint or grievance mechanism;

(c) The form and manner in which patient notices shall be made; and

(d) A schedule of fines, not to exceed $200 per offense, for the failure of a hospital or outpatient surgery center to comply with the provisions of this section.

Subd. 4. [Repealed, 1996 c 451 art 4 s 71]

History: *1976 c 325 s 8; 1977 c 305 s 45; 1981 c 311 s 39; 1982 c 545 s 24; 1986 c 444*

144.692 [Repealed, 1987 c 209 s 40]

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(a) The total number of claims made against each facility or organization which were filed or closed during the reporting period;

(b) The date each new claim was filed with the insurer;

(c) The allegations contained in each claim filed during the reporting period;

(d) The disposition and closing date of each claim closed during the reporting period;

(e) The dollar amount of the award or settlement for each claim closed during the reporting period; and

(f) Any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.

History: *1976 c 325 s 10; 1977 c 305 s 45; 1981 c 311 s 39; 1982 c 545 s 24; 1986 c 444*

HEALTH CARE COST INFORMATION

144.695 CITATION.

Sections 144.695 to 144.703 may be cited as the Minnesota health care cost information act of 1984.

History: *1976 c 296 art 2 s 1; 1984 c 534 s 3*

144.696 DEFINITIONS.

Subdivision 1. **Scope.** Unless the context clearly indicates otherwise, for the purposes of sections 144.695 to 144.703, the terms defined in this section have the meanings given them.

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

Subd. 3. **Hospital.** "Hospital" means any acute care institution licensed pursuant to sections 144.50 to 144.58, but does not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

Subd. 4. **Outpatient surgical center.** "Outpatient surgical center" means a facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

History: *1976 c 296 art 2 s 2; 1977 c 305 s 45; 1984 c 534 s 4*

144.697 GENERAL POWERS AND DUTIES OF STATE COMMISSIONER OF HEALTH.

Subdivision 1. **Contracts.** The commissioner of health may contract with third parties for services necessary to carry out the commissioner's activities where this will promote economy, avoid duplication of effort, and make best use of available expertise.

Subd. 2. **Grants; gifts.** The commissioner of health may apply for and receive grants and gifts from any governmental agency, private entity or other person.

Subd. 3. **Committees.** To further the purposes of sections 144.695 to 144.703, the commissioner of health may create committees from the membership and may appoint ad hoc advisory committees.

Subd. 4. **Coordinating rules and inspections.** The commissioner of health shall coordinate regulation and inspection of hospitals to avoid, to the extent possible, conflicting rules and duplicative inspections.

History: *1976 c 296 art 2 s 3; 1977 c 305 s 45; 1986 c 444*

144.698 REPORTING REQUIREMENTS.

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

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

(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.

Subd. 2. **Separate reports for facilities.** If more than one licensed hospital or outpatient surgical center is operated by the reporting organization, the commissioner of health may require that the information be reported separately for each hospital and each outpatient surgical center.

Subd. 3. **Attestation.** The commissioner of health may require attestation by responsible officials of the hospital or outpatient surgical center that the contents of the reports are true.

Subd. 4. **Reports open to public inspection.** All reports, except privileged medical information, filed pursuant to this section, section 144.701 or section 144.702, subdivision 3 or 4 shall be open to public inspection.

Subd. 5. **Commissioner's right to inspect records.** The commissioner of health shall have the right to inspect hospital and outpatient surgical center books, audits, and records as reasonably necessary to verify hospital and outpatient surgical center reports.

History: *1976 c 296 art 2 s 4; 1977 c 305 s 45; 1984 c 534 s 5; 1989 c 282 art 2 s 11; 1991 c 202 s 7*

144.699 CONTINUING ANALYSIS.

Subdivision 1. **Acute care costs.** The commissioner of health may:

(a) Undertake analyses and studies relating to acute care costs and to the financial status of any hospital or outpatient surgical center subject to the provisions of sections 144.695 to 144.703; and

(b) Publish and disseminate the information relating to acute care costs.

Subd. 2. **Fostering price competition.** The commissioner of health shall:

(a) Encourage hospitals, outpatient surgical centers, home care providers, and professionals regulated by the health related licensing boards as defined in section 214.01, subdivision 2, and by the commissioner of health under section 214.13, to publish prices for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment.

(b) Analyze and disseminate available price information and analyses so as to foster the development of price competition among hospitals, outpatient surgical centers, home care providers, and health professionals.

Subd. 3. **Cooperation with attorney general.** Upon request of the attorney general, the commissioner of health shall make available to the attorney general all requested information provided under sections 144.695 to 144.703 in order to assist the attorney general in discharging the responsibilities of section 8.31.

Subd. 4. **Other reports or costs.** The commissioner of health shall prepare and file summaries and compilations or other supplementary reports based on the information filed with or made available to the commissioner of health, which reports will advance the purposes of sections 144.695 to 144.703.

History: *1976 c 296 art 2 s 5; 1977 c 305 s 45; 1984 c 534 s 6; 1987 c 378 s 2*

144.70 BIENNIAL REPORT.

Subdivision 1. **Content.** The commissioner of health shall prepare a report every two years concerning the status and operations of the health care markets in Minnesota. The commissioner of health shall transmit the reports to the governor, and to the members of the legis-

lature under section 3.195. The first report must be submitted on January 15, 1987, and succeeding reports on January 15 every two years. Each report must contain information, analysis, and appropriate recommendations concerning the following issues associated with Minnesota health care markets:

(1) the overall status of the health care cost problem, including the costs faced by employers and individuals, and prospects for the problem's improving or getting worse;

(2) the status of competitive forces in the market for health services and the market for health plans, and the effect of the forces on the health care cost problem;

(3) the feasibility and cost–effectiveness of facilitating development of strengthened competitive forces through state initiatives;

(4) the feasibility of limiting health care costs by means other than competitive forces, including direct forms of government intervention such as price regulation; the commissioner of health may exclude this issue from the report if the report concludes that the overall status of the health care cost problem is improving, or that competitive forces are contributing significantly to health care cost containment;

(5) the overall status of access to adequate health services by citizens of Minnesota, the scope of financial and geographic barriers to access, the effect of competitive forces on access, and prospects for access improving or getting worse;

(6) the feasibility and cost–effectiveness of enhancing access to adequate health services by citizens of Minnesota through state initiatives; and

(7) the commissioner of health's operations and activities for the preceding two years as they relate to the duties imposed on the commissioner of health by sections 144.695 to 144.703.

Subd. 2. **Interagency cooperation.** In completing the report required by subdivision 1, in fulfilling the requirements of sections 144.695 to 144.703, and in undertaking other initiatives concerning health care costs, access, or quality, the commissioner of health shall cooperate with and consider potential benefits to other state agencies that have a role in the market for health services or the market for health plans. Other agencies include the department of 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: *1976 c 296 art 2 s 6; 1977 c 305 s 45; 1Sp1985 c 9 art 2 s 11; 1991 c 345 art 2 s 37; 1994 c 411 s 2*

144.701 RATE DISCLOSURE.

Subdivision 1. **Consumer information.** The commissioner of health shall ensure that the total costs, total revenues, and total services of each hospital and each outpatient surgical center are reported to the public in a form understandable to consumers.

Subd. 2. **Data for policy making.** The commissioner of health shall compile relevant financial and accounting data concerning hospitals and outpatient surgical centers in order to have statistical information available for legislative policy making.

Subd. 3. **Rate schedule.** The commissioner of health shall obtain from each hospital and outpatient surgical center a current rate schedule. Any subsequent amendments or modifications of that schedule shall be filed with the commissioner of health on or before their effective date.

Subd. 4. **Filing fees.** Each report which is required to be submitted to the commissioner of health under sections 144.695 to 144.703 and which is not submitted to a voluntary, nonprofit reporting organization in accordance with section 144.702 shall be accompanied by a filing fee in an amount prescribed by rule of the commissioner of health. Fees received pursuant to this subdivision shall be deposited in the general fund of the state treasury. Upon the withdrawal of approval of a reporting organization, or the decision of the commissioner to not renew a reporting organization, fees collected under section 144.702 shall be submitted to the commissioner and deposited in the general fund. The commissioner shall report the termination or nonrenewal of the voluntary reporting organization to the chair of the health

and human services subdivision of the appropriations committee of the house of representatives, to the chair of the health and human services division of the finance committee of the senate, and the commissioner of finance.

History: *1976 c 296 art 2 s 7; 1977 c 305 s 45; 1982 c 424 s 130; 1984 c 534 s 7; 1989 c 282 art 2 s 12*

144.702 VOLUNTARY REPORTING OF HOSPITAL AND OUTPATIENT SURGICAL CENTER COSTS.

Subdivision 1. **Reporting through a reporting organization.** A hospital or outpatient surgical center may agree to submit its financial reports to a voluntary, nonprofit reporting organization whose reporting procedures have been approved by the commissioner of health in accordance with this section.

Subd. 2. **Approval of organization's reporting procedures.** The commissioner of health may approve voluntary reporting procedures consistent with written operating requirements for the voluntary, nonprofit reporting organization which shall be established annually by the commissioner. These written operating requirements shall specify reports, analyses, and other deliverables to be produced by the voluntary, nonprofit reporting organization, and the dates on which those deliverables must be submitted to the commissioner. These written operating requirements shall specify deliverable dates sufficient to enable the commissioner of health to process and report health care cost information system data to the commissioner of human services by August 15 of each year. The commissioner of health shall, by rule, prescribe standards for submission of data by hospitals and outpatient surgical centers to the voluntary, nonprofit reporting organization or to the commissioner. These standards shall provide for:

(a) The filing of appropriate financial information with the reporting organization;

(b) Adequate analysis and verification of that financial information; and

(c) Timely publication of the costs, revenues, and rates of individual hospitals and outpatient surgical centers prior to the effective date of any proposed rate increase. The commissioner of health shall annually review the procedures approved pursuant to this subdivision.

Subd. 3. **Cost and rate information; time limits on filing.** Any voluntary, nonprofit reporting organization which collects information on costs, revenues, and rates of a hospital or outpatient surgical center located in this state shall file a copy of the information received for each hospital and outpatient surgical center with the commissioner of health within 30 days of completion of the information collection process, together with a summary of the financial information acquired by the organization during the course of its review.

Subd. 4. **Making information available to commissioner.** Any voluntary, nonprofit reporting organization which receives the financial information required by sections 144.695 to 144.703 shall make the information and all summaries and analyses of the information available to the commissioner of health in accordance with procedures prescribed by the commissioner of health.

Subd. 5. **Laws governing restraint of trade.** If the reporting and procedures of a voluntary, nonprofit reporting organization have been approved by the commissioner of health those reporting activities of the organization shall be exempt from the provisions of sections 325D.49 to 325D.66.

Subd. 6. **Reporting organization; definition.** For the purposes of this section "reporting organization" means an association or other organization which has as one of its primary functions the collection and dissemination of acute care cost information.

Subd. 7. **Staff support.** The commissioner may require as part of the written operating requirements for the voluntary, nonprofit reporting organization that the organization provide sufficient funds to cover the costs of one professional staff position who will directly administer the health care cost information system.

Subd. 8. **Termination or nonrenewal of reporting organization.** The commissioner may withdraw approval of any voluntary, nonprofit reporting organization for failure on the part of the voluntary, nonprofit reporting organization to comply with the written operating requirements under subdivision 2. Upon the effective date of the withdrawal, all funds col-

lected by the voluntary, nonprofit reporting organization under section 144.701, subdivision 4, but not expended shall be deposited in the general fund.

The commissioner may choose not to renew approval of a voluntary, nonprofit reporting organization if the organization has failed to perform its obligations satisfactorily under the written operating requirements under subdivision 2.

History: *1976 c 296 art 2 s 8; 1977 c 305 s 45; 1984 c 534 s 8; 1989 c 282 art 2 s 13–15; 1995 c 207 art 6 s 3*

144.7021 [Repealed, 1984 c 534 s 33]

144.703 ADDITIONAL POWERS.

Subdivision 1. **Rulemaking.** In addition to the other powers granted to the commissioner of health by law, the commissioner of health may:

(a) Adopt, amend, and repeal rules in accordance with chapter 14;

(b) Adopt in rule a schedule of fines, ranging from $100 to $1,000, for failure of a hospital or an outpatient surgical center to submit, or to make a timely submission of, information called for by sections 144.695 to 144.703.

Subd. 2. **Contested cases.** Any person aggrieved by a final determination of the commissioner of health as to any rule or determination under sections 144.695 to 144.703 shall be entitled to an administrative hearing and judicial review in accordance with the contested case provisions of chapter 14.

History: *1976 c 296 art 2 s 9; 1977 c 305 s 45; 1982 c 424 s 130; 1984 c 534 s 9*

144.704 [Repealed, 1984 c 534 s 33]

144.705 [Repealed, 1984 c 534 s 33]

CHILDREN'S CAMPS

144.71 PURPOSE; DEFINITIONS.

Subdivision 1. **Health and safety.** The purpose of sections 144.71 to 144.74 is to protect the health and safety of persons in attendance at youth camps.

Subd. 2. **Definition.** For the purpose of such sections, a youth camp is defined as a parcel or parcels of land with permanent buildings, tents or other structures together with appurtenances thereon, established or maintained as living quarters where both food and beverage service and lodging or the facilities therefor are provided for ten or more people, operated continuously for a period of five days or more each year for educational, recreational or vacation purposes, and the use of the camp is offered to minors free of charge or for payment of a fee.

Subd. 3. **What not included in definition.** This definition does not include cabin and trailer camps, fishing and hunting camps, resorts, penal and correctional camps, industrial and construction camps, nor does it include homes operated for care or treatment of children and for the operation of which a license is required under the provisions of chapter 257.

History: *1951 c 285 s 1; 1974 c 406 s 21; 1993 c 206 s 6; 1996 c 451 art 4 s 8,9*

144.72 OPERATION.

Subdivision 1. **Permits.** The state commissioner of health is authorized to issue permits for the operation of youth camps which are required to obtain the permits.

Subd. 2. **Application.** On or before June first annually, every person, partnership, limited liability company or corporation, operating or seeking to operate a youth camp, shall make application in writing to the commissioner for a permit to conduct a youth camp. Such application shall be in such form and shall contain such information as the commissioner may find necessary to determine that the youth camp will be operated and maintained in such a manner as to protect and preserve the health and safety of the persons using the camp. Where a person, partnership, limited liability company or corporation operates or is seeking to operate more than one youth camp, a separate application shall be made for each camp.

Subd. 3. **Issuance of permits.** If the commissioner should determine from the application that the health and safety of the persons using the camp will be properly safeguarded, the commissioner may, prior to actual inspection of the camp, issue the permit in writing. No fee shall be charged for the permit. The permit shall be posted in a conspicuous place on the premises occupied by the camp.

History: *1951 c 285 s 2; 1977 c 305 s 45; 1986 c 444; 1996 c 451 art 4 s 10,11*

144.73 STATE COMMISSIONER OF HEALTH, DUTIES.

Subdivision 1. **Inspection of camps.** It shall be the duty of the state commissioner of health to make an annual inspection of each youth camp, and where, upon inspection it is found that there is a failure to protect the health and safety of the persons using the camp, or a failure to comply with the camp rules prescribed by the commissioner, the commissioner shall give notice to the camp operator of such failure, which notice shall set forth the reason or reasons for such failure.

Subd. 2. [Repealed, 1993 c 206 s 25]

Subd. 3. [Repealed, 1993 c 206 s 25]

Subd. 4. [Repealed, 1993 c 206 s 25]

History: *1951 c 285 s 3; 1977 c 305 s 45; 1978 c 674 s 60; 1985 c 248 s 70; 1986 c 444; 1993 c 286 s 2; 1994 c 465 art 3 s 68; 1996 c 451 art 4 s 12*

144.74 RULES, STANDARDS.

The state commissioner of health is authorized to adopt and enforce such reasonable rules and standards as the commissioner determines necessary to protect the health and safety of persons in attendance at youth camps. Such rules and standards may include reasonable restrictions and limitations on the following:

(1) Camp sites and buildings, including location, layout, lighting, ventilation, heating, plumbing, drainage and sleeping quarters;

(2) Sanitary facilities, including water supply, toilet and shower facilities, sewage and excreta disposal, waste and garbage disposal, and the control of insects and rodents, and

(3) Food service, including storage, refrigeration, sanitary preparation and handling of food, the cleanliness of kitchens and the proper functioning of equipment.

History: *1951 c 285 s 4; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444; 1996 c 451 art 4 s 13*

144.75 [Repealed, 1973 c 250 s 2]

144.76 [Repealed, 1993 c 206 s 25]

NOTICE OF EXPOSURE AND TESTING OF EMERGENCY MEDICAL SERVICE PERSONNEL

144.761 DEFINITIONS.

Subdivision 1. **Scope of definitions.** For purposes of this chapter, the following terms have the meanings given them.

Subd. 2. **HIV.** "HIV" means the human immunodeficiency virus, the causative agent of AIDS.

Subd. 3. **Hepatitis B.** "Hepatitis B" means the hepatitis B virus.

Subd. 4. **Emergency medical services agency.** "Emergency medical services agency" means an agency, entity, or organization that employs or uses emergency medical services personnel as employees or volunteers licensed or certified under sections 144.801 to 144.8091.

Subd. 5. **Emergency medical services personnel.** "Emergency medical services personnel" means:

(1) individuals employed to provide prehospital emergency medical services;

(2) persons employed as licensed police officers under section 626.84, subdivision 1, who experience a significant exposure in the performance of their duties;

(3) firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as employees or volunteers of an ambulance service as defined by sections 144.801 to 144.8091, who provide prehospital emergency medical services;

(4) crime lab personnel receiving a significant exposure while involved in a criminal investigation;

(5) correctional guards, including security guards at the Minnesota security hospital, employed by the state or a local unit of government who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and

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

Subd. 6. **Patient.** "Patient" means an individual who is received by a facility and who receives the services of emergency medical services personnel. Patient includes, but is not limited to, victims of accident or injury, or deceased persons.

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

(1) contact of broken skin or mucous membrane of emergency medical services personnel with a patient's blood, amniotic fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, cerebrospinal fluid, semen, vaginal secretions, or bodily fluids grossly contaminated with blood;

(2) a needle stick, scalpel or instrument wound, or other wound inflicted by an object that is contaminated with blood, and that is capable of cutting or puncturing the skin of emergency medical services personnel; or

(3) an exposure that occurs by any other method of transmission recognized by contemporary epidemiological standards as a significant exposure.

Subd. 8. **Facility.** "Facility" means a licensed hospital and freestanding emergency medical care facility licensed under sections 144.50 to 144.56 that receives a patient cared for by emergency medical services personnel.

History: *1989 c 154 s 1; 1990 c 426 art 2 s 1; 1992 c 425 s 1; 1994 c 623 art 5 s 1*

144.762 NOTIFICATION PROTOCOL FOR EXPOSURE TO HIV AND HEPATITIS B.

Subdivision 1. **Notification protocol required.** Every facility that receives a patient shall adopt a postexposure notification protocol for emergency medical services personnel who have experienced a significant exposure.

Subd. 2. **Requirements for protocol.** The postexposure notification protocol must include the following:

(1) a method for emergency medical services personnel to notify the facility that they may have experienced a significant exposure from a patient that was transported to the facility. The facility shall provide to the emergency medical services personnel a significant exposure report form to be completed by the emergency medical services personnel in a timely fashion;

(2) a process to investigate whether a significant exposure has occurred. This investigation must be completed within 72 hours of receipt of the exposure report;

(3) if there has been a significant exposure, a process to determine whether the patient has hepatitis B or HIV infection;

(4) if the patient has an infectious disease that could be transmitted by the type of exposure that occurred, or, if it is not possible to determine what disease the patient may have, a process for making recommendations for appropriate counseling and testing to the emergency medical services personnel;

(5) compliance with applicable state and federal laws relating to data practices, confidentiality, informed consent, and the patient bill of rights; and

(6) a process for providing counseling for the patient to be tested and for the emergency medical services personnel filing the exposure report.

Subd. 3. **Immunity.** A facility is not civilly or criminally liable for actions relating to the notification of emergency medical services personnel if the facility has made a good faith effort to adopt and follow a notification protocol.

History: *1989 c 154 s 2*

144.763 COUNSELING REQUIREMENTS.

With regard to testing for HIV infection, facilities shall ensure that pretest counseling, notification of test results, and posttest counseling are provided to all patients tested and to emergency medical services personnel requesting notification.

History: *1989 c 154 s 3*

144.764 RESPONSIBILITY FOR TESTING; COSTS.

The facility that receives a patient shall ensure that tests under sections 144.761 to 144.7691 are performed. The emergency medical services agency that employs the emergency medical services personnel who request testing under sections 144.761 to 144.7691 must pay for the cost of counseling, testing, and costs associated with the testing of the patient and of the emergency medical services personnel.

History: *1989 c 154 s 4*

144.765 PATIENT'S RIGHT TO REFUSE TESTING.

Upon notification of a significant exposure, the facility shall ask the patient to consent to blood testing to determine the presence of the HIV virus or the hepatitis B virus. The patient shall be informed that the test results without personally identifying information will be reported to the emergency medical services personnel. The patient shall be informed of the right to refuse to be tested. If the patient refuses to be tested, the patient's refusal will be forwarded to the emergency medical services agency and to the emergency medical services personnel. The right to refuse a blood test under the circumstances described in this section does not apply to a prisoner who is in the custody or under the jurisdiction of the commissioner of corrections or a local correctional authority as a result of a criminal conviction.

History: *1989 c 154 s 5; 1993 c 326 art 4 s 1*

144.766 DEATH OF PATIENT.

If a patient who is the subject of a reported significant exposure dies before an opportunity to consent to blood testing under sections 144.761 to 144.7691, the facility shall conduct a test of the deceased person for hepatitis B and HIV infection. Consent of the deceased person's representative is not necessary for purposes of this section.

History: *1989 c 154 s 6*

144.767 TEST RESULTS; REPORTS.

Subdivision 1. **Report to employer.** Results of tests conducted under this section shall be reported by the facility to a designated agent of the emergency medical services agency that employs or uses the emergency medical services personnel and to the emergency medical services personnel who report the significant exposure. The test results shall be reported without personally identifying information.

Subd. 2. **Report to patient.** The facility that receives the patient shall inform the patient or, if the patient is deceased, the representatives of the deceased person, of test results for all tests conducted under this chapter.

History: *1989 c 154 s 7*

144.768 TEST INFORMATION CONFIDENTIALITY.

Subdivision 1. **Private data.** Information concerning test results obtained under this chapter is, with respect to patients and employees of persons in the private sector, private and

confidential information and, with respect to patients and employees of state agencies, statewide systems, or political subdivisions, private data.

Subd. 2. **Consent to release information.** A facility shall not disclose to emergency medical services personnel personally identifying information about a patient without a written release signed by the patient or a personal representative of the decedent.

History: *1989 c 154 s 8*

144.769 PENALTY FOR UNAUTHORIZED RELEASE OF PATIENT INFORMATION.

Any unauthorized release, by an individual or agency described in section 144.761, subdivision 4 or 5, of personally identifying information under sections 144.761 to 144.7691 is a misdemeanor. This section does not preclude the patient from pursuing remedies and penalties under sections 13.08 and 13.09 or other private causes of action against an individual, state agency, statewide system, political subdivision, or person responsible for releasing private data, or confidential or private information on the patient or employee.

History: *1989 c 154 s 9*

144.7691 DUTIES OF THE COMMISSIONER.

Subdivision 1. **Technical consultation.** The commissioner shall provide technical consultation for:

(1) development of an exposure report form to be used by the facility;

(2) development of a postexposure notification protocol to be adopted by the facility;

(3) training and education of emergency medical services personnel on infectious disease guidelines and protocols for emergency medical services personnel to use to prevent transmission of infectious disease;

(4) development of recommendations for counseling and testing the patient and emergency medical services personnel; and

(5) a mechanism for the facility to notify the patient of the results of the test.

Subd. 2. **Rulemaking authority.** The commissioner may adopt rules to carry out sections 144.761 to 144.7691. The commissioner may by rule add other infectious diseases to section 144.762, subdivision 2, clause (3).

History: *1989 c 154 s 10*

LIFE SUPPORT TRANSPORTATION SERVICES

144.801 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144.801 to 144.8091, the terms defined in this section have the meaning given them.

Subd. 2. **Ambulance.** "Ambulance" means any vehicle designed or intended for and actually used in providing ambulance service to ill or injured persons, or expectant mothers.

Subd. 3. **Board.** "Board" means the emergency medical services regulatory board.

Subd. 4. **Ambulance service.** "Ambulance service" means transportation and treatment which is rendered or offered to be rendered preliminary to or during transportation to, from, or between health care facilities for ill or injured persons, or expectant mothers. The term includes all transportation involving the use of a stretcher, unless the person to be transported is not likely to require ambulance service and medical treatment during the course of transport.

Subd. 5. **License.** "License" means authority granted by the board for the operation of an ambulance service in the state of Minnesota.

Subd. 6. **Licensee.** "Licensee" means a natural person, partnership, association, corporation, or unit of government which possesses an ambulance service license.

Subd. 7. **Base of operations.** "Base of operations" means the address at which the physical plant housing ambulances, related equipment and personnel is located.

Subd. 8. [Repealed, 1987 c 209 s 40]

Subd. 9. **Primary service area.** "Primary service area" means the geographic area that can reasonably be served by an ambulance service.

Subd. 10. **Municipality.** "Municipality" means any city of any class, however organized, and any town.

Subd. 11. **First responder.** "First responder" means an individual who is certified by the commissioner to perform, at a minimum, basic emergency skills before the arrival of a licensed ambulance service, and is:

(1) a member of an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service; or

(2) a member of an organized industrial medical first response team.

History: *1969 c 773 s 1; 1973 c 220 s 1,2; 1977 c 37 s 1; 1977 c 305 s 45; 1979 c 316 s 1; 1Sp1981 c 4 art 1 s 77; 1986 c 420 s 3; 1987 c 209 s 39; 1989 c 134 s 1; 1995 c 207 art 9 s 7,8; 1995 c 234 art 8 s 44*

144.802 LICENSING.

Subdivision 1. **Licenses; contents, changes, and transfers.** No natural person, partnership, association, corporation or unit of government may operate an ambulance service within this state unless it possesses a valid license to do so issued by the board. The license shall specify the base of operations, primary service area, and the type or types of ambulance service for which the licensee is licensed. The licensee shall obtain a new license if it wishes to establish a new base of operation, or to expand its primary service area, or to provide a new type or types of service. A license, or the ownership of a licensed ambulance service, may be transferred only after the approval of the board, based upon a finding that the proposed licensee or proposed new owner of a licensed ambulance service meets or will meet the requirements of section 144.804. If the proposed transfer would result in a change in or addition of a new base of operations, expansion of the service's primary service area, or provision of a new type or types of ambulance service, the board shall require the prospective licensee or owner to comply with subdivision 3. The board may approve the license or ownership transfer prior to completion of the application process described in subdivision 3 upon obtaining written assurances from the proposed licensee or proposed new owner that no change in the service's base of operations, expansion of the service's primary service area, or provision of a new type or types of ambulance service will occur during the processing of the application. The cost of licenses shall be in an amount prescribed by the board pursuant to section 144.122. Licenses shall expire and be renewed as prescribed by the board pursuant to section 144.122. Fees collected shall be deposited to the trunk highway fund.

Subd. 2. **Requirements for new licenses.** The board shall not issue a license authorizing the operation of a new ambulance service, provision of a new type or types of ambulance service by an existing service, or establishment of a new base of operation or an expanded primary service area for an existing service unless the requirements of sections 144.801 to 144.807 are met.

Subd. 3. **Applications; notice of application; recommendations.** (a) Each prospective licensee and each present licensee wishing to offer a new type or types of ambulance service, to establish a new base of operation, or to expand a primary service area, shall make written application for a license to the board on a form provided by the board.

(b) The board shall review the application for completeness, clarity, and content.

(c) For applications for the provision of ambulance services in a service area located within a county, the board shall promptly send notice of the completed application to the county board and to each community health board, governing body of a regional emergency medical services system designated under section 144.8093, ambulance service, and municipality in the area in which ambulance service would be provided by the applicant. The board shall publish the notice, at the applicant's expense, in the State Register and in a newspaper in the municipality in which the base of operation will be located, or if no newspaper is published in the municipality or if the service would be provided in more than one municipality,

in a newspaper published at the county seat of the county in which the service would be provided.

(d) For applications for the provision of ambulance services in a service area larger than a county, the board shall promptly send notice of the completed application to the municipality in which the service's base of operation will be located and to each community health board, county board, governing body of a regional emergency medical services system designated under section 144.8093, and ambulance service located within the counties in which any part of the service area described by the applicant is located, and any contiguous counties. The board shall publish this notice, at the applicant's expense, in the State Register.

(e) Within 30 days of receiving a completed application, the board shall forward the application, along with any recommendations regarding the application, and shall request that the chief administrative law judge appoint an administrative law judge to hold a public hearing in the municipality in which the service's base of operation will be located. The public hearing shall be conducted as contested case hearing under chapter 14.

(f) Each municipality, county, community health board, governing body of a regional emergency medical services system, ambulance service, and other person wishing to make recommendations concerning the disposition of the application shall make written recommendations to the administrative law judge within 30 days of the publication of notice of the application in the State Register.

(g) The administrative law judge shall:

(1) hold a public hearing in the municipality in which the service's base of operations is or will be located;

(2) provide notice of the public hearing in the newspaper or newspapers in which notice was published under paragraph (b) for two successive weeks at least ten days before the date of the hearing;

(3) allow any interested person the opportunity to be heard, to be represented by counsel, and to present oral and written evidence at the public hearing;

(4) provide a transcript of the hearing at the expense of any individual requesting it; and

(5) consider and make part of the public record the recommendations of the board.

(h) The administrative law judge shall review the application and shall forward a decision and order as to its disposition to the board within 90 days of receiving notice of the application. In making the decision, the administrative law judge shall consider and make written comments as to whether the proposed service, change in base of operations, or expansion in primary service area is needed, based on consideration of the following factors:

(1) the relationship of the proposed service, change in base of operations or expansion in primary service area to the current community health plan as approved by the commissioner of health under section 145A.12, subdivision 4;

(2) the recommendations or comments of the governing bodies of the counties, municipalities, and regional emergency medical services system designated under section 144.8093 in which the service would be provided;

(3) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;

(4) the estimated effect of the proposed service, change in base of operation or expansion in primary service area on the public health;

(5) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service, change in base of operations, or expansion in primary service area.

The administrative law judge shall order the board to grant or deny a license or order that a modified license be granted. The reasons for the order shall be set forth in detail. The administrative law judge shall make the order and reasons available to any individual requesting them.

Subd. 3a. **Licensure of air ambulance services.** Except for submission of a written application to the board on a form provided by the board, an application to provide air ambulance service shall be exempt from the provisions of subdivisions 3 and 4.

A license issued pursuant to this subdivision need not designate a primary service area.

No license shall be issued under this subdivision unless the board determines that the applicant complies with the requirements of applicable federal and state statutes and rules governing aviation operations within the state.

Subd. 3b. **Summary approval of primary service areas.** Except for submission of a written application to the board on a form provided by the board, an application to provide changes in a primary service area shall be exempt from subdivisions 3, paragraphs (d) to (g); and 4, if:

(1) the application is for a change of primary service area to improve coverage, to improve coordination with 911 emergency dispatching, or to improve efficiency of operations;

(2) the application requests redefinition of contiguous or overlapping primary service areas;

(3) the application shows approval from the ambulance licensees whose primary service areas are directly affected by a change in the applicant's primary service area;

(4) the application shows that the applicant requested review and comment on the application, and has included those comments received from: all county boards in the areas of coverage included in the application; all community health boards in the areas of coverage included in the application; all directors of 911 public safety answering point areas in the areas of coverage included in the application; and all regional emergency medical systems areas designated under section 144.8093 in the areas of coverage included in the application; and

(5) the application shows consideration of the factors listed in subdivision 3, paragraph (g).

Subd. 4. **Issuance of license.** Within 30 days after receiving the administrative law judge's order, the board shall grant or deny a license to the applicant.

Subd. 5. **Contested cases.** The board's decision made under subdivision 3a or the administrative law judge's decision under subdivision 3 shall be the final administrative decision. Any person aggrieved by the board's decision or action shall be entitled to judicial review in the manner provided in sections 14.63 to 14.69.

Subd. 6. **Temporary license.** Notwithstanding other provisions herein, the board may issue a temporary license for instances in which a primary service area would be deprived of ambulance service. The temporary license shall expire when an applicant has been issued a regular license under this section. The temporary license shall be valid no more than six months from date of issuance. A temporary licensee must provide evidence that the licensee will meet the requirements of section 144.804 and the rules adopted under this section.

History: *1969 c 399 s 1; 1969 c 773 s 2; 1973 c 220 s 3; 1974 c 471 s 7; 1975 c 310 s 8; 1977 c 37 s 2; 1977 c 305 s 45; 1977 c 346 s 8; 1979 c 316 s 2; 1982 c 424 s 130; 1986 c 421 s 1,2; 1987 c 209 s 24,25,39; 1987 c 384 art 2 s 1; 1989 c 134 s 2–5; 1990 c 568 art 2 s 10; 1993 c 76 s 1; 1Sp1993 c 1 art 9 s 22; 1994 c 625 art 8 s 45; 1995 c 207 art 9 s 9*

144.803 LICENSING; SUSPENSION AND REVOCATION.

The board may initiate a contested case hearing upon reasonable notice to suspend, revoke, or refuse to renew the license of a licensee upon finding that the licensee has violated sections 144.801 to 144.808 or has ceased to provide the service for which it is licensed. The decision of the administrative law judge in the contested case hearing shall be the decision of the board.

History: *1969 c 773 s 3; 1977 c 37 s 3; 1977 c 305 s 45; 1979 c 316 s 3; 1995 c 207 art 9 s 10*

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 board according to chapter 14. Until August 1, 1997, 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 success-

fully 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 board 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 board 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 and, until August 1, 1997, to use attendants who have successfully completed the United States Department of Transportation first responder curriculum, and who have been trained to use basic life support equipment as required by rules adopted by the commissioner under subdivision 3, in order to ensure 24–hour emergency ambulance coverage.

Subd. 2. **Equipment and staff.** (a) Every ambulance offering ambulance service shall be equipped as required by the board and carry at least the minimal equipment necessary for the type of service to be provided as determined by standards adopted by the board pursuant to subdivision 3.

(b) Each ambulance service shall offer service 24 hours per day every day of the year, unless otherwise authorized by the board.

(c) Each ambulance while transporting a patient shall be staffed by at least a driver and an attendant, according to subdivision 1. An ambulance service may substitute for the attendant a physician, osteopath, registered nurse, or physician's assistant who is qualified by training to use appropriate equipment in the ambulance. Advanced life support procedures including, but not limited to, intravenous fluid administration, drug administration, endotracheal intubation, cardioversion, defibrillation, and intravenous access may be performed by the physician, osteopath, registered nurse, or physician's assistant who has appropriate training and authorization, and who provides all of the equipment and supplies not normally carried on basic ambulances.

(d) An ambulance service shall not deny emergency ambulance service to any person needing emergency ambulance service because of inability to pay or due to source of payment for services if this need develops within the licensee's primary service area. Transport for such a patient may be limited to the closest appropriate emergency medical facility.

Subd. 3. **Types of services to be regulated.** The board may adopt rules needed to carry out sections 144.801 to 144.8091, including the following types of ambulance service:

(a) basic ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to rules adopted by the board according to chapter 14, and that provides a level of care so as to ensure that life–threatening situations and potentially serious injuries can be recognized, patients will be protected from additional hazards, basic treatment to reduce the seriousness of emergency situations will be administered and patients transported to an appropriate medical facility for treatment;

(b) intermediate ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the board adopts according to chapter 14, and that provides basic ambulance service and intravenous infusions or defibrillation or both. Standards adopted by the commissioner shall include, but not be limited to, equipment, training, procedures, and medical control;

(c) advanced ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the board adopts according to chapter 14, and that provides basic ambulance service, and in addition, advanced airway management, defibrillation, and administration of intravenous fluids and pharmaceuticals. Vehicles of advanced ambulance service licensees not equipped or staffed at the advanced ambulance service level shall not be identified to the public as capable of providing advanced ambulance service.

(d) specialized ambulance service that provides basic, intermediate, or advanced service as designated by the board, and is restricted by the board to (1) less than 24 hours of every day, (2) designated segments of the population, or (3) certain types of medical conditions; and

(e) air ambulance service, that includes fixed–wing and helicopter, and is specialized ambulance service.

Until standards have been developed under clauses (b), (d), and (e), the current provisions of Minnesota Rules shall govern these services.

Subd. 4. [Repealed, 1989 c 134 s 12]

Subd. 5. **Local government's powers.** Local units of government may, with the approval of the board, establish standards for ambulance services which impose additional requirements upon such services. Local units of government intending to impose additional requirements shall consider whether any benefit accruing to the public health would outweigh the costs associated with the additional requirements. Local units of government which desire to impose such additional requirements shall, prior to promulgation of relevant ordinances, rules or regulations, furnish the board with a copy of such proposed ordinances, rules or regulations, along with information which affirmatively substantiates that the proposed ordinances, rules or regulations: will in no way conflict with the relevant rules of the department of health; will establish additional requirements tending to protect the public health; will not diminish public access to ambulance services of acceptable quality; and will not interfere with the orderly development of regional systems of emergency medical care. The board shall base any decision to approve or disapprove such standards upon whether or not the local unit of government in question has affirmatively substantiated that the proposed ordinances, rules or regulations meet these criteria.

Subd. 6. **Rules on primary service areas.** The board shall promulgate rules defining primary service areas under section 144.801, subdivision 8, under which the board shall designate each licensed ambulance service as serving a primary service area or areas.

Subd. 7. **Drivers of ambulances.** An ambulance service vehicle shall be staffed by a driver possessing a current Minnesota driver's license or equivalent and whose driving privileges are not under suspension or revocation by any state. If red lights and siren are used, the driver must also have completed training approved by the board in emergency driving techniques. An ambulance transporting patients must be staffed by at least two persons who are trained according to subdivision 1, or section 144.809, one of whom may be the driver. A third person serving as driver shall be trained according to this subdivision.

History: *1969 c 773 s 4; 1973 c 220 s 4–6; 1976 c 166 s 7; 1976 c 202 s 1; 1977 c 37 s 4; 1977 c 305 s 45; 1979 c 316 s 4; 1982 c 424 s 130; 1986 c 421 s 3,4; 1987 c 209 s 39; 1989 c 134 s 6; 1990 c 568 art 2 s 11,12; 1991 c 199 art 1 s 36; 1995 c 207 art 9 s 11; 1995 c 234 art 8 s 45*

144.805 [Repealed, 1989 c 134 s 12]

144.806 PENALTIES.

Any person who violates a provision of sections 144.801 to 144.806 is guilty of a misdemeanor. The board may issue fines to assure compliance with sections 144.801 to 144.806 and rules adopted under those sections. The board shall adopt rules to implement a schedule of fines by January 1, 1991.

History: *1969 c 773 s 6; 1989 c 134 s 7; 1995 c 207 art 9 s 12*

144.807 REPORTS.

Subdivision 1. **Reporting of information.** Operators of ambulance services licensed pursuant to sections 144.801 to 144.806 shall report information about ambulance service to the board as the board may require. The reports shall be classified as "private data on individuals" under the Minnesota government data practices act, chapter 13.

Subd. 2. **Failure to report.** Failure to report all information required by the board shall constitute grounds for licensure revocation.

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

History: *1974 c 300 s 1; 1977 c 305 s 45; 1979 c 316 s 6; 1987 c 209 s 39; 1989 c 134 s 8; 1995 c 207 art 9 s 13*

144.808 INSPECTIONS.

The board may inspect ambulance services as frequently as deemed necessary. These inspections shall be for the purpose of determining whether the ambulance and equipment is

clean and in proper working order and whether the operator is in compliance with sections 144.801 to 144.804 and any rules that the board adopts related to sections 144.801 to 144.804.

History: *1977 c 37 s 6; 1977 c 305 s 45; 1979 c 316 s 7; 1989 c 134 s 9; 1995 c 207 art 9 s 14*

144.809 RENEWAL OF BASIC EMERGENCY CARE COURSE CERTIFICATE; FEE.

Subdivision 1. **Standards for recertification.** The board shall adopt rules establishing minimum standards for expiration and recertification of basic emergency care course certificates. These standards shall require:

(1) four years after initial certification, and every four years thereafter, formal classroom training and successful completion of a written test and practical examination, both of which must be approved by the board; and

(2) two years after initial certification, and every four years thereafter, in–service continuing education, including knowledge and skill proficiency testing, all of which must be conducted under the supervision of a medical director or medical advisor and approved by the board.

Course requirements under clause (1) shall not exceed 24 hours. Course requirements under clause (2) shall not exceed 36 hours, of which at least 12 hours may consist of course material developed by the medical director or medical advisor.

Individuals may choose to complete, two years after initial certification, and every two years thereafter, formal classroom training and successful completion of a written test and practical examination, both of which are approved by the board, in lieu of completing requirements in clauses (1) and (2).

Subd. 2. **Upgrading to basic emergency care course certificate.** The board shall adopt rules authorizing the equivalence of the following as credit toward successful completion of the board's basic emergency care course:

(1) successful completion of the United States Department of Transportation first responder curriculum;

(2) a minimum of two years of documented continuous service as an ambulance driver, as authorized in section 144.804, subdivision 7;

(3) documented clinical experience obtained through work or volunteer activity as a first responder; and

(4) documented continuing education in emergency care.

Subd. 3. **Limitation on fees.** No fee set by the board for biennial renewal of a basic emergency care course certificate by a volunteer member of an ambulance service, fire department, or police department shall exceed $2.

History: *1977 c 37 s 7; 1977 c 305 s 45; 1979 c 316 s 8; 1987 c 209 s 39; 1989 c 134 s 10; 1990 c 568 art 2 s 13; 1995 c 207 art 9 s 15*

144.8091 REIMBURSEMENT TO NONPROFIT AMBULANCE SERVICES.

Subdivision 1. **Repayment for volunteer training.** Any political subdivision, or nonprofit hospital or nonprofit corporation operating a licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial training of a volunteer ambulance attendant upon successful completion by the attendant of a basic emergency care course, or a continuing education course for basic emergency care, or both, which has been approved by the board, pursuant to section 144.804. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the training course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than $450 for successful completion of a basic course, and $225 for successful completion of a continuing education course.

Subd. 2. **Volunteer attendant defined.** For purposes of this section, "volunteer ambulance attendant" means a person who provides emergency medical services for a Minnesota

licensed ambulance service without the expectation of remuneration and who does not depend in any way upon the provision of these services for the person's livelihood. An individual may be considered a volunteer ambulance attendant even though that individual receives an hourly stipend for each hour of actual service provided, except for hours on standby alert, even though this hourly stipend is regarded as taxable income for purposes of state or federal law, provided that this hourly stipend does not exceed $3,000 within one year of the final certification examination. Reimbursement will be paid under provisions of this section when documentation is provided the board that the individual has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

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

History: *1977 c 305 s 45; 1977 c 427 s 1; 1979 c 316 s 9; 1986 c 444; 1987 c 209 s 39; 1989 c 134 s 11; 1990 c 568 art 2 s 14; 1Sp1993 c 1 art 9 s 23; 1995 c 207 art 9 s 16*

144.8092 [Repealed, 1989 c 134 s 12]

MINNESOTA EMERGENCY MEDICAL SERVICES SYSTEM SUPPORT ACT

144.8093 EMERGENCY MEDICAL SERVICES FUND.

Subdivision 1. **Citation.** This section is the "Minnesota emergency medical services system support act."

Subd. 2. **Establishment and purpose.** In order to develop, maintain, and improve regional emergency medical services systems, the emergency medical services regulatory board shall establish an emergency medical services system fund. The fund shall be used for the general purposes of promoting systematic, cost–effective delivery of emergency medical care throughout the state; identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs; providing discretionary grants for emergency medical service projects with potential regionwide significance; providing for public education about emergency medical care; promoting the exchange of emergency medical care information; ensuring the ongoing coordination of regional emergency medical services systems; and establishing and maintaining training standards to ensure consistent quality of emergency medical services throughout the state.

Subd. 2a. **Definition.** For purposes of this section, "board" means the emergency medical services regulatory board.

Subd. 3. **Use and restrictions.** Designated regional emergency medical services systems may use emergency medical services system funds to support local and regional emergency medical services as determined within the region, with particular emphasis given to supporting and improving emergency trauma and cardiac care and training. No part of a region's share of the fund may be used to directly subsidize any ambulance service operations or rescue service operations or to purchase any vehicles or parts of vehicles for an ambulance service or a rescue service.

Subd. 4. **Distribution.** Money from the fund shall be distributed according to this subdivision. Ninety–three and one–third percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the board. The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also include representatives from emergency medical services organizations. The board shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in the following areas: personnel training, transportation coordination, public safety agency cooperation, communications systems maintenance and development, public involvement, health care facilities involvement, and system management. If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the fund shall be distributed evenly among the regions. If one or more of the regions does not contract for the full amount of its even share or if its proposal is

unsatisfactory, then the board may reallocate the unused funds to the remaining regions on a pro rata basis. Six and two–thirds percent of the fund shall be used by the board to support regionwide reporting systems and to provide other regional administration and technical assistance.

History: *1Sp1985 c 9 art 2 s 13; 1987 c 209 s 39; 1992 c 549 art 5 s 14; 1995 c 207 art 9 s 17; 1996 c 324 s 1*

144.8095 FUNDING FOR THE EMERGENCY MEDICAL SERVICES REGIONS.

The emergency medical services regulatory board shall distribute funds appropriated from the general fund equally among the emergency medical service regions. Each regional board may use this money to reimburse eligible emergency medical services personnel for continuing education costs related to emergency care that are personally incurred and are not reimbursed from other sources. Eligible emergency medical services personnel include, but are not limited to, dispatchers, emergency room physicians, emergency room nurses, first responders, emergency medical technicians, and paramedics.

History: *1990 c 568 art 2 s 15; 1995 c 207 art 9 s 18*

144.8097 [Repealed, 1995 c 207 art 9 s 61 subd 2]

ALCOHOLISM COUNSELOR

144.81 [Repealed, 1973 c 572 s 18]

144.82 [Repealed, 1973 c 572 s 18]

144.83 [Repealed, 1967 c 893 s 5]

144.831 [Repealed, 1973 c 572 s 18]

144.832 [Repealed, 1973 c 572 s 18]

144.833 [Repealed, 1973 c 572 s 18]

144.834 [Repealed, 1973 c 572 s 18]

144.84 CIVIL SERVICE CLASSIFICATION.

The commissioner of employee relations and the civil service commission shall establish a classification to be known as "counselor on alcoholism" the qualifications of which shall give recognition to the value and desirability of recovered alcoholics in performing the duties of their employment.

History: *1953 c 705 s 4; 1973 c 507 s 45; 1980 c 617 s 47*

144.851 [Repealed, 1990 c 533 s 8]

144.852 [Repealed, 1990 c 533 s 8]

144.853 [Repealed, 1990 c 533 s 8]

144.854 [Repealed, 1990 c 533 s 8]

144.856 [Repealed, 1990 c 533 s 8]

144.860 [Repealed, 1990 c 533 s 8]

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

144.862 [Repealed, 1990 c 533 s 8]

144.871 [Repealed, 1995 c 213 art 1 s 13]

144.872 [Repealed, 1995 c 213 art 1 s 13]

144.8721 [Repealed, 1993 c 286 s 34; 1Sp1993 c 1 art 9 s 75]

144.873 [Repealed, 1995 c 213 art 1 s 13]

144.874 [Repealed, 1995 c 213 art 1 s 13]

144.876 [Repealed, 1995 c 213 art 1 s 13]

144.877 Subdivision 1. [Repealed, 1995 c 213 art 1 s 13]
Subd. 2. [Repealed, 1995 c 213 art 1 s 13]
Subd. 3. [Repealed, 1995 c 213 art 1 s 13]
Subd. 4. [Repealed, 1995 c 213 art 1 s 13]
Subd. 5. [Repealed, 1995 c 165 s 17; 1995 c 213 art 1 s 13]
Subd. 6. [Repealed, 1995 c 213 art 1 s 13]
Subd. 7. [Repealed, 1995 c 213 art 1 s 13]

144.8771 [Repealed, 1995 c 213 art 1 s 13]

144.878 [Repealed, 1995 c 213 art 1 s 13]

144.8781 Subdivision 1. [Repealed, 1994 c 567 s 24]
Subd. 2. [Repealed, 1994 c 567 s 24]
Subd. 3. [Repealed, 1994 c 567 s 24]
Subd. 4. [Repealed, 1995 c 165 s 17; 1995 c 213 art 1 s 13]
Subd. 5. [Repealed, 1994 c 567 s 24]
Subd. 6. [Repealed, 1995 c 213 art 1 s 13]

144.8782 [Repealed, 1995 c 213 art 1 s 13]

144.879 [Repealed, 1995 c 213 art 1 s 13]

HUMAN GENETICS

144.91 POWERS AND DUTIES.

The state commissioner of health is authorized to develop and carry on a program in the field of human genetics which shall include the collection and interpretation of data relating to human hereditary diseases and pathologic conditions; the assembly, preparation and dissemination of informational material on the subject for professional counselors and the lay public; the conduct of such research studies as may stimulate reduction in the frequency of manifestation of various deleterious genes, and the provision of counseling services to the public on problems of human genetics. It shall consult and cooperate with the University of Minnesota, the public health service and the children's bureau of the department of health, education and welfare, and with nationally recognized scientific and professional organizations engaged in studying the problems of human genetics.

History: *1959 c 572 s 1; 1977 c 305 s 45*

144.92 GRANTS OR GIFTS.

The board is authorized to receive and expend in accordance with approved plans such funds as may be granted by the public health service or any other federal agency which may appropriate funds for this purpose, or such funds as may be received as gifts from private organizations and individuals to the state for carrying out the purposes of section 144.91.

History: *1959 c 572 s 2; 1Sp1981 c 4 art 1 s 78*

144.93 [Repealed, 1973 c 250 s 2]

144.94 [Repealed, 1987 c 209 s 40]

MOSQUITO RESEARCH PROGRAM

144.95 MOSQUITO RESEARCH PROGRAM.

Subdivision 1. **Research program.** The commissioner of health shall establish and maintain a long–range program of research to study:

(1) the basic biology, distribution, population ecology, and biosystematics of Minnesota mosquitoes;

(2) the impact of mosquitoes on human and animal health and the economy, including such areas as recreation, tourism, and livestock production;

(3) the baseline population and environmental status of organisms other than mosquitoes that may be affected by mosquito management;

(4) the effects of mosquito management strategies on animals and plants that may result in changes in ecology of specific areas;

(5) the development of mosquito management strategies that are effective, practical, and environmentally safe;

(6) the costs and benefits of development of local and regional management and educational programs.

Subd. 2. **Research facility and field stations.** (a) The commissioner of health shall establish and maintain mosquito management research and development facilities, including but not limited to field research stations in the major mosquito ecologic regions and a center for basic mosquito management research and development. The commissioner shall, to the extent possible, contract with the University of Minnesota in establishing, maintaining, and staffing the research facilities.

(b) The commissioner of health shall establish and implement a program of contractual research grants with public and private agencies and individuals in order to:

(1) undertake supplemental research studies on basic mosquito biology, physiology, and life cycle history beyond those described in subdivision 1;

(2) undertake research into the effects of mosquitoes on human health, including vector–borne diseases, and on animal health, including agricultural and wildlife effects;

(3) undertake studies of other economic factors including tourism and recreation;

(4) collect and analyze baseline data on the ecology and distribution of organisms other than mosquitoes that may be affected as a result of mosquito management strategies;

(5) develop new, effective, practical, and biologically compatible control methods and materials;

(6) conduct additional monitoring of the environmental effects of mosquito control methods and materials;

(7) undertake demonstration, training, and education programs for development of local and regional mosquito management programs.

Subd. 3. **Conduct research trials.** The commissioner of health may develop and conduct research trials of mosquito management methods and materials. Trials may be conducted, with the agreement of the public or private landholder, wherever and whenever the commissioner considers necessary to provide accurate data for determining the efficacy of a method or material in controlling mosquitoes.

Subd. 4. **Research trials.** Research trials of mosquito management methods and materials are subject to the following laws and rules unless a specific written exemption, license, or waiver is granted; sections 84.0895, 103G.615, 97A.045, subdivision 1, 103A.201, 103G.255, and 103G.275 to 103G.285; and Minnesota Rules, chapters 1505, 6115, 6120, 6134, and 6140.

Subd. 5. **General authority.** (a) To carry out subdivisions 1 to 4, the commissioner of health may:

(1) accept money, property, or services from any source;

(2) receive and hold lands;

(3) accept gifts;

(4) cooperate with city, state, federal, or private agencies whose research on mosquito control or on other environmental matters may be affected by the commissioner's mosquito management and research activities; and

(5) enter into contracts with any public or private entity.

(b) The contracts must specify the duties performed, services provided, and the amount and method of reimbursement for them. Money collected by the commissioner under con-

tracts made under this subdivision is appropriated to the commissioner for the purposes specified in the contracts. Contractual agreements must be processed under section 16B.17.

Subd. 6. **Authority to enter property.** The commissioner of health, officers, employees, or agents may, with express permission of the owner, enter upon any property at reasonable times to:

(1) determine whether mosquito breeding exists;

(2) examine, count, study, or collect laboratory samples to determine the property's geographic, geologic, and biologic characteristics; or

(3) study and collect laboratory samples to determine the effect on animals and vegetation of an insecticide, herbicide, or other method used to control mosquitoes.

Subd. 7. **Research plots.** The commissioner of health may lease and maintain experimental plots of land for mosquito research. The commissioner of health shall determine the locations of the experimental plots and may enter into agreements with any public or private agency or individual to lease the land. The commissioners of agriculture, natural resources, transportation, and iron range resources and rehabilitation shall cooperate with the commissioner of health.

Subd. 8. **Emergencies.** The commissioner may suspend or revoke a contract, agreement, or delegated authority granted in this section at any time and without prior notice if an emergency, accident, or hazard threatens the public health.

Subd. 9. **Commissioner required to report.** Each year, the commissioner shall report to the legislature on basic mosquito research findings and progress toward cost–effective, environmentally sound mosquito management methods and materials. The report must recommend future research and management activities.

Subd. 10. **Contingency.** This section is effective only if the tax on cigarettes imposed by United States Code, title 26, section 5701, as amended, is reduced after June 1, 1985, or if other public or private funds sufficient to fund the program are made available to the commissioner for the purposes of this program.

History: *1Sp1985 c 14 art 19 s 17; 1987 c 149 art 2 s 10; 1987 c 312 art 1 s 26 subd 2; 1990 c 391 art 8 s 29; art 10 s 3; 1993 c 163 art 1 s 25*

CHILDHOOD LEAD POISONING ACT

144.9501 DEFINITIONS.

Subdivision 1. **Citation.** Sections 144.9501 to 144.9509 may be cited as the "childhood lead poisoning act."

Subd. 2. **Applicability.** The definitions in this section apply to sections 144.9501 to 144.9509.

Subd. 3. **Abatement.** (a) "Abatement" means any set of measures designed to permanently eliminate lead–based paint hazards, defined in United States Code, title 42, section 4851, of the federal Housing and Community Development Act of 1992, and that exceed the standards adopted under section 144.9508. Abatement includes:

(1) the removal of lead–based paint and lead–contaminated dust, the permanent containment or encapsulation of lead–based paint, the replacement of lead–painted surfaces or fixtures, and the removal or covering of lead–contaminated soil; and

(2) all preparation, cleanup, disposal, and postabatement clearance testing activities associated with these measures.

(b) Abatement does not include:

(1) activities such as remodeling, renovation, installation, rehabilitation, or landscaping activities whose primary intent is to remodel, repair, or restore a given structure or dwelling, rather than to permanently eliminate lead–based paint hazards, even though these activities may incidentally result in a reduction in lead–based paint hazards; and

(2) interim controls for the temporary reduction of exposure to lead hazards such as lead–specific cleaning, repairs, maintenance, painting, and temporary containment.

Subd. 4. **Areas at high risk for toxic lead exposure.** "Areas at high risk for toxic lead exposure" means a census tract which meets one or more of the following criteria:

(1) elevated blood lead levels have been diagnosed in a population of children or pregnant females;

(2) many residential structures that are known to have or suspected of having deteriorated lead–based paint; or

(3) median soil lead concentrations are greater than 100 parts per million for samples collected according to rules adopted under section 144.9508.

Subd. 5. **Bare soil.** "Bare soil" means any visible soil that is at least an area of 36 contiguous square inches.

Subd. 6. **Board of health.** "Board of health" means an administrative authority established under section 145A.03.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of the Minnesota department of health.

Subd. 8. **Deteriorated paint.** "Deteriorated paint" means paint that is chipped, peeled, or otherwise separated from its substrate or that is attached to damaged substrate.

Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic blood lead test with a result that is equal to or greater than ten micrograms of lead per deciliter of whole blood in any person, unless the commissioner finds that a lower concentration is necessary to protect public health.

Subd. 10. **Encapsulation.** "Encapsulation" means covering a surface coated with paint that exceeds the standards under section 144.9508 with a liquid or solid material, approved by the commissioner, that adheres to the surface, rather than mechanically attaches to it; or covering bare soil that exceeds the standards under section 144.9508 with a permeable material such as vegetation, mulch, or soil that meets the standards under section 144.9508.

Subd. 11. **Enclosure.** "Enclosure" means covering a surface coated with paint that exceeds the standards under section 144.9508 by mechanically fastening to the surface a durable, solid material approved by the commissioner; or covering bare soil that exceeds the standards under section 144.9508 with an impermeable material, such as asphalt or concrete.

Subd. 12. **Inspecting agency.** "Inspecting agency" means the commissioner or a board of health.

Subd. 13. **Intact paint.** "Intact paint" means paint that is not chipped, peeled, or otherwise separated from its substrate or attached to damaged substrate. Painted surfaces which may generate dust but are not chipped, peeled, or otherwise separated from their substrate or attached to damaged substrate are considered to be intact paint.

Subd. 14. **Lead contractor.** "Lead contractor" means any person who is licensed by the commissioner under section 144.9505.

Subd. 15. **Lead hazard.** "Lead hazard" means a condition that causes exposure to lead from dust, bare soil, drinking water, or deteriorated paint that exceeds the standards adopted under section 144.9508.

Subd. 16. **Lead hazard management.** "Lead hazard management" means a process by which a residence is made lead–safe through the use of lead–safe directives provided for under section 144.9503.

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means action undertaken in response to a lead order to make a residence, child care facility, school, or playground lead–safe by complying with the lead standards and methods adopted under section 144.9508, by:

(1) a property owner or lead contractor complying with a lead order issued under section 144.9504; or

(2) a swab team service provided in response to a lead order issued under section 144.9504.

Subd. 18. **Lead inspection.** "Lead inspection" means a qualitative or quantitative analytical inspection of a residence for deteriorated paint or bare soil and the collection of samples of deteriorated paint, bare soil, dust, or drinking water for analysis to determine if the

lead concentrations in the samples exceed standards adopted under section 144.9508. Lead inspection includes the clearance inspection after the completion of a lead order.

Subd. 19. **Lead inspector.** "Lead inspector" means a person who is licensed by the commissioner to perform a lead inspection under section 144.9506.

Subd. 20. **Lead order.** "Lead order" means a legal instrument to compel a property owner to engage in lead hazard reduction according to the specifications given by the inspecting agency.

Subd. 21. **Lead–safe.** "Lead–safe" means a condition in which lead may be present at the residence, child care facility, school, or playground, if the lead concentration in the dust, paint, soil, and water of a residence does not exceed the standards adopted under section 144.9508, or, if the lead concentrations in the paint or soil do exceed the standards, the paint is intact and the soil is not bare.

Subd. 22. **Lead–safe directives.** "Lead–safe directives" means methods for construction, renovation, remodeling, or maintenance activities that are not regulated as abatement or lead hazard reduction and that are performed so that they do not:

(1) violate the standards under section 144.9508;

(2) create lead dust through the use of prohibited practices;

(3) leave debris or a lead residue that can form a dust;

(4) provide a readily accessible source of lead dust, lead paint, lead paint chips, or lead contaminated soil, after the use of containment methods; and

(5) result in improper disposal of lead contaminated debris, dust, or soil.

Subd. 23. **Lead worker.** "Lead worker" means any person who is certified by the commissioner under section 144.9505.

Subd. 24. **Person.** "Person" has the meaning given in section 326.71, subdivision 8.

Subd. 25. **Persons at high risk for elevated blood lead level.** "Persons at high risk for elevated blood lead level" means:

(1) a child between six and 72 months of age:

(a) who lives in or visits, at least weekly, a residence, child care facility, or school built before 1978 which has peeling or chipping paint, ongoing remodeling or renovation, or bare soil; or

(b) who has a sibling, housemate, or playmate who has been diagnosed with an elevated blood lead level in the last 12 months; and

(2) a pregnant female or a child between six and 72 months of age:

(a) who lives in a census tract found to have a median foundation soil lead value exceeding 100 parts per million of lead;

(b) who lives near an industrial point source that emits lead;

(c) who lives near a road with an average daily traffic which exceeded 5,000 vehicles per day in 1986 or earlier; or

(d) who lives with a person whose occupation or hobby involves exposure to lead.

Subd. 26. **Primary prevention.** "Primary prevention" means preventing toxic lead exposure before blood levels become elevated.

Subd. 27. **Safe housing.** "Safe housing" means a residence that is lead–safe.

Subd. 28. **Secondary prevention.** "Secondary prevention" means intervention to mitigate health effects on people with elevated blood lead levels.

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

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

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

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

(4) health education;

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

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

Subd. 30. **Swab team worker.** "Swab team worker" means a person who is certified under section 144.9505.

Subd. 31. **Venous blood sample.** "Venous blood sample" means a quantity of blood drawn from a vein.

Subd. 32. **Voluntary lead hazard reduction.** "Voluntary lead hazard reduction" means action undertaken by a property owner with the intention to engage in lead hazard reduction or abatement, but not in response to the issuance of a lead order.

History: *1995 c 213 art 1 s 3*

144.9502 LEAD SURVEILLANCE AND THE OCCURRENCE OF LEAD IN THE ENVIRONMENT.

Subdivision 1. **Surveillance.** The commissioner of health shall establish a statewide lead surveillance system. The purpose of this system is to:

(a) monitor blood lead levels in children and adults to identify trends and populations at high risk for elevated blood lead levels;

(b) ensure that screening services are provided to populations at high risk for elevated blood lead levels;

(c) ensure that medical and environmental follow–up services for children with elevated blood lead levels are provided; and

(d) provide accurate and complete data for planning and implementing primary prevention programs that focus on the populations at high risk for elevated blood lead levels.

Subd. 2. **Studies and surveys.** The commissioner of health shall collect blood lead level and exposure information, analyze the information, and conduct studies designed to determine the potential for high risk for elevated blood lead levels among children and adults.

Subd. 3. **Reports of blood lead analysis required.** Every hospital, medical clinic, medical laboratory, or other facility performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission, with written or electronic confirmation within one month, for a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission, for a capillary or venous blood lead level less than 15 micrograms of lead per deciliter of whole blood.

The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

The reporting requirements of this subdivision shall expire on December 31, 1997. Beginning January 1, 1998, every hospital, medical clinic, medical laboratory, or other facility performing blood lead analysis shall report the results within two working days by telephone, fax, or electronic transmission, with written or electronic confirmation within one month, for capillary or venous blood lead level equal to the level for which reporting is recommended by the Center for Disease Control.

Subd. 4. **Blood lead analyses and epidemiologic information.** The blood lead analysis reports required in this section must specify:

(1) whether the specimen was collected as a capillary or venous sample;

(2) the date the sample was collected;

(3) the results of the blood lead analysis;

(4) the date the sample was analyzed;

(5) the method of analysis used;

(6) the full name, address, and phone number of the laboratory performing the analysis;

(7) the full name, address, and phone number of the physician or facility requesting the analysis;

(8) the full name, address, and phone number of the person with the elevated blood lead level, and the person's birthdate, gender, and race.

Subd. 5. **Follow–up epidemiologic information.** The follow–up epidemiologic information required in this section must specify:

(1) the name, address, and phone number of the agency or individual contacted to investigate the environment of the person with the elevated blood lead level to determine the sources of lead exposure; and

(2) the name, address, and phone number of all agencies or individuals to whom the person or the person's guardian was referred for education about the sources, effects, and prevention of lead exposure.

Subd. 6. **Paint, soil, dust, and drinking water lead analysis.** Every laboratory or other institution performing lead analysis on paint, soil, dust, or drinking water shall report the results to the commissioner of each specimen analysis and epidemiologic information required in this section. The paint, soil, dust, and drinking water analysis report must specify:

(1) the date the sample was collected;

(2) the type of sample tested;

(3) the results of the lead sample analysis;

(4) the method of analysis used;

(5) the date the sample was analyzed;

(6) the full name, address, and phone number of the laboratory performing the analysis;

(7) the full name, address, and phone number of the individual or agency requesting the analysis; and

(8) the address of the property and the owner of the property where the sample was collected.

Subd. 7. **Reporting without liability.** The furnishing of the information required under this section shall not subject the person, laboratory, or other facility furnishing the information to any action for damages or relief.

Subd. 8. **Laboratory standards.** (a) A laboratory performing blood lead analysis shall use methods that:

(1) meet or exceed the proficiency standards established in the federal Clinical Laboratory Improvement Regulations, Code of Federal Regulations, title 42, section 493, promulgated in accordance with the Clinical Laboratory Improvement Act amendments of 1988, Public Law Number 100–578; or

(2) meet or exceed the Occupational Safety and Health Standards for Lead in General Industries, Code of Federal Regulations, section 1910.1025, and Occupational Safety and Health Standards for Lead in Construction, Code of Federal Regulations, section 1926.62.

(b) A laboratory performing lead analysis of paint, soil, dust, or drinking water shall use methods that meet or exceed the proficiency standards established in the National Lead Accreditation Program pursuant to United States Code, title 42, section 4851, of the federal Housing and Community Development Act.

Subd. 9. **Classification of data.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected by the commissioner of health about persons with elevated blood lead levels, including analytic results from samples of paint, soil, dust, and drinking water taken from the individual's home and immediate property, shall be private and may only be used by the commissioner of health and authorized employees of local boards of health for the purposes set forth in this section.

History: *1995 c 213 art 1 s 4*

144.9503 PRIMARY PREVENTION.

Subdivision 1. **Primary prevention program.** The commissioner shall develop a primary prevention program to reduce lead exposure in young children and pregnant women.

The commissioner shall develop a priority list for high risk census tracts, provide primary prevention lead education, promote primary prevention swab team services in cooperation with the commissioner of economic security or housing finance, provide lead cleanup equipment and material grants, monitor voluntary lead hazard reduction or abatement, and develop lead–safe directives in cooperation with the commissioner of administration.

Subd. 2. **Priorities for primary prevention.** The commissioner of health shall publish in the State Register a priority list of census tracts at high risk for toxic lead exposure. All local governmental units and boards of health shall follow the priorities published in the State Register. In establishing the list, the commissioner shall use the surveillance data collected under section 144.9502 and other information as appropriate or specified in this section and shall award points to each census tract on which information is available. The priority for primary prevention in census tracts at high risk for toxic lead exposure shall be based on the cumulative points awarded to each census tract. A greater number of points means a higher priority. If a tie occurs in the number of points, priority shall be given to the census tract with the higher percentage of population with blood lead levels greater than ten micrograms of lead per deciliter of whole blood. The commissioner shall revise and update the priority list at least every five years. Points shall be awarded as specified in paragraphs (a) to (c).

(a) In a census tract where at least 20 children have been screened in the last five years, one point shall be awarded for each ten percent of children who were under six years old at the time they were screened for lead in blood and whose blood lead level exceeds ten micrograms of lead per deciliter of whole blood. An additional point shall be awarded if one percent of the children had blood lead levels greater than 20 micrograms of lead per deciliter of blood. Two points shall be awarded to a census tract, where the blood lead screening has been inadequate, that is contiguous with a census tract where more than ten percent of the children under six years of age have blood lead levels exceeding ten micrograms of lead per deciliter of whole blood.

(b) One point shall be awarded for every five percent of housing that is defined as dilapidated or deteriorated by the planning department or similar agency of the city in which the housing is located. Where data is available by neighborhood or section within a city, the percent of dilapidated or deteriorated housing shall apply equally to each census tract within the neighborhood or section.

(c) One point shall be awarded for every 100 parts per million of lead soil, based on the median soil lead values of foundation soil samples, calculated on 100 parts per million intervals, or fraction thereof. For the cities of St. Paul and Minneapolis, the commissioner shall use the June 1988 census tract version of the houseside map titled "Distribution of Houseside Lead Content of Soil–Dust in the Twin Cities," prepared by the Center for Urban and Regional Affairs, Humphrey Institute, University of Minnesota, Publication 1989, Center for Urban and Regional Affairs 89–4. Where the map displays a census tract that is crossed by two or more intervals, the commissioner shall make a reasoned determination of the median foundation soil lead value for that census tract. Values for census tracts may be updated by surveying the census tract according to the procedures adopted under this section.

Subd. 3. **Primary prevention lead education strategy.** The commissioner of health shall develop a primary prevention lead education strategy to prevent lead exposure. The strategy shall specify:

(1) the development of lead education materials that describe the health effects of lead exposure, safety measures, and methods to be used in the lead hazard reduction process;

(2) the provision of lead education materials to the general public;

(3) the provision of lead education materials to property owners, landlords, and tenants by swab team workers and public health professionals, such as nurses, sanitarians, health educators, other public health professionals in areas at high risk for toxic lead exposure; and

(4) the promotion of awareness of community, legal, and housing resources.

Subd. 4. **Swab team services.** Primary prevention must include the use of swab team services in census tracts identified at high risk for toxic lead exposure as identified by the commissioner under this section. The swab team services may be provided based on visual

inspections whenever possible and must at least include lead hazard management for deteriorated interior lead–based paint, bare soil, and dust.

Subd. 5. **Lead cleanup equipment and material grants.** (a) Nonprofit community–based organizations in areas at high risk for toxic lead exposure, as determined by the commissioner under this section, may apply for grants from the commissioner to purchase lead cleanup equipment and materials and to pay for training for staff and volunteers for lead certification.

(b) For the purposes of this section, lead cleanup equipment and materials means high efficiency particle accumulator (HEPA) and wet vacuum cleaners, wash water filters, mops, buckets, hoses, sponges, protective clothing, drop cloths, wet scraping equipment, secure containers, dust and particle containment material, and other cleanup and containment materials to remove loose paint and plaster, patch plaster, control household dust, wax floors, clean carpets and sidewalks, and cover bare soil.

(c) The grantee's staff and volunteers may make lead cleanup equipment and materials available to residents and property owners and instruct them on the proper use of the equipment. Lead cleanup equipment and materials must be made available to low–income households, as defined by federal guidelines, on a priority basis at no fee, and other households on a sliding fee scale.

(d) The grantee shall not charge a fee for services performed using the equipment or materials.

Subd. 6. **Voluntary lead hazard reduction.** The commissioner shall monitor the lead hazard reduction methods adopted under section 144.9508 in cases of voluntary lead hazard reduction. All contractors hired to do voluntary lead hazard reduction must be licensed lead contractors. If a property owner does not use a lead contractor for voluntary lead hazard reduction, the property owner shall provide the commissioner with a plan for lead hazard reduction at least ten working days before beginning the lead hazard reduction. The plan must include the details required in section 144.9505, and notice as to when lead hazard reduction activities will begin. Within the limits of appropriations, the commissioner shall review plans and shall approve or disapprove them as to compliance with the requirements in section 144.9505. No penalty shall be assessed against a property owner for discontinuing voluntary lead hazard reduction before completion of the plan, provided that the property owner discontinues the plan in a manner that leaves the property in a condition no more hazardous than its condition before the plan implementation.

Subd. 7. **Lead–safe directives.** By July 1, 1995, and amended and updated as necessary, the commissioner shall develop in cooperation with the commissioner of administration provisions and procedures to define lead–safe directives for residential remodeling, renovation, installation, and rehabilitation activities that are not lead hazard reduction, but may disrupt lead–based paint surfaces. The provisions and procedures shall define lead–safe directives for nonlead hazard reduction activities including preparation, cleanup, and disposal procedures. The directives shall be based on the different levels and types of work involved and the potential for lead hazards. The directives shall address activities including painting; remodeling; weatherization; installation of cable, wire, plumbing, and gas; and replacement of doors and windows. The commissioners of health and administration shall consult with representatives of builders, weatherization providers, nonprofit rehabilitation organizations, each of the affected trades, and housing and redevelopment authorities in developing the directives and procedures. This group shall also make recommendations for consumer and contractor education and training. The commissioner of health shall report to the legislature by February 15, 1996, regarding development of the provisions required under this subdivision.

Subd. 8. **Certification for lead–safe housing.** The commissioner shall propose to the legislature a program to certify residences as lead safe by February 15, 1997.

Subd. 9. **Landlord tenant study.** Within the limits of appropriations, the commissioner of health shall contract for a study of the legal responsibilities of tenants and landlords in the prevention of lead hazards, and shall report the findings to the legislature, along with recommendations as to any changes needed to clarify or modify current law. In conducting the study, the commissioner shall convene any public meetings necessary to hear the testimony

and recommendations of interested parties, and shall invite and consider written public comments.

History: *1995 c 213 art 1 s 5; 1996 c 451 art 4 s 14–16*

144.9504 SECONDARY PREVENTION.

Subdivision 1. **Jurisdiction.** (a) A board of health serving cities of the first class must conduct lead inspections for purposes of secondary prevention, according to the provisions of this section. A board of health not serving cities of the first class must conduct lead inspections for the purposes of secondary prevention, unless they certify in writing to the commissioner by January 1, 1996, that they desire to relinquish these duties back to the commissioner. At the discretion of the commissioner, a board of health may, upon written request to the commissioner, resume these duties.

(b) Inspections must be conducted by a board of health serving a city of the first class. The commissioner must conduct lead inspections in any area not including cities of the first class where a board of health has relinquished to the commissioner the responsibility for lead inspections. The commissioner shall coordinate with the board of health to ensure that the requirements of this section are met.

(c) The commissioner may assist boards of health by providing technical expertise, equipment, and personnel to boards of health. The commissioner may provide laboratory or field lead–testing equipment to a board of health or may reimburse a board of health for direct costs associated with lead inspections.

(d) The commissioner shall enforce the rules under section 144.9508 in cases of voluntary lead hazard reduction.

Subd. 2. **Lead inspection.** (a) An inspecting agency shall conduct a lead inspection of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

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

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

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

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

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

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

(d) Within the limits of appropriations, the inspecting agency shall identify the known addresses for the previous 12 months of the child or pregnant female with elevated blood lead levels; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them a copy of the lead inspection guide. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The inspecting agency shall conduct the lead inspection according to rules adopted by the commissioner under section 144.9508. An inspecting agency shall have lead inspections performed by lead inspectors licensed by the commissioner according to rules adopted

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

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

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

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

Subd. 3. **Lead education strategy.** At the time of a lead inspection or following a lead order, the inspecting agency shall ensure that a family will receive a visit at their residence by a swab team worker or public health professional, such as a nurse, sanitarian, public health educator, or other public health professional. The swab team worker or public health professional shall inform the property owner, landlord, and the tenant of the health–related aspects of lead exposure; nutrition; safety measures to minimize exposure; methods to be followed before, during, and after the lead hazard reduction process; and community, legal, and housing resources. If a family moves to a temporary residence during the lead hazard reduction process, lead education services should be provided at the temporary residence whenever feasible.

Subd. 4. **Lead inspection guides.** (a) The commissioner of health shall develop or purchase lead inspection guides that enable parents and other caregivers to assess the possible lead sources present and that suggest lead hazard reduction actions. The guide must provide information on lead hazard reduction and disposal methods, sources of equipment, and telephone numbers for additional information to enable the persons to either select a lead contractor or perform the lead hazard reduction. The guides must explain:

(1) the requirements of this section and rules adopted under section 144.9508;

(2) information on the administrative appeal procedures required under this section;

(3) summary information on lead–safe directives;

(4) be understandable at an eighth grade reading level; and

(5) be translated for use by non–English–speaking persons.

(b) An inspecting agency shall provide the lead inspection guides at no cost to:

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

(2) all property owners who are issued housing code or lead orders requiring lead hazard reduction of lead sources and all occupants of those properties; and

(3) occupants of residences adjacent to the inspected property.

(c) An inspecting agency shall provide the lead inspection guides on request to owners or occupants of residential property, builders, contractors, inspectors, and the public within the jurisdiction of the inspecting agency.

Subd. 5. **Lead orders.** An inspecting agency, after conducting a lead inspection, shall order a property owner to perform lead hazard reduction on all lead sources that exceed a standard adopted according to section 144.9508. If lead inspections and lead orders are conducted at times when weather or soil conditions do not permit the lead inspection or lead hazard reduction, external surfaces and soil lead shall be inspected, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow. If the paint standard under section 144.9508 is violated, but the paint is intact, the inspecting agency shall not order the paint to be removed unless the intact paint is a known source of actual lead

exposure to a specific person. Before the inspecting agency may order the intact paint to be removed, a reasonable effort must be made to protect the child and preserve the intact paint by the use of guards or other protective devices and methods. Whenever windows and doors or other components covered with deteriorated lead–based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping or be planed down to remove deteriorated lead–based paint or covered with protective guards instead of being replaced, provided that such an activity is the least cost method. Lead orders must require that any source of damage, such as leaking roofs, plumbing, and windows, be repaired or replaced, as needed, to prevent damage to lead–containing interior surfaces. The inspecting agency is not required to pay for lead hazard reduction. Lead orders must be issued within 30 days of receiving the blood lead level analysis. The inspecting agency shall enforce the lead orders issued to a property owner under this section. A copy of the lead order must be forwarded to the commissioner.

Subd. 6. **Swab team services.** After a lead inspection or after issuing lead orders, the inspecting agency, within the limits of appropriations and availability, shall offer the property owner the services of a swab team free of charge and, if accepted, shall send a swab team within ten working days to the residence to perform swab team services as defined in section 144.9501. If the inspecting agency provides swab team services after a lead inspection, but before the issuance of a lead order, swab team services do not need to be repeated after the issuance of the lead order if the swab team services fulfilled the lead order. Swab team services are not considered completed until the clearance inspection required under this section shows that the property is lead safe.

Subd. 7. **Relocation of residents.** (a) Within the limits of appropriations, the inspecting agency shall ensure that residents are relocated from rooms or dwellings during a lead hazard reduction process that generates leaded dust, such as removal or disruption of lead–based paint or plaster that contains lead. Residents shall not remain in rooms or dwellings where the lead hazard reduction process is occurring. An inspecting agency is not required to pay for relocation unless state or federal funding is available for this purpose. The inspecting agency shall make an effort to assist the resident in locating resources that will provide assistance with relocation costs. Residents shall be allowed to return to the residence or dwelling after completion of the lead hazard reduction process. An inspecting agency shall use grant funds under section 144.9507 if available, in cooperation with local housing agencies, to pay for moving costs and rent for a temporary residence for any low–income resident temporarily relocated during lead hazard reduction. For purposes of this section, "low–income resident" means any resident whose gross household income is at or below 185 percent of federal poverty level.

(b) A resident of rental property who is notified by an inspecting agency to vacate the premises during lead hazard reduction, notwithstanding any rental agreement or lease provisions:

(1) shall not be required to pay rent due the landlord for the period of time the tenant vacates the premises due to lead hazard reduction;

(2) may elect to immediately terminate the tenancy effective on the date the tenant vacates the premises due to lead hazard reduction; and

(3) shall not, if the tenancy is terminated, be liable for any further rent or other charges due under the terms of the tenancy.

(c) A landlord of rental property whose tenants vacate the premises during lead hazard reduction shall:

(1) allow a tenant to return to the dwelling unit after lead hazard reduction and clearance inspection, required under this section, is completed, unless the tenant has elected to terminate the tenancy as provided for in paragraph (b); and

(2) return any security deposit due under section 504.20 within five days of the date the tenant vacates the unit, to any tenant who terminates tenancy as provided for in paragraph (b).

Subd. 8. **Property owner responsibility.** Property owners shall comply with lead orders issued under this section within 60 days or be subject to enforcement actions as provided under section 144.9509. For orders or portions of orders concerning external lead hazards, property owners shall comply within 60 days, or as soon thereafter as weather permits. If the

property owner does not use a lead contractor for compliance with the lead orders, the property owner shall submit a plan to the inspecting agency within 30 days after receiving the orders. The plan must include the details required in section 144.9505 as to how the property owner intends to comply with the lead orders and notice as to when lead hazard reduction activities will begin. Within the limits of appropriations, the commissioner shall review plans and shall approve or disapprove them as to compliance with the requirements in section 144.9505, subdivision 5.

Subd. 9. **Clearance inspection.** After completion of swab team services and compliance with the lead orders by the property owner, including any repairs ordered by a local housing or building inspector, the inspecting agency shall conduct a clearance inspection by visually inspecting the residence for deteriorated paint and bare soil and retest the dust lead concentration in the residence to assure that violations of the lead standards under section 144.9508 no longer exist. The inspecting agency is not required to test a dwelling unit after lead hazard reduction that was not ordered by the inspecting agency.

Subd. 10. **Case closure.** A lead inspection is completed and the responsibility of the inspecting agency ends when all of the following conditions are met:

(1) lead orders are written on all known sources of violations of lead standards under section 144.9508;

(2) compliance with all lead orders has been completed; and

(3) clearance inspections demonstrate that no deteriorated lead paint, bare soil, or lead dust levels exist that exceed the standards adopted under section 144.9508.

Subd. 11. **Local ordinances.** No unit of local government shall have an ordinance, regulation, or practice which requires property owners to comply with any lead hazard reduction order in a period of time shorter than the period established for compliance with lead orders under this section.

History: *1995 c 213 art 1 s 6; 1996 c 451 art 4 s 17–19*

144.9505 LICENSING OF LEAD CONTRACTORS AND CERTIFICATION OF WORKERS.

Subdivision 1. **Licensing and certification.** (a) Lead contractors shall, before performing abatement or lead hazard reduction, obtain a license from the commissioner. Workers for lead contractors shall obtain certification from the commissioner. The commissioner shall specify training and testing requirements for licensure and certification as required in section 144.9508 and shall charge a fee for the cost of issuing a license or certificate and for training provided by the commissioner. Fees collected under this section shall be set in amounts to be determined by the commissioner to cover but not exceed the costs of adopting rules under section 144.9508, the costs of licensure, certification, and training, and the costs of enforcing licenses and certificates under this section. All fees received shall be paid into the state treasury and credited to the lead abatement licensing and certification account and are appropriated to the commissioner to cover costs incurred under this section and section 144.9508.

(b) Contractors shall not advertise or otherwise present themselves as lead contractors unless they have lead contractor licenses issued by the department of health.

Subd. 2. **Lead training.** Lead abatement and lead hazard reduction training must include a hands–on component and instruction on the health effects of lead exposure, the use of personal protective equipment, workplace hazards and safety problems, lead abatement and lead hazard reduction methods, lead–safe directives, decontamination procedures, cleanup and waste disposal procedures, lead monitoring and testing methods, swab team services, and legal rights and responsibilities.

Subd. 3. **Licensed building contractor; information.** The commissioner shall provide health and safety information on lead abatement and lead hazard reduction to all residential building contractors licensed under section 326.84. The information must include the lead–safe directives and any other materials describing ways to protect the health and safety of both workers and residents.

Subd. 4. **Notice of lead abatement or lead hazard reduction work.** (a) At least five working days before starting work at each lead abatement or lead hazard reduction worksite,

the person performing the lead abatement or lead hazard reduction work shall give written notice and an approved work plan as required in this section to the commissioner and the appropriate board of health. Within the limits of appropriations, the commissioner shall review plans and shall approve or disapprove them as to compliance with the requirements in subdivision 5.

(b) This provision does not apply to swab team workers performing work under an order of an inspecting agency.

Subd. 5. **Abatement or lead hazard reduction plans.** (a) A lead contractor shall present a lead abatement or lead hazard reduction work plan to the property owner with each bid or estimate for lead abatement or lead hazard reduction work. The plan does not replace or supersede more stringent contractual agreements. A written lead abatement or lead hazard reduction plan must be prepared which describes the equipment and procedures to be used throughout the lead abatement or lead hazard reduction work project. At a minimum, the plan must describe:

(1) the building area and building components to be worked on;

(2) the amount of lead–containing material to be removed, encapsulated, or enclosed;

(3) the schedule to be followed for each work stage;

(4) the workers' personal protection equipment and clothing;

(5) the dust suppression and debris containment methods;

(6) the lead abatement or lead hazard reduction methods to be used on each building component;

(7) cleaning methods;

(8) temporary, on–site waste storage, if any; and

(9) the methods for transporting waste material and its destination.

(b) A lead contractor shall itemize the costs for each item listed in paragraph (a) and for any other expenses associated with the lead abatement or lead hazard reduction work and shall present these costs to the property owner with any bid or estimate for lead abatement or lead hazard reduction work.

(c) A lead contractor shall keep a copy of the plan readily available at the worksite for the duration of the project and present it to the inspecting agency on demand.

(d) A lead contractor shall keep a copy of the plan on record for one year after completion of the project and shall present it to the inspecting agency on demand.

(e) This provision does not apply to swab team workers performing work under an order of an inspecting agency or providing services at no cost to a property owner with funding under a state or federal grant.

History: *1995 c 213 art 1 s 7; 1996 c 451 art 4 s 20*

144.9506 LICENSING OF LEAD INSPECTORS.

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

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

Subd. 2. **License application.** An application for a license or license renewal shall be on a form provided by the commissioner and shall include:

(1) a $50 nonrefundable fee, in a form approved by the commissioner; and

(2) evidence that the applicant has successfully completed a lead inspector training course approved under this section or from another state with which the commissioner has established reciprocity. The fee required in this section is waived for federal, state, or local government employees within Minnesota.

Subd. 3. **License renewal.** A license is valid for one year from the issuance date unless the commissioner revokes or suspends it, except that the initial license will be issued to ex-

pire one year after the completion date on the approved training course diploma. An applicant shall successfully complete either an approved annual refresher lead inspection training course or a repeat of the approved initial lead inspection training course in order to apply for license renewal.

Subd. 4. **License replacement.** A licensed lead inspector may obtain a replacement license by reapplying for a license. A replacement expires on the same date as the original license. A nonrefundable $25 fee is required with each replacement application.

Subd. 5. **Approval of lead inspection course.** A lead inspection course sponsored by the United States Environmental Protection Agency is an approved course for the purpose of this section, providing it covers the criteria listed in section 144.9505. The commissioner shall evaluate for approval by permit lead inspector courses other than those approved by the United States Environmental Protection Agency.

History: *1995 c 213 art 1 s 8*

144.9507 LEAD–RELATED FUNDING.

Subdivision 1. **Lead education strategy contracts.** The commissioner shall, within available federal or state appropriations, contract with:

(1) boards of health to provide funds for lead education as provided for in sections 144.9503 and 144.9504; and

(2) swab team workers and community–based advocacy groups to provide funds for lead education for primary prevention of toxic lead exposure in areas at high risk for toxic lead exposure.

Subd. 2. **Lead inspection contracts.** The commissioner shall, within available federal or state appropriations, contract with boards of health to conduct lead inspections to determine sources of lead contamination and to issue and enforce lead orders according to section 144.9504.

Subd. 3. **Temporary lead–safe housing contracts.** The commissioner shall, within the limits of available appropriations, contract with boards of health for temporary housing, to be used in meeting relocation requirements in section 144.9504, and award grants to boards of health for the purposes of paying housing and relocation costs under section 144.9504.

Subd. 4. **Lead cleanup equipment and material grants.** The commissioner shall, within the limits of available state or federal appropriations, provide funds for lead cleanup equipment and materials under a grant program to nonprofit community–based organizations in areas at high risk for toxic lead exposure, as provided for in section 144.9503.

Subd. 5. **Federal lead–related funds.** To the extent practicable under federal guidelines, the commissioner of health shall coordinate with the commissioner of housing finance so that at least 50 percent of federal lead funds are allocated for swab team services.

To the extent practicable under federal guidelines, the commissioner of health may also use federal funding to contract with boards of health for purposes as specified in this section, but only to the extent that the federal funds do not replace existing funding for these lead services.

History: *1995 c 213 art 1 s 9*

144.9508 RULES.

Subdivision 1. **Sampling and analysis.** The commissioner shall adopt, by rule, visual inspection and sampling and analysis methods for:

(1) lead inspections under section 144.9504;

(2) environmental surveys of lead in paint, soil, dust, and drinking water to determine census tracts that are areas at high risk for toxic lead exposure;

(3) soil sampling for soil used as replacement soil; and

(4) drinking water sampling, which shall be done in accordance with lab certification requirements and analytical techniques specified by Code of Federal Regulations, title 40, section 141.89.

Subd. 2. **Lead standards and methods.** (a) The commissioner shall adopt rules establishing lead hazard reduction standards and methods in accordance with the provisions of

this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

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

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

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

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

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

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

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

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

Subd. 3. **Lead contractors and workers.** The commissioner shall adopt rules to license lead contractors and to certify workers of lead contractors who perform lead abatement or lead hazard reduction.

Subd. 4. **Lead training course.** The commissioner shall establish by rule a permit fee to be paid by a training course provider on application for a training course permit or renewal period for each lead–related training course required for certification or licensure.

Subd. 5. **Variances.** In adopting the rules required under this section, the commissioner shall provide variance procedures for any provision in rules adopted under this section, except for the numerical standards for the concentrations of lead in paint, dust, bare soil, and drinking water.

Subd. 6. **Program directives.** In order to achieve statewide consistency in the application of lead abatement standards, the commissioner shall issue program directives that interpret the application of rules under this section in ambiguous or unusual lead abatement situations. These program directives are guidelines to local boards of health. The commissioner shall periodically review lead abatement orders and the program directives to determine if the rules under this section need to be amended to reflect new understanding of lead abatement practices and methods.

History: *1995 c 213 art 1 s 10*

144.9509 ENFORCEMENT.

Subdivision 1. **Enforcement.** When the commissioner exercises authority for enforcement, the provisions of sections 144.9501 to 144.9509 shall be enforced under the provisions of sections 144.989 to 144.993. The commissioner shall develop a model ordinance for boards of health to adopt to enforce section 144.9504. Boards of health shall enforce a lead order issued under section 144.9504 under a local ordinance or as a public health nuisance under chapter 145A.

Subd. 2. **Discrimination.** A person who discriminates against or otherwise sanctions an employee who complains to or cooperates with the inspecting agency in administering sections 144.9501 to 144.9509 is guilty of a petty misdemeanor.

Subd. 3. **Enforcement and status report.** The commissioner shall examine compliance with Minnesota's existing lead standards and rules and report to the legislature biennially, beginning February 15, 1997, including an evaluation of current lead program activities by the state and boards of health, the need for any additional enforcement procedures, recommendations on developing a method to enforce compliance with lead standards, and cost estimates for any proposed enforcement procedure. The report shall also include a geographic analysis of all blood lead assays showing incidence data and environmental analyses reported or collected by the commissioner.

History: *1995 c 213 art 1 s 11*

144.951 [Repealed, 1976 c 173 s 64]

144.952 Subdivision 1. [Repealed, 1977 c 347 s 23]
Subd. 2. [Repealed, 1976 c 173 s 64]
Subd. 3. [Repealed, 1977 c 347 s 23]

144.953 [Repealed, 1976 c 173 s 64]

144.954 [Repealed, 1976 c 173 s 64]

144.955 [Repealed, 1976 c 173 s 64]

144.9555 [Repealed, 1976 c 173 s 64]

144.956 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

144.957 [Repealed, 1976 c 173 s 64]

144.958 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

144.959 [Repealed, 1976 c 173 s 64]

144.96 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

144.961 [Repealed, 1976 c 173 s 64]

144.962 [Repealed, 1976 c 173 s 64]

144.963 [Repealed, 1976 c 173 s 64]

144.964 [Repealed, 1976 c 173 s 64]

144.965 [Repealed, 1976 c 173 s 64; 1976 c 222 s 209]

CERTIFICATION OF ENVIRONMENTAL LABORATORIES

144.97 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to section 144.98.

Subd. 2. **Certification.** "Certification" means written acknowledgment of a laboratory's demonstrated capability to perform tests for a specific purpose.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Contract laboratory.** "Contract laboratory" means a laboratory that performs tests on samples on a contract or fee–for–service basis.

Subd. 5. **Environmental sample.** "Environmental sample" means a substance derived from a nonhuman source and collected for the purpose of analysis.

Subd. 6. **Laboratory.** "Laboratory" means the state, a person, corporation, or other entity, including governmental, that examines, analyzes, or tests samples.

Subd. 7. **Sample.** "Sample" means a substance derived from a nonhuman source and collected for the purpose of analysis, or a tissue, blood, excretion, or other bodily fluid specimen obtained from a human for the detection of a chemical, etiologic agent, or histologic abnormality.

History: *1988 c 689 art 2 s 33*

144.98 CERTIFICATION OF ENVIRONMENTAL LABORATORIES.

Subdivision 1. **Authorization.** The commissioner of health may certify laboratories that test environmental samples.

Subd. 2. **Rules.** The commissioner may adopt rules to implement this section, including:

(1) procedures, requirements, and fee adjustments for laboratory certification, including provisional status and recertification;

(2) standards and fees for certificate approval, suspension, and revocation;

(3) standards for environmental samples;

(4) analysis methods that assure reliable test results;

(5) laboratory quality assurance, including internal quality control, proficiency testing, and personnel training; and

(6) criteria for recognition of certification programs of other states and the federal government.

Subd. 3. **Fees.** (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision. The fees are for:

(1) base certification fee, $500; and

(2) test category certification fees:

Test Category	Certification Fee
Bacteriology	$200
Inorganic chemistry, fewer than four constituents	$100
Inorganic chemistry, four or more constituents	$300
Chemistry metals, fewer than four constituents	$200
Chemistry metals, four or more constituents	$500
Volatile organic compounds	$600
Other organic compounds	$600

(b) The total biennial certification fee is the base fee plus the applicable test category fees. The biennial certification fee for a contract laboratory is 1.5 times the total certification fee.

(c) Laboratories located outside of this state that require an on–site survey will be assessed an additional $1,200 fee.

(d) The commissioner of health may adjust fees under section 16A.1285 without rulemaking. Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

Subd. 4. **Fees for laboratory proficiency testing and technical training.** The commissioner of health may set fees for proficiency testing and technical training services under section 16A.1285. Fees must be set so that the total fees cover the direct costs of the profi-

ciency testing and technical training services, including salaries, supplies and equipment, travel expenses, and attorney general costs attributable to the fee function.

Subd. 5. **State government special revenue fund.** Fees collected under this section must be deposited in the state government special revenue fund.

History: *1988 c 689 art 2 s 34; 1Sp1993 c 1 art 9 s 52; 1995 c 165 s 4; 1995 c 233 art 2 s 50; 1996 c 305 art 3 s 21*

HEALTH ENFORCEMENT CONSOLIDATION ACT OF 1993

144.989 TITLE; CITATION.

Sections 144.989 to 144.993 may be cited as the "health enforcement consolidation act of 1993."

History: *1993 c 206 s 7*

144.99 ENFORCEMENT.

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.121; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.491; 144.495; 144.71 to 144.74; 144.9501 to 144.9509; 144.992; 326.37 to 326.45; 326.57 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

Subd. 2. **Access to information and property.** The commissioner or an employee or agent authorized by the commissioner, upon presentation of credentials, may:

(1) examine and copy any books, papers, records, memoranda, or data of any person subject to regulation under the statutes listed in subdivision 1; and

(2) enter upon any property, public or private, for the purpose of taking any action authorized under statutes, rules, or other actions listed in subdivision 1 including obtaining information from a person who has a duty to provide information under the statutes listed in subdivision 1, taking steps to remedy violations, or conducting surveys or investigations.

Subd. 3. **Correction orders.** (a) The commissioner may issue correction orders that require a person to correct a violation of the statutes, rules, and other actions listed in subdivision 1. The correction order must state the deficiencies that constitute the violation; the specific statute, rule, or other action; and the time by which the violation must be corrected.

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

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

(2) explain why they are in error; and

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

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

Subd. 4. **Administrative penalty orders.** The commissioner may issue an order requiring violations to be corrected and administratively assessing monetary penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The procedures in section 144.991 must be followed when issuing administrative penalty orders. Except in the case of repeated or serious violations, the penalty assessed in the order must be forgiven if the person

who is subject to the order demonstrates in writing to the commissioner before the 31st day after receiving the order that the person has corrected the violation or has developed a corrective plan acceptable to the commissioner. The maximum amount of an administrative penalty order is $10,000 for each violator for all violations by that violator identified in an inspection or review of compliance.

Subd. 5. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action for injunctive relief in the district court in Ramsey county or, at the commissioner's discretion, in the district court in the county in which a violation of the statutes, rules, or other actions listed in subdivision 1 has occurred to enjoin the violation.

Subd. 6. **Cease and desist.** The commissioner, or an employee of the department designated by the commissioner, may issue an order to cease an activity covered by subdivision 1 if continuation of the activity would result in an immediate risk to public health. An order issued under this paragraph is effective for a maximum of 72 hours. In conjunction with the issuance of the cease and desist order, the commissioner may post a sign to cease an activity until the cease and desist order is lifted and the sign is removed by the commissioner. The commissioner must seek an injunction or take other administrative action authorized by law to restrain activities for a period beyond 72 hours. The issuance of a cease and desist order does not preclude the commissioner from pursuing any other enforcement action available to the commissioner.

Subd. 7. **Plan for use of administrative penalties and cease and desist authority.** The commissioner of health shall prepare a plan for using the administrative penalty and cease and desist authority in this section. The commissioner shall provide a 30–day period for public comment on the plan. The plan must be finalized by December 1, 1993.

Subd. 8. **Denial or refusal to reissue permits, licenses, registrations, or certificates.** (a) The commissioner may deny or refuse to renew an application for a permit, license, registration, or certificate required under the statutes or rules cited in subdivision 1, if the applicant does not meet or fails to maintain the minimum qualifications for holding a permit, license, registration, or certificate or has any unresolved violations related to the activity for which the permit, license, registration, or certificate was issued.

(b) The commissioner may also deny or refuse to renew a permit, license, registration, or certificate required under the statutes or rules cited in subdivision 1 if the applicant has a persistent pattern of violations related to the permit, license, registration, or certificate, or if the applicant submitted false material information to the department in connection with the application.

(c) The commissioner may condition the grant or renewal of a permit, license, registration, or certificate on a demonstration by the applicant that actions needed to ensure compliance with the requirements of the statutes listed in subdivision 1 have been taken, or may place conditions on or issue a limited permit, license, registration, or certificate as a result of previous violations by the applicant.

Subd. 9. **Suspension or revocation of permits, licenses, registrations, or certificates.** The commissioner may suspend, place conditions on, or revoke a permit, license, registration, or certificate issued under the statutes or rules cited in subdivision 1 for serious or repeated violations of the requirements in the statutes, rules, or other actions listed in subdivision 1 that apply to the permit, license, registration, or certificate, or if the applicant submitted false material information to the department in connection with the permit, license, registration, or certificate.

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

Subd. 11. **Misdemeanor penalties.** A person convicted of violating a statute or rule listed in subdivision 1 is guilty of a misdemeanor.

History: *1993 c 206 s 8; 1Sp1993 c 6 s 33; 1994 c 465 art 2 s 1; 1995 c 165 s 5–9; 1995 c 180 s 13; 1995 c 213 art 1 s 12*

144.991 ADMINISTRATIVE PENALTY ORDER PROCEDURE.

Subdivision 1. **Amount of penalty; considerations.** (a) In determining the amount of a penalty under section 144.99, subdivision 4, the commissioner may consider:

(1) the willfulness of the violation;

(2) the gravity of the violation, including damage to humans, animals, air, water, land, or other natural resources of the state;

(3) the history of past violations;

(4) the number of violations;

(5) the economic benefit gained by the person by allowing or committing the violation; and

(6) other factors as justice may require, if the commissioner specifically identifies the additional factors in the commissioner's order.

(b) For a violation after an initial violation, the commissioner shall, in determining the amount of a penalty, consider the factors in paragraph (a) and the:

(1) similarity of the most recent previous violation and the violation to be penalized;

(2) time elapsed since the last violation;

(3) number of previous violations; and

(4) response of the person to the most recent previous violation identified.

Subd. 2. **Contents of order.** An order assessing an administrative penalty under section 144.99, subdivision 4, must include:

(1) a concise statement of the facts alleged to constitute a violation;

(2) a reference to the section of the statute, rule, variance, order, stipulation agreement, or term or condition of a permit that has been violated;

(3) a statement of the amount of the administrative penalty to be imposed and the factors upon which the penalty is based; and

(4) a statement of the person's right to review of the order.

Subd. 3. **Corrective order.** (a) The commissioner may issue an order assessing a penalty and requiring the violations cited in the order to be corrected within 30 calendar days from the date the order is received.

(b) The person to whom the order was issued shall provide information to the commissioner before the 31st day after the order was received demonstrating that the violation has been corrected or that the person has developed a corrective plan acceptable to the commissioner. The commissioner shall determine whether the violation has been corrected and notify the person subject to the order of the commissioner's determination.

Subd. 4. **Penalty.** (a) Except as provided in paragraph (b), if the commissioner determines that the violation has been corrected or the person to whom the order was issued has developed a corrective plan acceptable to the commissioner, the penalty must be forgiven. Unless the person requests review of the order under subdivision 5 before the penalty is due, the penalty in the order is due and payable:

(1) on the 31st day after the order was received, if the person subject to the order fails to provide information to the commissioner showing that the violation has been corrected or that appropriate steps have been taken toward correcting the violation; or

(2) on the 20th day after the person receives the commissioner's determination under paragraph (b), if the person subject to the order has provided information to the commissioner that the commissioner determines is not sufficient to show the violation has been corrected or that appropriate steps have been taken toward correcting the violation.

(b) For repeated or serious violations, the commissioner may issue an order with a penalty that will not be forgiven after the corrective action is taken. The penalty is due by 31 days after the order was received unless review of the order under subdivision 5 has been sought.

(c) Interest at the rate established in section 549.09 begins to accrue on penalties under this subdivision on the 31st day after the order with the penalty was received.

Subd. 5. **Expedited administrative hearing.** (a) Within 30 days after receiving an order or within 20 days after receiving notice that the commissioner has determined that a violation has not been corrected or appropriate steps have not been taken, the person subject to an order under this section may request an expedited hearing, using the procedures of Minnesota Rules, parts 1400.8510 to 1400.8612, to review the commissioner's action. The hearing request must specifically state the reasons for seeking review of the order. The person to whom the order is directed and the commissioner are the parties to the expedited hearing. The commissioner must notify the person to whom the order is directed of the time and place of the hearing at least 15 days before the hearing. The expedited hearing must be held within 30 days after a request for hearing has been filed with the commissioner unless the parties agree to a later date.

(b) All written arguments must be submitted within ten days following the close of the hearing. The hearing shall be conducted under Minnesota Rules, parts 1400.8510 to 1400.8612, as modified by this subdivision. The office of administrative hearings may, in consultation with the agency, adopt rules specifically applicable to cases under this section.

(c) The administrative law judge shall issue a report making recommendations about the commissioner's action to the commissioner within 30 days following the close of the record. The administrative law judge may not recommend a change in the amount of the proposed penalty unless the administrative law judge determines that, based on the factors in subdivision 1, the amount of the penalty is unreasonable.

(d) If the administrative law judge makes a finding that the hearing was requested solely for purposes of delay or that the hearing request was frivolous, the commissioner may add to the amount of the penalty the costs charged to the agency by the office of administrative hearings for the hearing.

(e) If a hearing has been held, the commissioner may not issue a final order until at least five days after receipt of the report of the administrative law judge. The person to whom an order is issued may, within those five days, comment to the commissioner on the recommendations and the commissioner will consider the comments. The final order may be appealed in the manner provided in sections 14.63 to 14.69.

(f) If a hearing has been held and a final order issued by the commissioner, the penalty shall be paid by 30 days after the date the final order is received unless review of the final order is requested under sections 14.63 to 14.69. If review is not requested or the order is reviewed and upheld, the amount due is the penalty, together with interest accruing from 31 days after the original order was received at the rate established in section 549.09.

Subd. 6. **Mediation.** In addition to review under subdivision 5, the commissioner is authorized to enter into mediation concerning an order issued under this section if the commissioner and the person to whom the order is issued both agree to mediation.

Subd. 7. **Enforcement.** (a) The attorney general may proceed on behalf of the state to enforce penalties that are due and payable under this section in any manner provided by law for the collection of debts.

(b) The attorney general may petition the district court to file the administrative order as an order of the court. At any court hearing, the only issues parties may contest are procedural and notice issues. Once entered, the administrative order may be enforced in the same manner as a final judgment of the district court.

(c) If a person fails to pay the penalty, the attorney general may bring a civil action in district court seeking payment of the penalties, injunctive, or other appropriate relief including monetary damages, attorney fees, costs, and interest.

Subd. 8. **Revocation and suspension of permit, license, registration, or certificate.** If a person fails to pay a penalty owed under this section, the agency has grounds to revoke or refuse to reissue or renew a permit, license, registration, or certificate issued by the department.

Subd. 9. **Cumulative remedy.** The authority of the agency to issue a corrective order assessing penalties is in addition to other remedies available under statutory or common law, except that the state may not seek civil penalties under any other provision of law for the

violations covered by the administrative penalty order. The payment of a penalty does not preclude the use of other enforcement provisions, under which penalties are not assessed, in connection with the violation for which the penalty was assessed.

History: *1993 c 206 s 9; 1994 c 465 art 1 s 18,19; 1995 c 165 s 10*

144.992 FALSE INFORMATION.

A person subject to any of the requirements listed in section 144.99, subdivision 1, may not make a false material statement, representation, or certification in; omit material information from; or alter, conceal, or fail to file or maintain a notice, application, record, report, plan, or other document required under the statutes, rules, or other actions listed in section 144.99, subdivision 1.

History: *1993 c 206 s 10*

144.993 RECOVERY OF LITIGATION COSTS AND EXPENSES.

In any judicial action brought by the attorney general for civil penalties, injunctive relief, or an action to compel performance pursuant to the authority cited in section 144.99, subdivision 1, if the state finally prevails, and if the proven violation was willful, the state, in addition to other penalties provided by law, may be allowed an amount determined by the court to be the reasonable value of all or part of the litigation expenses incurred by the state. In determining the amount of the litigation expenses to be allowed, the court shall give consideration to the economic circumstances of the defendant.

History: *1993 c 206 s 11*