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State of Minnesota

S.F. No. 538 - Hospital and Health and Child Care Providers Videos or Education on Dangers of Shaking Infants and Young Children

Author: Senator Dean Johnson

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: February 24, 2005

S.F. No. 538 educates new parents, health care professionals, and child care providers on the dangers associated with shaking infants and young children.

Section 1 requires a hospital to make available for viewing by parents of newborns a video presentation on the dangers associated with shaking infants and young children. The hospital is required to use a video obtained from the commissioner or approved by the commissioner, and the commissioner is required to provide the video at cost. The commissioner shall review other video presentations for possible approval upon the request of a hospital.

The Commissioner of Health is also required to establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and small children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with parents and primary caregivers of infants and young children up to age three at each well-baby visit.

Section 2 requires the Commissioner of Human Services to make available for viewing by child care providers a video presentation on the dangers associated with shaking infants and young children. The video shall become part of the initial and ongoing training of child care providers. The commissioner is required to provide the video approved by the Commissioner of Health to child care providers at cost.

JW:rdr

Senators Johnson, D.E.; Kubly; Gerlach; Wergin and Lourey introduced--
S.F. No. 538: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing for education of parents, primary caregivers, and child care providers on the dangers associated with shaking infants and young children; proposing coding for new law in Minnesota Statutes, chapters 144; 245A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [144.574] [EDUCATION ABOUT THE DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.]

Subdivision 1. [EDUCATION BY HOSPITALS.] (a) A hospital licensed under sections 144.50 to 144.56 shall make available for viewing by the parents of each newborn baby delivered in the hospital a video presentation on the dangers associated with shaking infants and young children.

(b) A hospital shall use a video obtained from the commissioner or approved by the commissioner. The commissioner shall provide to a hospital at cost copies of an approved video. The commissioner shall review other video presentations for possible approval upon the request of a hospital.

Subd. 2. [EDUCATION BY HEALTH CARE PROVIDERS.] The commissioner shall establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with the parents and primary caregivers of

infants and young children up to the age of three at each well-baby visit.

Sec. 2. [245A.034] [CHILD CARE PROVIDER TRAINING; DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.]

The commissioner shall make available for viewing by all licensed and legal nonlicensed child care providers a video presentation on the dangers associated with shaking infants and young children. The video presentation shall be part of the initial and ongoing training of licensed and legal nonlicensed child care providers. The commissioner shall provide to child care providers at cost copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.

Senator ..... moves to amend S.F. No. 538 as follows:

Page 1, line 19, after the period, insert "The commissioner shall not require a hospital to use videos that would require the hospital to pay royalties for use of the video, restrict viewing in order to comply with public viewing or other restrictions, or be subject to other costs or restrictions associated with copyrights.

(c) A hospital shall, whenever possible, request both parents to view the video. The patient's chart shall indicate whether the parents viewed or declined to view the video.

(d) The showing or distribution of the video shall not subject any person or facility to any action for damages or other relief provided the person or facility acted in good faith."

Page 2, line 9, delete "and legal nonlicensed"

Page 2, line 10, after the period, insert "Legal nonlicensed child care providers may participate at their option in a video presentation session offered under this section."

KEY: ~~stricken~~ = removed, old language. underscored = added, new language.

NOTE: If you cannot see a difference in the key above, you can change the display of stricken and underscorec text.

Authors and Status ■ List versions

S.F. No. 46, as introduced - 84th Legislative Session (2005-2006) Posted on Jan 06, 2005

A bill for an act

relating to health; requiring hospitals to offer to the parents of a newborn a video presentation on the dangers associated with shaking infants and young children; proposing coding for new law in Minnesota Statutes, chapter 144.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [144.574] [VIDEO ON DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.]

(a) A hospital licensed under sections 144.50 to 144.56 shall make available for viewing by the parents of each newborn infant delivered in the hospital a video presentation on the dangers associated with shaking infants and young children.

(b) A hospital shall, whenever possible, request the signature of both parents indicating that each parent has viewed the video in the hospital or has declined to view the video. The signature forms shall be submitted to the commissioner of health annually.

(c) A hospital shall use a video obtained from the commissioner of health or approved by the commissioner. The commissioner shall provide to a hospital at cost copies of an approved video. The commissioner shall review other video presentations for possible approval upon the request of a hospital.

Please direct all comments concerning issues or legislation to your House Member or State Senator.

For Legislative Staff or for directions to the Capitol, visit the Contact Us page.

General questions or comments.

Connie Skillingstad

Prevent Child Abuse
Minnesota

Shaken Baby Syndrome Fact Sheet

· What is shaken baby syndrome?

Shaken baby syndrome (SBS) is a term used to describe the constellation of signs and symptoms resulting from violent shaking or shaking and impacting of the head of an infant or small child. The degree of brain damage depends on the amount and duration of the shaking and the forces involved in impact of the head.

· What are the signs and symptoms of shaken baby syndrome?

The most common symptoms of shaken baby injuries are subdural hematoma (bleeding on the brain), cerebral edema (massive brain swelling) and retinal hemorrhages (bleeding inside the eye). Most shaken baby injuries include one or more of these symptoms.

Subdural hematoma – When a child is violently shaken, the motion causes the blood vessels around the brain to stretch and tear.

Cerebral edema – Violent shaking causes the brain to swell, increasing the pressure inside the victim's head, which can lead to massive brain damage or death.

Retinal hemorrhages – The same kind of violent motion that happens in the brain during shaking also occurs in the eye. This type of bleeding can only be seen with special medical equipment.

· What is the outcome or prognosis of victims of shaken baby syndrome?

Approximately 20% of cases are fatal in the first few days after injury and the majority of the survivors are left with handicaps ranging from mild - learning disorders, behavioral changes - to moderate and severe, such as profound mental and developmental retardation, paralysis, blindness, inability to eat or exist in a permanent vegetative state.

· How many children are injured or die from shaken baby syndrome?

This is a frequently asked question and unfortunately there are not good statistics. Until a method for collecting such statistics is established, the true incidence will not be known. It is recognized, however, that it is the most common cause of mortality and accounts for the most long-term disability in infants and young children due to physical child abuse. Based on a North Carolina research project published in the Journal of the American Medical Association in August of 2003, approximately 1,300 U.S. children experience severe or fatal head trauma from child abuse every year. The same study revealed that approximately 30 per 100,000 children under age 1 suffered inflicted brain injuries.

· How can shaken baby syndrome be prevented?

It is important to note that SBS is preventable. Shaking occurs frequently when a frustrated caregiver loses control with an inconsolable crying baby. It is important to realize that just saying, "don't shake a baby" is not enough. A plan of action or suggestions to deal with the situation needs to be offered. Parents and other care providers need assurance that allowing a baby to cry is okay if all their needs have been met. The care provider should address their stress level and try stress management. Parents should share the message of the dangers of shaking with all who care for their infant or child, including spouses, their own parents, siblings, day care providers and others. Parents need to let those caring for the infant know it is okay to call for help when needed.

· Can tossing or rough play cause shaken baby syndrome?

Shaken baby syndrome, which may result in severe brain trauma, is caused when a child is violently shaken such that the head is subjected to back and forth motion in one or more directions resulting in rapid repeated severe acceleration and deceleration of the head. Activities involving an infant or a child such as tossing in the air, bouncing on the knee, placing a child in an infant swing or jogging with them in a backpack, do not cause the brain and eye injuries characteristic of shaken baby syndrome.

Source: The National Center on Shaken Baby Syndrome, www.dontshake.com

For more information, contact Prevent Child Abuse Minnesota, 651-523-0099
Visit our web site at: www.pcamn.org

Hug me, don't shake me

Shaking a baby can **kill**

or cause brain damage, blindness, or seizures.

Being a parent, caregiver, or babysitter is hard work! There are times when you may feel angry, or alone, or overwhelmed.

Don't take it out on your baby!

If your baby is crying, always go to your baby. Try to stay calm, take deep breaths to relax. Calm your baby in an area away from loud noises or bright lights.

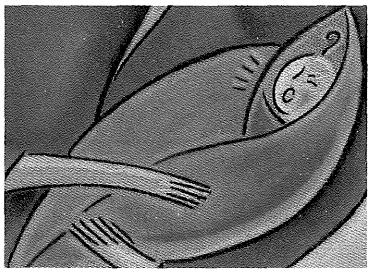
If your baby is still crying and you don't know what to do:

Change her diaper.

- Check to see if he is too warm or cool.
- Offer her a pacifier.
- Hold him close to your chest and walk around.
- Rock her gently.
- If he is hungry, feed him slowly. Burp him often.
- Put on soft music. Sing to her.
- Take him for a car or stroller ride.
- Check for fever, rash, or a cold.

Run a vacuum in the room.

- Wrap her snugly in a blanket.
- Sit down and read a book.



If your baby is still crying and you can't take much more:

- It's OK to let your baby cry for awhile. Put your baby in the bed, shut the door, and leave the room for a few minutes.
- Call someone to help you or to talk to you.
- Ask someone to watch your baby for awhile, but **never leave your baby with someone you don't trust.**
- Call your baby's health care provider.
- Call the Crisis Nursery at 824-8000.

Never ever shake a baby!

Developed by:

Hennepin County Medical Center
HCMC

HCMC Pediatrics salutes the American Academy of Pediatrics' mission, "solutions before problems." All children are our future.

 9/98

Imagine
1-800-CHILDREN www.pcamn.org
YOU CAN end child
abuse MINNESOTA

LOS BEBÉS LLORAN...

No es fácil cuidar a un bebé...
Los bebés pueden estar irritables
y llorar mucho.

Si su bebé no para de llorar y usted se siente frustrada:

- Ponga a su bebé en un lugar seguro y salga de la habitación por unos minutos...
  Llorar no es perjudicial para el bebé.
- Haga algo positivo para calmarse...
  escuche música, llame a un amigo, dese una ducha.
- Llame a alguien para ver si puede ayudarle, o por lo menos hablar con usted hasta que se calme.
- Si piensa que su bebé puede estar enfermo,
  llame al médico.

(página siguiente)

Mantenga a su bebé seguro...
Aunque se sienta *muy* frustrada

¡NUNCA, NUNCA sacuda a un bebé!!

Sacudir y golpear la cabeza de un bebé puede causar daño cerebral, ceguera o muerte.

PEDIR AYUDA NO ES DE DÉBILES, AL CONTRARIO, MUESTRA CARACTER

Si su bebé no para de llorar o si usted tiene preguntas, puede:

- Llamar a su médico o la clínica o
- Llame a la línea de apoyo para Padres "the Parent Warmline" un servicio de consulta gratuita por teléfono al (612)813-6336.

SÍ USTED ESTÁ AL BORDE DE UN ATAQUE DE NERVIOS PIDA AYUDA

- Lame al 911...
  los servicios de emergencia están a su disposición cuando necesite ayuda.
- Llame al teléfono de Crisis "Crisis Connection" en el (612)379-6363.

Asegúrese de decirle a toda persona que cuide a su bebe que...

¡NUNCA, NUNCA SACUDA A UN BEBÉ!

Children's HOSPITALS AND CLINICS

NEVER SHAKE A BABY!! NEVER

Twin Cities Metro
Shaken Baby Syndrome
Prevention Program

Midwest Children's Resource Center
Children's Hospitals and Clinics
Garden View Medical Building
347 North Smith Avenue, Suite 401
St. Paul, MN 55102
(651) 220-6750
Fax (651) 220-6770

www.childrenshc.org

NATIONAL CHILDREN'S ALLIANCE

www.nca-online.org

Children's HOSPITALS AND CLINICS

Minneapolis/St. Paul, Minnesota

1M/7-04
3210

Midwest Children's Resource Center

People love their children very much...

but sometimes not very well.

MCRC BRINGS TOGETHER A MULTI-DISCIPLINARY TEAM OF CHILD ABUSE SPECIALISTS WHO PROVIDE A BROAD RANGE OF SERVICES

MEDICAL

- Evaluations and treatment for sexual abuse, physical abuse, neglect and failure to thrive
- Forensic documentation
- 24-hour suspected child abuse and neglect **(SCAN)** services
- Professional training

PSYCHOLOGICAL

- Assessments
- Psychological testing
- Recommendations for ongoing treatment
- Therapy
- Professional training

PROFESSIONAL CONSULTATION

- Case reviews
- 24-hour telephone consultation service for professionals who work with abused children
- Expert testimony

PREVENTION PROGRAMS

- **Shaken Baby Syndrome Prevention** – Public awareness and community education materials and presentations
- **"First Steps"** – Teen parent mentoring program provided by trained volunteers to families of The Birth Center of United Hospital and Children's - St. Paul

MIDWEST REGIONAL CHILDREN'S ADVOCACY CENTER (MRCAC)

Midwest Children's Resource Center, the child abuse program at Children's Hospitals and Clinics, has gained national recognition. It was chosen in January 1999 as a regional center to help communities in 12 Midwest states to respond more effectively to the needs of abused children.

- Professional training
- Program development
- Phone consultation

Remember,
NEVER SHAKE A BABY!

For more information and materials, contact:

Midwest Children's Resource Center
Children's Hospitals and Clinics
Garden View Building
347 North Smith Avenue, Suite 401
St. Paul, MN 55102
St. Paul (651) 220-6750
Minneapolis (612) 813-6750
Fax (651) 220-6770
Toll-Free (MN only) (800) 422-0879

Children's
HOSPITALS AND CLINICS

The Junior League of Saint Paul

NEVER SHAKE A BABY

Prevent Shaken Baby Syndrome

Taking care of a small child is a BIG job

Caring for a baby can be a warm and wonderful experience. However, there can be another side of taking care of babies that isn't talked about much…feelings of being frustrated, alone and overwhelmed.

If you've ever felt this way while taking care of a baby, rest assured that it's perfectly normal. After all, taking care of a baby is a big responsibility. Perhaps the baby has been crying a lot, and you can't figure out why. Maybe you are just plain tired, and are at your wits end. Whatever the reason for your stress, REMEMBER, it's NEVER okay to shake a baby!

It's never okay to shake a baby… the results can be tragic.

Shaking a baby can kill

Shaken Baby Syndrome refers to the injuries that result from violently shaking a baby. Even a few seconds of violent shaking can cause serious damage or death to babies and young children.

Injuries from Shaken Baby Syndrome include:

- Brain damage
- Blindness
- Paralysis
- Fractures
- Seizures
- Death

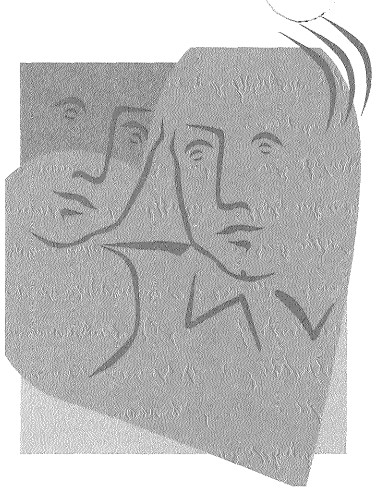
Shaking a baby is dangerous. It's child abuse.

Everyone who cares for your child must know

If you are a parent or if you care for a baby, it's important to know the dangers of shaki If you add a fussy baby to the stresses of everyday life…fatigue, family problems, money problems and overwork…it's easy to see how someone can reach a breaking point.

Everyone who cares for a baby…babysitters, daycare providers, grandparents, boyfriends, girlfriends…should never handle a baby when feeling angry or frustrated. It is important to take the time to relax and calm down before caring for a baby.

Everyone needs to know know about Shaken Baby Syndrome.



If your baby is crying d you're not sure why…

- Change her diaper.
- If he is hungry, feed him slowly and burp often.
- Offer a pacifier.
- Take the baby for a walk in the stroller or for a ride in the car.
- Check if he is dressed too warm or cool.
- Check for fever, rash or signs he may be sick. Call your health care provider if concerned.
- Wrap her snugly in a blanket, hug her closely and lk or sway.
- Run a vacuum cleaner or other "white noise" in the baby's room.

If you can't cope with your baby's crying...

- Put your baby in his crib or safe place, and leave the room for a few minutes. It's okay to let your baby cry for awhile.
- Try to let your frustration out in a safe way...watch TV, take a shower, listen to music, exercise...take some deep breaths, and calm down.
- Call your partner or a friend to talk out your frustration. Ask if they can relieve you for awhile.
- Remember, it's NEVER okay to shake a baby!

Asking for help is a sign of strength.

If you have questions about your baby's crying, you can:

- Call your doctor or health care provider, or
- Call the Parent Warmline, a free Children's phone service, at **(612) 813-6336.**

If you are at the end of your rope, reach out for help. Help is just a phone call away:

- Call **911** or your area's emergency number
- Call Crisis Connection at **(612) 379-6363,** or
- Call ChildHelp USA, a national child abuse hotline at **1-800-422-4453.**

Shaken Baby Syndrome (SBS)

What is it?

SBS is a lethal form of child maltreatment created by the violent shaking of an infant or young child (up to age 3years) by an adult caregiver leaving the child injured, disabled or dead.

- SBS (or abusive head trauma) is the most common cause of death from child abuse
- Leading cause in all trauma-related deaths among children

What happens to a baby when shaken?

Possible injuries include:

- Head trauma
- Blindness
- Fractures
- Seizures
- Paralysis
- Death (approx. 1/3 of SBS cases die)

Who shakes babies?

The medical literature cites cases of SBS perpetrated by young adults (as young as 13 years) on up to elderly adults. The perpetrator has to have the strength to shake a 10-20 pound child. A 1995 Colorado study of 127 shaken children where the perpetrator was identified demonstrated males shake children more often than women (approx. 70% male). This has been replicated in other smaller studies.

Other facts:

- Occurs in all socioeconomic and racial groups
- Daycare providers, babysitters, grandparents, birth parents, mother's boyfriends…all have shaken children

Why do they shake them?

Perpetrators have told investigators repeatedly that 'they couldn't get the baby to stop CRYING' and they shook the baby. Crying is apparently the 'last straw' when stressed caregivers are trying to cope:

Other risk factors:

- Social isolation
- Drug abuse
- Marital/relationship discord
- Financial troubles
- Parents of multiples
- Depression

Shaken Baby Syndrome (SBS)

How often does it occur?

No one knows EXACTLY how many children are shaken per year in the world, the USA, or in Minnesota. Why? Varies… Documentation inconsistencies; misdiagnosis; child abuse assessed. The most accurate assessment by child abuse experts is 1200 – 1500 cases/year in the USA.

Minnesota: 1988-1998, Midwest Children's Resource Center at Children's Hospitals and Clinics tracked cases at the St. Paul and Minneapolis sites.

- # SBS cases ranged from 3 – 10 cases/year in JUST these 2 hospitals
- No incidence reduction has been noted in recent years

Minnesota Department of Health: CDC grant to improve child maltreatment data surveillance. SBS or iTBI (inflicted traumatic brain injury) studied. Abstracted iTBIs of 1999-2001:
Findings:

- Majority are boys
- Majority are under 1 year of age
- Nearly half have documented previous abuse
- Perpetrators are parents or parent's partners, and day care providers
- Majority of perpetrators are male
- Cases in MN of iTBI identified from death certificates, abstracting TBI cases, and TBI state registry
  1999: N=42, 2000: N= 45, 2001: N= 46

How can we prevent SBS from occurring?

Most respected research and results are from Dr.Mark Dias, pediatric neurosurgeon and staff from Buffalo, NY.

Study: 1996-2003
Protocol: all parents upon discharge from hospital with baby

- Receive education on how to cope with crying
- Watch video about SBS effects and prevention
- Sign affidavit reflecting they learned about SBS
- Voluntary….Dads encouraged to listen and sign

Process: cases tracked and matched to affidavits
Results: 50% reduction in SBS incidence…SUSTAINED over time

Background on inflicted traumatic brain injury

Infants and children sustain brain injury when they are subjected to vigorous shaking, or when there is direct physical trauma to the head. The injury results when there is rapid acceleration and deceleration of the brain tissue, leading to retinal hemorrhage, brain contusion and or intracranial bleeding.[1] Sequelae range from respiratory difficulties and seizures to death.[2] There are also long-term consequences, which can include learning disabilities, physical disabilities, blindness, and Cerebral Palsy.[3] Occasionally, there are other physical or radiographic signs of battery or abuse such as skull or bone fractures, scalp injury and body bruises. Many cases of iTBI, formally referred to as Shaken Baby Syndrome (SBS), go unrecognized because there are no immediate or obvious physical signs, hence the low incidence of hospital-treated cases of inflicted neuro-trauma. Those that weren't recognized early and survive usually end up with some form of developmental and or neurological deficits later in life.[4, 5]

Even though many cases are not recognized as iTBI, child maltreatment is the leading cause of infant death due to head injury.[6, 7] Each year in the United States, children aged two or younger are hospitalized for serious iTBI at a rate of at least 13 to 21 per 100,000.[8] This is just the "tip of the ice-berg" because many cases are unrecognized and there are no established systems for tracking iTBI. While there is no established surveillance of iTBI, it is generally accepted that iTBI is a serious public health problem, and that more than one-half of all brain injury in children aged two or younger are inflicted.[9] Child maltreatment generally accounts for 80 percent of fatalities resulting from head trauma in children younger than two years.[9] Infants and children with inflicted brain injury have a lower mean age, higher mortality and morbidity rates and subsequently have a higher financial burden than children with unintentional brain injury.[10] Recent data[11] suggest that children with iTBI stayed 52 percent longer in the hospital, and generally incurred hospitalization bills 89 percent higher than children with unintentional head injury. As with any form of injury, indirect cost of iTBI runs into millions of dollars.

Generally, infants are at a greater risk of iTBI than children in their second year of life.[12, 13] The majority are boys[1, 13] born to mothers younger than 21 years.[13] Higher incidence of iTBI is also seen in premature infants,[14] twin gestations,[14] and military families.[15] The association between race/ethnicity and iTBI has not been fully elucidated, although a recent population-based study found higher incidence of iTBI in non-European Americans. The preponderance of evidence shows that most perpetrators of iTBI are male.[13]

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American Academy of Pediatrics Recommendations

The American Academy of Pediatrics recommends that pediatricians:

1. Become educated about the recognition, diagnosis, treatment, and outcome of shaken baby and abusive head-impact injuries in infants and children;
2. Be aware of and exercise their responsibility to report these injuries to appropriate authorities;
3. Provide pertinent medical information to other members of multidisciplinary teams investigating these injuries;
4. Support home visitation programs and any other child abuse prevention efforts that prove efficacious; and
5. Provide or have appropriate referrals to resources to educate parents about healthy coping strategies when dealing with their child.

Committee on Child Abuse and Neglect, 2000-2001

Summary:

Shaken baby syndrome is a clearly definable medical condition. A proper response requires integration of specific clinical management and community intervention in an interdisciplinary fashion. Greater attention and resources should be devoted to prevention of abusive injuries.

Legislation In Other States

Three states have taken a proactive stance in recent years regarding the prevention of shaken baby syndrome. New York, Texas and Utah have all issued regulations for day care providers, stating they must receive training on the dangers of shaking infants and young children in order to maintain their license.

New York
New York passed Bill A08314, which requires all child care providers in New York to receive training on shaken baby syndrome. Chapter 416, section 390-a, of the social services law of 2000 was amended to mandate that all child day care providers be educated and informed on the identification, diagnosis and prevention of shaken baby syndrome. This education is to be added to the training providers already receive on early childhood development, nutrition and statues and regulations toward safety issues.

Texas
The requirements for day care centers in Texas are found in chapter 42, sections 42.0421 (b) and 42.0421 (c) of Texas Human Resource Code. This code states that employees of licensed day care centers, group day care homes and registered family homes providing day care for children under 24 months must receive one hour of annual in-service training on recognizing and preventing shaken baby syndrome, preventing sudden infant death syndrome and understanding early childhood brain development.

Utah
Utah's administrative code number R430-100-6, section 5 requires all centers providing infant care to receive in-service training on preventing shaken baby syndrome, preventing sudden infant death syndrome, coping with crying babies and the development of the brain. The statute does not specify how many hours should be dedicated to this particular training, although it does require that all caregivers receive at least 20 hours of documented in-service training per year and that this training be conducted in person.

Enactment of such legislation is an important step in the goal of prevention through education. It is imperative to train and educate day care providers on the dangers of shaking children as well as what instigates the shaking. The reasoning for this education is two fold. First, providers are continuously faced with and deal with fussy babies and inconsolable crying. These situations tend to lead to the shaking of children. Second, providers form relationships with the child and his/her parents, thereby giving them an opportunity to watch for the signs of abuse and to educate the parents they associate with about shaken baby syndrome.

Background

The Injury and Violence Prevention of the Minnesota Department of Health conducts surveillance of traumatic brain injuries (TBI) sustained Minnesota residents that result in death or hospitalization. In 2001, the Midwest Children's Resource Center asked whether or not cases of inflicted TBI to infants and young children could be identified and counted. The TBI Registry has since incorporated inflicted TBI into its ongoing TBI surveillance activities.

Definition

For the purposes of Minnesota's TBI Registry, inflicted traumatic brain injury includes:

- Minnesota residents
- age 4 or younger
- who sustain a non-penetrating* traumatic brain injury**
- that results in death or an inpatient hospitalization
- the injury must be inflicted by a parent, guardian, or caregiver

*Non-penetrating traumatic brain injuries include injuries caused by shaking, shaking with impact, or other abusive head trauma. They do not include traumatic brain injuries caused by a firearm or sharp instruments.

**See the end of this document for the Center for Disease Control and Preventions (CDC) clinical case definition of TBI and the codes used to identify TBI from medical records and death certificates.

Surveillance

Multiple data sources are being utilized to identify and describe cases of inflicted TBI. For surveillance purposes the documentation in a medical record, death certificate, or autopsy report is relied upon to determine whether or not the case was an inflicted TBI. If a health care provider documents that the case was inflicted or was suspected to be inflicted, it is counted as an inflicted TBI.

The following data are preliminary data from 1999-2001. Abstraction is ongoing for potential cases with missing or conflicting data.

Counts

	Fatal	Non-Fatal	Total
1999	5	33	38
2000	7	29	36
2001	5	39	44
Total	17	101	118

DRAFT – PRELIMINARY DATA

Data prepared by Debra Hagel, Research Analyst and Sara Seifert, Epidemiologist under the supervision of Jon Roesler all from the Injury and Violence Prevention Unit of the Minnesota Department of Health

Preliminary Rates
Preliminary age-specific rates were calculated as 45 and 12 per 100,000 persons for under age 1 and under age 5 respectively. Note: 2000 population data were used to estimate the population for all three years for these preliminary rates.

Demographic Data
Of the 118 cases identified, two-thirds (79) of the victims were male. Seventy-four percent (87) were under one year of age. The county of residence for victims was examined. The number of cases are too small to report data by county. Age specific rates of iTBI were compared for the seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties) and Greater Minnesota (all other Minnesota counties). The preliminary rates for the seven county metro area and Greater Minnesota are 13.0 and 8.7 per 100,000 persons per year. It is not possible from these data to determine the reason for the difference in rates between the seven county metro area and Greater Minnesota. Differences in identification and reporting of inflicted TBI is one possible explanation for at least a portion of the difference.

Perpetrator Data
Sixty-three percent (47) of the perpetrators were parents. Nineteen percent (14) of the perpetrators were day-care providers and an additional four percent (3) were babysitters. Perpetrator data were missing for 44 cases.

Hospital Charges and Payer Source
The data available only include information on hospital charges for the initial hospital treatment. Hospital charges are the amount billed by a facility for care and may differ from reimbursement or the actual costs to care for a patient.

The mean charges for iTBI cases who were hospitalized were $36,219. The total charges were $2,390,476. At the time of this analysis charge data were only available for 65 of the iTBI cases and so the total charges are expected to increase. The payer source for these 65 cases was 32% Medicaid (21), 52% commercial (34), 3% other government programs (2), and 12% self-pay (8).

Traumatic Brain Injury

The clinical case definition of TBI for surveillance and research purposes from the CDC states that a case of traumatic brain injury (craniocerebral trauma) is defined either:

- As an occurrence of injury to the head that is documented in a medical record, with one or more of the following conditions attributed to head injury:
    - Observed or self-reported decreased level of consciousness
    - Amnesia
    - Skull fractures
    - Objective neurological or neuropsychological abnormality

DRAFT – PRELIMINARY DATA

Data prepared by Debra Hagel, Research Analyst and Sara Seifert, Epidemiologist under the supervision of Jon Roesler all from the Injury and Violence Prevention Unit of the Minnesota Department of Health

    - Diagnosed intracranial lesion
- Or as an occurrence of death resulting from trauma, with head injury listed on the death certificate, autopsy report, or medical examiner's report in the sequence of conditions that resulted in death.

The clinical definition of traumatic injury *excludes* the following:

- Lacerations or contusions of the face, eye, ear, or scalp without the other criteria listed above.
- Fractures of facial bones, without criteria listed above
- Birth trauma
- Primary anoxic, inflammatory, infectious, toxic or metabolic encephalopathies that are not complications of head trauma
- Cancer
- Brain infarction (ischemic stroke) and intracranial hemorrhage (hemorrhagic stroke) without associated trauma

International Classification of Diseases Codes used to identify iTBI (ICD-9-CM): 995.55 Shaken Infant Syndrome, 310.2 Postconcussion Syndrome, 348.1 Anoxic Brain Damage (when coded with N994.1 Drowning and Nonfatal Submersion or 994.7 Asphyxiation and Strangulation), 800.x Fracture of Vault of Skull, 801.x Fracture of Base of Skull, 803.x Other and Unqualified Skull Fractures, 804.x Multiple Fractures Involving Skull or Face with Other Bones, 850.x Concussion, 851.x Cerebral Laceration and Contusion, 852.x Subarachnoid, Subdural, and Extradural Hemorrhage, Following Injury, 853.x Other and Unspecified Intracranial Hemorrhage, Following Injury, 854.x Intracranial Injury of Other and Unspecified Nature, 950.x Injury to Optic Nerve and Pathways, 921.3 Contusion of Eyeball,

International Classification of Disease Codes used to identify iTBI (ICD-10): S01.0-9 Open Wound of Head, S02.0, 1, 3, 7-9 Fracture of Skull and Facial Bones (excluding nasal bones, malar and maxillary bones, teeth, and mandible), S04.0 Injury of Optic Nerve and Pathways, S06.0-9 Intracranial Injury, S07.0, 1, 8, 9 Crushing Injury of Head, T01.0 Open Wounds Involving Head with Neck, T02.0 Fractures Involving Head with Neck, T04.0 Crushing Injuries Involving Head with Neck, T06.0 Injuries of Brain and Cranial Nerves with Injuries of Nerves and Spinal Cord at Neck Level, T90.1, 2, 4, 5, 8, 9 Sequelae of Injuries of Head (excluding Superficial and Cranial Nerves)

DRAFT – PRELIMINARY DATA

Data prepared by Debra Hagel, Research Analyst and Sara Seifert, Epidemiologist under the supervision of Jon Roesler all from the Injury and Violence Prevention Unit of the Minnesota Department of Health

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TECHNICAL REPORT

PEDIATRICS Vol. 108 No. 1 July 2001, pp. 206-210

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AMERICAN ACADEMY OF PEDIATRICS:

Shaken Baby Syndrome: Rotational Cranial Injuries—Technical Report

Committee on Child Abuse and Neglect

ABSTRACT

Top
Abstract
Introduction
Conclusion
Recommendation
References

Shaken baby syndrome is a serious and clearly definable form of child abuse. It results from extreme rotational cranial acceleration induced by violent shaking or shaking/impact, which would be easily recognizable by others as dangerous. More resources should be devoted to prevention of this and other forms of child abuse.

INTRODUCTION

Top
Abstract
Introduction
Conclusion
Recommendation
References

Physical abuse is the leading cause of serious head injury in infants.[1,2] Although physical abuse in the past has been a diagnosis of exclusion, data regarding the nature and frequency of head trauma consistently support the need for a presumption of child abuse when a child younger than 1 year has suffered an intracranial injury.[1,2]

Shaken baby syndrome is a serious form of child maltreatment most often involving children younger than 2 years but may be seen in children up to 5 years old.[2-5] It occurs commonly, yet may be misdiagnosed in its most subtle form and underdiagnosed in its most serious form.[6] Caretakers may misrepresent or claim to have no knowledge of the cause of the brain injury. Caretakers who are not responsible for the injuries may not know how they occurred. Externally visible injuries are often absent. Given possible difficulties in initially identifying an infant as having been abusively shaken and the variability of the syndrome itself, physicians must be extremely vigilant when dealing with any brain trauma in infants and be familiar with radiologic and clinical findings that support the diagnosis of

shaken baby syndrome.

HISTORY

In 1972, pediatric radiologist John Caffey[7] popularized the term "whiplash shaken baby syndrome" to describe a constellation of clinical findings in infants, which included retinal hemorrhages, subdural and/or subarachnoid hemorrhages, and little or no evidence of external cranial trauma. One year earlier, Guthkelch[8] had postulated that whiplash forces caused subdural hematomas by tearing cortical bridging veins. In the mid-1970s, computed tomography (CT) began to be used to help with diagnosis. The advent of magnetic resonance imaging (MRI) in the mid-1980s has furthered the diagnostic capabilities.[9]

ETIOLOGY

The act of shaking leading to shaken baby syndrome is so violent that individuals observing it would recognize it as dangerous and likely to kill the child. Shaken baby syndrome injuries are the result of violent trauma. The constellation of these injuries does not occur with short falls, seizures, or as a consequence of vaccination. Shaking by itself may cause serious or fatal injuries.[10,11] In many instances, there may be other forms of head trauma, including impact injuries.[10-12] Thus, the term shaken/slam syndrome (or shaken-impact syndrome) may more accurately reflect the age range of the victims (who are not always babies) and the mechanisms of injury seen. Such shaking often results from tension and frustration generated by a baby's crying or irritability, yet crying is not a legal justification for such violence.[13] Caretakers at risk for abusive behavior generally have unrealistic expectations of their children and may exhibit a role reversal whereby caretakers expect their needs to be met by the child.[14]

Additionally, parents who are experiencing stress as a result of environmental, social, biological, or financial situations may also be more prone to impulsive and aggressive behavior. Those involved with domestic violence and/or substance abuse may also be at higher risk of inflicting shaken baby syndrome. Small children are particularly vulnerable to such abuse because of the large disparity in size between them and an adult-sized perpetrator.

EPIDEMIOLOGY

Head injuries are the leading cause of traumatic death and the leading cause of child abuse fatalities. Homicide is the leading cause of injury-related deaths in infants younger than 4 years.[2] Serious injuries in infants, particularly those that result in death, are rarely accidental unless there is another clear explanation, such as trauma from a motor vehicle crash. Billmire and Meyers[15] found that when uncomplicated documented severe trauma such as that resulting in skull fractures were excluded, 95% of serious intracranial injuries and 64% of all head injuries in infants younger than 1 year were attributable to child abuse. Bruce and Zimmerman[5] documented that 80% of deaths from head trauma in infants and children younger than 2 years were the result of nonaccidental trauma. Contrary to early speculations,[7,8] shaken baby syndrome is unlikely to be an isolated event. Evidence of prior child abuse is common.[16] Specific evidence of previous cranial injuries (eg, old intracranial hemorrhages) from shaking episodes is found in about 33% to 40% of all cases.[16,17] As with other forms of physical abuse, males are more

often perpetrators than are females.[2,18] However, in an individual case, gender should not be considered when trying to identify a possible perpetrator.

CLINICAL FEATURES AND EVALUATION

Signs of shaken baby syndrome may vary from mild and nonspecific to severe and immediately identifiable clinically as head trauma.[6] There is a spectrum of the consequences of shaken baby syndrome, and less severe cases may not be brought to the attention of medical professionals and may never be diagnosed. A shaken infant may suffer only moderate ocular or cerebral trauma. A victim of sublethal shaking may have a history of poor feeding, vomiting, lethargy, and/or irritability occurring for days or weeks. These clinical signs of shaken baby syndrome are immediate and identifiable as problematic, even to parents who are not medically knowledgeable.[19] However, depending on the severity of clinical signs, this may or may not result in caretakers seeking medical attention. These nonspecific signs are often minimized by physicians or attributed to viral illness, feeding dysfunction, or colic.[6] In these relatively milder cases, signs may resolve without the true cause being discovered. If the child presents later with indications for cerebral imaging (eg, altered consciousness and other physical signs of head trauma), signs of older intracranial trauma may retrospectively explain previously seen nonspecific signs and also serve as markers of previous assaults.[10,16] In the most severe cases, which usually result in death or severe neurologic consequences, the child usually becomes immediately unconscious and suffers rapidly escalating, life-threatening central nervous system dysfunction.

A caretaker who violently shakes a young infant, causing unconsciousness, may put the infant to bed hoping or expecting that the baby will later recover.[5] Thus, the opportunity for early therapeutic intervention may be lost.[6] When brought to medical attention, the brain-injured infant may be convulsing, may have altered consciousness, may not be able to suck or swallow, and may be unable to track with eye movements, smile, or vocalize. Occasionally, the comatose state may be unrecognized by caretakers or medical providers who assume that the infant is sleeping, lethargic, or suffering from a minor acute ailment or possibly an infection. Respiratory difficulty progressing to apnea or bradycardia, which requires cardiorespiratory resuscitation, results from severe injuries.[4,5]

Evidence of other injuries, such as bruises, rib fractures, long-bone fractures, and abdominal injuries, should be meticulously searched for and documented. Any external injuries should be documented with forensic photographs labeled with the patient's name and the date. Repeated physical examinations may reveal additional signs of trauma. In 75% to 90% of cases, unilateral or bilateral retinal hemorrhages are present but may be missed unless the child is examined by a pediatric ophthalmologist, pediatric neurologist, pediatric neurosurgeon, or other experienced physician who is familiar with such hemorrhages, has the proper equipment, and dilates the child's pupils.[4,5,21] The number, character, location, and size of retinal hemorrhages after a shaking injury vary from case to case. More severe retinal hemorrhages are associated with more dire brain injury.[22] Retinal and vitreous hemorrhages and nonhemorrhagic changes, including retinal folds and traumatic retinoschisis, are characteristic of shaken baby syndrome.[21,23,24]

At times, the clinical signs suggest meningitis, and a spinal tap yields bloody cerebrospinal fluid.[4]

Centrifuged spinal fluid that is xanthochromic should raise the suspicion of cerebral trauma that is at least several hours old and not the result of a traumatic spinal tap. Because of confusing respiratory symptoms, chest roentgenograms may be obtained and may appear normal or show unexplained rib fractures. The shaken infant is often mildly to moderately anemic.[25] Clotting dysfunction from cerebral trauma should be assessed initially and followed up. Mild to moderate changes in coagulation studies are common with brain trauma and occasionally severe (eg, disseminated intravascular coagulation).[26] High amylase levels may signify pancreatic damage, and elevated transaminase levels may indicate occult liver injury.[27]

RADIOLOGY

CT has the first-line role in the imaging evaluation of a brain-injured child, adequately demonstrating injuries that need urgent intervention. CT often fails to reveal some aspects of the injury, and some false-negative results occur, particularly early in the evolution of cerebral edema.[28] The initial CT evaluation should be performed without intravenous contrast and should be assessed using bone and soft-tissue windows. CT is generally the method of choice for demonstrating subarachnoid hemorrhage, mass effect, and large extra-axial hemorrhages.[28] CT should be repeated after a time interval or if the neurologic picture changes rapidly.[29]

MRI is of great value as an adjunct to CT in the evaluation of brain injuries in infants.[30] Because of the lack of universal availability of the technology, physical limitations of access to MRI when life support is required for critically ill infants or children, and relative insensitivity to subarachnoid blood and fractures, MRI is considered complementary to CT and should be obtained 2 to 3 days later if possible. Sato et al[28] have demonstrated a 50% greater rate of detection of subdural hematomae using MRI, compared with CT. The ability to detect and define intraparenchymal lesions of the brain is substantially improved by use of MRI, yet in the study by Sato et al,[28] CT did not miss any surgically treatable injuries. MRI and CT can assist in determining when injuries occurred and substantiating repeated injuries by documenting changes in the chemical states of hemoglobin in affected areas.[28]

A skeletal survey of the hands, feet, long bones, skull, spine, and ribs should be obtained as soon as the infant's medical condition permits. Skull films complement CT bone windows in detection of skull fractures. In a retrospective series of abused children, skull films were more sensitive and improved the confidence of diagnosis of skull fracture, compared with CT.[31] Skull fractures that are multiple, bilateral, diastatic, or that cross suture lines are more likely to be nonaccidental.[31] Single or multiple fractures of the midshaft or metaphysis of long bones or rib fractures may be associated findings. Specialized views may be needed to delineate subtle fractures.[30] In selected patients, a skeletal survey should be repeated after 2 weeks to better delineate new fractures that may not be apparent until they begin to heal (a process that does not become radiologically apparent for 7-10 days).[30]

PATHOLOGY

Subdural hemorrhage caused by the disruption of small bridging veins that connect the dura to the pia arachnoid is a common result of shaking.[7,8] Such hemorrhage may be most prominent in the

interhemispheric fissure and minimal over the convexities of the hemispheres.[5] Cerebral edema with subarachnoid hemorrhage may be the only finding. A child may have subdural hemorrhages, subarachnoid hemorrhages, or both. Intracranial or retinal hemorrhages may be unilateral or bilateral. Visible cerebral contusions are unusual, but diffuse axonal injury is common.[32] However, for technical reasons, it is often not possible to demonstrate this pathologically or radiologically in individual cases. Isolated or concomitant hypoxic-ischemic damage may result in mild to severe cerebral edema initially and cerebral atrophy and/or infarction as a later finding. Chronic extra-axial fluid collections, cerebral atrophy, and cystic encephalomalacia are common late sequelae.[29] Sequential cranial imaging studies are recommended. The diagnostic entity of "benign subdural effusions" should be viewed with caution, because multidisciplinary evaluations in previously described cases were lacking.[33]

OUTCOME AND CONSEQUENCES

There is a high rate of morbidity and mortality among infant victims of shaken baby syndrome.[2,4,11,16] Mortality rates range from 15%[4] to 38%,[10] with a median of 20% to 25%. In one series, of those infants who were comatose when initially examined, 60% died or had profound mental retardation, spastic quadriplegia, or severe motor dysfunction. Other infants initially had seizures, irritability, or lethargy but had no lacerations or infarctions of brain tissue. These children did not have severely elevated intracranial pressure, subtle neurologic sequelae, or persistent seizures.[29] When severely brain-injured children survive, they may be cortically blind; have spasticity, seizure disorders, or microcephaly; or have chronic subdural fluid collections, enlarging ventricles, cerebral atrophy, encephalomalacia, or porencephalic cysts.[28] The outcome of shaken infants who do not receive medical attention is presently unknown but may be revealed later as learning, motor, or behavior problems of unknown cause.

CLINICAL AND COMMUNITY MANAGEMENT OF ABUSIVE HEAD INJURIES

Because the differential diagnosis of head trauma is predominately that of accidental versus inflicted injury, prompt and accurate investigation is essential. A carefully recorded time line of the child's condition is of great assistance in determining when injuries may have occurred. Suspicion of serious head injury as a result of abuse must be reported immediately to the appropriate authorities. This facilitates a thorough investigation before the histories become clouded by time or caregivers compare or invent explanations. The clinical team should include a physician who can immediately resuscitate and stabilize the baby while diagnostic radiologic studies are being done. Specialists in pediatric radiology, pediatric neurology and/or pediatric neurosurgery, and ophthalmology and a pediatrician who specializes in child abuse should form the diagnostic team. Many children will need to be followed in a pediatric intensive care unit. In rural or medically underserved areas in which one or more of these specialists are not available, a regional consultation network for child abuse cases should be developed. Careful follow-up by this same team is desirable to document and treat ocular, developmental, and neurologic sequelae of the trauma. Ideally, a physician who works with a multidisciplinary child abuse team should be available to take a broad but detailed history from the caretakers. Information regarding symptom onset and information regarding the chain of caretakers needs to be quickly passed on to

mandated law enforcement and child protection investigators. Physicians can provide interpretation of the likely scenario, timing, and nature of the injuries involved.[3,4] If notified promptly, investigators may be able to explore the scene of the injury and elicit detailed information from the caretaker before defensive reactions develop. A psychosocial assessment of the caretakers should be a part of this comprehensive team approach. Siblings or other children in the same environment may have signs of inflicted trauma or repeated shaking.[9] Therefore, medical and child protection assessments need to be available immediately to ensure the current and future safety of these children.

PREVENTION

As a part of anticipatory guidance, the pediatrician should ask about caretaker stress, discipline practices, substance abuse, and response to the crying infant. The efficacy of home visitation programs in preventing intrafamilial physical abuse is established. Nationwide home visitation programs have been repeatedly recommended by the US Advisory Board on Child Abuse and Neglect.[2,35] Because males commit most physical abuse, special programs should also be developed to target them. Shaken baby syndrome awareness programs that erroneously state that shaken baby syndrome may be caused by bouncing a child on a knee, by tossing him in the air, or even by rough play are to be discouraged, because they are inaccurate and may cause parents who have not abused their child to feel guilty.[1] Whether or not educational efforts will prevent critically stressed or homicidal adults from violently shaking babies needs to be evaluated. The prevention of extrafamilial abuse in out-of-home care settings is more problematic. Careful checking of references, frequent unannounced visits, and conversations with others who use the same caretaker may be valuable, but there are no data available to verify the efficacy of these preventive measures as there are for home visitation programs.

SUMMARY

Top
Abstract
Introduction
Conclusion
Recommendation
References

Shaken baby syndrome is a clearly definable medical condition. A proper response requires integration of specific clinical management and community intervention in an interdisciplinary fashion. Greater attention and resources should be devoted to prevention of abusive injuries.

RECOMMENDATIONS

Top
Abstract
Introduction
Conclusion
Recommendation
References

The American Academy of Pediatrics recommends that pediatricians:

1. Become educated about the recognition, diagnosis, treatment, and outcome of shaken baby and abusive head-impact injuries in infants and children;
2. Be aware of and exercise their responsibility to report these injuries to appropriate authorities;
3. Provide pertinent medical information to other members of multidisciplinary teams investigating these injuries;
4. Support home visitation programs and any other child abuse prevention efforts that prove efficacious; and

Twyla Brase

27. Child Born in Wedlock? (Specify Yes or No)

Enter "Yes" if the mother was married at the time of conception, at the time of birth, or at any time between conception and birth; otherwise, enter "No." The father's name cannot be entered if the mother is not married, unless a Recognition of Parentage is signed by the parents. A woman is legally married even if she is separated from her husband. This information will not appear on certified copies of the birth certificate.

(This information is used to monitor the substantial differences in health and fertility between married and unmarried women. It enables the study of health problems encountered during and after pregnancies of unmarried women. This information allows researchers to measure medical risk factors of out-of-wedlock children and their mothers. These children tend to have lower birth weight and higher infant mortality, and they may be born to mothers with less prenatal care. Because of these differences, unmarried women and their babies are more likely to require additional health services.)

27a. If Item #27 is "No", Does Mother Designate Birth Record Public? (Yes or No)

In the case of an out-of-wedlock birth, Minnesota Statutes 144.225, Subd. 5 classifies the certificate of live birth as a private document unless the mother indicates on the birth certificate that she wants the data to be public. This means that unless the mother indicates she wants it public, information on the birth certificate may be disclosed only to the parent or guardian of the child, to the child if 18 years of age or older, or pursuant to a court order. If the mother indicates that she wants the record to be public she must sign the certificate in item #25.

MEDICAL SUPPLEMENT TO THE BIRTH CERTIFICATE (yellow copy)

Items 28-43 appear only on the medical supplement to the birth certificate. The information collected on the medical supplement to the certificate of live birth below the title INFORMATION FOR MEDICAL AND HEALTH USE ONLY may relate to the identification, description, prevention and control of disease and is part of an ongoing epidemiologic investigation necessary to analyze, describe, and protect the public health. Any information that permits identification of the child or either parent is classified as private under Minnesota Statutes. The information on the medical supplement to the certificate of live birth is used primarily for summary statistical purposes; however, private identifying information may be provided to local public health officials who are responsible for providing preventive health care services directed toward promoting the health and well being of the mother and/or the health and development of the child.

The failure to provide the known information sought on the certificate of live birth or the medical supplement to the certificate of live birth, or the failure to file these forms as prescribed by law, is a misdemeanor under Minnesota law.

Handbook on Birth Registration and Fetal Death Reporting MDH - Jan 1995

MINNESOTA DEPARTMENT OF HEALTH
SECTION OF VITAL STATISTICS

214759 1

MEDICAL SUPPLEMENT TO THE CERTIFICATE OF LIVE BIRTH

STATE FILE NUMB

NENT BLACK INK.
SEE HANDBOOK
TYPE/PRINT IN
FOR INSTRUCT)

1. CHILD'S NAME (First) (Middle) (Last)	2. DATE OF BIRTH (Month, Day, Year)	3. TIME OF BIRTH

4. SEX	5. PLURALITY Single, Twin, Triplets, etc. (Specify)	6. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)	7. COUNTY OF BIRTH

8. CITY OR TOWNSHIP OF BIRTH

9. PLACE OF BIRTH ☐ Hospital ☐ Residence ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Other (Specify)

10. FACILITY NAME (If not institution, give street & number)

11. I certify that I attended the birth of this child who was born alive at the place and on the date stated.
Signature ▶

12. DATE SIGNED (Month, Day, Year)

13. ATTENDANT'S NAME AND TITLE (Type or Print)
Name _____
☐ MD ☐ DO ☐ CNM
☐ Other (Specify) _____

14. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City, State, Zip Code)

15. REGISTRAR'S SIGNATURE

16. DATE FILED BY REGISTRAR (Month, Day, Year)

SAMPLE

17a. MOTHER'S PRESENT NAME (First, Middle, Last)	17b. MAIDEN SURNAME	18. DATE OF BIRTH (Month, Day, Year)

19. BIRTHPLACE (State or Foreign Country)	20a. RESIDENCE OF MOTHER - STATE	20b. COUNTY	20c. CITY OR TOWNSHIP

20d. STREET AND NUMBER	20e. INSIDE CITY LIMITS (Yes or No)	21. MOTHER'S MAILING ADDRESS (If same as residence, enter ZIP only)

22. FATHER'S NAME (First, Middle, Last)	23. DATE OF BIRTH (Month, Day, Year)	24. BIRTHPLACE (State or Foreign Country)

25. I certify that the personal information on this certifcate is correct to the best of my knowledge and belief.
Signature of parent ▶

TS WANT SOCIAL SECURITY
OR CHILD? ☐ YES ☐ NO

Public

THIS SPACE RESERVED FOR USE OF REGISTRAR

DC NUM

Private

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

26. BIRTH WEIGHT (Specify unit)	27. CHILD BORN IN WEDLOCK? (Specify Yes or No)	27a. DOES MOTHER DESIGNATE BIRTH RECORD PUBLIC? ☐ No ☐ Yes

	28. SOCIAL SECURITY NUMBERS OF PARENTS (Enter below)	29. OF HISPANIC ORIGIN? (Specify no or yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	30. RACE - American Indian, Black, White, etc. (Specify below)	31. EDUCATION (Specify only highest grade completed) Elem/Sec. (0-12)	College (1-4 or 5
MOTHER	28a.	29a.	30a.	31a.	
FATHER	28b.	29b.	30b.	31b.	

LIVE BIRTHS (Do not include this child)	OTHER TERMINATIONS (Spontaneous and induced at any time after conception)	33. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	36. CLINICAL ESTIMATE OF GESTATION (Weeks)
32a. NOW LIVING Number _____ ☐ None	32b. NOW DEAD Number _____ ☐ None	32d. Number _____ ☐ None	34. MONTH OF PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. (Specify)
32c. DATE OF LAST LIVE BIRTH (Month, Day, Year)	32e. DATE OF LAST OTHER TERMINATION (Month, Year)	35. PRENATAL VISITS - Total No. (If none, so state)	37. APGAR SCORE 37a. 1 Minute 37b. 5 Minutes

38a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If yes, enter name of facility transferred from:	38b. CHILD TRANSFERRED? ☐ No ☐ Yes If yes, enter name of facility transferred to:

39a. MEDICAL RISK FACTORS FOR THIS PREGNANCY
(Check all that apply)
01 ☐ Anemia (Hct. <30/Hgb. <10)
02 ☐ Cardiac disease
03 ☐ Acute or chronic lung disease
18 ☐ Diabetes, Gestational
19 ☐ Pre-pregnancy
05 ☐ Genital Herpes
06 ☐ Hydramnios/Oligohydramnios
07 ☐ Hemoglobinopathy
08 ☐ Hypertension, Chronic
09 ☐ Pregnancy-associated
10 ☐ Eclampsia
11 ☐ Incompetent cervix
12 ☐ Previous infant 4000+ grams
13 ☐ Previous preterm or small-for-gestational-age infant
14 ☐ Renal disease
15 ☐ Rh sensitization
16 ☐ Uterine bleeding
00 ☐ None of the above risk factors
17 ☐ Other (Specify) _____

39b. OTHER RISK FACTORS FOR THIS PREGNANCY
Weight gained during pregnancy _____ lbs.
Tobacco use during pregnancy ☐ Yes ☐ No
Average number of cigarettes per day _____
Alcohol use during pregnancy ☐ Yes ☐ No
Average number of drinks per week _____
Drug use during pregnancy ☐ Yes ☐ No
(Check all that apply)
01 ☐ Cocaine
02 ☐ Heroin
03 ☐ Phencyclidine
04 ☐ Methamphetamine
05 ☐ Amphetamine
06 ☐ Other (Specify) _____

40. OBSTETRIC PROCEDURES
(Check all that apply)
01 ☐ Amniocentesis
02 ☐ Electronic fetal monitoring
03 ☐ Induction of labor
04 ☐ Stimulation of labor
05 ☐ Tocolysis
06 ☐ Ultrasound
00 ☐ None
07 ☐ Other (Specify) _____

41. COMPLICATIONS OF LABOR AND/OR DELIVERY
(Check all that apply)
01 ☐ Febrile (>100° F or 38° C)
02 ☐ Meconium, moderate/heavy
03 ☐ Premature rupture of membrane (>12 hours)
04 ☐ Abruptio placenta
05 ☐ Placenta previa
06 ☐ Other excessive bleeding
07 ☐ Seizures during labor
08 ☐ Precipitous labor (<3 hours)
09 ☐ Prolonged labor (>20 hours)
10 ☐ Dysfunctional labor
11 ☐ Breech/Malpresentation
12 ☐ Cephalopelvic disproportion
13 ☐ Cord prolapse
14 ☐ Anesthetic complications
15 ☐ Fetal distress
00 ☐ None
16 ☐ Other (Specify) _____

42. METHOD OF DELIVERY
(Check all that apply)
01 ☐ Vaginal
02 ☐ Vaginal birth after previous C-section
03 ☐ Primary C-section
04 ☐ Repeat C-section
05 ☐ Forceps

43. ABNORMAL CONDITIONS OF THE CHILD
(Check all that apply)
01 ☐ Anemia (Hct. <39/Hgb. <13)
02 ☐ Birth Injury
03 ☐ Fetal alcohol syndrome
04 ☐ Hyaline membrane disease/RDS
05 ☐ Meconium aspiration syndrome
06 ☐ Assisted ventilation <30 min
07 ☐ Assisted ventilation ≥30 min
08 ☐ Seizures
00 ☐ None
09 ☐ Other (Specify) _____

44. CONGENITAL ANOMALIES OF CHILD
(Check all that apply)
01 ☐ Anencephalus
02 ☐ Spina bifida/Meningocele
03 ☐ Hydrocephalus
04 ☐ Microcephalus
05 ☐ Other central nervous system anomalies
(Specify) _____
06 ☐ Heart malformations
07 ☐ Other circulatory/respiratory anomalies
(Specify) _____
08 ☐ Rectal atresia/stenosis
09 ☐ Tracheo-esophageal fistula/Esophageal atresia
10 ☐ Omphalocele/Gastroschisis
11 ☐ Other gastrointestinal anomalies
(Specify) _____
12 ☐ Malformed genitalia
13 ☐ Renal agenesis
14 ☐ Other urogenital anomalies
(Specify) _____
15 ☐ Cleft lip/palate
16 ☐ Polydactyly/Syndactyly/Adactyly
17 ☐ Club foot
18 ☐ Diaphragmatic hernia
19 ☐ Other musculoskeletal/Integumental anomalies
(Specify) _____
20 ☐ Down syndrome
21 ☐ Other chromosomal anomalies

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Table 1

Descriptions of the Home Visiting Program Models Included in the Evaluations Reported in This Journal Issue[a]

Program	Program Goals	Scheduled Onset, Duration, and Frequency of Home Visits	Population Served	Background of Home Visitors	Training Requirements for Home Visitors
The Comprehensive Child Development Program (CCDP)	• Enhance the physical, social, emotional, and intellectual development of children • Provide support to parents and other family members • Assist families in becoming economically self-sufficient	Birth to one year old through fifth birthday Biweekly	Low-income families, all ethnicities, at 24 sites in the United States	Paraprofessionals and those with associate's degrees or other forms of post-high school training	Extensive in-service training
Hawaii Healthy Start	• Advance optimal child development • Promote positive parenting • Enhance parent-child interaction and parenting skills • Assure a regular physician and "medical home" • Prevent child abuse and neglect	Birth through fifth birthday Weekly, fading to quarterly	All parents of newborns in Hawaii, all income levels and ethnicities, who were identified at the time of children's birth as at risk for abuse and neglect	Paraprofessionals and those with bachelor's degrees	One week of preservice training plus 30 additional hours of in-service training
Healthy Families America (HFA)	• Promote positive parenting • Prevent child abuse and neglect	Birth through fifth birthday Weekly, fading to quarterly	Parents in the mainland United States and Canada, all income levels and ethnicities, who were identified at the time of children's birth as at risk for abuse	Paraprofessionals and those with bachelor's degrees	One week of preservice training; one day of continuing training quarterly; and 80 hours of additional training in the first 6 months of service are recommended by Prevent Child Abuse America.
The Home Instruction Program for Preschool Youngsters (HIPPY)	• Empower parents as primary educators of their children • Foster parent involvement in school and community life • Maximize children's chances for successful early school experiences	Academic year, or two years before, through the end of kindergarten Biweekly, that is, at least 15 times over 30 weeks during the school year	Families in the United States and Guam, all income levels and ethnicities	Paraprofessionals; most work part time (20 to 25 hours per week)	Intensive preservice training in the HIPPY program model plus weekly ongoing training

" Home Visiting: Recent Program Evaluations - Analysis and Recommendations"

Senators Johnson, D.E.; Solon; Lourey and Dille introduced--

S.F. No. 724: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; creating an exception to the intermediate care facility for persons with mental retardation and related conditions payment system; amending Minnesota Statutes 2004, section 256B.5012, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.5012, is amended by adding a subdivision to read:

Subd. 6. [FACILITY RATE INCREASE.] For the rate year beginning July 1, 2005, a six-bed facility located in Atwater and licensed as an intermediate care facility for persons with mental retardation and related conditions shall receive an incremental increase in rates of $28.23 per person per calendar day above the rate in effect on June 30, 2005.

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Senate

State of Minnesota

S.F. No. 836 - Modifies Hospital and Clinic Grant

Author: Senator Michelle L. Fischbach

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KC

Date: March 1, 2005

S.F. No. 836 modifies the hospital and community health clinic grant programs.

Section 1 (144.147, subdivision 2) authorizes the Commissioner of Health to award a grant under the rural hospital planning and transition grant program to an eligible hospital for the purpose of establishing an electronic health records system.

Section 2 (144.148, subdivision 1) expands the definition of an eligible project under the rural hospital capital improvement grant program to include the establishment of an electronic health records system.

Section 3 (144.1483) deletes reference to the rural community health centers under Minnesota Statutes, section 144.1486 (which is being repealed).

Section 4 (144.9268) combines statutorily the rural community health center grant program with the community clinic grants. Adds to the list of possible grant activities establishing, updating, or improving an electronic health records system and building a new clinic or expanding an existing facility.

Section 5 repeals section 144.1486 (rural community health centers).

KC:ph

Senators Fischbach, Koering, Nienow and Wergin introduced—

S. F. No. 836 Referred to the Committee on Health & Family Security

A bill for an act

relating to health; modifying hospital and clinic grant programs; eliminating community health center program; amending Minnesota Statutes 2004, sections 144.147, subdivision 2; 144.148, subdivision 1; 144.1483; 145.9268; repealing Minnesota Statutes 2004, section 144.1486.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.147, subdivision 2, is amended to read:

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

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

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

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

(3) an implementation plan.

The strategic plan must be developed by a committee that

includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community.

(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan. Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, an electronic health records system, or a rural health care system or to cover expenses associated with being designated as a critical access hospital for the Medicare rural hospital flexibility program. Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals.

Sec. 2. Minnesota Statutes 2004, section 144.148, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 10,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital,

including establishing an electronic health records system.

Sec. 3. Minnesota Statutes 2004, section 144.1483, is amended to read:

144.1483 [RURAL HEALTH INITIATIVES.]

The commissioner of health, through the Office of Rural Health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the Higher Education Services Office, and other state agencies, shall:

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

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

~~(3)~~ develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

~~(4)~~ (3) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

~~(5)~~ (4) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

~~(6)~~ (5) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

~~(7)~~ (6) support efforts to ensure continued funding for

medical and nursing education programs that will increase the number of health professionals serving in rural areas;

~~(8)~~ (7) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

~~(9)~~ (8) coordinate the development of a statewide plan for emergency medical services, in cooperation with the Emergency Medical Services Advisory Council;

~~(10)~~ (9) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota Department of Transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or health professional shortage area designation is subsequently withdrawn; and

~~(11)~~ (10) carry out other activities necessary to address rural health problems.

Sec. 4. Minnesota Statutes 2004, section 145.9268, is

amended to read:

145.9268 [COMMUNITY CLINIC GRANTS.]

Subdivision 1. [DEFINITION.] For purposes of this section, "eligible community clinic" means:

(1) a nonprofit clinic that ~~provides~~ is established to provide health services ~~under conditions as defined in Minnesota Rules, part 9505.0255,~~ to low income or rural population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay;

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

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

(4) a nonprofit, tribal, or governmental entity proposing the establishment of a clinic that will provide services and utilize a sliding fee scale or other procedure as described under clause (1).

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

Subd. 3. [ALLOCATION OF GRANTS.] (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline

established by the commissioner. A grant may be awarded upon the signing of a grant contract. Community clinics may apply for and the commissioner may award grants for one-year or two-year periods.

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

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

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

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

(4) a process for documenting and evaluating results of the grant.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the ~~priority level~~ eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base and the degree to which grant funds will be used to support services increasing or maintaining access to health care services. During application review, the commissioner may request additional information about a proposed project, including

information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.

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

Subd. 3a. [AWARDING GRANTS.] (a) The commissioner may award grants for activities to:

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

(2) establish, update, or improve information, data collection, or billing systems, including electronic health records systems;

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

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

(5) build a new clinic or expand an existing facility; or

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

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

Subd. 4. [EVALUATION AND REPORT.] The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on ~~priority~~

~~areas for grants set under subdivision 3~~ the needs of community clinics and provide any recommendations for adding or changing ~~priority areas~~ eligible activities.

Sec. 5. [REPEALER.]

Minnesota Statutes 2004, section 144.1486, is repealed.

APPENDIX
Repealed Minnesota Statutes for 05-0141

144.1486 RURAL COMMUNITY HEALTH CENTERS.

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

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

Subd. 3. **Grants.** The commissioner shall provide grants to communities for planning, establishing, and operating community health centers through the Minnesota community health center program. Grant recipients shall develop and implement a strategy that allows them to become self-sufficient and qualify for other supplemental funding and enhanced reimbursement. The commissioner shall coordinate the grant program with the federal rural health clinic, federally qualified health center, and migrant and community health center programs to encourage federal certification.

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

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

(2) represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental or tribal entity. Applicants in the process of forming a nonprofit corporation may have a nonprofit coapplicant serve as financial agent through the remainder of the formation period. With the exception of governmental or tribal entities, all applicants must submit application for nonprofit incorporation and 501(c)(3) tax-exempt status within six months of accepting community health center grant funds; and

(3) for an application for an operating expense grant, demonstrate that expenses exceed revenues or demonstrate other extreme need that cannot be met from other sources.

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

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

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

(1) population below 200 percent of poverty;

(2) geographic barriers based on average travel time and distance to the next nearest source of primary care that is

accessible to Medicaid and Medicare recipients and uninsured low-income individuals;

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

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

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

(1) proposed scope of health services;

(2) clinical management plan;

(3) governance;

(4) financial and administrative management; and

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

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

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

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

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

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

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

(5) initial operating expenses of community health centers;

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

(7) facilities;

(8) necessary consultant fees; and

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

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

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

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

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

(1) provide ongoing active local governance to the community health center and pursue community support, integration, collaboration, and resources;

(2) offer primary care services responsive to community needs and maintain compliance with requirements of all cognizant regulatory authorities, health center funders, or health care payers;

(3) maintain policies and procedures that ensure that no person will be denied services because of inability to pay; and

(4) submit brief quarterly activity reports and utilization data to the commissioner.

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

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

Senator Fischbach ..... moves to amend S.F. No. 836 as follows:

Page 1, after line 8, insert:

"Section 1. [62J.495] [HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE ADVISORY COMMITTEE.]

Subdivision 1. [LEGISLATIVE FINDINGS AND PURPOSE.] There is a need for coordination and collaboration among health care payers, providers, consumers, and government in designing and implementing a statewide interoperable health information infrastructure that includes standards for administrative data exchange, clinical support programs, quality performance measures, and maintenance of the security and confidentiality of individual patient data.

Subd. 2. [ESTABLISHMENT; MEMBERS; DUTIES.] (a) The commissioner shall establish a Health Information Technology and Infrastructure Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for administrative data exchange, clinical support programs, and maintenance of the security and confidentiality of individual patient data; and

(3) other related issues as requested by the commissioner.

(b) The members of the Health Information Technology and Infrastructure Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise

in health information technology, and other stakeholders as identified by the Health Information Technology and Infrastructure Advisory Committee.

Subd. 3. [ANNUAL REPORT.] The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending future projects.

Subd. 4. [EXPIRATION.] Notwithstanding section 15.059, this section expires June 30, 2009."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Berglin moves to amend S.F. No. 836 as follows:

Page 2, line 19, after the period, insert "The commissioner shall give priority to grant applications for projects involving electronic health records systems."

Page 3, line 1, after the period, insert "The commissioner shall give priority to grant applications for projects involving electronic health records systems."

Page 7, line 8, after the period, insert "In addition, the commissioner shall give priority to grant applications for projects involving electronic health records systems."

Policy Position

Minnesota Department of Health SF 836

Electronic Health Records and Rural Health Care Grants

M.S.144.148, M.S. 144.147, M.S. 144.1486, M.S.145.9268

Electronic Health Records and Rural Health Care Grants

As part of its initiative to speed the implementation of electronic health records and technology throughout the health care system, MDH is proposing a straightforward statutory change in several current programs to accentuate the department's commitment to health information technology projects.

What does the legislation do?

The department administers several grant programs that support rural hospital planning, and capital improvements, and community and rural clinic projects. The legislation adds specific language to these programs clarifying that electronic health records projects are eligible activities for state grant support. This legislation will encourage and support the transition to electronic health records.

The legislation adds Electronic Health Records language to the following existing grant programs:

Hospitals:

- Rural Hospital Capital Improvement Grant Program (M.S.144.148)
- Rural Hospital Planning and Transition Grant Program (M.S. 144.147)

Clinics:

- Rural Community Health Center (M.S. 144.1486) and
- Community Clinic Grant Programs (M.S.145.9268)

The legislation combines the two clinic programs cited above into one section of statute in order to better support the capacity of rural and urban clinics in:

- Serving rural or low-income populations
- Reducing uncompensated care burdens or
- Providing for improved quality of care.

The programs are similar enough in objectives, structure and function that combining them can retain the fundamental nature of each, improve the operation of the programs, and make the application process clearer and simpler for the safety net clinics supported by the programs.

Moved is backed by stakeholders

The Minnesota Hospital Association supports the hospital program changes. The Minnesota Primary Care Association and the Neighborhood Health Care Network support the clinic program changes. No opponents or controversies are known or expected.

Supports the department's goals

Adding Electronic Health Records language to these programs supports these department goals:

- E-Health Initiative
- Stewarding resources and fostering best business practices
- MDH priority to reduce health care gaps in rural communities.

MINNESOTA MDH DEPARTMENT OF HEALTH

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Community Health Center Grant Program

What is the Community Health Center Grant Program?
The Community Health Center Grant Program provides funding to rural communities and clinics for planning, establishing and operating community health centers. Eligible applicants include Nonprofit, governmental or tribal entities located in a rural shortage area outside the Twin Cities, Duluth, St. Cloud, East Grand Forks, Moorhead, Rochester or La Crosse urbanized areas. Grantees must provide local governance to the clinic, offer primary care services responsive to the community needs, and maintain policies and procedures that ensure that no person will be denied services because of inability to pay.

What is the history of the Community Health Center Grant Program?
The Minnesota legislature enacted the Community Health Center Grant Program in 1995. The program is funded under intergovernmental transfers and has experienced significant budget reductions since the first year. The maximum request amount was reduced to $100,000 in year two and then, again, reduced to $45,000 to accommodate the decreasing budget.

Fiscal Year	Applications Received	Total Request	Grants Approved	Total Awards	Program Budget
1995	6	$412,250	5	$337,250	$337,250
1996	5	$206,899	5	$185,000	$250,000
1997	3	$250,000	3	$250,000	$250,000
1998	9	$533,149	5	$250,000	$250,000
1999	6	$291,688	6	$250,000	$250,000
2000	7	$287,381	7	$250,000	$250,000
2001	8	$511,826	8	$250,000	$250,000
2002	9	$1,939,152	4	$250,000	$250,000
2003	10	$871,497	7	$250,000	$250,000
2004	10	$513,888	6	$250,000	$250,000

How do clinics spend the grant funds?
Community Clinic Grants have been awarded to help cover expenses in the following categories:

- Provide a direct offset to expenses incurred for services provided to the clinic's target population: (e.g. clinical salaries.)
- Establish, update, or improve information, data collection, or billing systems (e.g. billing software, computer hardware.)
- Procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic (e.g. exam tables, medical equipment, dental equipment.)
- Provide improvements for care delivery, such as increased translation and interpretation services.
- Other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve (e.g. clinical staff training, multilingual patient information brochures.)

Awards have varied from $10,000 to offset uncompensated care to $437,300 to establish a 12-facility shared management information system. The attached tables provide detail about grant recipients, amounts and projects.

Why are Community Health Center Grants important to the State of Minnesota? Community Health Center grants have provided support for rural Minnesota's smallest and most isolated communities to secure and maintain access to basic health care services.

Who administers the Community Health Center Program?
The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Community Clinic Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Community Clinic Program?
Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

Community Clinic Grant Program

What is the Community Clinic Grant Program?
A Community Clinic Grant Program provides funding to support the capacity of rural and urban community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delive infrastructure. Eligible clinics include those that provide physician directed primary care services and utilize a sliding fe schedule for uninsured and underinsured patients or a consortium of clinics providing these services. Eligible applicants also include Indian tribal governments or Indian Health Service units.

What is the history of the Community Clinic Grant Program?
The Minnesota legislature enacted the Community Clinic Grant Program in 2001. The program is funded under intergovernmental transfers and has experienced significant budget reductions since the first year. The maximum request amount was reduced to $100,000 in year two and then, again, reduced to $45,000 to accommodate the decreasing budget.

Fiscal Year	Applications Received	Total Request	Grants Approved	Outstate Awards	Program Budget
2002	27	$6,293,752	22	8	$3,039,300
2003	27	$2,569,613 *	21	11	$1,009,907
2004	20	$896,604 *	9	3	$317,000

* maximum request amount reduced as a result of declining budget.

How do clinics spend the grant funds?
Community Clinic Grants have been awarded to help cover expenses in the following categories:

- Provide a direct offset to expenses incurred for services provided to the clinic's target population: (e.g. clinical salaries.)
- Establish, update, or improve information, data collection, or billing systems (e.g. billing software, compute. hardware.)
- Procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic (e.g. exam tables, medical equipment, dental equipment.)
- Provide improvements for care delivery, such as increased translation and interpretation services.
- Other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve (e.g. clinical staff training, multilingual patient information brochures.)

Awards have varied from $10,000 to offset uncompensated care to $437,300 to establish a 12-facility shared management information system. The attached tables provide detail about grant recipients, amounts and projects.

Why are Community Clinic Grants important to the State of Minnesota? Community Clinic grants improve the ability of the state's safety net primary care providers to provide quality, responsive services to uninsured and underinsured patients.

Who administers the Community Clinic Program?
The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Community Clinic Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Community Clinic Program?
Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

Rural Hospital Capital Improvement Grant Program

What is the Rural Hospital Capital Improvement Grant Program?

The Rural Hospital Capital Improvement Grant Program provides funding to assist small, rural hospitals to maintain or update their buildings and equipment when other options are limited or unavailable. Minnesota has 80 rural hospitals with 50 or fewer licensed beds. Many of these hospitals were built with federal Hill Burton funds in the 1950s and 60s. Though essential to maintaining health care access in their communities, their modest revenues have made it difficult for many to update their buildings or modernize their medical equipment to keep pace with changes in technology.

What is the history of the Rural Hospital Capital Improvement Grant Program?

The Minnesota legislature enacted the Rural Hospital Capital Improvement Program in 1997. In its first two years the program made awards to five remote, financially fragile hospitals to renovate their facilities. For FY 2000, the legislature expanded eligibility criteria for the program, making all small rural hospitals eligible.

Fiscal Year	Eligible Hospitals	Applications Received	Total Request	Grants Approved	Program Budget
1998-99	5	5	$7.5 million	5	$7.5 million (for biennium)
2000	81	48	$11 million	22	$2.8 million
2001	81	44	$9.5 million	24	$2.8 million
2002	81	50	$16.8 million	24	$4.6 million
2003	81	48	$ 8.9 million *	26	$2.6 million
2004	80	43	$4.9 million *	22	$1.8 million

* maximum request amount reduced as a result of declining budget.

How do hospitals spend the grant funds?

Capital Improvement Grants have been awarded to help cover expenses in the following categories:

- Building/facility upgrades: (for example, roofs, boilers, room renovations, building additions and repairs, HVAC, fire protection system, heliport etc.)
- Technological improvements and equipment upgrades (for example, mammography, radiology, information technology, cardiac ultrasound, teleradiology etc.)

The 2001 legislature set the maximum award amount at $500,000; awards have varied from $15,000 to help build a new helicopter-landing pad to $500,000 for major facility enhancement and updates. The attached tables provide detail about grant recipients, amounts and projects.

Why are Capital Improvement Grants important to the State of Minnesota?

Two-thirds of Minnesota's small rural hospitals were built in the 1960's or earlier and are being used to accommodate new and changing community health care needs. According to a survey conducted in 2000 by the MDH, 70% of Minnesota's small rural hospitals are classified as "struggling" or "distressed" regarding the status of capital investments in their facilities and equipment as they try to keep pace with burgeoning infrastructure needs and advances in medical technology. The capital investment needs of these hospitals cannot be fully supported by operating profits. They face significant barriers to borrowing for their capital improvement needs, such as low operating margins and lack of cash. Hospitals report that grant awards have been necessary for projects to move forward. Grants help these struggling hospitals meet their capital improvement needs so that they can continue to provide critical health care services in their communities. Sixty hospitals in Minnesota have been recipients of Rural Hospital Capital Improvement Grants, benefiting local communities throughout the entire state.

Who administers the Rural Hospital Capital Improvement Program?

The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Rural Hospital Capital Improvement Program. The office works to promote access to quality health care in rural and underserved urban areas. It provides a variety of financial assistance and professional services to safety net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Rural Hospital Capital Improvement Program?

Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

Minnesota Rural Hospital Planning and Transition Grant Program

What is the Rural Hospital Planning and Transition Grant Program?

The Rural Hospital Planning and Transition Grant Program is a state administered program that helps small rural hospitals plan for preserving access to health services or to respond to changing conditions. Hospitals have transition grants to prepare strategic plans, implement new uses for hospital space and develop commu... services.

What is the history of the Rural Hospital Planning and Transition Grant Program?

The Rural Hospital Planning and Transition Grant Program was enacted by the Minnesota State Legislature in 1990 to assist small hospitals and their communities in developing strategic plans for preserving access to health services, and implementing transition projects to modify the type and extent of services provided. It was modeled after the federal Rural Hospital Planning and Transition Grant Program that ended in 1996.

Year	Eligible Hospitals	Applications Received	Total Request	Hospitals Funded	Program Budget
1991	25	11	$371,722	4	$100,000
1992	77	21	$613,660	9	$250,000
1993	64	26	$865,786	11	$235,000
1994	51	9		7	$211,765
1995	73	18	$592,000	9	$250,000
1996	73	15	$521,076	8	$238,750
1997	78	20	$818,146	11	$250,000
1998	78	20	$651,411	8	$250,000
1999	80	21	$860,545	13	$250,000
2000	81	24	$890,625	12	$250,000
2001	80	28	$954,339	12	$250,000
2002	80	23	$882,035	11	$250,000
2003	82	17	$726,838	12	$300,000
2004	82	22	$802,497	15	$300,000

How do hospitals spend the grant funds?

The Rural Hospital Planning and Transition Grant program is intended to assist hospitals as they develop alternatives to inpatient acute care in an effort to remain viable health care providers. The majority of funding has been spent on consulting, personnel and equipment expenses for strategic planning, clinic expansion and relocation, emergency and ambulance services, and recruitment projects.

Why are Planning and Transition Grants important to the State of Minnesota?

These grants help to preserve and improve access to health care in rural areas. With the use of these funds, small hospitals (fewer than 50 beds) that are in designated rural areas or in communities with populations less than 5,000 are able to continue providing needed, quality health services in their communities.

Who administers the Rural Hospital Planning and Transition Grant Program?

The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) administers the Rural Hospital Planning and Transition Grant Program. The office works to promote access to quality health ca... rural and underserved urban areas. It provides a variety of financial assistance and professional services to sa... net hospitals, clinics and health professionals, collects data on the health care system, conducts research and analysis and involves rural leaders in health policy issues through the Rural Health Advisory Committee.

Where can I get more information about the Rural Hospital Planning and Transition Grant Program?

Contact Mark Schoenbaum at 651.282.3859 or mark.schoenbaum@health.state.mn.us.

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S.F. No. 999 - Nursing Home Surcharge Reduction and Cigarette Tax Increase

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (296-7178)

Date: February 25, 2005

S.F. No. 999 reduces the nursing home license surcharge to its pre-2003 level of $990 per bed and increases the cigarette tax by 25 cents per pack.

Section 1 (256.9657, subdivision 1) reduces the nursing home surcharge to $990 per bed from $2,815 after the surcharge payment due on June 15, 2005.

Section 2 (256B.431, subdivision 38) ends the Medical Assistance nursing home payment to offset the increased surcharge as of May 31, 2005. (The facilities would receive payments for services rendered in May in time to pay the June 15 surcharge payment.)

Section 3 (297F.05, subdivision 1) increases the cigarette tax by 25 cents per pack.

Section 4 increases the tax on cigarettes already in dealers' stocks as of July 1, 2005, by 25 cents per pack.

DG:rdr

Senators Berglin, Lourey, Rosen, Moua and Koering introduced--
S.F. No. 999: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; reducing the nursing home license surcharge; increasing the cigarette tax; amending Minnesota Statutes 2004, sections 256.9657, subdivision 1; 256B.431, subdivision 38; 297F.05, subdivision 1.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. [NURSING HOME LICENSE SURCHARGE.] (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of

human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, to June 15, 2005, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Notwithstanding section 256B.431, subdivision 27, paragraph (i), rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2004, section 256B.431, subdivision 38, is amended to read:

Subd. 38. [NURSING HOME RATE INCREASES EFFECTIVE IN FISCAL YEAR 2003.] Effective June 1, 2003, to May 31, 2005, the

commissioner shall provide to each nursing home reimbursed under this section or section 256B.434, an increase in each case mix payment rate equal to the increase in the per-bed surcharge paid under section 256.9657, subdivision 1, paragraph (d), divided by 365 and further divided by .90. The increase shall not be subject to any annual percentage increase. The 30-day advance notice requirement in section 256B.47, subdivision 2, shall not apply to rate increases resulting from this section. The commissioner shall not adjust the rate increase under this subdivision unless the adjustment is greater than 1.5 percent of the monthly surcharge payment amount under section 256.9657, subdivision 4.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2004, section 297F.05, subdivision 1, is amended to read:

Subdivision 1. [RATES; CIGARETTES.] A tax is imposed upon the sale of cigarettes in this state, upon having cigarettes in possession in this state with intent to sell, upon any person engaged in business as a distributor, and upon the use or storage by consumers, at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, ~~24~~ 36.5 mills on each such cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, ~~48~~ 73 mills on each such cigarette.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 4. [FLOOR STOCKS TAX.]

Subdivision 1. [CIGARETTES.] (a) A floor stocks tax is imposed on every person engaged in business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, on the stamped cigarettes and unaffixed stamps in the person's possession or under the person's control at 12:01 a.m. on July 1, 2005. The tax is imposed at the following rates, subject to the discount in Minnesota Statutes, section 297F.08, subdivision 7:

(1) on cigarettes weighing not more than three pounds per

thousand, 12.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, 25 mills on each cigarette.

(b) Each distributor, by July 8, 2005, shall file a report with the commissioner of revenue, in the form the commissioner prescribes, showing the stamped cigarettes and unaffixed stamps on hand at 12:01 a.m. on July 1, 2005, and the amount of tax on the cigarettes and unaffixed stamps. The tax imposed by this section is due and payable by August 1, 2005, and after that date bears interest as provided in Minnesota Statutes, section 270.75. Each retailer, subjobber, vendor, manufacturer, or manufacturer's representative shall file a return with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 2005, and pay the tax due on them by August 1, 2005. Tax not paid by the due date bears interest as provided in Minnesota Statutes, section 270.75.

Subd. 2. [AUDIT AND ENFORCEMENT.] The tax imposed by this section is subject to the audit, assessment, and collection provisions applicable to the taxes imposed under Minnesota Statutes, chapter 297F.

[EFFECTIVE DATE.] This section is effective July 1, 2005.