CHAPTER 145

PUBLIC HEALTH PROVISIONS

145.01 [Repealed, 1987 c 309 s 27]

145.02 [Repealed, 1976 c 44 s 70]

145.03 [Repealed, 1987 c 309 s 27]

145.031 [Repealed, 1987 c 309 s 27]

145.04 [Repealed, 1987 c 309 s 27]

145.05 [Repealed, 1987 c 309 s 27]

145.06 [Repealed, 1987 c 309 s 27]

145.07 [Repealed, 1987 c 309 s 27]

145.075 INJUNCTIVE RELIEF BROUGHT BY COMMISSIONER.

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

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

145.08 [Repealed, 1987 c 309 s 27]

145.085 [Repealed, 1987 c 309 s 27]

145.09 [Repealed, 1965 c 45 s 73]

145.10 [Repealed, 1987 c 309 s 27]

145.11 [Repealed, 1987 c 309 s 27]

145.12 [Repealed, 1987 c 309 s 27]

145.123 [Repealed, 1987 c 309 s 27]

145.125 [Repealed, 1987 c 309 s 27]

145.13 [Repealed, 1980 c 357 s 22]

145.131 FINDINGS AND PURPOSE.

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

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

145.132 AUTHORIZED REMOVAL OF BRAIN.

If the attending physician of a recipient of medical assistance is of the opinion that the deceased recipient was a victim of Alzheimer's disease, the physician or a designated pathologist may remove the brain of the decedent. Before the physician removes the brain, the physician shall obtain the permission of the decedent's next of kin, the authorization of the county coroner or medical examiner, and the authorization of the appropriate department of the St. Paul Ramsey medical center. The extracted brain shall be immediately transported to the St. Paul Ramsey medical center in a manner prescribed by the St. Paul Ramsey medical center.

History: *1Sp1985 c 9 art 2 s 15*

145.135 DETERMINATION OF DEATH.

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

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

(1) circulatory and respiratory functions; or

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

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

History: *1989 c 93 s 1*

145.14 [Repealed, 1997 c 215 s 47]

145.15 [Repealed, 1997 c 215 s 47]

145.16 [Repealed, 1997 c 215 s 47]

145.161 DISSECTION; WHEN PERMITTED.

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

History: *(10227) RL s 4975; 1967 c 220 s 1; 1986 c 444*

145.162 [Repealed, 1997 c 215 s 47]

145.1621 DISPOSITION OF ABORTED OR MISCARRIED FETUSES.

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

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

Subd. 3. **Regulation of disposal.** Remains of a human fetus resulting from an abortion or miscarriage, induced or occurring accidentally or spontaneously at a hospital, clinic, or medical facility must be deposited or disposed of in this state only at the place and in the manner provided by this section or, if not possible, as directed by the commissioner of health.

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

a criminal investigation or determination of parentage prior to disposing of the remains.

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

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

History: *1987 c 238 s 1*

145.163 [Repealed, 1997 c 215 s 47]

145.17 [Repealed, 1987 c 309 s 27]

145.18 [Repealed, 1987 c 309 s 27]

145.19 [Repealed, 1987 c 309 s 27]

145.20 [Repealed, 1987 c 309 s 27]

145.21 [Repealed, 1987 c 309 s 27]

145.22 [Repealed, 1987 c 309 s 27]

145.23 [Repealed, 1987 c 309 s 27]

145.24 [Repealed, 1997 c 215 s 47]

145.30 SUPERINTENDENT OF HOSPITALS TO TRANSFER RECORDS.

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

History: *1941 c 229 s 1*

145.31 PHOTOSTATIC COPIES TO BE USED AS EVIDENCE.

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

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

145.32 OLD RECORDS MAY BE DESTROYED.

Subdivision 1. **Hospital records.** The superintendent or other chief administrative officer of any public or private hospital, by and with the consent and approval of the board of directors or other governing body of the hospital, may divest the files and

records of that hospital of any individual case records bearing dates more than three years prior to the date of the divestiture and, with that consent and approval, may destroy the records. The records shall first have been transferred and recorded as authorized in section 145.30.

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

All portions of individual hospital medical records of minors shall be maintained for seven years following the age of majority.

Nothing in this section shall be construed to prohibit the retention of hospital medical records beyond the periods described in this section. Nor shall anything in this section be construed to prohibit patient access to hospital medical records as provided in section 144.335.

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

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

History: *1941 c 229 s 3; 1971 c 231 s 2; 1983 c 237 s 1; 1988 c 670 s 9*

145.33 CONSTRUCTION.

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

History: *1941 c 229 s 4*

145.34 [Repealed, 1991 c 202 s 42]

145.35 [Repealed, 1991 c 202 s 42]

145.36 EXPOSING PERSON WITH CONTAGIOUS DISEASE.

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

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

145.365 TRAFFICKING IN SKUNKS.

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

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

(b) Acquire, sell, barter, exchange, give, or purchase any live skunks.

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

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

Subd. 4. **Penalty.** Violation of subdivision 1 or 3 is a misdemeanor.

History: *1982 c 591 s 1*

145.37 MANUFACTURE OF CERTAIN PRODUCTS WHICH MAY BE INJURIOUS.

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

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

History: *1957 c 67 s 1*

145.38 [Repealed, 1992 c 485 s 3]

145.385 [Repealed, 1992 c 485 s 3]

145.39 [Repealed, 1992 c 485 s 3]

145.40 [Repealed, 1992 c 485 s 3]

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

145.41 BLOOD DONATIONS, AGE OF DONOR.

Any person of the age of 17 years or over shall be eligible to donate blood in any voluntary and noncompensatory blood program without the necessity of obtaining parental permission or authorization.

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

145.411 REGULATION OF ABORTIONS; DEFINITIONS.

Subdivision 1. **Terms.** As used in sections 145.411 to 145.416, the terms defined in this section have the meanings given to them.

Subd. 2. **Viable.** "Viable" means able to live outside the womb even though artificial aid may be required. During the second half of its gestation period a fetus shall be considered potentially "viable".

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

Subd. 4. **Abortion facility.** "Abortion facility" means those places properly recognized and licensed by the state commissioner of health under lawful rules promulgated by the commissioner for the performance of abortions.

Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument, medicine or drug which is supplied or prescribed for or administered to a pregnant woman which results in the termination of pregnancy.

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

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

145.412 CRIMINAL ACTS.

Subdivision 1. **Requirements.** It shall be unlawful to willfully perform an abortion unless the abortion is performed:

(1) by a physician licensed to practice medicine pursuant to chapter 147, or a physician in training under the supervision of a licensed physician;

(2) in a hospital or abortion facility if the abortion is performed after the first trimester;

(3) in a manner consistent with the lawful rules promulgated by the state commissioner of health; and

(4) with the consent of the woman submitting to the abortion after a full explanation of the procedure and effect of the abortion.

Subd. 2. **Unconsciousness; lifesaving.** It shall be unlawful to perform an abortion upon a woman who is unconscious except if the woman has been rendered unconscious for the purpose of having an abortion or if the abortion is necessary to save the life of the woman.

Subd. 3. **Viability.** It shall be unlawful to perform an abortion when the fetus is potentially viable unless:

(1) the abortion is performed in a hospital;

(2) the attending physician certifies in writing that in the physician's best medical judgment the abortion is necessary to preserve the life or health of the pregnant woman; and

(3) to the extent consistent with sound medical practice the abortion is performed under circumstances which will reasonably assure the live birth and survival of the fetus.

Subd. 4. **Penalty.** A person who performs an abortion in violation of this section is guilty of a felony.

History: *1974 c 177 s 2; 1977 c 305 s 45; 1985 c 248 s 70; 1986 c 444*

145.413 RECORDING AND REPORTING HEALTH DATA.

Subdivision 1. **Rules.** The state commissioner of health shall promulgate rules to effect a reporting system on terminated pregnancies in order that statistical data is obtained that will relate to maternal health. The rules and reporting system shall not interfere with the right of a pregnant woman to seek an abortion before the fetus is potentially viable. No such report, or any part thereof, shall be disclosed, in any manner, by any official or clerk or other employee or person having access thereto, and all such information shall be confidential.

Subd. 2. **Death of woman.** If any woman who has had an abortion dies from any cause within 30 days of the abortion or from any cause potentially related to the abortion within 90 days of the abortion, that fact shall be reported to the state commissioner of health.

Subd. 3. **Penalty.** A physician who performs an abortion and who fails to comply with subdivision 1 and transmit the required information to the state commissioner of health within 30 days after the abortion is guilty of a misdemeanor.

History: *1974 c 177 s 3; 1977 c 305 s 45; 1985 c 248 s 70*

145.4131 RECORDING AND REPORTING ABORTION DATA.

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

(b) The form shall require the following information:

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

(2) the method used for each abortion;

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

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

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

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

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

(11) the medical specialty of the physician performing the abortion.

Subd. 2. **Submission.** A physician performing an abortion or a facility at which an abortion is performed shall complete and submit the form to the commissioner no later than April 1 for abortions performed in the previous calendar year. The annual report to the commissioner shall include the methods used to dispose of fetal tissue and remains.

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

History: *1998 c 407 art 10 s 2*

145.4132 RECORDING AND REPORTING ABORTION COMPLICATION DATA.

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare an abortion complication reporting form for all physicians licensed and practicing in the state. A copy of this section shall be attached to the form.

(b) The board of medical practice shall ensure that the abortion complication reporting form is distributed:

(1) to all physicians licensed to practice in the state, within 120 days after July 1, 1998, and by December 1 of each subsequent year; and

(2) to a physician who is newly licensed to practice in the state, at the same time as official notification to the physician that the physician is so licensed.

Subd. 2. **Required reporting.** A physician licensed and practicing in the state who knowingly encounters an illness or injury that, in the physician's medical judgment, is related to an induced abortion or the facility where the illness or injury is encountered shall complete and submit an abortion complication reporting form to the commissioner.

Subd. 3. **Submission.** A physician or facility required to submit an abortion complication reporting form to the commissioner shall do so as soon as practicable after the encounter with the abortion-related illness or injury.

Subd. 4. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortion complications.

History: *1998 c 407 art 10 s 3*

145.4133 REPORTING OUT-OF-STATE ABORTIONS.

The commissioner of human services shall report to the commissioner by April 1 each year the following information regarding abortions paid for with state funds and performed out of state in the previous calendar year:

(1) the total number of abortions performed out of state and partially or fully paid for with state funds through the medical assistance, general assistance medical care, or MinnesotaCare program, or any other program;

(2) the total amount of state funds used to pay for the abortions and expenses incidental to the abortions; and

(3) the gestational age at the time of abortion.

History: *1998 c 407 art 10 s 4*

145.4134 COMMISSIONER'S PUBLIC REPORT.

(a) By July 1 of each year, except for 1998 and 1999 information, the commissioner shall issue a public report providing statistics for the previous calendar year compiled from the data submitted under sections 145.4131 to 145.4133. For 1998 and 1999 information, the report shall be issued October 1, 2000. Each report shall provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner shall ensure that none of the information included in the public reports can reasonably lead to identification of an individual having performed or having had an abortion. All data included on the forms under sections 145.4131 to 145.4133 must be included in the public report, except that the commissioner shall maintain as confidential, data which alone or in combination may constitute information from which an individual having performed or having had an abortion may be identified using epidemiologic principles. The commissioner shall submit the report to the senate health and family security committee and the house health and human services committee.

(b) The commissioner may, by rules adopted under chapter 14, alter the submission dates established under sections 145.4131 to 145.4133 for administrative convenience, fiscal savings, or other valid reason, provided that physicians or facilities and the commissioner of human services submit the required information once each year and the commissioner issues a report once each year.

History: *1998 c 407 art 10 s 5*

145.4135 ENFORCEMENT; PENALTIES.

(a) If the commissioner finds that a physician or facility has failed to submit the required form under section 145.4131 within 60 days following the due date, the commissioner shall notify the physician or facility that the form is late. A physician or facility who fails to submit the required form under section 145.4131 within 30 days following notification from the commissioner that a report is late is subject to a late fee of $500 for each 30-day period, or portion thereof, that the form is overdue. If a physician or facility required to report under this section does not submit a report, or submits only an incomplete report, more than one year following the due date, the commissioner may take action to fine the physician or facility or may bring an action to require that the physician or facility be directed by a court of competent jurisdiction to submit a complete report within a period stated by court order or be subject to sanctions for civil contempt. Notwithstanding section 13.39 to the contrary, action taken by the commissioner to enforce the provision of this section shall be treated as private if the data related to this action, alone or in combination, may constitute information from which an individual having performed or having had an abortion may be identified using epidemiologic principles.

(b) If the commissioner fails to issue the public report required under section 145.4134 or fails in any way to enforce this section, a group of 100 or more citizens of the state may seek an injunction in a court of competent jurisdiction against the commissioner requiring that a complete report be issued within a period stated by court order or requiring that enforcement action be taken.

(c) A physician or facility reporting in good faith and exercising due care shall have immunity from civil, criminal, or administrative liability that might otherwise result from reporting. A physician who knowingly or recklessly submits a false report under this section is guilty of a misdemeanor.

(d) The commissioner may take reasonable steps to ensure compliance with sections 145.4131 to 145.4133 and to verify data provided, including but not limited to, inspection of places where abortions are performed in accordance with chapter 14.

(e) The commissioner shall develop recommendations on appropriate penalties and methods of enforcement for physicians or facilities who fail to submit the report required under section 145.4132, submit an incomplete report, or submit a late report. The commissioner shall also assess the effectiveness of the enforcement methods and penalties provided in paragraph (a) and shall recommend appropriate changes, if any. These recommendations shall be reported to the chairs of the senate health and family security committee and the house health and human services committee by November 15, 1998.

History: *1998 c 407 art 10 s 6*

145.4136 SEVERABILITY.

If any one or more provision, section, subdivision, sentence, clause, phrase, or word in sections 145.4131 to 145.4135, or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4131 to 145.4135 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4131 to 145.4135, and each provision, section, subdivision, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subdivision, sentence, clause, phrase, or word be declared unconstitutional.

History: *1998 c 407 art 10 s 7*

145.414 ABORTION NOT MANDATORY.

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

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

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

History: *1974 c 177 s 4; 1995 c 234 art 2 s 30*

145.415 LIVE FETUS AFTER ABORTION, TREATMENT.

Subdivision 1. **Recognition.** A potentially viable fetus which is live born following an attempted abortion shall be fully recognized as a human person under the law.

Subd. 2. **Medical care.** If an abortion of a potentially viable fetus results in a live birth, the responsible medical personnel shall take all reasonable measures, in keeping with good medical practice, to preserve the life and health of the live born person.

Subd. 3. **Status.** (1) Unless the abortion is performed to save the life of the woman or child, or, (2) unless one or both of the parents of the unborn child agrees within 30 days of the birth to accept the parental rights and responsibilities for the child if it survives the abortion, whenever an abortion of a potentially viable fetus results in a live birth, the child shall be an abandoned ward of the state and the parents shall have no parental rights or obligations as if the parental rights had been terminated pursuant to section 260C.301. The child shall be provided for pursuant to chapter 256J.

History: *1974 c 177 s 5; 1999 c 139 art 4 s 2; 1999 c 159 s 26*

145.416 LICENSING AND REGULATION OF FACILITIES.

The state commissioner of health shall license and promulgate rules for facilities as defined in section 145.411, subdivision 4, which are organized for purposes of delivering abortion services.

History: *1974 c 177 s 6; 1977 c 305 s 45; 1985 c 248 s 70*

145.42 ABORTIONS; NONLIABILITY FOR REFUSAL TO PERFORM.

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

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

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

145.421 HUMAN CONCEPTUS, EXPERIMENTATION, RESEARCH OR SALE; DEFINITIONS.

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

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

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

History: *1973 c 562 s 1*

145.422 EXPERIMENTATION OR SALE.

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

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

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

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

145.423 ABORTION; LIVE BIRTHS.

Subdivision 1. **Recognition; medical care.** A live child born as a result of an abortion shall be fully recognized as a human person, and accorded immediate protection under the law. All reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, shall be taken to preserve the life and health of the child.

Subd. 2. **Physician required.** When an abortion is performed after the twentieth week of pregnancy, a physician, other than the physician performing the abortion, shall be immediately accessible to take all reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, to preserve the life and health of any live birth that is the result of the abortion.

Subd. 3. **Death.** If a child described in subdivision 1 dies after birth, the body shall be disposed of in accordance with the provisions of section 145.1621.

History: *1976 c 170 s 1; 1997 c 215 s 4*

145.424 PROHIBITION OF TORT ACTIONS.

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

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

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

The failure or refusal of any person to perform or have an abortion shall not be a defense in any action, nor shall that failure or refusal be considered in awarding damages or in imposing a penalty in any action.

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

145.425 PAY TOILETS IN PUBLIC PLACES; PROHIBITIONS; PENALTY.

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

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

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

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

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

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

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

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

145.44 [Repealed, 1984 c 418 s 2]

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

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

145.47 [Repealed, 1987 c 309 s 27]

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

145.48 [Repealed, 1987 c 309 s 27]

145.49 [Repealed, 1987 c 309 s 27]

145.50 [Repealed, 1987 c 309 s 27]

145.51 [Repealed, 1987 c 309 s 27]

145.52 [Repealed, 1987 c 309 s 27]

145.53 [Repealed, 1987 c 309 s 27]

145.54 [Repealed, 1987 c 309 s 27]

145.55 [Repealed, 1987 c 309 s 27]

145.56 SUICIDE PREVENTION.

Subdivision 1. **Suicide prevention plan.** The commissioner of health shall refine, coordinate, and implement the state's suicide prevention plan using an evidence-based, public health approach focused on prevention, in collaboration with the commissioner of human services; the commissioner of public safety; the commissioner of children, families, and learning; and appropriate agencies, organizations, and institutions in the community.

Subd. 2. **Community-based programs.** (a) The commissioner shall establish a grant program to fund:

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

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

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of

depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources; and

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12.

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

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

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

Subd. 5. **Periodic evaluations; biennial reports.** The commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. By July 1, 2002, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services issues.

History: *1Sp2001 c 9 art 1 s 45; 2002 c 379 art 1 s 113*

HEALTH CARE INFORMATION, REVIEW ORGANIZATIONS

145.61 DEFINITIONS.

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

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

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

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

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

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

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

Subd. 5. **Review organization.** "Review organization" means a nonprofit organization acting according to clause (l), a committee as defined under section 144E.32, subdivision 2, or a committee whose membership is limited to professionals, administrative staff, and consumer directors, except where otherwise provided for by state or

federal law, and which is established by one or more of the following: a hospital, a clinic, a nursing home, an ambulance service or first responder service regulated under chapter 144E, one or more state or local associations of professionals, an organization of professionals from a particular area or medical institution, a health maintenance organization as defined in chapter 62D, a community integrated service network as defined in chapter 62N, a nonprofit health service plan corporation as defined in chapter 62C, a preferred provider organization, a professional standards review organization established pursuant to United States Code, title 42, section 1320c-1 et seq., a medical review agent established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), the department of human services, or a nonprofit corporation that owns, operates, or is established by one or more of the above referenced entities, to gather and review information relating to the care and treatment of patients for the purposes of:

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

(b) reducing morbidity or mortality;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) acting as a medical review agent under section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b);

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

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

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

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

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

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

145.62 LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION.

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

History: *1971 c 283 s 2*

145.63 LIMITATION ON LIABILITY FOR SPONSORING ORGANIZATIONS, REVIEW ORGANIZATIONS, AND MEMBERS OF REVIEW ORGANIZATIONS.

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

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

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

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

145.64 CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION.

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

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

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

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

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

Subd. 3. **Hennepin county emergency medical services data.** Data collected, created, or maintained by the quality committee of the Hennepin county emergency

medical services advisory council when conducting a health care review activity of the emergency medical services function or services are private data on individuals or nonpublic data not on individuals, as defined in section 13.02.

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

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

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

145.65 GUIDELINES NOT ADMISSIBLE IN EVIDENCE.

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

History: *1971 c 283 s 5*

145.66 PENALTY FOR VIOLATION.

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

History: *1971 c 283 s 6*

145.67 PROTECTION OF PATIENT.

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

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

MALPRACTICE ACTIONS; EXPERT REVIEW

145.682 CERTIFICATION OF EXPERT REVIEW; AFFIDAVIT.

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

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

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

(a) the facts of the case have been reviewed by the plaintiff's attorney with an expert whose qualifications provide a reasonable expectation that the expert's opinions could be admissible at trial and that, in the opinion of this expert, one or more

defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff; or

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

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

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

(c) In any action alleging medical malpractice, all expert interrogatory answers must be signed by the attorney for the party responding to the interrogatory and by each expert listed in the answers. The court shall include in a scheduling order a deadline prior to the close of discovery for all parties to answer expert interrogatories for all experts to be called at trial. No additional experts may be called by any party without agreement of the parties or by leave of the court for good cause shown.

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

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

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

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

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

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

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

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

plaintiff responsible for such conduct to reasonable attorney's fees, costs, and disbursements.

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

DRUG DEPENDENT PERSONS; COMMITMENT

145.696 [Repealed, 1973 c 572 s 18]

145.697 [Repealed, 1973 c 572 s 18]

145.698 CONFINEMENT OF DRUG DEPENDENT PERSON.

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

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

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

145.699 [Repealed, 1973 c 572 s 18]

145.71 [Repealed, 1979 c 323 s 16]

OPHTHALMIC GOODS AND SERVICES

145.711 DEFINITIONS.

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

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

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

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

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

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

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

Subd. 8. **Prescription.** "Prescription" means a written directive from an optometrist or physician for contact lenses that must include the manufacturer's brand name,

power, base curve, the name and telephone number of the prescribing optometrist or physician, patient's name, and the expiration date of the prescription. If applicable, the prescription may also include diameter, axis, add power, cylinder, peripheral curve, optical zone, or center thickness.

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

History: *2002 c 259 s 1*

145.712 REQUIREMENTS FOR CONTACT LENSES PRESCRIPTIONS.

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

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

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

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

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

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

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

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

History: *2002 c 259 s 2*

145.713 OPTOMETRIST AND PHYSICIAN PRACTICES.

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

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

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

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

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

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

History: *2002 c 259 s 3*

145.714 ENFORCEMENT.

Failure to comply with sections 145.711 to 145.713 shall be grounds for disciplinary action by the board of optometry or the board of medical practice.

History: *2002 c 259 s 4*

145.72 [Repealed, 1979 c 323 s 16]

145.73 [Repealed, 1979 c 323 s 16]

145.74 [Repealed, 1979 c 323 s 16]

145.75 [Repealed, 1979 c 323 s 16]

145.751 [Repealed, 1979 c 323 s 16]

145.76 [Repealed, 1979 c 323 s 16]

145.761 [Repealed, 1979 c 323 s 16]

145.77 [Repealed, 1979 c 323 s 16]

145.78 [Repealed, 1979 c 323 s 16]

145.79 [Repealed, 1979 c 323 s 16]

145.80 [Repealed, 1979 c 323 s 16]

145.81 [Repealed, 1975 c 299 s 12]

145.811 [Repealed, 1979 c 323 s 16]

145.812 [Repealed, 1979 c 323 s 16]

145.82 [Repealed, 1979 c 323 s 16]

145.83 [Repealed, 1979 c 323 s 16]

145.831 [Repealed, 1979 c 323 s 16]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UNIFORM DUTIES TO DISABLED PERSONS ACT

145.851 DEFINITIONS.

In sections 145.851 to 145.858:

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

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

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

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

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

History: *1973 c 428 s 1*

145.852 IDENTIFYING DEVICES FOR PERSONS HAVING CERTAIN CONDITIONS.

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

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

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

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

145.853 DUTY OF LAW ENFORCEMENT OFFICER.

Subdivision 1. **Diligent effort required.** A law enforcement officer shall make a diligent effort to determine whether any disabled person found is a person having

epilepsy or a diabetic, or suffers from some other type of illness that would cause the condition. Whenever feasible, this effort shall be made before the person is charged with a crime or taken to a place of detention.

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

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

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

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

History: *1973 c 428 s 3; 1983 c 10 s 1; 1986 c 444; 1988 c 689 art 2 s 44*

145.854 DUTY OF MEDICAL PRACTITIONERS.

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

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

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

145.855 DUTY OF OTHERS.

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

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

History: *1973 c 428 s 5*

145.856 FALSIFYING IDENTIFICATION OR MISREPRESENTING CONDITION; PENALTY.

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

History: *1973 c 428 s 6*

145.857 OTHER DUTIES.

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

History: *1973 c 428 s 7*

145.858 CITATION.

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

History: *1973 c 428 s 8*

145.861 [Repealed, 1976 c 222 s 209]

145.862 [Repealed, 1976 c 222 s 209]

145.863 [Repealed, 1976 c 222 s 209]

145.864 [Repealed, 1976 c 222 s 209]

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

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

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

145.866 [Repealed, 1976 c 222 s 209]

145.867 PERSONS REQUIRING SPECIAL DIETS.

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

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

Subd. 3. **Exemption from food and drink prohibitions.** Persons with medical conditions requiring a special diet who present a valid special diet identification card to any employee of a public facility shall be allowed to bring in outside food and drink, subject to the limitations in subdivision 4. To be valid, the card must be filled out

according to subdivision 2 and must be current. Persons with special diet identification cards must obey all other food and drink regulations established by a public facility including prohibitions on eating or drinking in certain areas of the public facility.

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

History: *1989 c 282 art 2 s 32*

MATERNAL AND CHILD HEALTH

145.88 PURPOSE.

The legislature finds that it is in the public interest to assure:

(a) statewide planning and coordination of maternal and child health services through the acquisition and analysis of population-based health data, provision of technical support and training, and coordination of the various public and private maternal and child health efforts; and

(b) support for targeted maternal and child health services in communities with significant populations of high risk, low income families through a grants process.

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

(1) assure access to quality maternal and child health services for mothers and children, especially those of low income and with limited availability to health services and those children at risk of physical, neurological, emotional, and developmental problems arising from chemical abuse by a mother during pregnancy;

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

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

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

(5) provide and locate medical, surgical, corrective and other service for children who are crippled or who are suffering from conditions that lead to crippling.

History: *1982 c 431 s 1; 1990 c 542 s 3*

145.881 MATERNAL AND CHILD HEALTH ADVISORY TASK FORCE.

Subdivision 1. **Composition of task force.** The commissioner shall establish and appoint a maternal and child health advisory task force consisting of 15 members who will provide equal representation from:

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

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

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

No members shall be employees of the state department of health. Section 15.059 governs the maternal and child health advisory task force.

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

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

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

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

(d) review staff recommendations of the department of health regarding maternal and child health grant awards before the awards are made;

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

(f) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services: (1) prenatal, delivery and postpartum care, (2) comprehensive health care for children, especially from birth through five years of age, (3) adolescent health services, (4) family planning services, (5) preventive dental care, (6) special services for chronically ill and handicapped children and (7) any other services which promote the health of mothers and children;

(g) make recommendations to the commissioner of health on the process to distribute, award and administer the maternal and child health block grant funds; and

(h) review the measures that are used to define the variables of the funding distribution formula in section 145.882, subdivision 4, every two years and make recommendations to the commissioner of health for changes based upon principles established by the advisory task force for this purpose.

History: *1982 c 431 s 2; 1983 c 312 art 4 s 1; 1987 c 209 s 32; 1987 c 309 s 24; 1997 c 192 s 25; 1Sp2001 c 9 art 1 s 46; 2002 c 379 art 1 s 113*

145.882 MATERNAL AND CHILD HEALTH BLOCK GRANT DISTRIBUTION.

Subdivision 1. **Funding levels and advisory task force review.** Any decrease in the amount of federal funding to the state for the maternal and child health block grant must be apportioned to reflect a proportional decrease for each recipient. Any increase in the amount of federal funding to the state must be distributed under subdivisions 2, 3, and 4.

The advisory task force shall review and recommend the proportion of maternal and child health block grant funds to be expended for indirect costs, direct services and special projects.

Subd. 2. **Allocation to the commissioner of health.** Beginning January 1, 1986, up to one-third of the total maternal and child health block grant money may be retained by the commissioner of health for administrative and technical assistance services, projects of regional or statewide significance, direct services to children with handicaps, and other activities of the commissioner.

Subd. 3. **Allocation to community health services areas.** (a) The maternal and child health block grant money remaining after distributions made under subdivision 2 must be allocated according to the formula in subdivision 4 to community health services areas for distribution by community health boards as defined in section 145A.02, subdivision 5, to qualified programs that provide essential services within the community health services area as long as:

(1) the Minneapolis community health service area is allocated at least $1,626,215 per year;

(2) the St. Paul community health service area is allocated at least $822,931 per year; and

(3) all other community health service areas are allocated at least $30,000 per county per year or their 1988-1989 funding cycle award, whichever is less.

(b) Notwithstanding paragraph (a), if the total amount of maternal and child health block grant funding decreases, the decrease must be apportioned to reflect a

proportional decrease for each recipient, including recipients who would otherwise receive a guaranteed minimum allocation under paragraph (a).

Subd. 4. **Distribution formula.** The amount available for each community health services area is determined according to the following formula:

(a) Each community health services area is allocated an amount based on the following three variables:

(1) the proportion of resident mothers within the city, county, or counties who are under 20 years of age or over 35 years of age, as determined by averaging the data available for the three most current years;

(2) the proportion of resident infants within the city, county, or counties whose weight at birth is less than 2,500 grams, as determined by averaging the data available for the three most current years; and

(3) the proportion of resident children within the city, county, or counties under the age of 19 who are on general assistance or medical assistance and the proportion of resident women within the city, county, or counties aged 19 to 49 who are on general assistance or medical assistance, as determined by using the data available for the most current year.

(b) Each variable is expressed as a city or county score consisting of the city or county frequency of each variable divided by the statewide frequency of the variable.

(c) A total score for each city or county jurisdiction is computed by totaling the scores of the three factors and dividing the total by three. The resulting amount is added to the total score for the most recent two-year grant period and the sum is divided by two.

(d) Each community health services area is allocated an amount equal to the total score obtained above for the city, county, or counties in its area multiplied by the amount of money available for special projects of local significance.

Subd. 5. **Nonparticipants in the community health services subsidy program.** A city or county that is not participating in the community health services subsidy program must be allocated money under subdivisions 3 and 4, and for this limited purpose the city or county is a "community health services area." For these areas, the commissioner shall convene a meeting of public and private nonprofit agencies in the city or county that have expressed an intent to submit an application for funding, in order to attempt to develop a single coordinated grant application for the city or county. Applications, whether consolidated into a single application or submitted as individual applications, must be submitted according to section 145.885. Grants for qualified programs providing essential services in these areas are awarded and distributed by the commissioner.

Subd. 6. **Reallocation.** If no approvable applications are received for a community health services area, the commissioner must reallocate the money available for that area to other community health service areas for which approvable applications have been received.

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

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

(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications

associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

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

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

(5) specifically address the frequency and severity of childhood injuries in high risk target populations by providing services calculated to produce measurable decreases in mortality and morbidity. However, money may be used for this purpose only if the community health board's application includes program components for the purposes in clauses (1) to (4) in the proposed geographic service area and the total expenditure for injury-related programs under this clause does not exceed ten percent of the total allocation under subdivision 3.

(b) Maternal and child health block grant money may be used for purposes other than the purposes listed in this subdivision only under the following conditions:

(1) the community health board or community health services area can demonstrate that existing programs fully address the needs of the highest risk target populations described in this subdivision; or

(2) the money is used to continue projects that received funding before creation of the maternal and child health block grant in 1981.

(c) Projects that received funding before creation of the maternal and child health block grant in 1981, must be allocated at least the amount of maternal and child health special project grant funds received in 1989, unless (1) the local board of health provides equivalent alternative funding for the project from another source; or (2) the local board of health demonstrates that the need for the specific services provided by the project has significantly decreased as a result of changes in the demographic characteristics of the population, or other factors that have a major impact on the demand for services. If the amount of federal funding to the state for the maternal and child health block grant is decreased, these projects must receive a proportional decrease as required in subdivision 1. Increases in allocation amounts to local boards of health under subdivision 4 may be used to increase funding levels for these projects.

Subd. 8. **Report.** The commissioner shall prepare, with the advice of the advisory task force, an annual report to the legislature which details the distribution of maternal and child health block grant money, including the amounts to be expended for indirect costs, direct services, and local grants. The report shall also identify the statewide needs of low income and high risk populations and the department of health's plans and community health board plans for meeting their needs. The legislature must receive the report no later than January of each year.

History: *1982 c 431 s 3; 1983 c 312 art 4 s 2; 1Sp1985 c 14 art 19 s 18; 1987 c 209 s 33; 1987 c 309 s 24; 1989 c 282 art 2 s 33-35; 1990 c 542 s 4*

145.883 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 145.881 to 145.888, the terms defined in this section shall have the meanings given them.

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

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

Subd. 4. **Essential services.** "Essential services" means (a) prenatal, delivery, and post partum care; (b) comprehensive health care for children from birth through five years of age; (c) adolescent health services; (d) family planning services, as defined in section 145.925, subdivision 1a; (e) preventive dental care; or (f) special services for chronically ill children and for handicapped children.

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

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

Subd. 7. **Special project.** "Special project" means a qualified program that receives maternal and child health block grant money and is administered by a public or private nonprofit agency other than the Minnesota department of health. A special project may not impose residency requirements, other than state residence, as a condition of receiving essential services. A special project that can demonstrate a need to reduce services as a result of high demand for these services from outside the project's proposed service area may apply for additional funds. Any special project providing statewide essential services may serve a population that is low income or high risk.

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

Subd. 9. **Community health services area.** "Community health services area" means a city, county, or multicounty area that is organized as a community health board under section 145A.09 and for which a state subsidy is received under sections 145A.09 to 145A.13.

History: *1983 c 312 art 4 s 3; 1Sp1985 c 14 art 19 s 19,20; 1987 c 309 s 24-26; 1991 c 36 s 3; 1Sp1993 c 1 art 3 s 1*

145.884 GRANTS TO QUALIFIED PROGRAMS.

Subdivision 1. **Rules.** The commissioner shall, in the name of the state and within the limit of the federal maternal and child health block grant appropriation, make grants under sections 145.881 to 145.888 for qualified programs of maternal and child health care services. The commissioner shall promulgate rules for the administration of grants. The rules shall establish and contain as a minimum:

(a) procedures for grant applications;

(b) conditions and procedures for the administration of grants;

(c) criteria of eligibility for grants; and

(d) other matters the commissioner finds necessary for the proper administration of the grant program.

Subd. 2. [Repealed, 1Sp1985 c 14 art 19 s 38]

History: *1983 c 312 art 4 s 4; 1Sp1985 c 14 art 19 s 21*

145.885 APPLICATION FOR A GRANT.

Subdivision 1. **Requirements for all applications.** An application for a grant shall be submitted to the commissioner at a time and in a form and manner as the commissioner prescribes. Department of health technical staff shall be available to provide technical assistance in development of grant applications. The application must contain:

(1) a complete description of the program and the manner in which the applicant intends to conduct the program;

(2) a description of the manner in which the program responds to needs and priorities for services identified by the maternal and child health task force under section 145.881, subdivision 2, and rules adopted by the commissioner; differences must be explained in detail;

(3) a budget and justification for the amount of grant funds requested;

(4) a description of the target population served by the qualified program and estimates of the number of low income or high risk patients the program is expected to serve;

(5) the name or names of the person or persons who shall have primary responsibility for the administration and delivery of services of the qualified program; and

(6) the reporting and accounting procedures to be followed by the qualified agency to enable the commissioner to evaluate the activities of the qualified program.

Subd. 2. **Additional requirements for community boards of health.** Applications by community health boards as defined in section 145A.02, subdivision 5, under section 145.882, subdivision 3, must also contain a summary of the process used to develop the local program, including evidence that the community health board notified local public and private providers of the availability of funding through the community health board for maternal and child health services; a list of all public and private agency requests for grants submitted to the community health board indicating which requests were included in the grant application; and an explanation of how priorities were established for selecting the requests to be included in the grant application. The community health board shall include, with the grant application, a written statement of the criteria to be applied to public and private agency requests for funding.

History: *1983 c 312 art 4 s 5; 1Sp1985 c 14 art 19 s 22; 1987 c 309 s 24*

145.886 GRANT REVIEW PROCESS.

Primary review of all grant applications shall be conducted by the department of health technical staff. All technically completed applications will be forwarded for secondary review to the advisory task force. The commissioner shall award grants under section 145.885 and this section only after receiving the comments and recommendation of the advisory task force on completed grant applications.

History: *1983 c 312 art 4 s 6; 1Sp1985 c 14 art 19 s 23*

145.888 LIMITATIONS.

Grants awarded to qualified programs under this section and sections 145.885 and 145.886 shall not exceed 75 percent of the estimated annual cost of the qualified program for the fiscal year for which the grant is awarded.

History: *1983 c 312 art 4 s 7*

145.889 RULES.

The commissioner may adopt rules for the efficient administration of sections 145.881 to 145.886 and 145.888.

History: *1983 c 312 art 4 s 8; 1984 c 640 s 32; 1996 c 305 art 2 s 30*

145.890 CHILDREN WITH SPECIAL NEEDS.

When cost-effective, the commissioner may use money received for the services for children with special health care needs program to purchase health coverage for eligible children.

History: *1995 c 207 art 9 s 36*

145.891 CITATION.

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

History: *1975 c 346 s 1*

145.892 DEFINITIONS.

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

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

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

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

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

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

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

(a) For pregnant and lactating women:

(i) Known inadequate nutritional patterns;

(ii) Anemia;

(iii) History of prematurity or miscarriage; or

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

(b) For infants and children:

(i) Low birth weight;

(ii) Deficient patterns of growth;

(iii) Anemia; or

(iv) Known inadequate nutritional patterns.

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

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

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

History: *1975 c 346 s 2; 1977 c 305 s 45; 1978 c 762 s 4; 1986 c 404 s 7; 1986 c 444*

145.893 NUTRITIONAL SUPPLEMENT PROGRAM.

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

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

(a) Is pregnant or lactating; or

(b) Is an infant or a child; and

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

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

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

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

(b) For children, at five years of age.

History: *1975 c 346 s 3; 1977 c 305 s 45; 1978 c 762 s 5*

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

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

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

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

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

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

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

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

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

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

(j) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC) and, in 1986, 1987, and 1988, at the commissioner's discretion, designate a different food program deliverer if the current deliverer fails to increase the participation of pregnant women in the program by at least ten percent over the previous year's participation rate;

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

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

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

145.895 DEPARTMENT OF HUMAN SERVICES.

The commissioner of human services shall cooperate with the commissioner of health in identifying eligible individuals. The commissioner of human services shall provide a procedure for the notification of pregnant or lactating women, infants and children receiving any form of public assistance of eligibility for benefits under this program.

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

145.896 PROGRAM NOT A SUBSTITUTE OR REPLACEMENT.

This program shall not be a replacement or substitute for any other local, state, or federal program administered through the departments of health or human services, nor shall the value of the nutritional supplements be included in eligibility determination for other assistance programs.

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

145.897 VOUCHERS.

Vouchers issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the commissioner to be desirable nutritional supplements for pregnant and lactating women, infants and children. These foods shall include, but not be limited to, iron fortified infant formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.

History: *1975 c 346 s 7; 1977 c 305 s 45*

145.898 SUDDEN INFANT DEATH.

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

History: *1989 c 282 art 2 s 36*

145.90 [Repealed, 2001 c 211 s 4]

145.901 MATERNAL DEATH STUDIES.

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

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers as defined in section 144.335, subdivision 1, paragraph (b), without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to deaths that occur on or after July 1, 2000.

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

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

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

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

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

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

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

History: *2001 c 211 s 3*

145.902 SAFE PLACE FOR NEWBORNS; HOSPITAL DUTIES AND IMMUNITY FROM LIABILITY.

Subdivision 1. **General.** (a) A hospital licensed under sections 144.50 to 144.56 shall receive a newborn left with a hospital employee on the hospital premises, provided that:

(1) the newborn was born within 72 hours of being left at the hospital, as determined within a reasonable degree of medical certainty; and

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

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

Subd. 2. **Reporting.** Within 24 hours of receiving a newborn under this section, the hospital must inform the local welfare agency that a newborn has been left at the hospital, but must not do so before the mother or the person leaving the newborn leaves the hospital.

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

(b) A hospital performing duties under this section, or an employee, doctor, or other medical professional working at the hospital who is a mandated reporter under section 626.556, is immune from any criminal or civil liability that otherwise might result from the failure to make a report under that section if the person is acting in good faith in complying with this section.

History: *2000 c 421 s 1*

145.905 LOCATION FOR BREAST-FEEDING.

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

History: *1998 c 407 art 2 s 83*

COMMUNITY HEALTH SERVICES

145.911 [Repealed, 1987 c 309 s 27]

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

Subd. 2. [Repealed, 1987 c 309 s 27]
Subd. 3. [Repealed, 1987 c 309 s 27]
Subd. 4. [Repealed, 1987 c 309 s 27]
Subd. 5. [Repealed, 1987 c 309 s 27]
Subd. 6. [Repealed, 1987 c 309 s 27]
Subd. 7. [Repealed, 1987 c 309 s 27]
Subd. 8. [Repealed, 1987 c 309 s 27]
Subd. 9. [Renumbered 145.925 subd 1a]
Subd. 10. [Repealed, 1987 c 309 s 27]
Subd. 11. [Repealed, 1987 c 309 s 27]
Subd. 12. [Repealed, 1987 c 309 s 27]
Subd. 13. [Repealed, 1987 c 309 s 27]
Subd. 14. [Repealed, 1987 c 309 s 27]
Subd. 15. [Repealed, 1987 c 309 s 27]
Subd. 16. [Repealed, 1Sp1985 c 9 art 2 s 104]
Subd. 17. [Repealed, 1Sp1985 c 9 art 2 s 104]
Subd. 18. [Repealed, 1Sp1985 c 9 art 2 s 104]
Subd. 19. [Repealed, 1987 c 309 s 27]
Subd. 20. [Repealed, 1987 c 309 s 27]

145.913 [Repealed, 1987 c 309 s 27]

145.914 [Repealed, 1987 c 309 s 27]

145.915 [Repealed, 1987 c 309 s 27]

145.916 [Repealed, 1987 c 309 s 27]

145.917 [Repealed, 1987 c 309 s 27]

145.918 [Repealed, 1987 c 309 s 27]

145.919 [Repealed, 1987 c 309 s 27]

145.92 [Repealed, 1987 c 309 s 27]

145.921 [Renumbered 145A.13]

145.922 [Repealed, 1987 c 309 s 27]

145.923 [Renumbered 145A.14, subd 3]

145.924 AIDS PREVENTION GRANTS.

(a) The commissioner may award grants to boards of health as defined in section 145A.02, subdivision 2, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, minorities, adolescents, intravenous drug users, and homosexual men.

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

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

History: *1987 c 309 s 24; 1988 c 689 art 2 s 46; 1991 c 292 art 2 s 31; 1999 c 245 art 2 s 31*

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

145.925 FAMILY PLANNING GRANTS.

Subdivision 1. **Eligible organizations; purpose.** The commissioner of health may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to provide prepregnancy family planning services.

Subd. 1a. **Family planning services; defined.** "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.

Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to this section to any nonprofit corporation which performs abortions. No state funds shall be used under contract from a grantee to any nonprofit corporation which performs abortions. This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or health maintenance organizations certified pursuant to chapter 62D.

Subd. 3. **Minors.** No funds provided by grants made pursuant to this section shall be used to support any family planning services for any unemancipated minor in any elementary or secondary school building.

Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part from funds provided under this section who advises an abortion or sterilization to

any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.

Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans and budgets of prospective grant recipients, for the submission of annual financial and statistical reports, and the maintenance of statements of source and application of funds by grant recipients. The commissioner of health may not require that any home rule charter or statutory city or county apply for or receive grants under this subdivision as a condition for the receipt of any state or federal funds unrelated to family planning services.

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

Any employee of the agencies engaged in the administration of the provisions of this section may refuse to accept the duty of offering family planning services to the extent that the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal, suspension, demotion, or any other discrimination in employment. The directors or supervisors of the agencies shall reassign the duties of employees in order to carry out the provisions of this section.

All information gathered by any agency, entity, or individual conducting programs in family planning is private data on individuals within the meaning of section 13.02, subdivision 12.

Subd. 7. **Family planning services; information required.** A grant recipient shall inform any person requesting counseling on family planning methods or procedures of:

(1) Any methods or procedures which may be followed, including identification of any which are experimental or any which may pose a health hazard to the person;

(2) A description of any attendant discomforts or risks which might reasonably be expected;

(3) A fair explanation of the likely results, should a method fail;

(4) A description of any benefits which might reasonably be expected of any method;

(5) A disclosure of appropriate alternative methods or procedures;

(6) An offer to answer any inquiries concerning methods of procedures; and

(7) An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time.

Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under any program receiving financial assistance under this section, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening the person with the loss of or disqualification for the receipt of any benefit or service under a program receiving state or federal financial assistance shall be guilty of a misdemeanor.

Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant funds for family planning special projects, shall not limit the total amount of funds that can be allocated to an organization. The commissioner shall allocate to an organization receiving grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the organization submits an application that meets grant funding criteria. This subdivision does not affect any procedure established in rule for allocating special project money to the different regions. The commissioner shall revise the rules for family planning special project grants so that they conform to the requirements of this subdivision. In adopting these revisions, the commissioner is

not subject to the rulemaking provisions of chapter 14, but is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

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

145.9255 MN ENABL, MINNESOTA EDUCATION NOW AND BABIES LATER; HEALTH.

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

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

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

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

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

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

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

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

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

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

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

(3) development of local media linkages.

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

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

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

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

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

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

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

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

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

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

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

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

History: *1995 c 257 art 4 s 1; 1Sp1995 c 3 art 16 s 13; 1999 c 245 art 2 s 32,33*

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

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

145.9261 ABSTINENCE EDUCATION GRANT PROGRAM.

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

History: *1998 c 407 art 2 s 84*

145.9265 FETAL ALCOHOL SYNDROME AND EFFECTS AND DRUG-EXPOSED INFANT PREVENTION.

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

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

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

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

History: *1992 c 571 art 10 s 8; 1Sp1995 c 3 art 16 s 13*

145.9266 FETAL ALCOHOL SYNDROME CAMPAIGN AND EDUCATION.

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

Subd. 2. **Statewide network of fetal alcohol syndrome diagnostic clinics.** A statewide network of regional fetal alcohol syndrome diagnostic clinics shall be developed between the department of health and the University of Minnesota. This collaboration shall be based on a statewide needs assessment and shall include involvement from consumers, providers, and payors. By the end of calendar year 1998, a plan shall be developed for the clinic network, and shall include a comprehensive evaluation component. Sites shall be established in calendar year 1999. The commissioner shall not access or collect individually identifiable data for the statewide network of regional fetal alcohol syndrome diagnostic clinics. Data collected at the clinics shall be maintained according to applicable data privacy laws, including section 144.335.

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

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

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

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

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

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

(1) birth to three years;

(2) three to five years;

(3) six to 12 years; and

(4) 13 to 18 years.

(c) Grant proposals must include an evaluation plan, demonstrate evidence of a collaborative or multisystem approach, provide parent education and support, and show evidence of a child- and family-focused approach consistent with research-based best educational practices and other guidelines developed by the department of children, families, and learning.

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

Subd. 6. **Fetal alcohol coordinating board; duties.** (a) The fetal alcohol coordinating board consists of:

(1) the commissioners of health, human services, corrections, public safety, economic security, and children, families, and learning;

(2) the director of the office of strategic and long-range planning;

(3) the chair of the maternal and child health advisory task force established by section 145.881, or the chair's designee;

(4) a representative of the University of Minnesota academic health center, appointed by the provost;

(5) five members from the general public appointed by the governor, one of whom must be a family member of an individual with fetal alcohol syndrome or fetal alcohol effect; and

(6) one member from the judiciary appointed by the chief justice of the supreme court.

Terms, compensation, removal, and filling of vacancies of appointed members are governed by section 15.0575. The board shall elect a chair from its membership to serve a one-year term. The commissioner of health shall provide staff and consultant support for the board. Support must be provided based on an annual budget and work plan developed by the board. The board shall contract with the department of health for necessary administrative services. Administrative services include personnel, budget, payroll, and contract administration. The board shall adopt an annual budget and work program.

(b) Board duties include:

(1) reviewing programs of state agencies that involve fetal alcohol syndrome and coordinating those that are interdepartmental in nature;

(2) providing an integrated and comprehensive approach to fetal alcohol syndrome prevention and intervention strategies both at a local and statewide level;

(3) approving on an annual basis the statewide public awareness campaign as designed and implemented by the commissioner of health under subdivision 1;

(4) reviewing fetal alcohol syndrome community grants administered by the commissioner of health under subdivision 4; and

(5) submitting a report to the governor on January 15 of each odd-numbered year summarizing board operations, activities, findings, and recommendations, and fetal alcohol syndrome activities throughout the state.

(c) The board expires on January 1, 2001.

Subd. 7. **Federal funds; contracts; donations.** The fetal alcohol coordinating board may apply for, receive, and disburse federal funds made available to the state by federal law or rules adopted for any purpose related to the powers and duties of the board. The board shall comply with any requirements of federal law, rules, and regulations in order to apply for, receive, and disburse funds. The board may contract with or provide grants to public and private nonprofit entities. The board may accept donations or grants from any public or private entity. Money received by the board must be deposited in a separate account in the state treasury and invested by the state board of investment. The amount deposited, including investment earnings, is appropriated to the board to carry out its duties. Money deposited in the state treasury shall not cancel.

History: *1998 c 398 art 9 s 2; 1998 c 407 art 2 s 85; 2002 c 220 art 16 s 1*

145.9268 COMMUNITY CLINIC GRANTS.

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

(1) a clinic that provides services under conditions as defined in Minnesota Rules, part 9505.0255, and utilizes a sliding fee scale to determine eligibility for charity care;

(2) an Indian tribal government or Indian health service unit; or

(3) a consortium of clinics comprised of entities under clause (1) or (2).

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to eligible community clinics to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. The commissioner shall award grants to community clinics in metropolitan and rural areas of the state, and shall ensure geographic representation in grant awards among all regions of the state.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. Community clinics may apply for and the commissioner may award grants for one-year or two-year periods.

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

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

(2) a description of the problem or problems the grant funds will be used to address; and

(3) a description of achievable objectives, a workplan, and a timeline for implementation and completion of processes or projects enabled by the grant.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the priority level of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base and the

degree to which grant funds will be used to support services increasing access to health care services. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.

(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations. In addition, the commissioner shall give priority, in declining order, to grant applications for projects that:

(1) provide a direct offset to expenses incurred for services provided to the clinic's target population;

(2) establish, update, or improve information, data collection, or billing systems;

(3) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;

(4) provide improvements for care delivery, such as increased translation and interpretation services; or

(5) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

(e) A grant awarded to an eligible community clinic may not exceed $300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed $300,000 per clinic included in the consortium. The commissioner has discretion over the number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on priority areas for grants set under subdivision 3 and provide any recommendations for adding or changing priority areas.

History: *1Sp2001 c 9 art 1 s 47; 2002 c 379 art 1 s 113*

145.927 [Repealed, 1Sp2001 c 9 art 1 s 62]

145.928 ELIMINATING HEALTH DISPARITIES.

Subdivision 1. **Goal; establishment.** It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Subd. 2. **State-community partnerships; plan.** The commissioner, in partnership with culturally based community organizations; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3. **Measurable outcomes.** The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in

the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. **Statewide assessment.** The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. **Technical assistance.** The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6. **Process.** (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. **Community grant program; immunization rates and infant mortality rates.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; or

(2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact both priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 8. **Community grant program; other health disparities.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact more than one priority area;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. **Health of foreign-born persons.** (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

(1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;

(2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;

(3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and

(4) $50 per foreign-born person in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. **Tribal governments.** The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 11. **Coordination.** The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

Subd. 12. **Evaluation.** Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs, community health board activities, and tribal government activities funded under this section. Grant recipients, tribal governments, and community health boards shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 13. **Report.** The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

Subd. 14. **Supplantation of existing funds.** Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

History: *1Sp2001 c 9 art 1 s 48; 2002 c 379 art 1 s 113*

POISON CONTROL SYSTEM

145.93 MINNESOTA POISON INFORMATION CENTERS; ESTABLISHMENT.

Subdivision 1. **Purpose.** The legislature finds that the needs of citizens of the state for information relating to the prompt identification and appropriate home management or referral of cases of human poisoning are best served by establishment of a single integrated poison control system, consisting of one or more regional poison information centers organized to provide statewide information and education services to the public and to health professionals.

Subd. 2. [Repealed, 1993 c 337 s 20]

Subd. 3. **Grant award; designation; payments under grant.** Each odd-numbered year the commissioner shall solicit applications for the poison information centers by giving reasonable public notice of the availability of money appropriated or otherwise available. The commissioner shall select from among the entities, whether profit or nonprofit, or units of government the applicants that best fulfill the criteria specified in subdivision 4. The grant shall be paid to the grantees quarterly beginning on July 1.

Subd. 4. **Selection criteria.** In selecting grantees under this section, the commissioner of health shall determine that the following criteria are met:

(a) whether the applicant can demonstrate the ability to provide appropriate and adequate telephone poison information services to the general public and to health professionals 24 hours a day at no direct cost to users and in a manner that appropriately utilizes "911" emergency telephone services developed pursuant to chapter 403;

(b) whether the applicant can demonstrate the ability to provide adequate medical direction as well as the toxicological and related professional and technical resources needed for poison information services;

(c) whether the applicant can demonstrate the ability to provide appropriate public education and professional education services;

(d) whether the applicant can demonstrate the ability to provide poison information services in a financially sound and cost-effective manner; and

(e) whether the applicant can demonstrate the ability to cooperate with interested health professionals throughout the state to provide poison information in a coordinated fashion.

Subd. 5. [Repealed, 1985 c 223 s 5]

Subd. 6. **Reports; monitoring; termination.** The grantees selected shall report quarterly to the commissioner of health, on a form provided by the commissioner, information about fiscal performance and status. Grantees shall also report annually information about programmatic status and performance. All relevant records and the performance of the grantee shall be monitored by the commissioner for purposes of assuring that the grantee continues to fulfill the criteria specified in subdivision 4. Should the commissioner at any time find that a grantee is not continuing to fulfill the criteria specified in subdivision 4, the commissioner may terminate the grant upon 30 days' notice.

History: *1980 c 577 s 1; 1983 c 260 s 32,33; 1985 c 223 s 1-4; 1989 c 209 art 2 s 1; 1999 c 159 s 27*

HAZARDOUS SUBSTANCE EXPOSURE

145.94 EXPOSURE TO HAZARDOUS SUBSTANCE.

Subdivision 1. **Site inspection.** To determine hazardous substance exposure to the community, the commissioner of health may enter the premises of any employer as defined in section 182.651, subdivision 7, including the University of Minnesota, to investigate the actual, suspected, or potential release of a hazardous substance if there is evidence or risk of exposure to the community. Before entering the commissioner shall present to the employer a statement of the reason, nature, and scope of the investigation at a particular location. As part of the investigation, and upon request to the employer, the commissioner must be allowed access to information required under the Employee Right-To-Know Act to determine if there are existing or potential health hazards to the community from the release of any hazardous substance originating in the workplace of the employer.

Subd. 2. **Disclosure of information.** The commissioner may disclose to individuals or to the community, information including data made nonpublic by law, relating to the hazardous properties and health hazards of hazardous substances released from a workplace if the commissioner finds:

(1) evidence that a person requesting the information may have suffered or is likely to suffer illness or injury from exposure to a hazardous substance; or

(2) evidence of a community health risk and if the commissioner seeks to have the employer cease an activity which results in release of a hazardous substance.

Nonpublic data obtained under subdivision 1 is subject to handling, use, and storage according to established standards to prevent unauthorized use or disclosure. If the nonpublic data is required for the diagnosis, treatment, or prevention of illness or injury, a personal physician may be provided with this information if the physician agrees to preserve the confidentiality of the information, except for patient health records subject to section 144.335. After the disclosure of any hazardous substance information relating to a particular workplace, the commissioner shall advise the employer of the information disclosed, the date of the disclosure, and the person who received the information.

History: *1986 c 456 s 1; 1Sp1986 c 3 art 2 s 9*

145.95 MS 1980 [Expired]

LONG-TERM DEVELOPMENT PROGRAM FOR CHILDREN

145.951 CHILDREN HELPED IN LONG-TERM DEVELOPMENT; IMPLEMENTATION PLAN.

The commissioner of health, in consultation with the commissioners of children, families, and learning; corrections; public safety; and human services, and with the directors of the office of strategic and long-range planning, the council on disability, and the councils and commission under sections 3.922 to 3.9226, may develop an

implementation plan for the establishment of a statewide program to assist families in developing the full potential of their children. The program must be designed to strengthen the family, to reduce the risk of abuse to children, and to promote the long-term development of children in their home environments. The program must also be designed to use volunteers to provide support to parents, and to link parents with existing public health, education, and social services as appropriate.

History: *1996 c 451 art 4 s 25*

145.952 DEFINITIONS.

Subdivision 1. **Scope.** The definitions in this section apply to sections 145.951 to 145.957.

Subd. 2. **Abuse.** "Abuse" means physical abuse, sexual abuse, neglect, mental injury, and threatened injury, as those terms are defined in section 626.556, subdivision 2.

Subd. 3. **CHILD program or program.** "CHILD program" or "program" means the children helped in long-term development program that the commissioner shall plan to be implemented under sections 145.951 to 145.957.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 5. **Local organization.** "Local organization" means an organization that contracts with the commissioner under section 145.953, subdivision 1, to administer the CHILD program on a local level.

History: *1996 c 451 art 4 s 26*

145.953 PROGRAM STRUCTURE.

Subdivision 1. **Local administration of program.** The implementation plan must require the commissioner to contract with appropriate private nonprofit and governmental organizations to administer the CHILD program on a local level. The local organization, in collaboration and coordination with the department of health, shall be responsible for recruiting, screening training, and overseeing volunteers for the program.

Subd. 2. **Volunteer component.** The implementation plan must provide that a volunteer will be matched with a family to provide ongoing support in parenting. The volunteer shall provide the family with information on the CHILD program and other social services available. Through home visits and frequent contact, the volunteer shall provide support and guidance on raising the child and coping with stresses that may increase the risk of abuse. The volunteer shall also assist the family in obtaining other needed services from existing social services programs.

History: *1996 c 451 art 4 s 27*

145.954 STANDARDS FOR PROGRAM.

In planning for the implementation of the program, the commissioner shall:

(1) establish mechanisms to encourage families to participate in the CHILD program;

(2) establish mechanisms to identify families who may wish to participate in the CHILD program and to match volunteers with these families either before or as soon as possible after a child is born;

(3) ensure that local organizations coordinate with services already provided by the departments of health, human services, and children, families, and learning to ensure that participating families receive a continuum of care;

(4) coordinate with local social services agencies, local health boards, and community health boards;

(5) ensure that services provided through the program are community-based and that the special needs of minority communities are addressed;

(6) develop and implement appropriate systems to gather data on participating families and to monitor and evaluate their progress; and

(7) evaluate the program's effectiveness.

History: *1996 c 451 art 4 s 28*

145.955 DUTIES OF LOCAL ORGANIZATION.

The implementation plan shall require the local organizations to:

(1) recruit and train volunteers to serve families under the program, according to section 145.956;

(2) provide ongoing supervision and consultation to volunteers; and

(3) develop resource and referral booklets that volunteers can distribute to families served by the program. The booklets shall contain comprehensive information on the spectrum of services available to assist the family and to reduce the risk of abuse.

History: *1996 c 451 art 4 s 29*

145.956 TRAINING AND RECRUITMENT OF VOLUNTEERS.

Subdivision 1. **Training requirements.** (a) The implementation plan shall require the local organization to carefully screen and train volunteers to provide program services. Training must prepare volunteers to:

(1) identify signs of abuse or other indications that a child may be at risk of abuse;

(2) help families develop communications skills;

(3) teach and reinforce healthy discipline techniques;

(4) provide other support a family needs to cope with stresses that increase the risk of abuse; and

(5) refer the family to other appropriate public health, education, and social services.

(b) The implementation plan shall also include procedures whereby the local agency will provide ongoing support, supervision, and training for all volunteers. Training must be culturally appropriate and community-based, and must incorporate input from parents who will be using the program's services.

Subd. 2. **Recruitment of volunteers.** The implementation plan must require that the local organization recruit minority volunteers to serve communities of color.

History: *1996 c 451 art 4 s 30*

145.957 ELIGIBILITY.

The implementation plan must ensure that all residents of Minnesota are eligible for services under the program. The plan must make services available on a sliding fee basis. The commissioner shall develop a sliding fee scale for the program.

History: *1996 c 451 art 4 s 31*

HILL-BURTON PROGRAM

145.97 HILL-BURTON PROGRAM; RECORD KEEPING.

The commissioner shall maintain records on the number and nature of complaints received and any actions taken to implement or enforce the Hill-Burton laws and rules.

History: *1981 c 360 art 2 s 8; 1982 c 424 s 130; 1984 c 640 s 32; 1996 c 305 art 2 s 31*

145.98 COUNCIL ON HEALTH PROMOTION AND WELLNESS.

Subdivision 1. **Creation; membership.** The commissioner of health may appoint an advisory task force on health promotion and wellness. Members of the task force shall be experienced or interested in health promotion and wellness. There shall be at least

one member from each congressional district. The task force shall expire, and the terms, compensation, and removal of members shall be governed by section 15.059.

Subd. 2. [Repealed, 1983 c 260 s 68]

Subd. 3. **Powers.** The task force may solicit, receive, and disburse funds made available for health promotion and wellness.

Subd. 4. [Repealed, 1983 c 260 s 68]

History: *1982 c 453 s 1; 1983 c 260 s 34,35*