

1.1 ..... moves to amend H.F. No. 2005 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. Minnesota Statutes 2012, section 62U.04, subdivision 4, is amended to read:

1.4 Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months  
1.5 thereafter, all health plan companies and third-party administrators shall submit encounter  
1.6 data to a private entity designated by the commissioner of health. The data shall be  
1.7 submitted in a form and manner specified by the commissioner subject to the following  
1.8 requirements:

1.9 (1) the data must be de-identified data as described under the Code of Federal  
1.10 Regulations, title 45, section 164.514;

1.11 (2) the data for each encounter must include an identifier for the patient's health care  
1.12 home if the patient has selected a health care home; and

1.13 (3) except for the identifier described in clause (2), the data must not include  
1.14 information that is not included in a health care claim or equivalent encounter information  
1.15 transaction that is required under section 62J.536.

1.16 (b) The commissioner or the commissioner's designee shall only use the data  
1.17 submitted under paragraph (a) to carry out its responsibilities in this section, including  
1.18 supplying the data to providers so they can verify their results of the peer grouping process  
1.19 consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d),  
1.20 and adopted by the commissioner and, if necessary, submit comments to the commissioner  
1.21 or initiate an appeal.

1.22 (c) Data on providers collected under this subdivision are private data on individuals  
1.23 or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary  
1.24 data in section 13.02, subdivision 19, summary data prepared under this subdivision  
1.25 may be derived from nonpublic data. The commissioner or the commissioner's designee  
1.26 shall establish procedures and safeguards to protect the integrity and confidentiality of  
1.27 any data that it maintains.

2.1 (d) The commissioner or the commissioner's designee shall not publish analyses or  
2.2 reports that identify, or could potentially identify, individual patients.

2.3 (e) The commissioner shall compile summary information on the data submitted  
2.4 under this subdivision. The commissioner shall work with its vendors to assess the  
2.5 data submitted in terms of compliance with the data submission requirements and the  
2.6 completeness of the data submitted by comparing the data with summary information  
2.7 compiled by the commissioner and with established and emerging data quality standards  
2.8 to ensure data quality.

2.9 Sec. 2. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision  
2.10 to read:

2.11 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding  
2.12 subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the  
2.13 commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for  
2.14 the following purposes:

2.15 (1) to evaluate the performance of the health care home program as authorized under  
2.16 sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

2.17 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
2.18 (RARE) campaign, hospital readmission trends and rates;

2.19 (3) to analyze variations in health care costs, quality, utilization, and illness burden  
2.20 based on geographical areas or populations; and

2.21 (4) to evaluate the state innovation model (SIM) testing grant received by the  
2.22 Departments of Health and Human Services, including the analysis of health care cost,  
2.23 quality, and utilization baseline and trend information for targeted populations and  
2.24 communities.

2.25 (b) The commissioner may publish the results of the authorized uses identified  
2.26 in paragraph (a) so long as the data released publicly do not contain information or  
2.27 descriptions in which the identity of individual hospitals, clinics, or other providers may  
2.28 be discerned.

2.29 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from  
2.30 using the data collected under subdivision 4 to complete the state-based risk adjustment  
2.31 system assessment due to the legislature on October 1, 2015.

2.32 (d) The commissioner or the commissioner's designee may use the data submitted  
2.33 under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until  
2.34 July 1, 2016.

3.1 Sec. 3. Minnesota Statutes 2013 Supplement, section 144.493, subdivision 1, is  
3.2 amended to read:

3.3 Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a  
3.4 comprehensive stroke center if the hospital has been certified as a comprehensive stroke  
3.5 center by the joint commission or another nationally recognized accreditation entity and  
3.6 the hospital participates in the Minnesota stroke registry program.

3.7 Sec. 4. Minnesota Statutes 2013 Supplement, section 144.493, subdivision 2, is  
3.8 amended to read:

3.9 Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke  
3.10 center if the hospital has been certified as a primary stroke center by the joint commission  
3.11 or another nationally recognized accreditation entity and the hospital participates in the  
3.12 Minnesota stroke registry program.

3.13 Sec. 5. Minnesota Statutes 2012, section 152.126, as amended by Laws 2013, chapter  
3.14 113, article 3, section 3, is amended to read:

3.15 **~~152.126 CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC~~**  
3.16 **~~REPORTING SYSTEM PRESCRIPTION MONITORING PROGRAM.~~**

3.17 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in  
3.18 this subdivision have the meanings given.

3.19 ~~(a)~~ (b) "Board" means the Minnesota State Board of Pharmacy established under  
3.20 chapter 151.

3.21 ~~(b)~~ (c) "Controlled substances" means those substances listed in section 152.02,  
3.22 subdivisions 3 to ~~5~~ 6, and those substances defined by the board pursuant to section  
3.23 152.02, subdivisions 7, 8, and 12. For the purposes of this section, controlled substances  
3.24 includes tramadol and butalbital.

3.25 ~~(c)~~ (d) "Dispense" or "dispensing" has the meaning given in section 151.01,  
3.26 subdivision 30. Dispensing does not include the direct administering of a controlled  
3.27 substance to a patient by a licensed health care professional.

3.28 ~~(d)~~ (e) "Dispenser" means a person authorized by law to dispense a controlled  
3.29 substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does  
3.30 not include a licensed hospital pharmacy that distributes controlled substances for inpatient  
3.31 hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

3.32 ~~(e)~~ (f) "Prescriber" means a licensed health care professional who is authorized to  
3.33 prescribe a controlled substance under section 152.12, subdivision 1 or 2.

3.34 ~~(f)~~ (g) "Prescription" has the meaning given in section 151.01, subdivision 16.

4.1 Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or  
 4.2 interfere with the legitimate prescribing of controlled substances for pain. No prescriber  
 4.3 shall be subject to disciplinary action by a health-related licensing board for prescribing a  
 4.4 controlled substance according to the provisions of section 152.125.

4.5 Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish  
 4.6 by January 1, 2010, an electronic system for reporting the information required under  
 4.7 subdivision 4 for all controlled substances dispensed within the state.

4.8 (b) The board may contract with a vendor for the purpose of obtaining technical  
 4.9 assistance in the design, implementation, operation, and maintenance of the electronic  
 4.10 reporting system.

4.11 Subd. 3. **Prescription Electronic Reporting Monitoring Program Advisory**  
 4.12 **Committee Task Force.** (a) The board ~~shall convene~~ shall appoint an advisory committee.  
 4.13 ~~The committee must include~~ task force consisting of at least one representative of:

- 4.14 (1) the Department of Health;
- 4.15 (2) the Department of Human Services;
- 4.16 (3) each health-related licensing board that licenses prescribers;
- 4.17 (4) a professional medical association, which may include an association of pain  
 4.18 management and chemical dependency specialists;
- 4.19 (5) a professional pharmacy association;
- 4.20 (6) a professional nursing association;
- 4.21 (7) a professional dental association;
- 4.22 (8) a consumer privacy or security advocate; and
- 4.23 (9) a consumer or patient rights organization.

4.24 (b) The advisory ~~committee~~ task force shall advise the board on the development and  
 4.25 operation of the ~~electronic reporting system~~ prescription monitoring program, including,  
 4.26 but not limited to:

- 4.27 (1) technical standards for electronic prescription drug reporting;
- 4.28 (2) proper analysis and interpretation of prescription monitoring data; and
- 4.29 (3) an evaluation process for the program.

4.30 (c) The task force is governed by section 15.059. Notwithstanding section 15.059,  
 4.31 subdivision 5, the task force shall not expire.

4.32 Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the  
 4.33 following data to the board or its designated vendor, ~~subject to the notice required under~~  
 4.34 ~~paragraph (d):~~

- 4.35 (1) name of the prescriber;
- 4.36 (2) national provider identifier of the prescriber;

- 5.1 (3) name of the dispenser;
- 5.2 (4) national provider identifier of the dispenser;
- 5.3 (5) prescription number;
- 5.4 (6) name of the patient for whom the prescription was written;
- 5.5 (7) address of the patient for whom the prescription was written;
- 5.6 (8) date of birth of the patient for whom the prescription was written;
- 5.7 (9) date the prescription was written;
- 5.8 (10) date the prescription was filled;
- 5.9 (11) name and strength of the controlled substance;
- 5.10 (12) quantity of controlled substance prescribed;
- 5.11 (13) quantity of controlled substance dispensed; and
- 5.12 (14) number of days supply.

5.13 (b) The dispenser must submit the required information by a procedure and in a  
 5.14 format established by the board. The board may allow dispensers to omit data listed in this  
 5.15 subdivision or may require the submission of data not listed in this subdivision provided  
 5.16 the omission or submission is necessary for the purpose of complying with the electronic  
 5.17 reporting or data transmission standards of the American Society for Automation in  
 5.18 Pharmacy, the National Council on Prescription Drug Programs, or other relevant national  
 5.19 standard-setting body.

5.20 (c) A dispenser is not required to submit this data for those controlled substance  
 5.21 prescriptions dispensed for:

5.22 ~~(1) individuals residing in licensed skilled nursing or intermediate care facilities;~~

5.23 ~~(2) individuals receiving assisted living services under chapter 144G or through a  
 5.24 medical assistance home and community-based waiver;~~

5.25 ~~(3) individuals receiving medication intravenously;~~

5.26 ~~(4) individuals receiving hospice and other palliative or end-of-life care; and~~

5.27 ~~(5) individuals receiving services from a home care provider regulated under chapter  
 5.28 144A.~~

5.29 (1) individuals residing in a health care facility as defined in section 151.58,  
 5.30 subdivision 2, paragraph (b), when a drug is distributed through the use of an automated  
 5.31 drug distribution system according to section 151.58; and

5.32 (2) individuals receiving a drug sample that was packaged by a manufacturer and  
 5.33 provided to the dispenser for dispensing as a professional sample pursuant to Code of  
 5.34 Federal Regulations, title 21, section 203, subpart D.

5.35 ~~(d) A dispenser must not submit data under this subdivision unless provide to the~~  
 5.36 ~~patient for whom the prescription was written a conspicuous notice of the reporting~~

6.1 requirements of this section is ~~given to the patient for whom the prescription was written~~  
6.2 and notice that the information may be used for program administration purposes.

6.3 Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database  
6.4 of the data reported under subdivision 4. The board shall maintain data that could identify  
6.5 an individual prescriber or dispenser in encrypted form. Except as otherwise allowed  
6.6 under subdivision 6, the database may be used by permissible users identified under  
6.7 subdivision 6 for the identification of:

6.8 (1) individuals receiving prescriptions for controlled substances from prescribers  
6.9 who subsequently obtain controlled substances from dispensers in quantities or with a  
6.10 frequency inconsistent with generally recognized standards of use for those controlled  
6.11 substances, including standards accepted by national and international pain management  
6.12 associations; and

6.13 (2) individuals presenting forged or otherwise false or altered prescriptions for  
6.14 controlled substances to dispensers.

6.15 (b) No permissible user identified under subdivision 6 may access the database  
6.16 for the sole purpose of identifying prescribers of controlled substances for unusual or  
6.17 excessive prescribing patterns without a valid search warrant or court order.

6.18 (c) No personnel of a state or federal occupational licensing board or agency may  
6.19 access the database for the purpose of obtaining information to be used to initiate or  
6.20 substantiate a disciplinary action against a prescriber.

6.21 (d) Data reported under subdivision 4 shall be ~~retained by the board in the database~~  
6.22 ~~for a 12-month period, and shall be removed from the database no later than 12 months~~  
6.23 ~~from the last day of the month during which the data was received.~~ made available to  
6.24 permissible users for a 12-month period beginning the day the data was received and  
6.25 ending 12 months from the last day of the month in which the data was received, except  
6.26 that permissible users defined in subdivision 6, paragraph (b), clauses (5) and (6), may  
6.27 use all data collected under this section for the purposes of administering, operating,  
6.28 and maintaining the prescription monitoring program and conducting trend analyses  
6.29 and other studies necessary to evaluate the effectiveness of the program. Data retained  
6.30 beyond 12 months must be de-identified.

6.31 (e) The board shall not retain data reported under subdivision 4 for a period longer  
6.32 than five years from the date the data was received.

6.33 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this  
6.34 subdivision, the data submitted to the board under subdivision 4 is private data on  
6.35 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

7.1 (b) Except as specified in subdivision 5, the following persons shall be considered  
7.2 permissible users and may access the data submitted under subdivision 4 in the same or  
7.3 similar manner, and for the same or similar purposes, as those persons who are authorized  
7.4 to access similar private data on individuals under federal and state law:

7.5 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has  
7.6 delegated the task of accessing the data, to the extent the information relates specifically to  
7.7 a current patient, to whom the prescriber is:

7.8 (i) prescribing or considering prescribing any controlled substance;

7.9 (ii) providing emergency medical treatment for which access to the data may be  
7.10 necessary; or

7.11 (iii) providing other medical treatment for which access to the data may be necessary  
7.12 and the patient has consented to access to the submitted data, and with the provision that  
7.13 the prescriber remains responsible for the use or misuse of data accessed by a delegated  
7.14 agent or employee;

7.15 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has  
7.16 delegated the task of accessing the data, to the extent the information relates specifically  
7.17 to a current patient to whom that dispenser is dispensing or considering dispensing any  
7.18 controlled substance and with the provision that the dispenser remains responsible for the  
7.19 use or misuse of data accessed by a delegated agent or employee;

7.20 (3) an individual who is the recipient of a controlled substance prescription for  
7.21 which data was submitted under subdivision 4, or a guardian of the individual, parent or  
7.22 guardian of a minor, or health care agent of the individual acting under a health care  
7.23 directive under chapter 145C;

7.24 (4) personnel of the board specifically assigned to conduct a bona fide investigation  
7.25 of a specific licensee;

7.26 (5) personnel of the board engaged in the collection, review, and analysis  
7.27 of controlled substance prescription information as part of the assigned duties and  
7.28 responsibilities under this section;

7.29 (6) authorized personnel of a vendor under contract with the ~~board~~ state of  
7.30 Minnesota who are engaged in the design, implementation, operation, and maintenance of  
7.31 the ~~electronic reporting system~~ prescription monitoring program as part of the assigned  
7.32 duties and responsibilities of their employment, provided that access to data is limited to  
7.33 the minimum amount necessary to carry out such duties and responsibilities, and subject  
7.34 to the requirement of de-identification and time limit on retention of data specified in  
7.35 subdivision 5, paragraphs (d) and (e);

8.1 (7) federal, state, and local law enforcement authorities acting pursuant to a valid  
8.2 search warrant;

8.3 (8) personnel of the ~~medical assistance program~~ Minnesota health care programs  
8.4 assigned to use the data collected under this section to identify recipients whose usage of  
8.5 controlled substances may warrant restriction to a single primary care ~~physician provider~~,  
8.6 a single outpatient pharmacy, ~~or~~ and a single hospital; ~~and~~

8.7 (9) personnel of the Department of Human Services assigned to access the data  
8.8 pursuant to paragraph (h); and

8.9 (10) personnel of the health professionals services program established under section  
8.10 214.31, to the extent that the information relates specifically to an individual who is  
8.11 currently enrolled in and being monitored by the program, and the individual consents to  
8.12 access to that information. The health professionals services program personnel shall not  
8.13 provide this data to a health-related licensing board or the Emergency Medical Services  
8.14 Regulatory Board, except as permitted under section 214.33, subdivision 3.

8.15 For purposes of clause ~~(3)~~ (4), access by an individual includes persons in the  
8.16 definition of an individual under section 13.02.

8.17 (c) ~~Any~~ A permissible user identified in paragraph (b), ~~who~~ clauses (1), (2), (5), (6),  
8.18 and (8) may directly access the data electronically; If the data is directly accessed  
8.19 electronically, the permissible user shall implement and maintain a comprehensive  
8.20 information security program that contains administrative, technical, and physical  
8.21 safeguards that are appropriate to the user's size and complexity, and the sensitivity of the  
8.22 personal information obtained. The permissible user shall identify reasonably foreseeable  
8.23 internal and external risks to the security, confidentiality, and integrity of personal  
8.24 information that could result in the unauthorized disclosure, misuse, or other compromise  
8.25 of the information and assess the sufficiency of any safeguards in place to control the risks.

8.26 (d) The board shall not release data submitted under ~~this section~~ subdivision 4 unless  
8.27 it is provided with evidence, satisfactory to the board, that the person requesting the  
8.28 information is entitled to receive the data.

8.29 ~~(e) The board shall not release the name of a prescriber without the written consent~~  
8.30 ~~of the prescriber or a valid search warrant or court order. The board shall provide a~~  
8.31 ~~mechanism for a prescriber to submit to the board a signed consent authorizing the release~~  
8.32 ~~of the prescriber's name when data containing the prescriber's name is requested.~~

8.33 ~~(f)~~ (e) The board shall maintain a log of all persons who access the data for a period  
8.34 of at least three years and shall ensure that any permissible user complies with paragraph  
8.35 (c) prior to attaining direct access to the data.



9.1 ~~(g)~~ (f) Section 13.05, subdivision 6, shall apply to any contract the board enters into  
 9.2 pursuant to subdivision 2. A vendor shall not use data collected under this section for  
 9.3 any purpose not specified in this section.

9.4 (g) The board may participate in an interstate prescription monitoring program data  
 9.5 exchange system provided that permissible users in other states have access to the data  
 9.6 only as allowed under this section, and that section 13.05, subdivision 6, applies to any  
 9.7 contract or memorandum of understanding that the board enters into under this paragraph.

9.8 (h) With available appropriations, the commissioner of human services shall  
 9.9 establish and implement a system through which the Department of Human Services shall  
 9.10 routinely access the data for the purpose of determining whether any client enrolled in  
 9.11 an opioid treatment program licensed according to chapter 245A has been prescribed or  
 9.12 dispensed a controlled substance in addition to that administered or dispensed by the  
 9.13 opioid treatment program. When the commissioner determines there have been multiple  
 9.14 prescribers or multiple prescriptions of controlled substances, the commissioner shall:

9.15 (1) inform the medical director of the opioid treatment program only that the  
 9.16 commissioner determined the existence of multiple prescribers or multiple prescriptions of  
 9.17 controlled substances; and

9.18 (2) direct the medical director of the opioid treatment program to access the data  
 9.19 directly, review the effect of the multiple prescribers or multiple prescriptions, and  
 9.20 document the review.

9.21 If determined necessary, the commissioner of human services shall seek a federal waiver  
 9.22 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, part  
 9.23 2.34, item (c), prior to implementing this paragraph.

9.24 (i) The board may provide de-identified data submitted under subdivision 4 for public  
 9.25 research, policy, or education purposes, that does not involve information that is likely to  
 9.26 reveal the identity of the patient, prescriber, or dispenser who is the subject of the data.

9.27 **Subd. 7. Disciplinary action.** (a) A dispenser who knowingly fails to submit data to  
 9.28 the board as required under this section is subject to disciplinary action by the appropriate  
 9.29 health-related licensing board.

9.30 (b) A prescriber or dispenser authorized to access the data who knowingly discloses  
 9.31 the data in violation of state or federal laws relating to the privacy of health care data  
 9.32 shall be subject to disciplinary action by the appropriate health-related licensing board,  
 9.33 and appropriate civil penalties.

9.34 ~~Subd. 8. Evaluation and reporting.~~ (a) ~~The board shall evaluate the prescription~~  
 9.35 ~~electronic reporting system to determine if the system is negatively impacting appropriate~~

10.1 ~~prescribing practices of controlled substances. The board may contract with a vendor to~~  
 10.2 ~~design and conduct the evaluation.~~

10.3 ~~(b) The board shall submit the evaluation of the system to the legislature by July~~  
 10.4 ~~15, 2011.~~

10.5 Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A  
 10.6 pharmacist, prescriber, or other dispenser making a report to the program in good faith  
 10.7 under this section is immune from any civil, criminal, or administrative liability, which  
 10.8 might otherwise be incurred or imposed as a result of the report, or on the basis that the  
 10.9 pharmacist or prescriber did or did not seek or obtain or use information from the program.

10.10 (b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser  
 10.11 to obtain information about a patient from the program, and the pharmacist, prescriber,  
 10.12 or other dispenser, if acting in good faith, is immune from any civil, criminal, or  
 10.13 administrative liability that might otherwise be incurred or imposed for requesting,  
 10.14 receiving, or using information from the program.

10.15 Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit  
 10.16 charitable foundations, the federal government, and other sources to fund the enhancement  
 10.17 and ongoing operations of the prescription ~~electronic reporting system~~ monitoring  
 10.18 program established under this section. Any funds received shall be appropriated to the  
 10.19 board for this purpose. The board may not expend funds to enhance the program in a way  
 10.20 that conflicts with this section without seeking approval from the legislature.

10.21 (b) Notwithstanding any other section, the administrative services unit for the  
 10.22 health-related licensing boards shall apportion between the Board of Medical Practice, the  
 10.23 Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of  
 10.24 Optometry, the Board of Veterinary Medicine, and the Board of Pharmacy an amount to  
 10.25 be paid through fees by each respective board. The amount apportioned to each board  
 10.26 shall equal each board's share of the annual appropriation to the Board of Pharmacy  
 10.27 from the state government special revenue fund for operating the prescription ~~electronic~~  
 10.28 ~~reporting system~~ monitoring program under this section. Each board's apportioned share  
 10.29 shall be based on the number of prescribers or dispensers that each board identified in  
 10.30 this paragraph licenses as a percentage of the total number of prescribers and dispensers  
 10.31 licensed collectively by these boards. Each respective board may adjust the fees that the  
 10.32 boards are required to collect to compensate for the amount apportioned to each board by  
 10.33 the administrative services unit.

10.34 Sec. 6. Minnesota Statutes 2013 Supplement, section 256N.21, is amended by adding a  
 10.35 subdivision to read:

11.1 Subd. 7. **Background study.** (a) A county or private agency conducting a  
 11.2 background study for purposes of child foster care licensing or approval must conduct  
 11.3 the study in accordance with chapter 245C and must meet the requirements in United  
 11.4 States Code, title 42, section 671(a)(20).

11.5 (b) A tribal organization conducting a background study for purposes of child foster  
 11.6 care licensing or approval must conduct the study in accordance with the requirements in  
 11.7 United States Code, title 25, sections 1931 to 1932. The study must meet the requirements  
 11.8 in United States Code, title 42, section 671(a)(20), when applicable.

11.9 Sec. 7. **[403.51] AUTOMATIC EXTERNAL DEFIBRILLATION;**  
 11.10 **REGISTRATION.**

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

11.13 (b) "Automatic external defibrillator" or "AED" means an electronic device designed  
 11.14 and manufactured to operate automatically or semiautomatically for the purpose of  
 11.15 delivering an electrical current to the heart of a person in sudden cardiac arrest.

11.16 (c) "AED registry" means a registry of AEDs that requires a maintenance program  
 11.17 or package, and includes, but is not limited to, the following registries: the Minnesota  
 11.18 AED Registry, the National AED Registry, iRescu, or a manufacturer-specific program.

11.19 (d) "Person" means a natural person, partnership, association, corporation, or unit  
 11.20 of government.

11.21 (e) "Public access AED" means any AED that is intended, by its markings or display,  
 11.22 to be used or accessed by the public for the benefit of the general public that may happen  
 11.23 to be in the vicinity or location of that AED. It does not include an AED that is owned or  
 11.24 used by a hospital, clinic, business, or organization that is intended to be used by staff and  
 11.25 is not marked or displayed in a manner to encourage public access.

11.26 (f) "Maintenance program or package" means a program that will alert the AED  
 11.27 owner when the AED has electrodes and batteries due to expire or replaces those expiring  
 11.28 electrodes and batteries for the AED owner.

11.29 (g) "Public safety agency" means local law enforcement, county sheriff, municipal  
 11.30 police, tribal agencies, state law enforcement, fire departments, including municipal  
 11.31 departments, industrial fire brigades, and nonprofit fire departments, joint powers agencies,  
 11.32 and licensed ambulance services.

11.33 (h) "Mobile AED" means an AED that (1) is purchased with the intent of being located  
 11.34 in a vehicle, including, but not limited to, public safety agency vehicles; or (2) will not be  
 11.35 placed in stationary storage, including, but not limited to, an AED used at an athletic event.

12.1 (i) "Private use AED" means an AED that is not intended to be used or accessed by  
 12.2 the public for the benefit of the general public. This may include, but is not limited to,  
 12.3 AEDs found in private residences.

12.4 Subd. 2. **Registration.** A person who purchases or obtains a public access AED shall  
 12.5 register that device with an AED registry within 30 working days of receiving the AED.

12.6 Subd. 3. **Required information.** A person registering a public access AED shall  
 12.7 provide the following information for each AED:

12.8 (1) AED manufacturer, model, and serial number;

12.9 (2) specific location where the AED will be kept; and

12.10 (3) the title, address, and telephone number of a person in management at the  
 12.11 business or organization where the AED is located.

12.12 Subd. 4. **Information changes.** The owner of a public access AED shall notify their  
 12.13 AED registry of any changes in the information that is required in the registration within  
 12.14 30 working days of the change occurring.

12.15 Subd. 5. **Public access AED requirements.** A public access AED:

12.16 (1) may be inspected during regular business hours by a public safety agency with  
 12.17 jurisdiction over the location of the AED;

12.18 (2) shall be kept in the location specified in the registration; and

12.19 (3) shall be reasonably maintained, including replacement of dead batteries and  
 12.20 pads/electrodes, and comply with all manufacturer's recall and safety notices.

12.21 Subd. 6. **Removal of AED.** An authorized agent of a public safety agency with  
 12.22 jurisdiction over the location of the AED may direct the owner of a public access AED  
 12.23 to comply with this section. Such authorized agent of a public safety agency may direct  
 12.24 the owner of the AED to remove the AED from its public access location and to remove  
 12.25 or cover any public signs relating to that AED if it is determined that the AED is not  
 12.26 ready for immediate use.

12.27 Subd. 7. **Private use AEDs.** The owner of a private use AED is not subject to the  
 12.28 requirements of this section but is encouraged to maintain the AED in a consistent manner.

12.29 Subd. 8. **Mobile AEDs.** The owner of a mobile AED is not subject to the  
 12.30 requirements of this section but is encouraged to maintain the AED in a consistent manner.

12.31 Subd. 9. **Signs.** A person acquiring a public use AED is encouraged but is not  
 12.32 required to post signs bearing the universal AED symbol in order to increase the ease of  
 12.33 access by the public to the AED in the event of an emergency. A person may not post any  
 12.34 AED sign or allow any AED sign to remain posted upon being ordered to remove or cover  
 12.35 any AED signs by an authorized agent of a public safety agency.

13.1 Subd. 10. **Emergency response plans.** The owner of one or more public access  
 13.2 AEDs shall develop an emergency response plan appropriate for the nature of the facility  
 13.3 the AED is intended to serve.

13.4 Subd. 11. **No civil liability.** Nothing in this section shall create any civil liability on  
 13.5 the part of an AED owner.

13.6 **EFFECTIVE DATE.** This section is effective August 1, 2014.

13.7 Sec. 8. **[604A.04] GOOD SAMARITAN OVERDOSE PREVENTION.**

13.8 Subdivision 1. **Definitions; opiate antagonist.** For purposes of this section, "opiate  
 13.9 antagonist" means naloxone hydrochloride or any similarly acting drug approved by the  
 13.10 federal Food and Drug Administration for the treatment of a drug overdose.

13.11 Subd. 2. **Authority to possess and administer opiate antagonists; release from**  
 13.12 **liability.** (a) A person who is not a health care professional may possess or administer  
 13.13 an opiate antagonist that is prescribed, dispensed, or distributed by a licensed health  
 13.14 care professional pursuant to subdivision 3.

13.15 (b) A person who is not a health care professional who acts in good faith in  
 13.16 administering an opiate antagonist to another person whom the person believes in good  
 13.17 faith to be suffering a drug overdose is immune from criminal prosecution for the act and  
 13.18 is not liable for any civil damages for acts or omissions resulting from the act.

13.19 Subd. 3. **Health care professionals; release from liability.** A licensed health  
 13.20 care professional who is permitted by law to prescribe an opiate antagonist, if acting  
 13.21 in good faith, may directly or by standing order prescribe, dispense, distribute, or  
 13.22 administer an opiate antagonist to a person without being subject to civil liability or  
 13.23 criminal prosecution for the act. This immunity applies even when the opiate antagonist  
 13.24 is eventually administered in either or both of the following instances: (1) by someone  
 13.25 other than the person to whom it is prescribed; or (2) to someone other than the person  
 13.26 to whom it is prescribed.

13.27 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to  
 13.28 actions arising from incidents occurring on or after that date.

13.29 Sec. 9. Minnesota Statutes 2013 Supplement, section 626.557, subdivision 9, is  
 13.30 amended to read:

13.31 Subd. 9. **Common entry point designation.** (a) Each county board shall designate a  
 13.32 common entry point for reports of suspected maltreatment, for use until the commissioner  
 13.33 of human services establishes a common entry point. Two or more county boards may

14.1 jointly designate a single common entry point. The commissioner of human services shall  
14.2 establish a common entry point effective ~~July 1, 2014~~ no sooner than January 1, 2015.  
14.3 The common entry point is the unit responsible for receiving the report of suspected  
14.4 maltreatment under this section.

14.5 (b) The common entry point must be available 24 hours per day to take calls from  
14.6 reporters of suspected maltreatment. The common entry point shall use a standard intake  
14.7 form that includes:

14.8 (1) the time and date of the report;

14.9 (2) the name, address, and telephone number of the person reporting;

14.10 (3) the time, date, and location of the incident;

14.11 (4) the names of the persons involved, including but not limited to, perpetrators,  
14.12 alleged victims, and witnesses;

14.13 (5) whether there was a risk of imminent danger to the alleged victim;

14.14 (6) a description of the suspected maltreatment;

14.15 (7) the disability, if any, of the alleged victim;

14.16 (8) the relationship of the alleged perpetrator to the alleged victim;

14.17 (9) whether a facility was involved and, if so, which agency licenses the facility;

14.18 (10) any action taken by the common entry point;

14.19 (11) whether law enforcement has been notified;

14.20 (12) whether the reporter wishes to receive notification of the initial and final  
14.21 reports; and

14.22 (13) if the report is from a facility with an internal reporting procedure, the name,  
14.23 mailing address, and telephone number of the person who initiated the report internally.

14.24 (c) The common entry point is not required to complete each item on the form prior  
14.25 to dispatching the report to the appropriate lead investigative agency.

14.26 (d) The common entry point shall immediately report to a law enforcement agency  
14.27 any incident in which there is reason to believe a crime has been committed.

14.28 (e) If a report is initially made to a law enforcement agency or a lead investigative  
14.29 agency, those agencies shall take the report on the appropriate common entry point intake  
14.30 forms and immediately forward a copy to the common entry point.

14.31 (f) The common entry point staff must receive training on how to screen and  
14.32 dispatch reports efficiently and in accordance with this section.

14.33 (g) The commissioner of human services shall maintain a centralized database  
14.34 for the collection of common entry point data, lead investigative agency data including  
14.35 maltreatment report disposition, and appeals data. The common entry point shall

15.1 have access to the centralized database and must log the reports into the database and  
 15.2 immediately identify and locate prior reports of abuse, neglect, or exploitation.

15.3 (h) When appropriate, the common entry point staff must refer calls that do not  
 15.4 allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations  
 15.5 that might resolve the reporter's concerns.

15.6 (i) A common entry point must be operated in a manner that enables the  
 15.7 commissioner of human services to:

15.8 (1) track critical steps in the reporting, evaluation, referral, response, disposition,  
 15.9 and investigative process to ensure compliance with all requirements for all reports;

15.10 (2) maintain data to facilitate the production of aggregate statistical reports for  
 15.11 monitoring patterns of abuse, neglect, or exploitation;

15.12 (3) serve as a resource for the evaluation, management, and planning of preventative  
 15.13 and remedial services for vulnerable adults who have been subject to abuse, neglect,  
 15.14 or exploitation;

15.15 (4) set standards, priorities, and policies to maximize the efficiency and effectiveness  
 15.16 of the common entry point; and

15.17 (5) track and manage consumer complaints related to the common entry point.

15.18 (j) The commissioners of human services and health shall collaborate on the  
 15.19 creation of a system for referring reports to the lead investigative agencies. This system  
 15.20 shall enable the commissioner of human services to track critical steps in the reporting,  
 15.21 evaluation, referral, response, disposition, investigation, notification, determination, and  
 15.22 appeal processes.

15.23 **EFFECTIVE DATE.** This section is effective the day following final enactment."

15.24 Delete the title and insert:

15.25 "A bill for an act  
 15.26 relating to health; modifying health data provisions; changing requirements for  
 15.27 establishment of a common entry point; establishing registration of automatic  
 15.28 external defibrillators; modifying stroke center criteria; changing the prescription  
 15.29 monitoring program; establishing immunity from civil liability for use of opiate  
 15.30 antagonists; modifying background study requirements; amending Minnesota  
 15.31 Statutes 2012, sections 62U.04, subdivision 4, by adding a subdivision;  
 15.32 152.126, as amended; Minnesota Statutes 2013 Supplement, sections 144.493,  
 15.33 subdivisions 1, 2; 256N.21, by adding a subdivision; 626.557, subdivision 9;  
 15.34 proposing coding for new law in Minnesota Statutes, chapters 403; 604A."