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State of Minnesota

S.F. No. 1836 - HIV Prevention and Health Care Access

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Date: March 30, 2005

S.F. No. 1836 creates a new HIV prevention and health care access program.

Section 1 (256.9370) creates a new HIV prevention and health care access program.

Subdivision 1 states the purpose of the program.

Subdivision 2 requires the Commissioner of Human Services to create a new program to provide for persons who have contracted HIV: (1) prescription drug coverage; (2) early intervention diagnostic services; and (3) payment for private health plan premiums in order to secure or continue coverage under a group or individual health plan.

Subdivision 3, paragraph (a), states that to be eligible for the program an applicant must:

(1) be HIV positive;

(2) have no health coverage or be undercovered for medications; have no health coverage due to a preexisting condition; face losing health coverage due to a change in employment status; or have limited coverage that is not consistent with the guidelines of the U.S. Public Health Service for best practices for HIV treatment;

(3) have a monthly gross family income that does not exceed 300 percent of the federal poverty guidelines (FPG) after deducting medical expenses and insurance premiums; and

Senators Hottinger, Dibble, Higgins, Foley and Lourey introduced--

S.F. No. 1836: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; creating a program for individuals with HIV; appropriating money; amending Minnesota Statutes 2004, section 256.9365, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256.

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

Section 1. [256.9370] [HIV PREVENTION AND HEALTH CARE ACCESS PROGRAM.]

Subdivision 1. [PURPOSE.] The commissioner of human services shall establish an HIV prevention and health care access program for low-income Minnesotans that:

(1) provides access to HIV treatment consistent with the guidelines of the United States Public Health Service;

(2) promotes reduction of HIV transmission through continuous and uninterrupted access to treatment consistent with the United States Public Health Service guidelines;

(3) provides uniform benefits that are comprehensive as defined by the most recent recommendations of the Institute of Medicine and medically appropriate as established by the United States Public Health Service to best meet HIV needs with a minimum of administrative cost and efforts;

(4) ensures service delivery accountability to the people it serves, including due notice; opportunities for community input; and uniform, transparent procedures communicated to current and eligible persons, their health care and social

service providers, community planning and advisory groups, and agencies established under the Ryan White Care Act;

(5) provides access to HIV treatment inclusive of treatment for substance abuse and mental health treatment as those conditions interfere with HIV treatment adherence; and

(6) provides initial and continued access to HIV treatment that is, to the maximum extent practicable, without regard to the ability of the person to pay for the services and without regard to the current or past health condition of the person with HIV.

Subd. 2. [ESTABLISHMENT.] The commissioner of human services shall establish a program to provide prescription drug coverage and basic early intervention diagnostic services and to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to secure or continue coverage under a group or individual health plan and to ensure continuous comprehensive treatment.

Subd. 3. [ELIGIBILITY REQUIREMENTS.] (a) To be eligible for the program, an applicant must satisfy the following requirements:

(1) the applicant must be HIV positive;

(2) the applicant must:

(i) have no health insurance coverage, or be undercovered for medications;

(ii) have no health insurance coverage because of ineligibility due to a preexisting condition;

(iii) face losing health insurance coverage due to a change in employment status; or

(iv) have limited coverage not consistent with the guidelines of the United States Public Health Service for best practice HIV treatment;

(3) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines after deducting medical expenses and insurance premiums; and

(4) the applicant must not own assets with a combined value of more than $30,000, excluding:

(i) all assets excluded under section 256B.056;

(ii) retirement accounts, Keogh plans, and pension plans; and

(iii) medical expense accounts set up through the individual's employer.

(b) To be eligible for drug reimbursement, the applicant may not be a recipient of medical assistance, medical assistance for employed persons with disabilities, or general assistance medical care.

(c) Individuals whose income and assets exceed the amounts established in paragraph (a), but who meet all the other eligibility requirements, shall be eligible for this program upon payment of a premium. The premium shall be based on the person's gross income using a sliding fee scale established by the commissioner. The premium shall not exceed ten percent of the person's annual gross income.

Subd. 4. [BENEFITS.] (a) If an individual is determined to be eligible under subdivision 3, the commissioner shall pay that portion of the group plan premium for which the individual is responsible or shall pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents. Requirements for the payment of individual plan premiums under this section must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance and general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

(b) If an individual is determined to be eligible under subdivision 3, the program benefits shall provide access to HIV drugs and related drug treatments included in the HIV care drug formulary established by the commissioner. The program benefits shall include those services specified in subdivision 1 and shall also provide access to early intervention treatment, including initial diagnostics, hepatitis B and C, sexually

transmitted infections, and tuberculosis screening and tests, and any treatment for HIV that is consistent with the guidelines of the United States Public Health Service for HIV best practice treatment.

(c) There shall be no co-payments or premiums or cost-shares charged to any individual determined to be eligible under subdivision 3, paragraph (a).

(d) The state may use nonfederal funds to supplement drug assistance benefits available through the Medicare Part D program.

(e) The priority use for all funds received through prescription drug rebates through HIV drug purchases must be used to purchase benefits for eligible persons.

Subd. 5. [PUBLIC ADVISORY PROCESS.] The commissioner shall establish a transparent, public advisory process for establishing and revising an HIV care drug formulary. At a minimum, the process shall include consultation with HIV health care providers, HIV social service providers, persons living with HIV, the Minnesota HIV Services Planning Council, and entities directly contracted by the federal government to administer funds from the Ryan White Care Act. Participants in this process shall be appointed in equal numbers by the commissioner and by the Minnesota HIV Services Planning Council.

Sec. 2. Minnesota Statutes 2004, section 256.9365, is amended by adding a subdivision to read:

Subd. 4. [EXPIRATION.] This section expires upon implementation of the HIV prevention and health care access program.

Sec. 3. [APPROPRIATION.]

(a) $12,400,000 is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services for the purposes of section 1.

(b) Funding sources include, but are not limited to, drug rebate funds, the Ryan White Care Act, health care access funds, and the general fund. The commissioner may use 100 percent of the funds available for the AIDS drug assistance program, but no

more than 25 percent of the funds received through the Title II formula allocation.

Sec. 4. [EFFECTIVE DATE.]

Sections 1 to 3 are effective July 1, 2005.

Minnesota AIDS Project™

MAP *Facts*

HIV Prevention and Health Care Access

MAP Action

MAP supports the establishment of a new program for providing HIV care to low-income Minnesotans. The new program should be funded through a combination of federal and state money.

MAP supports S.F. 1836 authored by Senator Hottinger, and H.F. 1892 authored by Representative Thissen.

Follow the progress of the bills through ***MAP***'s Bill Tracker:
www.mnaidsproject.org/publicpolicy/billtracker

For Information:

Contact MAP community affairs
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Access to Treatment is Critical for Prevention

- HIV disease requires comprehensive and continuous care because it is a potentially fatal infectious agent that can spread rapidly in vulnerable, hard-to-insure populations.
- For the highly active antiretroviral treatments (HAART) to be effective, adherence to the medication regimen is critical. If individuals with HIV miss more than 1 in 20 doses, or in other words, are less than 95% adherent to their regimen, they face the possibility of developing a drug resistant strain of the virus. This strain could then be passed along to others.
- People with consistent access to treatment and medication are more likely to adjust their risk behaviors, thereby reducing the risk that the virus will spread.

Current Policies are Out of Date

- Existing policies for care were based on assumptions of HIV and AIDS formed prior to the benefits and challenges arising from the development of HAART therapies. The new treatment regimen and longer life expectancy require more continuous and comprehensive health care delivery.
- Cost share and co-pay policies implemented by the Department of Human Services in 2004 require low-income Minnesotans to pay a portion of their income in order to receive access to HIV treatment and medication. Around 200 have been unable to make at least one payment. At least 50 Minnesotans may now face removal from the program and loss of access to benefits because they have been unable to meet the payment requirements for at least six months.

Goals of the HIV Prevention and Health Care Access Program

- Provide access to health care that is consistent with guidelines established by the Centers for Disease Control
- Promote the reduction of HIV transmission through continuous and uninterrupted access to treatment
- Provide access to HIV treatment inclusive of treatment for substance abuse and mental health because these factors interfere with HIV treatment adherence
- Provide access to services for low-income Minnesotans that is not dependent on their ability to pay for the services

Effective: 3/30/2005
Revised:

Minnesota

HIV Planning Council Newsletter

Planning Council History and Purpose

The Planning Council was formally organized in 1995 to address treatment, care and advocacy issues for people living with HIV/AIDS (PLWH/A), their friends, family and caregivers. As the decision-making body for funds authorized under the Ryan White Comprehensive AIDS Resources (CARE) Act of 1990, the Planning Council works collaboratively with a number of agencies. The Planning Council collaborates with the Hennepin County Human Services and Public Health Department, Public Health Protection division to ensure comprehensive treatment, care and advocacy for PLWH/A living in the metropolitan area. The Planning Council also collaborates with the Minnesota Department of Human Services HIV/AIDS program to maximize treatment, care and advocacy for PLWH/A across the entire state.

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HIV Care: Decision Making and Rationing

By Sarah Rybicki

A Clear and Positive Message

As HIV/AIDS treatment has improved, we have been able to use medications and medical care to help people live longer, healthier lives. Popular wisdom is that these advances come with a very high price tag. But how high, and compared to what? Does HIV care really cost more than it used to when people sickened and died quickly of AIDS-related illnesses? The answer might surprise you. The cost of helping a person living with HIV/AIDS (PLWH/A) maintain his or her health has not gone up significantly since 1996, with the availability of highly active antiretroviral therapy (HAART). What has driven up the cost of the epidemic is the increasing numbers of persons with HIV who are living longer and more productive years, and requiring medication to do so. Hospital costs have gone down, and long-term medication costs have gone up. Additionally, approximately 40,000 newly infected persons are added to the service-delivery system every year, resulting in an epidemic with steeply rising costs. These dynamics put stress on programs like the AIDS Drug Assistance Program (ADAP). It is essentially designed to meet the healthcare and medication-access needs of low-income working people. We know that long-term HIV care continues to be expensive, because of the high cost of drugs, the potential lifelong treatment, and the increasing number of persons requiring treatment. What is missing in this equation is the contribution to society that PLWH/As make when they are healthy and able to work, decreasing the cost of long-term care.

In the spring of 2004, increasing costs of HIV care and shrinking resources led decision makers at the Minnesota Department of Human Services (DHS) to institute a cost-share requirement. The purpose of the cost-share was to reduce a projected deficit in the ADAP program and avoid the creation of a waiting list. Access to CARE Act-funded services is limited

The new cost-sharing policy for Minnesota ADAP is based on the idea that current ADAP recipients have low enough incomes to qualify for ADAP, but enough money to share the cost of accessing drugs and insurance by making payments for them. At this time, DHS has indicated that it may not be finished making changes and further rationing HIV-related insurance and medication-related services. Steps under discussion are:

- Limiting the number of people who can participate in the program, thereby creating a waiting list for ADAP.
- Changing income guidelines for who qualifies for the program.
- Implementing medical criteria for the waiting list that assist physicians in identifying a patient's relative position to the top of the list—the more ill the person, the closer he or she is to the top of the list.

For more information on the ADAP program, go to www.mnaidsproject.org and follow the links to the publications section, AIDSLine Brief, Basic HIV Education Edition, pp. 11-12, "What happened to ADAP?"

So what should we do now that our ADAP program has been rationed because it "costs too much"? This is a simple question with a very complicated response. Community action and decision making around HIV care is difficult, requiring that funding entities, medical and social services, and PLWH/As work together to resolve this funding crisis. A minute or two, or a page or two, is not enough time or space to explain to a legislator or administrator why HIV care is well worth the money. Infected and affected community members already know about indirect costs of HIV/AIDS, because they live them. The common scenarios of the days of work missed because of exhaustion after a hospitalization; the child left motherless; or the surviving partner now alone, grieving, and depressed are familiar to the community. These hidden costs or stories need to be communicated to decision makers. Sometimes, stories are ignored for hard, cold cost statistics. We know that the stories are as real as bottom-line numbers, but don't fit well on any accounting sheet. Even if you could talk about the hidden cost to society of having PLWH/As too sick to work, it would be difficult to add up the exact dollar amount.

"....evidence exists that ADAP programs with the most generous benefits...actually save money"

HIV Care *(continued)*

My message in this money-conscious, sound-bite world about the cost of HIV treatment for financially strapped ADAP programs is this: Evidence exists that ADAP programs with the most generous benefits for low-income PLWH/As (paying for drugs and/or insurance to cover HIV care) actually *save money* for the states that pay for them. Essentially, the more generous a state is in covering the drugs and medical care of low-income persons living with HIV, the *more* money it will save on their long-term care. This financial investment insures that PLWH/As are healthy and productive members of our state. Paying for PLWH/As to live healthy years of life, instead of ill and disabled ones, just makes good sense.

Our Current Challenge

What do we do in the event that we still have to ration the resource of HIV care even after our advocacy efforts around ADAP? In times of scarcity, our decisions should be based on a shared set of values and principles that are acceptable to the decision makers, the community, and those most affected by the decision. We have resources and options that HIV/AIDS advocates did not have in the 1980s and 1990s. Therefore, collectively, we have to make decisions that they did not have to make. We are experiencing the consequences of decisions that are being made far away from the people who will benefit from them or be harmed by them. Decisions that have huge implications for our health care are made out of our sight in state and national capitals, in health departments, and by health and social service administrators.

A set of moral principles or values must be determined to guide decision making when resources are limited. It is key that the values and principles used to make decisions about distributing resources reflect scientific knowledge and community values. Larger societal values such as wise stewardship of resources and the value of a human life must be considered. We must ask the following questions to ensure ethical decision making in rationing HIV Care:

- Who should get the resource?
- Who should make the decision?
- What information should be used in making decisions?
- How are the decisions communicated, so that everyone understands how the decision was made and why?

Currently, the Planning Council and others are working hard to answer these questions. However, this is not the time to rely on others to make decisions that will affect the health and well-being of PLWH/As. Everyone needs to be involved in ensuring our ADAP program continues to serve all our best interests. To find out more about how to get involved in keeping decision-making processes for our ADAP responsive and reflective, contact the ADAP Ad Hoc Committee of the Minnesota HIV Services Planning Council. Now is the time to act. We need your stories. We need your help.■

The ADAP Ad Hoc Committee of the Planning Council meets at Hennepin Powderhorn Partners. For more information, contact the Planning Council Offices at (612) 348-6827 or (612) 596-7894, or toll-free at (888) 638-3224.

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TA is on the Wayyyyyyyyyy!

By Andy Ansell

The letters "TA" can conjure a distinctly different image than what I'm writing about in this context. When I say "TA" is on the way, I'm talking about technical assistance for the HIV-Positive Committee of the MN HIV Services Planning Council.

In the spring of 2004, the HIV-Positive Committee determined we had reached a point where we felt we weren't utilizing our time and talent to their full potential. Up to that point the main job of the committee had been recruitment and new-member orientation. While these are vital duties that the committee isn't entirely separating from, we also felt like we could be more involved in some of the important issues set before the Planning Council.

We wanted our unique knowledge of living with HIV and our expertise in being a part of the HIV community to come to bear during some of the critical work the Council did in 2004. We came to the conclusion that we wouldn't be able to create this new role all by ourselves, so we looked to the Health Resources and Services Administration (HRSA) for guidance. We asked HRSA to provide us with the technical assistance necessary to redefine our role and determine how best to integrate these changes with the rest of the Planning Council. We embarked on a six-month process of compiling needs, defining our request, and interviewing candidates.

I'm happy to say that the moment finally arrived, and our technical assistance began. Our technical assistant's name is Lennie Green. He observed the October Planning Council meeting to get an idea of how our EMA functions, and then met with the HIV-Positive Committee to help us develop our work plan. Based on these meetings we jointly developed a training agenda. Lennie will return in March to complete this phase of his work with the HIV-Positive Committee.

All of us on the HIV-Positive Committee are truly excited for this opportunity to grow and learn, and continue to serve the HIV community through our participation. The technical assistance period will last for a period no shorter than six months. During this time, we look forward to working with the Planning Council and other committees as we move into the next stage of our development as a committee.■

A Personal Story: A Celebration of Two

A Short-term HIV+ Person's Story of Survival

By Francis Mark

On October 10, 2002, I was officially informed that I was HIV-positive. I remember that day well. I was working in a high security-level position, a job that I knew was important, and for which I needed to be alert, ready, and professional. I remember that I wasn't really amazed or shocked. Why? Actually, I'd been expecting the news since I first heard about HIV and AIDS 16 years earlier.

I was a very scrawny kid growing up, the one everyone picked on, because I was an easy target. I wasn't a fighter. I was too compassionate for that. I was too gentle. I hated physical conflict. I was called sissy, fag, and queer. My own family even treated me badly. When I was 15, I started suffering from chronic severe depression. Because of the ongoing homophobic treatment I received, I never really had a much of a sense of self-worth or self-esteem, but it diminished even more once I started suffering from depression.

Then, I had to deal with the fact that I was attracted to men, which meant I was gay. My family couldn't cope with my homosexuality and threatened to hurt me. I tried to take my own life a number of times. An older sibling who knew I was gay commented to my family and me, "All gays should get AIDS and die." I knew my father had come a long way when, upon hearing that, he said, "You know, gay people don't choose to be that way. Why do you think anyone would choose to be persecuted?" I remember feeling quite proud of my father.

Continued on Page 7.

African American Women and HIV

By Sarah Armwood-Moses

Let's talk about a revelation of black women: "shifting." Said differently: "accommodating." It involves hiding who we really are to placate black men, white colleagues, or other segments of our community and lives—such as government, as well as social economic, health-care, and education systems, alongside home. The name of the game is survival, and we have managed to develop this coping skill, along with a complex called "sisterella"—what a sister will become or do to get where she's going.

Could shifting be the root of the evil that makes us vulnerable to HIV disease? Hearing the songs of infected women who are mothers, daughters, wives, grandmothers, and sisters: Yes! Their song goes like this: "We are the Chameleons of the world, forced to accommodate our own worth! "We use it to get by, but we aren't really satisfied with what we get.

Do we feel safe enough to demand nonbiased and proper health care? Are our health-care providers listening to us and administering to our health needs on an individual basis, or as just another number to experiment with? We do not feel safe to ask our partners to protect us for fear of losing them. We want to be loved and share love, and experience the full body, soul, and mind effect as much as anyone. We do not feel safe to share information with anyone viewed as the "system" for fear of being stereotyped as loose, promiscuous, angry black women.

"...our voices reach to the heavens where our creator hears us and provides us with strength.."

We do not feel safe to express ourselves for fear of being judged and mistaken for having an attitude, or not being responsible or accountable for our actions. To expect a human being to be inferior to his/her counterparts—companions, colleagues, peers, or "the majority"—is insane.

To expect a person to keep silent when subtle racism, sexism, and classism are happening to him or her is horrific, but not to be able to ask for what you want or need without resistance or question is what America is to us.

What connection does living in the confines of this way of life have to do with HIV? Well, depression is a major result of shifting, which also doubles with being infected. These issues can be the result of chemical/alcohol abuse; prostitution; physical, emotional, and psychological abuse; low self-esteem; and plain old "just don't give a hoot anymore." These are the doors to HIV. These are the doors to our hearts and souls, in our world of accommodating. These are doors that we want to feel safe to close.

Society has programmed us to be silent, take it face down, and not dare to make any waves. It has taught us to "settle" for the bare minimum, because the best is for "them," not us.

HIV-infected African-American women believe we aren't being heard, although our voices reach to the heavens, where our creator hears us and provides us with strength unmeasurable by the strongest man in this world. We have gained a resiliency that others have not been able to conquer. We have kept our songs ringing through our country from centuries ago, rising above our disease, and "lack of." We continue to have faith that in the days to come, our voices will ring for all the world to hear, so our daughters may have a chance to live in a world where shifting is no more, and HIV is an epidemic of the past. This is our song. ■

Recommended Reading:

SHIFTING : The Double Lives of Black Women in America

By Charisse Jones, Kumea Shorter-Gooden

ISBN: 0060090545 Published by: Harper Collins (September 3, 2003)

Planning Council forced to cut funding for services

By Mary S. Doyle

How many people living with HIV/AIDS (PLWH/A) in Minnesota receive services for their care from the Ryan White CARE Act without knowing how that funding is administered or where it really comes from? And why should they care?

In the past few years, for the first time in the history of the CARE Act, funding to Minnesota from the federal government has been decreasing. In 2004, additional changes were made in the way the state funds health care in Minnesota for low-income people. The result of these two changes was that folks won't be receiving some of the medical and supportive social services for HIV that they've come to depend upon.

The Minnesota HIV Services Planning Council has a mandate from the federal government to prioritize and allocate funds for services to PLWH/A in Minnesota using funding from the Ryan White CARE Act. The CARE Act pays for services like medical care and case management for PLWH/A who are high risk for being unable to get or keep health care. There are a variety of reasons why PLWH/A in Minnesota may lack health care insurance coverage.

The Ryan White CARE Act funding is for PLWH/A who are in danger of "falling through the cracks" and unable to have their care paid for by other sources. The CARE Act only pays for care that other funding does not cover. In this role, the CARE Act is referred to as "payer of last resort." When these other sources of funding disappear or become harder to access, more demand exists for CARE Act Funded services. Today, the demand for CARE Act services is at an all-time high. That was the situation when we met to allocate our funding in August 2004. A shortage of other funding and a heavy reliance on CARE Act funding made the allocations process especially difficult for the Planning Council in 2004.

At the same time other funding has disappeared in the past two years, the Planning Council federal award has been cut by five percent for the metropolitan area and four percent for the state. So the Council, assuming a similar decrease for 2005, started the prioritization and allocation process with approximately $200,000 less than the previous year.

In this environment of more needs and fewer resources, several service areas emerged as needing funding increases. For example, as eligibility for the Minnesota health care insurance programs has been tightened, fewer people have been able to qualify for and use those programs. For many of them, their only option is transfer to the state AIDS Drug Assistance Program (ADAP), also funded by the CARE Act. This has resulted in a larger group of PLWH/A needing to have their medication and health insurance needs met by ADAP funding. Also adding to the increase in the group of people using ADAP is that PLWH/A are living much longer, and the cost of HIV drugs has increased. This leaves us with a triple challenge: less non-CARE Act funding, expensive drugs, and a larger number of people who need care both because of medical success and new infections.

In July 2004, in an effort to maintain service to all on ADAP, the Minnesota Department of Human Services (DHS) instituted "cost-sharing" measures. Now, all recipients of ADAP services must make a co-pay for prescriptions and/or pay a percentage of the cost for health insurance premiums paid for by ADAP. During the allocations process, Council members, concerned about the effects of the cost share on low-income people with HIV, allocated some of the Planning Council funding for 2005 to help cover some of these costs.

In the past, one service area, medication adherence, had been paid for using ADAP funds. Because of the implementation of cost sharing for ADAP recipients, ADAP funds can no longer cover medication-adherence services. Thus, the Planning Council decided to add this expense to its budget for 2005.

The Planning Council also added more dollars to the medical and dental services service area—again, to help address the impact of changes to ADAP and Minnesota Health Care Programs. (For more information on the ADAP situation, see Sarah Rybicki's article in this issue.)

The Planning Council did its work this year keeping in mind that the resources it anticipates for 2005 and 2006 are not nearly enough to meet the needs of low-income persons living with HIV. Given this reality, some services had to be cut to preserve others. Council members realize that the resulting cuts will have an enormous impact on services.

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Council forced to cut funding for some services *(continued)*

There will be less funding for services such as health education, outreach, HIV-specific food shelf, and complimentary care. The resource and referral phone line and resource directory funds for the whole state were also decreased. In addition, cuts were made to funding for systems development work for housing, corrections, women and children's needs, and chemical dependency. Council members weighed and researched these decisions carefully. They tried to preserve parts of the care system that they felt were most critical to the health and well-being of PLWH/A. Council members hope that the community will understand how much they regretted having to make these difficult decisions.■

If you have questions or comments, please feel free to contact the Planning Council Co-chairs: Paul Tucker at ptucker@agcmcc.org or Aaron Keith Stewart at stewa327@umn.edu. Or contact Mary Doyle of the Planning Council staff at mary.s.doyle@co.hennepin.mn.us, or (612) 348-6827 or (888) 638-3224.

A Celebration of Two *(continued)*

My former partner, who was married to a woman, and had two kids and a successful career, was infected with HIV in 1990. We went and got tested together. We loved each other. We went back for the results together. He was positive. I was negative. I thought the doctors had made a mistake, because if anyone should have been positive, it should have been me. I had no self-worth, no real purpose for my life, and I was questioning why I was even alive.

Most of my life, I've thought it important to contribute to others. In 1993-1994, I established a non-profit organization to benefit those persons living with HIV/AIDS, many of whom were dying. It was an adult form of the "Make-a-Wish Foundation." With the help of a friend, in the early 1990s, I also organized an AIDS Awareness Safe Sex Education Seminar, which I thought could be used in area schools. We even presented it to the Science Museum of Minnesota, because it was starting to focus on a new health concept for youth relating to HIV and AIDS.

I have also come to feel that surviving my depression has helped me make a positive statement: "Hey, look, I've battled chronic severe depression and haven't let it destroy me completely. If I can battle something like that for more than 20 years, then I think I have the strength to battle HIV." The important thing is that I'm not alone in my fight with HIV and AIDS, as I felt I was so many times with my depression. I have so many wonderful people in my life who love me for me—not what I can give them, but just because of who I am: a human being, deserving of respect, love, nurturing, acceptance, quality health care and more. It has helped. For example, I joined the first HIV-positive softball team, last year. I never thought in all my dreams I would be doing that. I have also helped raise awareness and money for local HIV/AIDS organizations the past two years by making a commitment to pedal my bicycle 300 miles over four days across southern Minnesota.

> *"I want to use myself to make a difference"*

Why do I call this story "A Celebration of Two"? It is because I have been living with HIV for at least two years. I am not sad or depressed that I acquired HIV and now have full-blown AIDS. I celebrate! You may think, "This guy is nuts. He really is crazy." I say just the opposite. For me, it took acquiring a life-altering illness to get me back on track. I want to use myself to make a difference in this world: to feel like there really is a valid and meaningful reason why I am alive and a part of our world; to be compassionate; to give back; to help teach and educate; to be a role model to others; to help them understand and appreciate what it looks and feels like to belong to something; to care; to love and be loved. I would not trade the past two years for anything.

My rewards came because the disease forced me to decide how I was going to live my life, knowing I had HIV. I did not go out and make myself HIV-positive because I thought all these wonderful things would happen to me. I didn't care about myself the way truly healthy, mentally sound people would care about themselves. But now, I am able to see all the beautiful faces of the wonderful people who have come across my path and touched me. I have also taken this time in my life to try to give back to my community, while I am able. As a member of the Minnesota HIV Services Planning Council, I can do just that. ■

Calendar of Events

April

8	9:00 - 11:30am	Community Participation, Hennepin Powderhorn Partners LL
12	9:00 - 12 Noon	Planning Council, Redeemer Missionary Baptist Church
12	1:00 - 3:00pm	HIV Positive, Aliveness Project
13	9:00 - 11:00am	Planning & Priorities, Minnesota AIDS Project
21	9:00 - 11:00am	Operations, Hennepin Powderhorn Partners LL
26	8:45 - 11:15am	Needs Assessment, Minnesota AIDS Project
27	9:00 - 11:00am	Planning & Priorities, Minnesota AIDS Project
28	1:30 - 3:30pm	Executive, Hennepin Powderhorn Partners LL

May

10	6:00 - 9:00pm	Planning Council, TBD
10	1:00 - 3:00pm	HIV Positive, Aliveness Project
11	9:00 - 11:00am	Planning & Priorities, Minnesota AIDS Project
13	10:00 - 11:30am	Community Participation, Hennepin Powderhorn Partners LL
19	9:00 - 11:00am	Operations, Hennepin Powderhorn Partners LL
24	8:45 - 11:15am	Needs Assessment, Minnesota AIDS Project
25	9:00 - 11:00am	Planning & Priorities, Minnesota AIDS Project
26	1:30 - 3:30pm	Executive, Hennepin Powderhorn Partners LL

Meeting dates and times may change,
please call 612.596.7894 for last minute up-to-date information.

Minnesota HIV Services Planning Council
Health Services Building
525 Portland Avenue South, MC L963
Minneapolis, MN 55415-1569

Senate Counsel, Research, and Fiscal Analysis

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Senate
State of Minnesota

S.F. No. 1025 - Authorizing Programs for All-Inclusive Care for the Elderly (PACE)

Author: Senator Bob Kierlin

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

Date: March 30, 2005

S. F. No. 1025 authorizes the Commissioner of Human Services to approve and implement Programs for All-Inclusive Care for the Elderly (PACE) under the statute that permits Medical Assistance (MA) demonstration projects to create alternative integrated delivery systems for acute and long-term care services. The following conditions would apply to PACE programs:

- PACE providers would not be required to be licensed or certified as health plan companies.
- Persons aged 55 or older who have been found eligible for the Elderly Waiver or Community Alternatives for Disabled Individuals Waiver or who are eligible for MA but meet the criteria for receipt of waiver services may choose to enroll in PACE.
- Medicare and MA services will be provided according to state and federal requirements.
- PACE enrollees will receive MA home and community-based services through the PACE provider as an alternative to receiving regular waiver services.
- MA rates for PACE providers must not exceed the costs that would be incurred under fee-for-service or relevant managed care programs.

DG:rdr

Senators Kierlin, Kiscaden and LeClair introduced--

S.F. No. 1025: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; allowing PACE programs to be covered under alternative integrated long-term care services; amending Minnesota Statutes 2004, section 256B.69, subdivision 23.

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

Section 1. Minnesota Statutes 2004, section 256B.69, subdivision 23, is amended to read:

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457,

subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental

disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related conditions, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health

plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

Senator ..... moves to amend S.F. No. 1025 as follows:

Page 3, line 35, after the period, insert "The process for solicitation and approval of these programs shall only begin after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grants for this purpose shall be deposited in a special revenue account and used solely for the purpose of PACE administrative and actuarial costs."

Senate File 1025

(Companion HF 1059)

Program for the All-inclusive Care of the Elderly (PACE)

Winona Rural PACE Initiative

Introduction of Members

Timothy Gaspar: Dean of College of Nursing and Health Sciences, Winona State University
Constance Schein: CEO, Saint Anne of Winona a member organization of the Benedictine Health System
Mary Miller-Hyland: Administrator, Lake Winona Manor an affiliate of Winona Health
Grant Brandon: Administrator, Sauer Memorial Home

The purpose of our testimony is to seek legislative support in order to secure approval for the implementation of ***Program for All-inclusive Care of the Elderly*** also known as **PACE** in Minnesota. This is an alternative program for integrated long term care services for the very frail elderly.

Current Minnesota Models for Integrating Services for Seniors

Current models of senior care in Minnesota focus on the coordination of services for elders needing health care. This coordination is essential for effective senior services. Care coordination involves supporting seniors in accessing needed services in a timely and efficient manner. Sometimes care coordination is not enough to address the needs of a specific high risk group of seniors. These seniors represent a segment of elders who are the most complex, highest risk for nursing home placement or extended hospital stays and are the most costly to care for. In order for services to be efficient for this special population, care coordination must be augmented with a focused care delivery approach. **PACE** can provide this focused approach to care and complete the senior service model in Minnesota.

The PACE Model

PACE features four innovative aspects that enable the program to adapt itself to the needs of each individual participant, instead of attempting to adapt each participant to the needs of the program.

Flexibility. PACE creatively plans for and coordinates the care of each participant enrolled in the program based on his or her individual needs with the goal of enabling older individuals to remain living in the community.

All-inclusive Care. PACE programs provide, coordinate and oversee all needed preventive, primary, acute and long term care. PACE programs provide transportation that enables participants to live as independently as possible in the community while having access to the supportive services, medical specialists, therapies and other medical care they need. If a participant needs hospital or nursing home care, it is coordinated and paid for by the PACE program.

Interdisciplinary Teams. Care planning teams comprised of physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides and others meet to exchange information and solve problems as the conditions and needs of PACE participants change. The interdisciplinary teams allow information gained through interaction with the PACE participant over time, and in different settings, to be shared and the viewpoints of various disciplines to be brought together. Because PACE participants have regular contact with primary care professionals who know them well, changes in health status can be proactively and comprehensively addressed by a wide range of health care professionals. The team approach allows for more information to be available at the critical points when important and immediate health care decisions need to be made than would be possible among a fragmented array of fee-for-service providers.

Capitated Payment Arrangements. The PACE program's capitated payment arrangement allows participants to avoid costly and often preventable nursing home and hospital stays by expanding the range and intensity of services provided where they prefer to live - in the community. PACE provides a comprehensive set of health care and supportive services that are specifically tailored to the needs of each PACE participant regardless of whether such services would be reimbursed under traditional fee-for-service Medicare and Medicaid. This system of payment provides for a more common sense, and less restrictive, approach to organizing and delivering services than what is currently available in the traditional fee-for-service health care system.

Cost of PACE

The primary cost benefits of PACE are realized by meeting the needs of frail seniors before they require more complicated and costly services such as hospitalization or nursing home placement. It has been demonstrated by numerous PACE programs that PACE participants have significantly fewer nursing home and hospital admissions and when hospitalized their stays are dramatically shorter.

Consumer Satisfaction with PACE

The PACE model is consistent with changing consumer demands. Studies of PACE participants indicate they are more satisfied with the care and attention they and their family members receive in PACE, compared to more traditional care options (i.e., nursing homes and other institutional providers). PACE participants and their families speak forcefully about what their key expectations are as they arrange care for their parents, their spouses and themselves. Participants consistently stated that they expect:

- To have care options to choose from;
- To be listened to and respected;
- To be supported, without being replaced, in their care giving role;
- To have choices even as loved one's needs change; and
- To have access to professional caregivers that knew them individually.

These five care expectations clearly illuminate the preferences of consumers across the country, including Minnesota. They are saying, "Give me what I want to buy not what you want to sell."

Looking Forward. One of the most difficult challenges in meeting the needs of older adults will be effectively recognizing and successfully responding to their service preferences as consumers. While the fragmented and institutionally biased financing and delivery systems for care for older adults are significant obstacles to overcoming these challenges, the most promising place to start is to align the goals of the customer with the services available. Focusing efforts on allowing more flexibility in care environments would be a significant step in the right direction. Through the provision of a comprehensive and highly coordinated array of cost effective services, PACE teams will help to meet the needs of older adults by honoring their wishes to remain living in their homes as independently as possible.

Fiscal Note Considerations for PACE

Currently, a fiscal note attached to SF 1025 of approximately $120,000. It is estimated that $50,000 of this note is allocated for actuarial expenses and the remaining $70,000 will provide for personnel to oversee PACE programs. It is proposed that a special revenue management account be established that will accept grants and other forms of income for actuarial and oversight costs of PACE in Minnesota. In addition, there will be an opportunity for these fees to be revisited in two years for adequacy and appropriateness. With this approach to management of the fiscal note we believe this bill is budget neutral.

Senate Counsel, Research, and Fiscal Analysis

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Senate
State of Minnesota

S.F. No. 1445 - Postpartum Depression Information

Author: Senator Steve Dille

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

Date: March 30, 2005

S.F. No. 1445 amends the chapter of law relating to public health provisions by adding a new section of law, which requires the Commissioner of Health to work with health care facilities and licensed health care professionals to develop policies and procedures to comply with this section.

Paragraph (b) requires physicians, traditional midwives, and other licensed health care professionals providing prenatal care to provide education to women and their families about postpartum depressions.

Paragraph (c) requires hospitals and other health care facilities to provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including a hotline to be determined by the commissioner.

JW:rdr

Senators Dille, Berglin, Foley, Lourey and Nienow introduced--

S.F. No. 1445: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; requiring information about postpartum depression to be given to mothers and their families; proposing coding for new law in Minnesota Statutes 2004, chapter 145.

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

Section 1. [145.906] [POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.]

(a) The commissioner of health shall work with health care facilities and licensed health care professionals in the state to develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must provide education to women and their families about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources, including a hotline to be determined by the commissioner.

Please remember Mine's story

What she was like before her depression and psychosis

Something must be done

Postpartum Depression & Psychosis

What is Postpartum Depression?

Postpartum depression (PPD) is an illness/condition that some women have following the birth of a child. It may occur shortly after childbirth, but may not appear for some months. It is manifested through a range of physical and emotional symptoms that can vary in severity and intensity. The exact causes of PPD are not clear, but it is likely that hormonal changes due to pregnancy and childbirth, as well as the stresses of having a new baby, contribute to this illness.

At least 10% of all new mothers develop symptoms severe enough to be diagnosed with PPD. Some estimates are as high as 25%. Signs and symptoms include: increased crying, irritability, and impatience; hopelessness and sadness; uncontrollable mood swings; feeling overwhelmed or unable to cope; fear of harming the baby or herself; fatigue and inability to sleep or sleeping more than usual; loss of appetite; lack of interest in the baby or over concern about the baby; withdrawal; inability to think clearly or make decisions; unexplained weight loss or gain.

At a time that most women expect to be one of the happiest of their lives, these signs and symptoms are confusing and frightening. The vast majority of women and their partners/families have not been prepared, through information and education, to watch for the signs of this serious mental health problem. As with all mental illnesses, the stigma involved makes it more difficult to ask for help. In addition, many women report that when they did seek help, it was not readily or easily available. Treatment for PPD, like most depressions, can be very successful. Treatment may include antidepressant medication, hormone therapy, psychotherapy and support. If untreated, PPD leads to maternal disability, poor mother-infant attachment, and affects infant development.

Postpartum depression is different from the "baby blues". Between 70-80% of women experience some of the symptoms of PPD, but in a much milder form. While disturbing and frightening to women who are not informed about the "baby blues", these symptoms usually disappear in a week or two.

What is Postpartum Psychosis?

Approximately 1 in 1000 women suffers from this extremely serious disorder that requires immediate medical attention. Women suffering from this experience delusions, hallucinations, exhibit bizarre behaviors and feelings, and can become extremely agitated. Although rare, postpartum psychosis can be devastating to women and their families, and some cases have resulted in child abuse, infanticide, and suicide.

What can be done?

As a first step, women and their families must be made aware of these potential conditions, their signs and symptoms, the likelihood that they might experience them, and where to go for help. All forms of PPD are highly treatable when the condition is recognized and proper help is found. Several states have passed legislation to insure that this basic education and information is made available to expectant and new mothers and their families.

Beyond this basic information and education, health care providers must routinely screen for this form of depression before and after delivery.

HENNEPIN WOMEN'S MENTAL HEALTH PROGRAM
HENNEPIN FACULTY ASSOCIATES
HENNEPIN COUNTY MEDICAL CENTER
PHONE (612) 347-2218/FAX (612) 373-1859

March 30, 2005-03-30

Honorable Senators:

My name is Dr. Helen Kim. I am a psychiatrist at Hennepin County Medical Center and Director of the Hennepin Women's Mental Health Program which is a clinic that serves pregnant and postpartum women with depression, anxiety and other forms of mental illness. Since our inception in 2000, we have seen hundreds of pregnant and postpartum women and serve as a resource to patients and clinicians around Minnesota who want more information about depression during and after pregnancy. I am writing now to give my whole-hearted support for the postpartum depression bill before you.

First a few facts:

1) Postpartum depression occurs in 10 to 25% of all women during the first year after delivery and is particularly common in low income and minority populations. In a study in the Obstetric Clinic at Hennepin County Medical Center, 25% of pregnant women presenting for routine prenatal care screened positive for depression and 10% screened positive for significant anxiety symptoms.

2) Postpartum depression leads to maternal disability, poor mother-infant attachment and impaired infant development. In short, untreated postpartum depression affects mothers, children, and entire families.

3) Although it is very common and has significant negative consequences, postpartum depression frequently goes undetected and untreated by health care providers. In one large-scale study of pregnant and postpartum women, only 23% of women who met criteria for a psychiatric disorder were diagnosed by their health care provider.

In our clinic, many postpartum women tell similar stories of suffering for months with depression, anxiety, and feelings of guilt for being emotionally detached from their newborns. Unfortunately, many of the women we see go without treatment until their symptoms have escalated to the point where they have started to have disturbing thoughts of suicide or hurting their beloved newborns. All too commonly, mothers come to us saying that no one ever asked them about depressive symptoms or educated them about ways to get help.

The Senate bill you are considering would require health care providers and hospitals to provide mothers and families with information about postpartum depression. This information is essential for women who feel too guilty or ashamed to mention how bad they feel following delivery. In addition, the referral information and hotline that are proposed in this bill would help depressed mothers access help quickly rather than leave them alone with worsening symptoms as they adjust to caring for their vulnerable newborns.

I think this bill is a step in the right direction and could potentially help scores of women, children and families. Please contact me if you have additional questions.

Sincerely,

Helen Kim, MD
Clinical Asst Professor of Psychiatry, University of Minnesota
Director, Hennepin Women's Mental Health Program**
Hennepin County Medical Center
Minneapolis, MN
VM (612) 347-6851 pager (612) 530-1152
**http://www.hcmc.org/depts/psych/mentalhealth.htm

March 31, 2005

Senators on the Health and Family Security Committee:

I am Lisa Mountain a 35 year old mom of 2 wonderful children. I wish I could be there in person, but spring break travel plans have made impossible for me to be there.

My son Alex was born in May of 2000 and I had no idea I was suffering from Post Partum Depression. I remember thinking I just had the "baby blues". I am a very lucky woman in the fact that my husband is 100% supportive and my parents live two blocks away from us in Burnsville. I remember calling my mom two weeks after Alex's birth and sobbing saying I was so depressed. She of course not knowing any better said it was just "Baby Blues". Well the "Baby Blues" went on at least a year. I was irritable, extremely exhausted, not able to sleep at night...and the simple tasks of doing the laundry seemed like climbing a Mountain.

My husband was wondering who I was and where his wife went. Luckily as I said, I have an extremely supportive husband and extended family.

When I was pregnant with my daughter in 2003, my best friend delivered twins. I went to visit and help. What I found was a woman out of her mind. She was depressed and out of control. She needed medication and HELP! What it made me realize was how much I missed with my son because I was so depressed!

I talked to my husband and my doctor. My Doctor prescribed an anti-depressant and told me to fill the prescription if I needed it. My doctor also told my husband what to look for etc. It was two weeks after my daughter was born that my husband suggested that I "TRY" the medication. I did and my life has never been better! The world truly opened up for me and I am a much better mother, wife and person because of it.

I encourage you to pass legislation to help other women in my same situation, and those women who are not so lucky to have the support that I have had.

The future of our children can only benefit from this legislation.

Sincerely,
Lisa Mountain
608 E. 131st Street
Burnsville, MN 55337

NAMI
MINNESOTA
National Alliance for the Mentally Ill

March 30, 2005

Dear Members of the Senate Health and Family Security Committee:

The National Alliance for the Mentally Ill of Minnesota strongly supports SF 1445 which would ensure that women receive information about postpartum depression. This is a serious disorder that requires serious attention.

In any given year, 10 to 14 million people experience a clinical depression; women 18 to 45 years of age account for the largest proportion of this group. Clinical depression is a serious medical illness that is much more than temporarily feeling sad or blue. It involves disturbances in mood, concentration, sleep, activity level, interests, appetite, and social behavior. Clinical depression can develop in anyone, regardless of race, culture, social class, age, or gender. However, across virtually all cultures and socioeconomic classes, women are more likely than men are to experience depression.

The explanation for the gender gap in susceptibility to depression most probably lies in a combination of biological, genetic, psychological, and social factors. There appear to be important links between mood changes and reproductive health events. Gender differences in rates of depression emerge when females enter puberty and remain high throughout the childbearing years and into late middle age. Hormonal factors seem to play a role in some of the mood disturbance experienced by women. Twenty to 40 percent of menstruating women experience premenstrual mood and behavioral changes. Approximately 2 to 10 percent of women experience Premenstrual Dysphoric Disorder, a severe form of premenstrual syndrome that is characterized by severely impairing behavior and mood changes. As many as 10 percent to 15 percent of women experience a clinical depression during pregnancy or after the birth of a baby. There also appears to be an increase in depression during the perimenopausal period, but after menopause, this does not appear to be the case.

Although it once was thought that women experienced low rates of mental illness during pregnancy, recent research reveals that over 10% of pregnant women and approximately 15% of postpartum women experience depression. As many as 80 percent of women experience the "postpartum blues," a brief period of mood symptoms that is considered normal following childbirth. However, the related hormonal and biological changes associated with pregnancy or giving birth may initiate a clinical depression. Or, the changes in lifestyle associated with caring for a young infant may constitute a set of stressors that have mental health consequences for the mother. There is a three-fold increase in risk for depression during or following a pregnancy among women with a history of mood disorders. Once a woman has experienced a postpartum depression, her risk of having another reaches 70 percent. One woman in a thousand experiences

Member
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a postpartum psychosis-a medical emergency in which the woman may inflict harm upon herself and/or her baby.

Postpartum depression can occur within a few days or months after childbirth. Because it is more intense than the "baby blues" it will interfere with the mother's ability to function. Postpartum psychosis often occurs within the first three months after childbirth. Mothers can experience hallucinations, delusions, and insomnia along with exhibiting anger or odd behaviors. When you are pregnant and excited about the upcoming birth of your child, learning about postpartum depression is just not on your radar screen. However, if your health care provider gives you information during your pregnancy and if a packet of information is given to you when you leave the hospital it will be on your – and your family's – radar screen. What we want is for mothers and fathers to know that postpartum depression exists, that it is important to intervene early and that it is treatable.

Marie Osmond, the entertainer, wrote a book about her experience with postpartum depression called Behind the Smile. In an interview she stated that "I became immobilized. I literally shut down. I could not get through a day. The idea of making a phone call or keeping an appointment seemed impossible. I was previously 'Miss Workhorse.' I will admit I used to be somebody who thought depression was just self-pity. I am ashamed of that. Because I now know different. No one wants to be depressed or go through it. You cannot just snap out of it. Trust me, I tried."

SF 1445 will help countless women by educating them about this illness and directing them towards appropriate resources. NAMI urges your support for this bill.

Sincerely,

Sue Abderholden

Sue Abderholden
Executive Director

Senate Counsel, Research, and Fiscal Analysis

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State of Minnesota

S.F. No. 1818 - Children's Therapeutic Services (The Delete-Everything Amendment)

Author: Senator Linda Berglin

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

Date: March 31, 2005

S.F. No. 1818 amends the section of law related to children's therapeutic services by defining the terms "care coordination" and "family psychoeducation services." The bill includes these services as a covered service component under the children's therapeutic services program.

The bill become effective upon federal approval, if necessary, or on July 1, 2006, if federal approval is not necessary.

JW:rdr

Senator Berglin introduced--

S.F. No. 1818: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; expanding children's therapeutic services and support; amending Minnesota Statutes 2004, section 256B.0943, subdivisions 1, 2.

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

Section 1. Minnesota Statutes 2004, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Case management services" has the meaning given in section 245.4871, subdivision 3.

(b) "Case management service provider" is a provider of case management services chosen by the client or the client's parent or guardian, who is a certified provider of children's therapeutic services and support under subdivision 4, or a provider who meets the requirements under section 245.4871, subdivision 4.

(c) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b)~~ (d) "Clinical supervision" means the overall

responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

~~(c)~~ (e) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

~~(d)~~ (f) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

~~(e)~~ (g) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (h) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

~~(g)~~ (i) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

~~(h)~~ (j) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the

client's mental health status, preparing reports, receiving clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

~~(i)~~ (k) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (l) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

~~(k)~~ (m) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

~~(l)~~ (n) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

~~(m)~~ (o) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

~~(n)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

~~(o)~~ (q) "Skills training" means individual, family, or group training designed to improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve

the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or institutionalization of children with emotional disturbance.

Sec. 2. Minnesota Statutes 2004, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. [COVERED SERVICE COMPONENTS OF CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.] (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity under subdivisions 4 and 5 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) individual, family, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services; ~~and~~

(5) direction of a mental health behavioral aide<u>; and</u>

<u>(6) case management services</u>.

(c) Service components may be combined to constitute therapeutic programs, including day treatment programs and

preschool programs. Although day treatment and preschool programs have specific client and provider eligibility requirements, medical assistance only pays for the service components listed in paragraph (b).

Sec. 3. [FEDERAL APPROVAL; EFFECTIVE DATE.]

If federal approval is required, the commissioner shall apply for federal approval, and sections 1 and 2 are effective upon federal approval. If federal approval is not necessary, sections 1 and 2 are effective July 1, 2005.

Senator ..... moves to amend S.F. No. 1818 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Care coordination" means activities that ensure:

(1) services are provided in the most appropriate manner to achieve maximum benefit to the client;

(2) nonduplication of services with county case managers;

(3) coordination of care with county social services, community corrections, and schools; and

(4) services are culturally competent, child-centered, and family-driven.

Care coordination may include activities that coordinate, for a particular client, any of the following:

(1) children's therapeutic services and supports covered service components, as provided in subdivision 2, paragraph (b), including psychotherapy, skills training, crisis assistance, mental health behavioral aide services, direction to a mental health behavioral aide, and family psychoeducation;

(2) other medical assistance reimbursable services that are not covered components of children's therapeutic services and supports, including, but not limited to, outpatient treatment and home and community-based waivered services;

(3) other components of a therapeutic program not covered by medical assistance as part of children's therapeutic services and supports, including, but not limited to, a day treatment program, a preschool program, and other therapeutic activities included in the child's individual treatment plan;

(4) obtaining the client's history;

(5) diagnostic assessment, including functional assessment;

(6) development, review, and updating of the client's individual treatment plan;

(7) development, review, and updating of the client's individual behavioral plan;

(8) entry of a client's data into the performance measurement system;

(9) maintenance of clinical records;

(10) scheduling for the client;

(11) documentation required for billing;

(12) consultation with other providers;

(13) services that are the responsibility of a residential treatment provider, foster care provider, hospital, group home, regional treatment center, or other institutional group setting and the discharge planning from such settings; and

(14) adjunctive activities offered by a provider who does not provide children's therapeutic services and supports that are not covered by medical assistance, including, but not limited to, recreational services; social or educational services not expected to have a therapeutic outcome related to the client's emotional disturbance; consultation with other providers; and chemical dependency treatment.

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b)~~ (c) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

~~(c)~~ (d) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

~~(d)~~ (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

~~(e)~~ (f) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (g) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

~~(g)~~ (h) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

~~(h)~~ (i) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

~~(i)~~ (j) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (k) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

~~(k)~~

(l) "Family psychoeducation services" means education provided under the supervision of a mental health professional to a parent, family member, foster parent, or guardian about the child's mental health condition.

(m) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

~~(l)~~ (n) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

~~(m)~~ (o) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

~~(n)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

~~(o)~~ (q) "Skills training" means individual, family, or group training designed to improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of

age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or institutionalization of children with emotional disturbance.

Sec. 2. Minnesota Statutes 2004, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. [COVERED SERVICE COMPONENTS OF CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.] (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity under subdivisions 4 and 5 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) individual, family, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services; ~~and~~

(5) direction of a mental health behavioral aide;

(6) care coordination services; and

(7) family psychoeducation services.

(c) Service components may be combined to constitute therapeutic programs, including day treatment programs and preschool programs. Although day treatment and preschool programs have specific client and provider eligibility requirements, medical assistance only pays for the service components listed in paragraph (b).

Sec. 3. [FEDERAL APPROVAL; EFFECTIVE DATE.]

If federal approval is required, the commissioner shall apply for federal approval, and sections 1 and 2 are effective upon federal approval. If federal approval is not necessary, sections 1 and 2 are effective July 1, 2006."

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Senate
State of Minnesota

S.F. No. 1822 - Medical Assistance Coverage of Special Transportation

Author: Senator Linda Higgins

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

Date: March 30, 2005

S.F. No. 1822 clarifies Medical Assistance (MA) coverage of special transportation for persons with physical or mental impairments. It increases special transportation reimbursement rates. It extends for an additional year, until July 1, 2006, the prohibition on using a broker or coordinator to manage all aspects of special transportation services. It requires an evaluation of special transportation service providers.

Section 1 (256B.0625, subdivision 17) clarifies MA coverage of special transportation for persons with physical or mental impairments. It states that a recipient qualifies for special transportation due to an impairment that would prohibit the person from safely using commercial transportation or a private car if the recipient:

- lacks the strength or coordination to safely transfer from a wheelchair to a vehicle;
- is unable to safely walk or propel a wheelchair from a residence to a vehicle and from the vehicle into a medical facility; or
- is a vulnerable adult as defined by law. (Section 626.5572, subdivision 21, defines a vulnerable adult as a person aged 18 or older who (1) is a resident or inpatient of a facility; (2) receives services at or from a facility licensed by the Department of Human Services (with exceptions); (3) receives home care or personal care assistant services; or (4) possesses an infirmity or dysfunction that impairs the individual's ability to provide self care without assistance and impairs the ability to protect the individual from maltreatment.)

This section also increases the maximum MA rates for special transportation as follows:

- for persons who need a wheelchair-accessible van, the base rate is increased to $18.75 from $18 and the per mile rate is increased to $1.60 from $1.40; and

- for persons who need a stretcher-accessible vehicle, the base rate is increased to $60 from $36 and the per mile rate is increase to $2.40 from $1.40.

Section 2 delays until July 1, 2006, the authority of the Department of Human Services (DHS) to use a broker or coordinator to completely manage special transportation services. Under current law, until July 1, 2005, a coordinator may only be utilized to check recipient eligibility; authorize recipients for appropriate level of service; and monitor provider compliance with the statute authorizing MA coverage of special transportation and establishing provider requirements regarding documentation, billing, and trip routing.

Section 3 requires DHS, in consultation with interested parties, to evaluate methods for assuring special transportation quality and safety and reducing its cost, with a report due by February 1, 2006. A partial list of methods to be evaluated is included.

DG:rdr

Senators Higgins, Solon and Koering introduced--

S.F. No. 1822: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; specifying criteria for coverage of medical assistance special transportation services; increasing special transportation reimbursement rates; extending the prohibition on the use of brokers or coordinators to manage special transportation services; requiring a review of special transportation services; amending Minnesota Statutes 2004, section 256B.0625, subdivision 17; Laws 2003, First Special Session chapter 14, article 12, section 93.

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

Section 1. Minnesota Statutes 2004, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. [TRANSPORTATION COSTS.] (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. For purposes of this requirement, a recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, a taxi, other commercial

transportation, or a private automobile if the recipient:

(1) lacks the upper body strength, lower body strength, or coordination to safely transfer from a wheelchair and position and secure the recipient's body in a prone or seated position in a vehicle;

(2) is unable to safely walk or self-propel a wheelchair from the recipient's residence to a vehicle and from the vehicle through the outside door of the medical facility to the medical appointment; or

(3) is a vulnerable adult as defined in section 626.5572, subdivision 21.

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the nearest appropriate health care provider, using the most direct route available. The maximum medical assistance reimbursement rates for special transportation services are:

(1) ~~$18~~ $18.75 for the base rate and ~~$1.40~~ $1.60 per mile for services to eligible persons who need a wheelchair-accessible van;

(2) $12 for the base rate and $1.35 per mile for services to eligible persons who do not need a wheelchair-accessible van; and

(3) ~~$36~~ $60 for the base rate and ~~$1.40~~ $2.40 per mile, and

an attendant rate of $9 per trip, for services to eligible persons who need a stretcher-accessible vehicle.

Sec. 2. Laws 2003, First Special Session chapter 14, article 12, section 93, is amended to read:

Sec. 93. [REVIEW OF SPECIAL TRANSPORTATION ELIGIBILITY CRITERIA AND POTENTIAL COST SAVINGS.]

The commissioner of human services, in consultation with the commissioner of transportation and special transportation service providers, shall review eligibility criteria for medical assistance special transportation services and shall evaluate whether the level of special transportation services provided should be based on the degree of impairment of the client, as well as the medical diagnosis. The commissioner shall also evaluate methods for reducing the cost of special transportation services, including, but not limited to:

(1) requiring providers to maintain a daily log book confirming delivery of clients to medical facilities;

(2) requiring providers to implement commercially available computer mapping programs to calculate mileage for purposes of reimbursement;

(3) restricting special transportation service from being provided solely for trips to pharmacies;

(4) modifying eligibility for special transportation;

(5) expanding alternatives to the use of special transportation services;

(6) improving the process of certifying persons as eligible for special transportation services; and

(7) examining the feasibility and benefits of licensing special transportation providers.

The commissioner shall present recommendations for changes in the eligibility criteria and potential cost-savings for special transportation services to the chairs and ranking minority members of the house and senate committees having jurisdiction over health and human services spending by January 15, 2004. The commissioner is prohibited from using a broker or coordinator to manage special transportation services until July

1, ~~2005~~ 2006, except for the purposes of checking for recipient eligibility, authorizing recipients for appropriate level of transportation, and monitoring provider compliance with Minnesota Statutes, section 256B.0625, subdivision 17. This prohibition does not apply to the purchase or management of common carrier transportation.

Sec. 3. [EVALUATION OF SPECIAL TRANSPORTATION SERVICE PROVIDERS.]

The commissioner of human services, in consultation with the commissioner of transportation, special transportation service providers, and the broker or coordinator for access transportation service, shall evaluate methods for assuring quality and safety and reducing the cost of special transportation services, including, but not limited to:

(1) restricting special transportation service from being provided for trips to day treatment and habilitation services;

(2) establishing an independent complaint and dispute resolution process for clients and providers;

(3) establishing additional levels of service with corresponding levels of reimbursement; and

(4) establishing appropriate safety standards for vehicles and drivers, including standards for vehicle inspections and driver background checks.

The commissioner of human services shall present recommendations for changes in eligibility criteria and quality and safety standards, and provide estimates of potential cost-savings, to the chairs and ranking minority members of the house and senate committees having jurisdiction over health and human services spending by February 1, 2006.

Senator ..... moves to amend S.F. No. 1822 as follows:

Page 1, delete lines 26 to 28

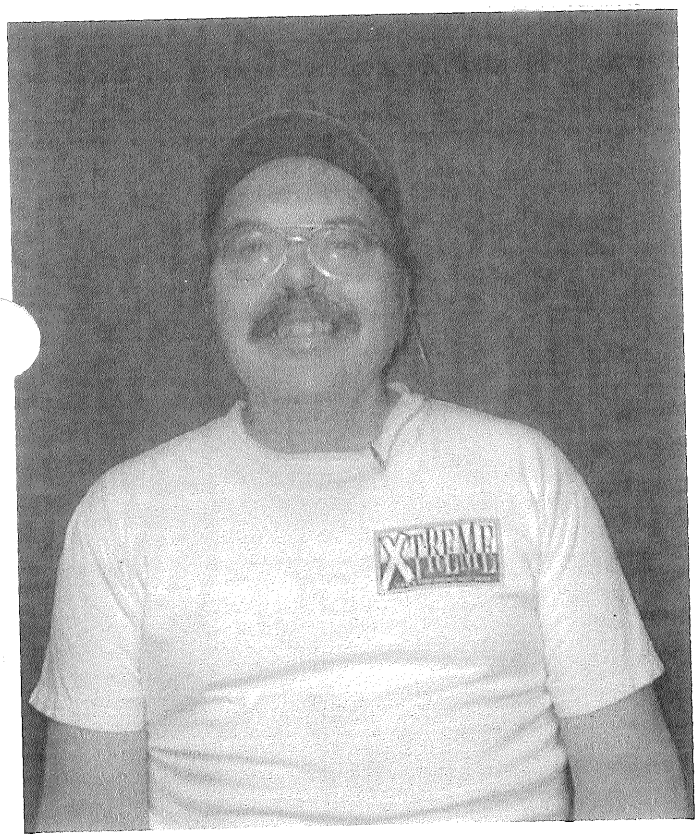
Page 2, delete lines 1 to 11

Page 4, delete lines 15 and 16

Page 4, line 17, delete "(2)" and insert "(1)"

Page 4, line 19, delete "(3)" and insert "(2)"

Page 4, line 21, delete "(4)" and insert "(3)"



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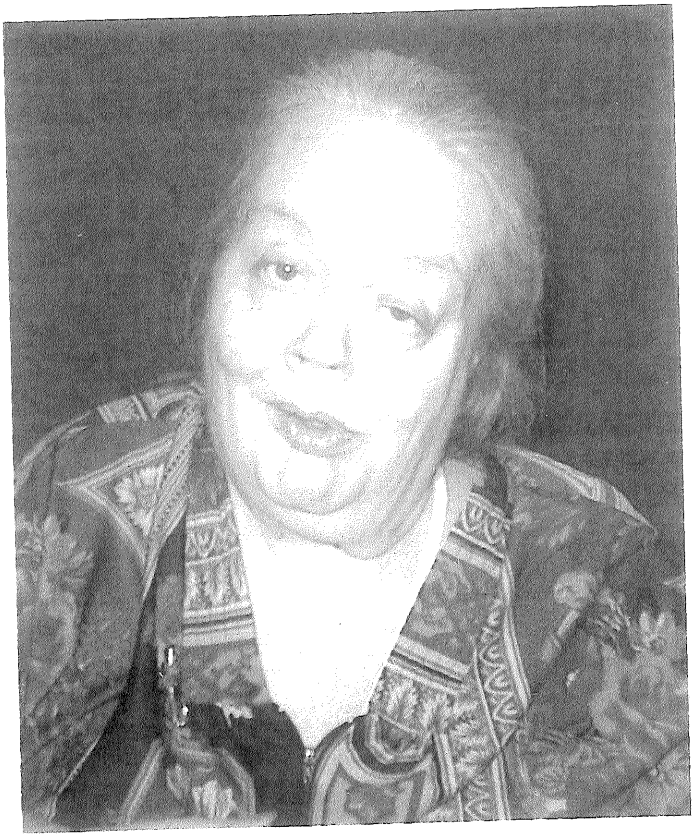


CHRISTINE SHANNON 08/03

DIANE DIEKEN 12/22/04

HELEN ("HEDY") GROSZ 2/27/04

Diane Cleveland

Minnesota Department of **Human Services**

MNET: Early signs of success

Background

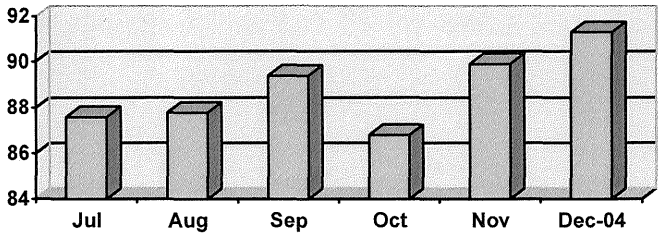
Minnesota Health Care Programs pay for transportation to health care services for certain enrollees who do not have a means of transportation and for enrollees who need special transportation due to a health condition. Traditionally, counties administered this benefit for enrollees who could not afford their own transportation; this is known as Access Transportation Services or ATS. The state administered this benefit for enrollees needing special transportation due to a health condition; this is known as Special Transportation Services or STS. Enrollees made their own arrangements for transportation after the county or state approved the request.

In July 2004, Minnesota changed the way transportation assistance and services are provided in the Twin Cities metro area. Based on 2003 legislation, the state introduced the Minnesota Non-emergency Transportation (MNET) program. Under MNET, a central clearinghouse evaluates enrollees' transportation needs. MNET makes arrangements for ATS, and enrollees arrange their own STS. The MNET program is slowly expanding to Greater Minnesota. In February 2005, MNET began conducting STS needs assessments for MHCP enrollees statewide.

Making this sort of operational change can be challenging, but the MNET program already shows signs of success.

Better enrollee benefits

Enrollee Survey: Percent Satisfied with MNET



- Enrollees have easier access to transportation through MNET's one-stop shopping approach. Enrollees call a single number to a single office, which has their needs assessment on file. This stays the same even if enrollees move to another metro-area county.
- MNET's customer service staff includes people who speak English, Hmong, Spanish and Somali. (MNET uses AT&T Language Line for other languages.)
- Service is available 24/7. MNET's after hours service assists enrollees who need transportation to urgent care, which prevents unnecessary use of ambulances and emergency rooms.

- An increase in use of ATS suggests that enrollees are better able to keep appointments and comply with follow-up visits. Increased use of preventive care and compliance with recommended medical appointments leads to improved health status overall.
- Some enrollees have a greater variety of transportation options available to them due to standardizing how services are provided.

Improved quality of transportation services

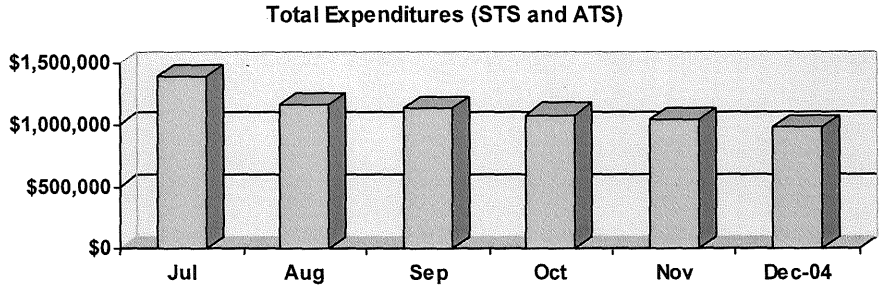
- All non-emergency transportation now has standardized performance requirements for drivers and vehicles. MNET subcontracts with more than 60 transportation providers in the Twin Cities metro area. For example, the contracts require that providers inspect vehicles, conduct background checks on drivers, and provide first aid and other training to drivers.
- With one transportation coordinator, the state now has enough information and leverage to identify and deal with unsafe or incompetent transporters.

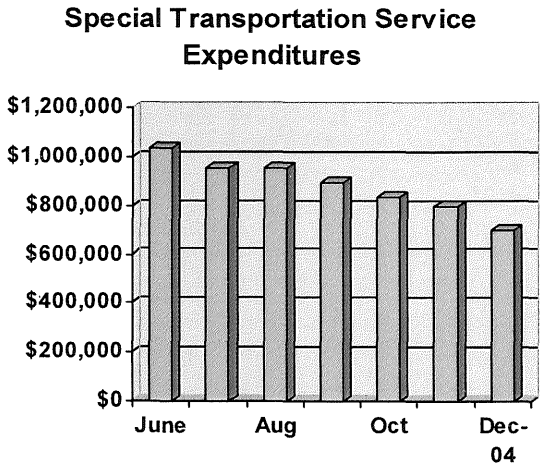
Improved program integrity

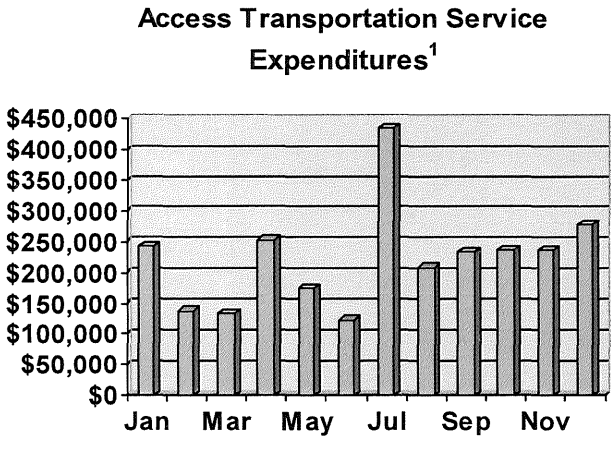
- Enrollees requesting transportation assistance are assessed to determine the appropriate level of service needed. This helps prevent inappropriate use of special transportation, which is the most expensive form of transportation. For example, if an enrollee is capable of riding a bus, they will be given bus fare. If an enrollee has difficulty walking a distance but is otherwise mobile, they may receive cab fare.
- The use of transportation services for health care related purposes is verified.
- Payment for mileage is standardized.
- The state is now able to analyze detailed information on use and cost of transportation services due to the centralized approach.

Reduced cost to state health care budget

- Overall transportation costs for the metro area decreased 30 percent in MNET's first six months of service.

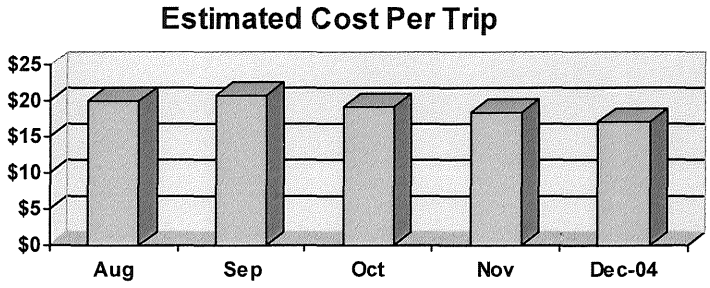






[1] This graph shows ATS expenditures per month for 2004. From January through the middle of June, counties were billing DHS for ATS. MNET began operations mid-month in July, 2004. The "bump" in July reflects counties closing out operations and MNET beginning operations.

- The cost per trip of non-emergency transportation in the metro area decreased between September and December 2004.



- Expensive health care costs may be avoided because:
  - The availability of after hours approval of transportation assistance or services gives enrollees better access to after hours urgent care, thereby preventing unnecessary use of emergency transportation to hospital emergency rooms.
  - Improved access to preventive care and compliance with recommended medical appointments leads to improved health status overall.

Customer service

The Department of Human Services (DHS), which oversees the MNET program, was surprised by and unprepared for the level of unmet need for ATS that existed when MNET was implemented in July 2004. Since then DHS and the contracted MNET vendor have worked hard to keep up with the increased number of

enrollees calling MNET seeking services. The following graph shows the increase in demand during the first six months of operation:

2004	July*	Aug	Sept	Oct	Nov	Dec
Completed ATS trips	4,839	19,138	19,316	22,348	26,260	30,452
Calls answered	6,456	10,711	10,375	11,742	12,775	14,200
Minutes to answer calls	4.3	1.2	2.4	1.5	2	2

* Reflects trips scheduled for July 15 through July 31.

Since July 2004, the following changes have been made to keep up with this increased utilization of lower cost ATS services:

- Customer service reps have been increased from 5 to 18.
- Three customer reps have been dedicated to handling phone requests from facilities such as nursing homes, group homes and hospitals.
- Nurses doing level-of-need assessments have increased from 1 to 3.
- A new phone system with over 100 lines was installed in February 2005.

These changes are reflected in these graphs:

2004	July*	Aug	Sept	Oct	Nov	Dec
% satisfied with customer service reps	87.5	85.71	91.96	86.57	91.32	95.72
% of complaints	0.41	0.31	0.23	0.10	0.14	0.17

The phone system installed in late February and the additional customer service reps are making a big difference. This graph shows the third week of March:

Week of March 14, 2005	Attempted calls	Answered calls	Abandoned calls	Abandoned percentage	Minutes to Answer
Monday*	1,026	910	115	11.21	1.5
Tuesday*	891	814	77	8.64	1.5
Wednesday	836	712	124	14.83	5
Thursday	784	752	32	4.08	1
Friday	701	683	18	2.57	.28 sec.

* Phone volume is typically higher on Mondays and Tuesdays.

Notes about the graphs

- For all graphs, seven-county area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties.
- For all graphs, providers have up to one year to bill.
- Figures are not yet available for program costs during the first quarter of 2005, but preliminary numbers indicate that the trends that began during the first six months of MNET operation have continued.

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Senate

State of Minnesota

S.F. No. 1710 - DHS Child Protection, Child Care, and Child and Family Support Provisions Modifications

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Article 1 amends the Maltreatment of Minors Act, by incorporating the alternative response approach to child maltreatment into the act. The alternative response is currently an option to counties, but the bill will make it mandatory. The alternative response approach deals with the front end of child welfare, evaluating the family by completing a family assessment and an investigation if appropriate, and providing supports and services to the family in an effort to avoid placement of the child in foster care.

Section 1 (626.556, subdivision 1) incorporates the alternative response approach into public policy statement at the beginning of the maltreatment of minors statute.

Section 2 (626.556, subdivision 2) defines the term "family assessment," "investigation," "substantial child endangerment," and modifies the definition of "neglect" to include growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect. This section also strikes the existing definition of "assessment."

Section 3 (626.556, subdivision 3) adds probation or correctional services to persons who are mandated to report maltreatment. Also makes conforming changes with regard to the new family assessment approach to child maltreatment.

Section 4 (626.556, subdivision 3d) adds a new subdivision giving the agency that is responsible for assessing and investigating reports of child maltreatment the authority to interview the child, the person or persons responsible for the child's care, the alleged perpetrator, and any other person with

knowledge of the abuse or neglect for the purpose of gathering facts, assessing safety and risk to the child, and formulating a plan.

Section 5 (626.556, subdivision 10) lists the duties of the local welfare agency and local law enforcement agency upon receipt of a maltreatment report, using the alternative response approach.

This section also clarifies that upon receipt of a report the local welfare agency shall conduct a face-to-face contact with the child who is the subject of the report, and with the child's primary caregiver. The contact must be sufficient to complete a safety assessment and ensure the immediate safety of the child. The face-to-face contact must occur immediately if substantial child endangerment is alleged and within five calendar days for all other reports.

Section 6 (262.556, subdivision 10b) makes a conforming change by updating a cross-reference.

Section 7 (626.556, subdivision 10e) shortens from 90 to 45 days the time-frame for the local welfare agency to conclude the family assessment or investigation. The local welfare agency must determine if services are needed to address the safety of the child and other family members and must also determine the risk of subsequent maltreatment.

Section 8 (626.556, subdivision 10f) requires the local welfare agency to notify the parent or guardian of the child of the need for services to address child safety concerns or the significant risk of subsequent child maltreatment within ten working days of the conclusion of the family assessment.

Section 9 (626.556, subdivision 10i) specifies that administrative reconsideration is not applicable for family assessments because no determination concerning maltreatment is made.

Section 10 (626.556, subdivision 10l) requires the local welfare agency to document the outcome of the family assessment or investigation when a case is closed, if the family received services. The documentation must include a description of services provided and the removal or reduction of risk to the child, if a risk existed.

Section 11 (626.556, subdivision 10m) adds a new subdivision requiring the local welfare agency to create a written plan, in collaboration with the family whenever possible, within 30 days of the determination that protective services are needed or upon joint agreement that family support and preservation services are needed.

Section 12 (626.556, subdivision 11) makes a conforming change by updating a cross-reference.

Section 13 (626.556, subdivision 11c) makes conforming changes with regard to family assessments.

Section 14 repeals the permissive alternative response language and time-frames in rule, which were clarified in this article.

Article 2
Child Welfare; Permanency

The article amends the child custody, adoption, and child protection chapters of law .

Sections 1 and 2 amend the relative custody assistance program, a program in which a relative is given permanent legal and physical custody of a child, and the relative receives assistance for the care of the child.

Section 1 (257.85, subdivision 2) modifies the scope of the relative custody assistance program, by expanding this program to a tribal court order on or after July 1, 2005.

Section 2 (257.85, subdivision 3) amends the relative custody assistance program to include "tribal social services" in the definition of "local agency," and updates a cross-reference.

Sections 3 to 8 amend the adoption chapter of law

Section 3 (259.23, subdivision 1) amends the adoption chapter of law, by clarifying venue for an adoption proceeding when the child is committed to the guardianship of the Commissioner of Human Services.

Section 4 (259.23, subdivision 2) is technical.

Section 5 (259.41, subdivision 3) modifies the background check statute, by requiring the addresses of prospective adoptive parent's residences for the previous five years instead of the previous ten years, and strikes language related to fingerprints, which is moved to a new paragraph (d).

Section 6 (259.75, subdivision 1) amends the adoption exchange by striking the requirement that the exchange include a book that is updated monthly of each child who has been legally freed for adoption. The exchange still requires a photograph and description of the child, which is made available to local social service agencies and other child placing agencies to assist in the adoptive placement of the child.

Section 7 (259.79, subdivision 1) requires the Commissioner of Human Services to maintain a permanent record of all adoptions granted in district court for children who fall under any of the categories in this section. This section also specifies what must be contained in the record.

Section 8 (259.85, subdivision 1) modifies the postadoption service grants program, by clarifying that this program is available to individuals who are not receiving adoption assistance.

Section 9 (260.012) amends the chapter of law related to juveniles, specifically the duty of the court to ensure that reasonable efforts have been made to prevent placement and reunite the family. Many of the changes made in this section are to achieve compliance with federal Title IV-E requirements

related to judicial determinations for reasonable efforts, agency responsibilities, permanency planning, and permanency hearings.

This section also clearly states that a permanency hearing must be held within 30 days of the court making a prima facie determination of any of the following: egregious harm, the parent's parental rights have been involuntary terminated with regard to another child or the parent's custodial rights to another child have been involuntarily transferred to another person, and abandonment of a child.

This section also modifies the definition of "reasonable efforts to prevent placement."

Sections 10 to 18 amend the child protection chapter of law.

Section 10 (260C.001, subdivision 3) amends the permanency and termination of parental rights statute, to clarify when reasonable efforts to reunify the child with the parent are not required.

Section 11 (260C.007, subdivision 8) modifies the definition of "compelling reasons" by making clarifying changes.

Section 12 (260C.151, subdivision 6) clarifies that if the court finds that the child is in surroundings that endanger the child's health, safety, or welfare, the responsible social services agency, instead of the court, assumes custody for placement of the child in foster care, and clarifies that this action is consistent with the court ordering emergency protective care as defined in the juvenile court rules.

Section 13 (260C.178) changes the heading of the statute from "detention hearing" to "emergency removal hearing," and modifies and clarifies court duties and agency duties with regard to the emergency removal hearing. This section clarifies when a court can order the child into foster care, and specifies the findings the court must make regarding reasonable efforts made by the responsible social services agency. This section specifies what the agency must do if a parent refuses to cooperate with the case planning. Makes other conforming changes.

Section 14 (260C.201, subdivision 1) modifies the disposition of a case when a child is in need of protection or services or neglected and in foster care by allowing a court to order a trial home visit, in which the child is returned to the home of a period not to exceed six months. This section specifies the duties of the responsible social services agency if a trial home visit is ordered by the court.

Section 15 (260C.201, subdivision 10) specifies that the court shall review the out-of-home placement of a child at least every 90 days. This section also specifies when the court review is not required.

Section 16 (260C.201, subdivision 11) makes several changes in the statute that requires a review of court-ordered placements and a possible permanent placement determination. This section specifies that the court, at the "admit-deny" hearing, must determine whether there is a prima facie basis for finding that the agency made reasonable efforts, or in the case of an Indian child, active

efforts. This section also clarifies the agency's role and responsibilities when a child is ordered into long-term foster care, allows the commissioner to identify and make an alternative adoptive placement without having to wait 12 months, when the prospective adoptive home is not viable, and makes a consent to adoption irrevocable, except under the Indian Child Welfare Act.

Section 17 (260C.312) allows the court to order a trial home visit when a child has been in placement for 15 out of the last 22 months.

Section 18 (260C.317, subdivision 3) prohibits an agency from requesting the court to order long-term foster care for a child under the guardianship of the agency unless there have been exhaustive efforts to recruit, identify, and place the child in an adoptive home.

Article 3
Child Care

Section 1 119B.025, subdivision 1) amends the factors that must be verified when applying for child care assistance, by streamlining the process to allow, the applicant to use a child care addendum under certain circumstances, and by requiring that eligibility be redetermined every six months.

Section 2 (119B.03, subdivision 6) modifies the child care assistance allocation formula to expand the families who are included in the formula used to redistribute basic sliding fee funds among counties, to include families whose cases were closed due to a reduction in the county allocation.

Section 3 (119B.09, subdivision 4) requires that the participant's income be "recalculated" instead of "redetermined" for purposes of determining eligibility for the child care assistance program.

Section 4 (119B.09, subdivision 9) allows child care providers to be eligible for child care assistance for their own children during the time they are participating in authorized activities.

Article 4
Child Support

Section 1 (256.978, subdivision 2) allows the public authority to request and obtain information from any third party who contracts with an obligor for purposes of gathering information to determine child support.

Section 2 (518.551, subdivision 5) amends the child support guidelines. Current law allows the child support obligor's income to be reduced in an amount equal to the amount of a child support order "being paid." The bill strikes that language, and allows the obligor's income to be reduced by a child support order amount, whether the child support is being paid, and clarifies that payments for child support arrears or maintenance debts do not reduce the obligor's income for purposes of determining child support. This section also allows the suspension of child care payments when either party informs the public authority that there are no child care costs being incurred and the

public authority verifies the accuracy of the information, and allows the public authority to administratively resume the collection for child care expenses when the costs have resumed.

Section 3 (518.68, subdivision 2) modifies the notice that is provided in a court order apprising the parties of the authority of the public authority to suspend and resume payments made for child care expenses.

Section 4 (548.091, subdivision 1a) amends the statute related to a child support judgment by operation of law, to allow the obligor to make a motion to the court to stop the accrual of interest on a child support debt if there have been 12 months of consecutive payments, instead of 36 months of consecutive payments.

Article 5
Family Supports

Section 1 (119A.43, subdivision 2) modifies the Department of Education transitional housing program by allowing the commissioner to use up to ten percent of the appropriation available for this program for persons needing housing assistance longer than 24 months.

Section 2 (144D.025) modifies the housing with services chapter of law to allow a supportive housing establishment developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness to register as a housing with services establishment. The session law referenced in this section is the "working group on supportive housing for long-term homelessness," which was required to report to the legislature on February 15, 2004.

Section 3 (256D.02, subdivision 17) makes the definition of "professional certification" under GAMC the same as the definition of "qualified professional" under MFIP.

Section 4 (256D.051, subdivision 6c) amends the food stamp employment and training program. Last session, the statute was changed, which resulted in the county's cost of services for FSET not to exceed "the annual allocated amount" instead of "an average of $400 per participant." A sunset of June 30, 2005, was also added. The bill strikes the sunset.

Sections 5 and 6 amend the group residential housing (GRH) program.

Section 5 (256I.04, subdivision 2a) expands the GRH program to allow housing with services establishments to contract with the county to provide GRH services. Current law specifically excludes housing with services establishment from GRH funding.

Section 6 (256I.05, subdivision 1g) allows a county to negotiate a supplemental service rate for recipients of GRH, not to exceed $456.75, who relocate from a homeless shelter licensed and registered by the Commissioner of Health to a supportive housing establishment developed and funded in whole or in part with the plan in the Governor's budget to end long-term homelessness.

Sections 7 to 11 amend Minnesota Family Investment Program Statutes.

Section 7 (256J.626, subdivision 6) modifies the base allocation to counties and tribes for the Minnesota Family Investment Program, by defining "adjusted caseload factor," and by changing the allocation formula for 2006 to 2008.

Section 8 (256J.626, subdivision 7) modifies the MFIP performance base funds, by providing an allocation formula for performance-based funds for federally approved tribal TANF programs.

Section 9 (256J.626, subdivision 8) allows the commissioner to reallocate unencumbered or unexpended money appropriated according to the new formula in the bill.

Section 10 (256.751, subdivision 2) requires the commissioner to report quarterly, instead of twice annually, an expected range of performance for each county, county grouping, and tribe on the self-support index.

Section 11 (256J.751, subdivision 5) amends the statute related to the county's failure to meet federal performance standards, by changing the definition of low-performing county.

Section 12 repeals the definitions of "medical certification," qualified professional," and "qualified provider" in rule.

JW:rdr

Senator Lourey introduced--

S.F. No. 1710: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; implementing child protection, child care, and child and family support provisions; amending Minnesota Statutes 2004, sections 119A.43, subdivision 2; 119B.025, subdivision 1; 119B.03, subdivision 6; 119B.09, subdivisions 4, 9; 144D.025; 256.978, subdivision 2; 256D.02, subdivision 17; 256D.051, subdivision 6c; 256I.04, subdivision 2a; 256I.05, by adding a subdivision; 256J.626, subdivisions 6, 7, 8; 256J.751, subdivisions 2, 5; 257.85, subdivisions 2, 3; 259.23, subdivisions 1, 2; 259.41, subdivision 3; 259.75, subdivision 1; 259.79, subdivision 1; 259.85, subdivision 1; 260.012; 260C.001, subdivision 3; 260C.007, subdivision 8; 260C.151, subdivision 6; 260C.178; 260C.201, subdivisions 1, 10, 11; 260C.312; 260C.317, subdivision 3; 518.551, subdivision 5; 518.68, subdivision 2; 548.091, subdivision 1a; 626.556, subdivisions 1, 2, 3, 10, 10b, 10e, 10f, 10i, 11, 11c, by adding subdivisions; repealing Minnesota Statutes 2004, sections 626.5551, subdivisions 1, 2, 3, 4, 5; Minnesota Rules, parts 9500.1206, subparts 20, 26d, 27; 9560.0220, subpart 6, item B; 9560.0230, subpart 2.

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

ARTICLE 1

CHILD WELFARE: ALTERNATIVE RESPONSE

Section 1. Minnesota Statutes 2004, section 626.556, subdivision 1, is amended to read:

Subdivision 1. [PUBLIC POLICY.] The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse. <u>While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their</u>

ability to do so. When this occurs, families are best served by interventions that engage their protective capacities and address immediate safety concerns and ongoing risks of child maltreatment. In furtherance of this public policy, it is the intent of the legislature under this section to strengthen the family and make the home, school, and community safe for children by promoting responsible child care in all settings; and to provide, when necessary, a safe temporary or permanent home environment for physically or sexually abused or neglected children.

In addition, it is the policy of this state to require the reporting of neglect, physical or sexual abuse of children in the home, school, and community settings; to provide for the voluntary reporting of abuse or neglect of children; to require ~~the~~ a family assessment ~~and~~, when appropriate, as the preferred response to reports not alleging substantial child endangerment; to require an investigation ~~of the reports~~ when the report alleges substantial child endangerment; and to provide protective ~~and counseling~~, family support, and family preservation services when needed in appropriate cases.

Sec. 2. Minnesota Statutes 2004, section 626.556, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(b) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred

and whether child protective services are needed. An investigation must be used when reports involve substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10; or in a nonlicensed personal care provider association as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(c) "Substantial child endangerment" means a person responsible for a child's care, a person who has a significant relationship to the child as defined in section 609.341, or a person in a position of authority as defined in section 609.341, who by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) sexual abuse as defined in paragraph (d);

(3) abandonment under section 260C.301, subdivision 2;

(4) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(5) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(6) manslaughter in the first or second degree under section 609.20 or 609.205;

(7) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(8) solicitation, inducement, and promotion of prostitution under section 609.322;

(9) criminal sexual conduct under sections 609.342 to 609.3451;

(10) solicitation of children to engage in sexual conduct

under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.301, subdivision 3, paragraph (a).

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse.

~~(b)~~ (e) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

~~(c)~~ (f) "Neglect" means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health,

medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that

medically indicate prenatal exposure to a controlled substance;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

~~(d)~~ (g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825. Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following that are done in anger or without regard to the safety of the child:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

~~(e)~~ (h) "Report" means any report received by the local welfare agency, police department, county sheriff, or agency responsible for assessing or investigating maltreatment pursuant to this section.

~~(f)~~ (i) "Facility" means a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245B; or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

~~(g)~~ (j) "Operator" means an operator or agency as defined in section 245A.02.

~~(h)~~ (k) "Commissioner" means the commissioner of human services.

~~(i) "Assessment" includes authority to interview the child, the person or persons responsible for the child's care, the alleged perpetrator, and any other person with knowledge of the abuse or neglect for the purpose of gathering the facts, assessing the risk to the child, and formulating a plan.~~

~~(j)~~ (l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

~~(k)~~ (m) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

~~(l)~~ (n) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph ~~(b)~~ (e), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under section 260C.201, subdivision 11, paragraph (d), clause (1), or a similar law of another jurisdiction.

~~(m)~~ (o) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

Sec. 3. Minnesota Statutes 2004, section 626.556, subdivision 3, is amended to read:

Subd. 3. [PERSONS MANDATED TO REPORT.] (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency, or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing. The county sheriff and the head of every local welfare agency, agency responsible for assessing or investigating reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph and paragraph (b) are carried out. Nothing in this subdivision shall be construed to require more than one report from any institution, facility, school, or agency.

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person

knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of <u>a family assessment or investigation related to</u> any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this subdivision, "immediately" means

as soon as possible but in no event longer than 24 hours.

Sec. 4. Minnesota Statutes 2004, section 626.556, is amended by adding a subdivision to read:

Subd. 3d. [AUTHORITY TO INTERVIEW.] The agency responsible for assessing or investigating reports of child maltreatment has the authority to interview the child, the person or persons responsible for the child's care, the alleged perpetrator, and any other person with knowledge of the abuse or neglect for the purpose of gathering the facts, assessing safety and risk to the child, and formulating a plan.

Sec. 5. Minnesota Statutes 2004, section 626.556, subdivision 10, is amended to read:

Subd. 10. [DUTIES OF LOCAL WELFARE AGENCY AND LOCAL LAW ENFORCEMENT AGENCY UPON RECEIPT OF A REPORT.] (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment or an investigation as appropriate to prevent or provide a remedy for child maltreatment. The local welfare agency:

(1) shall conduct an investigation on reports involving substantial child endangerment;

(2) shall begin an immediate investigation if, at any time when it is using a family assessment response, it determines that there is reason to believe that substantial child endangerment or a serious threat to the child's safety exists;

(3) may conduct a family assessment for reports that do not allege substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response; and

(4) may conduct a family assessment on a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, the local welfare agency shall immediately conduct ~~an~~ a family assessment ~~including gathering~~ or investigation as identified in clauses (1) to (4). In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence and offer ~~protective social~~ services for purposes of preventing ~~further abuses~~ future child maltreatment, safeguarding and enhancing the welfare of the abused or neglected minor, and supporting and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part 9530.6615. The local welfare agency shall report the determination of the chemical use assessment, and the recommendations and referrals for alcohol and other drug treatment services to the state authority on

alcohol and drug abuse.

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97. The commissioner of education shall inform the ombudsman established under sections 245.91 to 245.97 of reports regarding a child defined as a client in section 245.91 that maltreatment occurred at a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10.

(c) Authority of the local welfare agency responsible for assessing or investigating the child abuse or neglect report, the agency responsible for assessing or investigating the report, and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at, a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. For family assessments, it is the preferred practice to request a parent or guardian's permission to interview the child prior to conducting the child interview, unless doing so would compromise the safety assessment. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding

rule 49.02 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare, local law enforcement agency, or the agency responsible for assessing or investigating a report of maltreatment determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded, unless a school employee or agent is alleged to have maltreated the child. Until that time, the local welfare or law enforcement agency or the agency responsible for assessing or investigating a report of maltreatment shall be solely responsible for any disclosures

regarding the nature of the assessment or investigation.

Except where the alleged offender is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(e) Where the alleged offender or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the alleged offender or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (e), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner of human services, the ombudsman for mental health and mental retardation, the local welfare agencies responsible for investigating reports, the commissioner of education, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(h) The local welfare agency ~~or the agency~~ responsible for ~~assessing or~~ conducting a family assessment shall collect available and relevant information to determine child safety, risk of subsequent child maltreatment, and family strengths and needs. The local welfare agency or the agency responsible for investigating the report shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. The local welfare agency or the agency responsible for assessing or investigating the report may make a determination of no maltreatment early in an assessment, and close the case and retain immunity, if the collected information shows no basis for a full assessment or investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age, prior reports of maltreatment,

information relating to developmental functioning, credibility of the child's statement, and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions. The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency, the local law enforcement agency, or the agency responsible for assessing or investigating the report from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding section 13.384 or 144.335, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare agency or the agency responsible for assessing or investigating the report during the course of the assessment or investigation are private data on individuals

and must be maintained in accordance with subdivision 11. Data of the commissioner of education collected or maintained during and for the purpose of an investigation of alleged maltreatment in a school are governed by this section, notwithstanding the data's classification as educational, licensing, or personnel data under chapter 13.

In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph ~~(f)~~ (i), the commissioner of education shall collect investigative reports and data that are relevant to a report of maltreatment and are from local law enforcement and the school facility.

(i) ~~In the initial stages of an assessment or investigation~~ Upon receipt of a report, the local welfare agency shall conduct a face-to-face ~~observation of~~ contact with the child reported to be maltreated ~~and a face-to-face interview of the alleged offender~~ and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. The face-to-face contact with the child and primary caregiver shall occur immediately if substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. At the initial contact, the local child welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(j) When conducting an investigation, the local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. For investigations only, the following interviewing

methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

(k) In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph ~~(f)~~ (i), the commissioner of education shall collect available and relevant information and use the procedures in paragraphs ~~(h),~~ (i), (k), and ~~(j)~~ subdivision 3d, except that the requirement for face-to-face observation of the child and face-to-face interview of the alleged offender is to occur in the initial stages of the assessment or investigation provided that the commissioner may also base the assessment or investigation on investigative reports and data received from the school facility and local law enforcement, to the extent those investigations satisfy the requirements of paragraphs ~~(h),~~ (i), and (k), and ~~(j)~~ subdivision 3d.

Sec. 6. Minnesota Statutes 2004, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. [DUTIES OF COMMISSIONER; NEGLECT OR ABUSE IN FACILITY.] (a) This section applies to the commissioners of human services, health, and education. The commissioner of the agency responsible for assessing or investigating the report shall immediately assess or investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, sexually abused, or is the victim of maltreatment in a facility by an individual in that facility, or has been so neglected or abused, or been the victim of maltreatment in a facility by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, sexually abused, or is the victim of maltreatment in a facility by an

individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may interview any children who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the commissioner or local welfare agency shall obtain access to information consistent with subdivision 10, paragraphs (h), (i), and (j). In conducting assessments or investigations under this

subdivision, the commissioner of education shall obtain access to reports and investigative data that are relevant to a report of maltreatment and are in the possession of a school facility as defined in subdivision 2, paragraph ~~(f)~~ (i), notwithstanding the classification of the data as educational or personnel data under chapter 13. This includes, but is not limited to, school investigative reports, information concerning the conduct of school personnel alleged to have committed maltreatment of students, information about witnesses, and any protective or corrective action taken by the school facility regarding the school personnel alleged to have committed maltreatment.

(d) The commissioner may request assistance from the local social services agency.

Sec. 7. Minnesota Statutes 2004, section 626.556, subdivision 10e, is amended to read:

Subd. 10e. [DETERMINATIONS.] ~~Upon-the-conclusion-of-every assessment-or-investigation-it-conducts,~~ (a) The local welfare agency shall conclude the family assessment or the investigation within 45 days of the receipt of a report. The conclusion of the assessment or investigation may be extended to permit the completion of a criminal investigation or the receipt of expert information requested within 45 days of the receipt of the report.

(b) After conducting a family assessment, the local welfare agency shall determine whether services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment.

(c) After conducting an investigation, the local welfare agency shall make two determinations: first, whether maltreatment has occurred; and second, whether child protective services are needed. ~~Upon-the-conclusion-of~~

(d) If the commissioner of education conducts an assessment or investigation ~~by-the-commissioner-of-education~~, the commissioner shall determine whether maltreatment occurred and what corrective or protective action was taken by the school facility. If a determination is made that maltreatment has

occurred, the commissioner shall report to the employer, the school board, and any appropriate licensing entity the determination that maltreatment occurred and what corrective or protective action was taken by the school facility. In all other cases, the commissioner shall inform the school board or employer that a report was received, the subject of the report, the date of the initial report, the category of maltreatment alleged as defined in paragraph ~~(a)~~ (f), the fact that maltreatment was not determined, and a summary of the specific reasons for the determination.

(e) When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible, or whether both the facility and the individual were responsible for the maltreatment using the mitigating factors in paragraph ~~(d)~~ (i). Determinations under this subdivision must be made based on a preponderance of the evidence and are private data on individuals or nonpublic data as maintained by the commissioner of education.

~~(a)~~ (f) For the purposes of this subdivision, "maltreatment" means any of the following acts or omissions:

(1) physical abuse as defined in subdivision 2, paragraph ~~(d)~~ (g);

(2) neglect as defined in subdivision 2, paragraph ~~(c)~~ (f);

(3) sexual abuse as defined in subdivision 2, paragraph ~~(a)~~ (d);

(4) mental injury as defined in subdivision 2, paragraph ~~(k)~~ (m); or

(5) maltreatment of a child in a facility as defined in subdivision 2, paragraph ~~(f)~~ (i).

~~(b)~~ (g) For the purposes of this subdivision, a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker, as defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment

if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

~~(c)~~ (h) This subdivision does not mean that maltreatment has occurred solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, in lieu of medical care. However, if lack of medical care may result in serious danger to the child's health, the local welfare agency may ensure that necessary medical services are provided to the child.

~~(d)~~ (i) When determining whether the facility or individual is the responsible party for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

(j) Individual counties may implement more detailed

definitions or criteria that indicate which allegations to investigate, as long as a county's policies are consistent with the definitions in the statutes and rules and are approved by the county board. Each local welfare agency shall periodically inform mandated reporters under subdivision 3 who work in the county of the definitions of maltreatment in the statutes and rules and any additional definitions or criteria that have been approved by the county board.

Sec. 8. Minnesota Statutes 2004, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. [NOTICE OF DETERMINATIONS.] Within ten working days of the conclusion of a family assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent child maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed. Within ten working days of the conclusion of an ~~assessment~~ investigation, the local welfare agency or agency responsible for assessing or investigating the report shall notify the parent or guardian of the child, the person determined to be maltreating the child, and if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section or section 256.022.

Sec. 9. Minnesota Statutes 2004, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. [ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.]

(a) Administrative reconsideration is not applicable in family assessments since no determination concerning maltreatment is made. For investigations, except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of education determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services or the commissioner of education a written request for a hearing under that section. Section 256.045 also

governs hearings requested to contest a final determination of the commissioner of education. For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the Child Maltreatment Review Panel under section 256.022 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) Effective January 1, 2002, if an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be

consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or the disqualification is not set aside under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) Effective January 1, 2002, if a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

Sec. 10. Minnesota Statutes 2004, section 626.556, is amended by adding a subdivision to read:

Subd. 101. [DOCUMENTATION.] When a case is closed that has been open for services, the local welfare agency shall document the outcome of the family assessment or investigation, including

a description of services provided and the removal or reduction of risk to the child, if it existed.

Sec. 11. Minnesota Statutes 2004, section 626.556, is amended by adding a subdivision to read:

Subd. 10m. [PROVISION OF CHILD PROTECTIVE SERVICES.] The local welfare agency shall create a written plan, in collaboration with the family whenever possible, within 30 days of the determination that protective services are needed or upon joint agreement of the local welfare agency and the family that family support and preservation services are needed.

Sec. 12. Minnesota Statutes 2004, section 626.556, subdivision 11, is amended to read:

Subd. 11. [RECORDS.] (a) Except as provided in paragraph (b) or (d) and subdivisions 10b, 10d, 10g, and 11b, all records concerning individuals maintained by a local welfare agency or agency responsible for assessing or investigating the report under this section, including any written reports filed under subdivision 7, shall be private data on individuals, except insofar as copies of reports are required by subdivision 7 to be sent to the local police department or the county sheriff. All records concerning determinations of maltreatment by a facility are nonpublic data as maintained by the Department of Education, except insofar as copies of reports are required by subdivision 7 to be sent to the local police department or the county sheriff. Reports maintained by any police department or the county sheriff shall be private data on individuals except the reports shall be made available to the investigating, petitioning, or prosecuting authority, including county medical examiners or county coroners. Section 13.82, subdivisions 8, 9, and 14, apply to law enforcement data other than the reports. The local social services agency or agency responsible for assessing or investigating the report shall make available to the investigating, petitioning, or prosecuting authority, including county medical examiners or county coroners or their professional delegates, any records which contain information relating to a specific incident of neglect or abuse which is

under investigation, petition, or prosecution and information relating to any prior incidents of neglect or abuse involving any of the same persons. The records shall be collected and maintained in accordance with the provisions of chapter 13. In conducting investigations and assessments pursuant to this section, the notice required by section 13.04, subdivision 2, need not be provided to a minor under the age of ten who is the alleged victim of abuse or neglect. An individual subject of a record shall have access to the record in accordance with those sections, except that the name of the reporter shall be confidential while the report is under assessment or investigation except as otherwise permitted by this subdivision. Any person conducting an investigation or assessment under this section who intentionally discloses the identity of a reporter prior to the completion of the investigation or assessment is guilty of a misdemeanor. After the assessment or investigation is completed, the name of the reporter shall be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and that there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure.

(b) Upon request of the legislative auditor, data on individuals maintained under this section must be released to the legislative auditor in order for the auditor to fulfill the auditor's duties under section 3.971. The auditor shall maintain the data in accordance with chapter 13.

(c) The commissioner of education must be provided with all requested data that are relevant to a report of maltreatment and are in possession of a school facility as defined in subdivision 2, paragraph ~~(f)~~ (i), when the data is requested pursuant to an assessment or investigation of a maltreatment report of a student in a school. If the commissioner of education makes a determination of maltreatment involving an individual performing

work within a school facility who is licensed by a board or other agency, the commissioner shall provide necessary and relevant information to the licensing entity to enable the entity to fulfill its statutory duties. Notwithstanding section 13.03, subdivision 4, data received by a licensing entity under this paragraph are governed by section 13.41 or other applicable law governing data of the receiving entity, except that this section applies to the classification of and access to data on the reporter of the maltreatment.

(d) The investigating agency shall exchange not public data with the Child Maltreatment Review Panel under section 256.022 if the data are pertinent and necessary for a review requested under section 256.022. Upon completion of the review, the not public data received by the review panel must be returned to the investigating agency.

Sec. 13. Minnesota Statutes 2004, section 626.556, subdivision 11c, is amended to read:

Subd. 11c. [WELFARE, COURT SERVICES AGENCY, AND SCHOOL RECORDS MAINTAINED.] Notwithstanding sections 138.163 and 138.17, records maintained or records derived from reports of abuse by local welfare agencies, agencies responsible for assessing or investigating the report, court services agencies, or schools under this section shall be destroyed as provided in paragraphs (a) to (d) by the responsible authority.

(a) ~~If upon~~ For family assessment ~~or~~ cases and cases where an investigation ~~there is~~ results in no determination of maltreatment or the need for child protective services, the assessment or investigation records must be maintained for a period of four years. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future risk and safety assessments.

(b) All records relating to reports which, upon ~~assessment or~~ investigation, indicate either maltreatment or a need for child protective services shall be maintained for at least ten years after the date of the final entry in the case record.

(c) All records regarding a report of maltreatment,

including any notification of intent to interview which was received by a school under subdivision 10, paragraph (d), shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(d) Private or confidential data released to a court services agency under subdivision 10h must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

Sec. 14. [REPEALER.]

(a) Minnesota Statutes 2004, section 626.5551, subdivisions 1, 2, 3, 4, and 5, are repealed.

(b) Minnesota Rules, parts 9560.0220, subpart 6, item B; and 9560.0230, subpart 2, are repealed.

ARTICLE 2

CHILD WELFARE: PERMANENCY

Section 1. Minnesota Statutes 2004, section 257.85, subdivision 2, is amended to read:

Subd. 2. [SCOPE.] The provisions of this section apply to those situations in which the legal and physical custody of a child is established with a relative or important friend with whom the child has resided or had significant contact according to section 260C.201, subdivision 11, by a district court order issued on or after July 1, 1997, or a tribal court order issued on or after July 1, 2005, when the child has been removed from the care of the parent by previous district or tribal court order.

Sec. 2. Minnesota Statutes 2004, section 257.85, subdivision 3, is amended to read:

Subd. 3. [DEFINITIONS.] For purposes of this section, the

terms defined in this subdivision have the meanings given them.

(a) "MFIP standard" means the transitional standard used to calculate assistance under the MFIP program, or, if permanent legal and physical custody of the child is given to a relative custodian residing outside of Minnesota, the analogous transitional standard or standard of need used to calculate assistance under the TANF program of the state where the relative custodian lives.

(b) "Local agency" means the ~~local~~ county social services agency or tribal social services agency with legal custody of a child prior to the transfer of permanent legal and physical custody.

(c) "Permanent legal and physical custody" means permanent legal and physical custody ordered by a Minnesota Juvenile Court under section 260C.201, subdivision ~~27~~ 11.

(d) "Relative" has the meaning given in section 260C.007, subdivision 27.

(e) "Relative custodian" means a person who has permanent legal and physical custody of a child. When siblings, including half-siblings and stepsiblings, are placed together in permanent legal and physical custody, the person receiving permanent legal and physical custody of the siblings is considered a relative custodian of all of the siblings for purposes of this section.

(f) "Relative custody assistance agreement" means an agreement entered into between a local agency and a person who has been or will be awarded permanent legal and physical custody of a child.

(g) "Relative custody assistance payment" means a monthly cash grant made to a relative custodian pursuant to a relative custody assistance agreement and in an amount calculated under subdivision 7.

(h) "Remains in the physical custody of the relative custodian" means that the relative custodian is providing day-to-day care for the child and that the child lives with the relative custodian; absence from the relative custodian's home for a period of more than 120 days raises a presumption that the

child no longer remains in the physical custody of the relative custodian.

Sec. 3. Minnesota Statutes 2004, section 259.23, subdivision 1, is amended to read:

Subdivision 1. [VENUE.] (a) Except as provided in section 260C.101, subdivision 2, the juvenile court shall have original jurisdiction in all adoption proceedings. The proper venue for an adoption proceeding shall be the county of the petitioner's residence, except as provided in paragraph (b). ~~However,~~

(b) Venue for the adoption of a child committed to the guardianship of the commissioner of human services shall be the county with jurisdiction in the matter according to section 260C.317, subdivision 3.

(c) Upon request of the petitioner, the court having jurisdiction over the matter under section 260C.317, subdivision 3, may transfer venue of an adoption proceeding involving a child under the guardianship of the commissioner to the county of the petitioner's residence upon determining that:

(1) the commissioner has given consent to the petitioner's adoption of the child or that consent is unreasonably withheld;

(2) there is no other adoption petition for the child that has been filed or is reasonably anticipated by the commissioner or the commissioner's delegate to be filed; and

(3) transfer of venue is in the best interests of the child. Transfer of venue under this paragraph shall be according to the rules of adoption court procedure.

(d) In all other adoptions, if the petitioner has acquired a new residence in another county and requests a transfer of the adoption proceeding, the court in which an adoption is initiated may transfer the proceeding to the appropriate court in the new county of residence if the transfer is in the best interests of the person to be adopted. The court transfers the proceeding by ordering a continuance and by forwarding to the court administrator of the appropriate court a certified copy of all papers filed, together with an order of transfer. The transferring court also shall forward copies of the order of

transfer to the commissioner of human services and any agency participating in the proceedings. The judge of the receiving court shall accept the order of the transfer and any other documents transmitted and hear the case; provided, however, the receiving court may in its discretion require the filing of a new petition prior to the hearing.

Sec. 4. Minnesota Statutes 2004, section 259.23, subdivision 2, is amended to read:

Subd. 2. [CONTENTS OF PETITION.] The petition shall be signed by the petitioner and, if married, by the spouse. It shall be verified, and filed in duplicate. The petition shall allege:

(a) The full name, age and place of residence of petitioner, and if married, the date and place of marriage;

(b) The date petitioner acquired physical custody of the child and from what person or agency;

(c) The date of birth of the child, if known, and the state and county where born;

(d) The name of the child's parents, if known, and the guardian if there be one;

(e) The actual name of the child, if known, and any known aliases;

(f) The name to be given the child if a change of name is desired;

(g) The description and value of any real or personal property owned by the child;

(h) That the petitioner desires that the relationship of parent and child be established between petitioner and the child, and that it is to the best interests of the child for the child to be adopted by the petitioner.

In agency placements, the information required in clauses (d) and (e) ~~above~~ shall not be required to be alleged in the petition but shall be transmitted to the court by the commissioner of human services or the agency.

Sec. 5. Minnesota Statutes 2004, section 259.41, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND CHECK; AFFIDAVIT OF HISTORY.] (a) At the time an adoption study is commenced, each prospective adoptive parent must:

(1) authorize access by the agency to any private data needed to complete the study;

(2) provide all addresses at which the prospective adoptive parent and anyone in the household over the age of 13 has resided in the previous ~~ten~~ five years; and

(3) disclose any names used previously other than the name used at the time of the study~~;-and~~

~~(4)-provide-a-set-of-fingerprints,-which-shall-be-forwarded to-the-Bureau-of-Criminal-Apprehension-to-facilitate-the criminal-conviction-background-check-required-under-paragraph (b)~~.

(b) When the requirements of paragraph (a) have been met, the agency shall immediately begin a background check, on each person over the age of 13 living in the home, consisting, at a minimum, of the following:

(1) a check of criminal conviction data with the Bureau of Criminal Apprehension and local law enforcement authorities;

(2) a check for data on substantiated maltreatment of a child or vulnerable adult and domestic violence data with local law enforcement and social services agencies and district courts; and

(3) for those persons under the age of 25, a check of juvenile court records.

Notwithstanding the provisions of section 260B.171 or 260C.171, the Bureau of Criminal Apprehension, local law enforcement and social services agencies, district courts, and juvenile courts shall release the requested information to the agency completing the adoption study.

(c) When paragraph (b) requires checking the data or records of local law enforcement and social services agencies and district and juvenile courts, the agency shall check with the law enforcement and social services agencies and courts whose jurisdictions cover the addresses under paragraph (a),

clause (2). In the event that the agency is unable to complete any of the record checks required by paragraph (b), the agency shall document the fact and the agency's efforts to obtain the information.

(d) For a study completed under this section, when the agency has reasonable cause to believe that further information may exist on the prospective adoptive parent or household member over the age of 13 that may relate to the health, safety, or welfare of the child, the prospective adoptive parent or household member over the age of 13 shall provide the agency with a set of classifiable fingerprints obtained from an authorized law enforcement agency and the agency may obtain criminal history data from the National Criminal Records Repository by submitting fingerprints to the Bureau of Criminal Apprehension. The agency has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the prospective adoptive parent or household member over the age of 13 is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;

(3) the agency has received a report from the prospective adoptive parent or household member over the age of 13 or a third party indicating that the prospective adoptive parent or household member over the age of 13 has a criminal history in a jurisdiction other than Minnesota; or

(4) the prospective adoptive parent or household member over the age of 13 is or has been a resident of a state other than Minnesota in the prior five years.

~~(c)~~ (e) At any time prior to completion of the background check required under paragraph (b), a prospective adoptive parent may submit to the agency conducting the study a sworn affidavit stating whether they or any person residing in the household have been convicted of a crime. The affidavit shall also state whether the adoptive parent or any other person residing in the household is the subject of an open

investigation of, or have been the subject of a substantiated allegation of, child or vulnerable-adult maltreatment within the past ten years. A complete description of the crime, open investigation, or substantiated abuse, and a complete description of any sentence, treatment, or disposition must be included. The affidavit must contain an acknowledgment that if, at any time before the adoption is final, a court receives evidence leading to a conclusion that a prospective adoptive parent knowingly gave false information in the affidavit, it shall be determined that the adoption of the child by the prospective adoptive parent is not in the best interests of the child.

~~(d)~~ (f) For the purposes of subdivision 1 and section 259.47, subdivisions 3 and 6, an adoption study is complete for placement, even though the background checks required by paragraph (b) have not been completed, if each prospective adoptive parent has completed the affidavit allowed by paragraph ~~(c)~~ (e) and the other requirements of this section have been met. The background checks required by paragraph (b) must be completed before an adoption petition is filed. If an adoption study has been submitted to the court under section 259.47, subdivision 3 or 6, before the background checks required by paragraph (b) were complete, an updated adoption study report which includes the results of the background check must be filed with the adoption petition. In the event that an agency is unable to complete any of the records checks required by paragraph (b), the agency shall submit with the petition to adopt an affidavit documenting the agency's efforts to complete the checks.

Sec. 6. Minnesota Statutes 2004, section 259.75, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT; CONTENTS; AVAILABILITY.] The commissioner of human services shall establish an adoption exchange~~, which shall include but not be limited to a book, updated monthly,~~ that contains a photograph and description of each child who has been legally freed for adoption. The

exchange service shall be available to all local social service agencies and licensed child-placing agencies whose purpose is to assist in the adoptive placement of children~~,-and-the-exchange book-shall-be-distributed-to-all-such-agencies~~.

Sec. 7. Minnesota Statutes 2004, section 259.79, subdivision 1, is amended to read:

Subdivision 1. [CONTENT.] (a) The adoption records of ~~the commissioner,~~ the commissioner's agents and licensed child-placing agencies shall contain copies of all relevant legal documents, responsibly collected genetic, medical and social history of the child and the child's birth parents, the child's placement record, copies of all pertinent agreements, contracts, and correspondence relevant to the adoption, and copies of all reports and recommendations made to the court.

(b) The commissioner of human services shall maintain a permanent record of all adoptions granted in district court in Minnesota regarding children who are:

(1) under guardianship of the commissioner or a licensed child-placing agency according to section 260C.201, subdivision 11, or 260C.317;

(2) placed by the commissioner, commissioner's agent, or licensed child-placing agency after a consent to adopt according to section 259.24 or under an agreement conferring authority to place for adoption according to section 259.25; or

(3) adopted after a direct adoptive placement approved by the district court under section 259.47.

Each record shall contain identifying information about the child, the birth or legal parents, and adoptive parents. The record must also contain: (1) the date the child was legally freed for adoption; (2) the date of the adoptive placement; (3) the name of the placing agency; (4) the county where the adoptive placement occurred; (5) the date that the petition to adopt was filed; (6) the county where the petition to adopt was filed; and (7) the date and county where the adoption decree was granted.

(c) Identifying information contained in the adoption

record shall be confidential and shall be disclosed only pursuant to section 259.61.

Sec. 8. Minnesota Statutes 2004, section 259.85, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE.] The commissioner of human services shall establish and supervise a postadoption service grants program to be administered by local social service agencies for the purpose of preserving and strengthening adoptive families. The program will provide financial assistance to adoptive parents who are not receiving adoption assistance under section 259.67 to meet the special needs of an adopted child that cannot be met by other resources available to the family.

Sec. 9. Minnesota Statutes 2004, section 260.012, is amended to read:

260.012 [DUTY TO ENSURE PLACEMENT PREVENTION AND FAMILY REUNIFICATION; REASONABLE EFFORTS.]

(a) Once a child alleged to be in need of protection or services is under the court's jurisdiction, the court shall ensure that reasonable efforts including culturally appropriate services by the social services agency are made to prevent placement ~~or~~ and to finalize a permanent plan for the child, as appropriate. "Reasonable efforts to finalize the permanent plan for the child" include the agency's efforts to eliminate the need for removal and to reunite the child with the child's family at the earliest possible time, ~~consistent with the best interests, safety, and protection of the child~~ or to place the child with a family that will be the legally permanent home for the child in the event the child cannot be reunited with the parent or guardian from whom the child was removed. In determining reasonable efforts to be made with respect to a child and in making those reasonable efforts, the child's best interests, health, and safety must be of paramount concern. Reasonable efforts to prevent placement or for rehabilitation and reunification are not required upon a determination by the court that:

~~(i)~~ a ~~termination-of-parental-rights~~ petition has been filed stating a prima facie case that:

~~(i)~~ (1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

~~(ii)~~ (2) the parental rights of the parent to another child have been terminated involuntarily;

~~(iii)~~ (3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2); ~~or~~

~~(iv)~~ (4) the parent's custodial rights to another child have been involuntarily transferred to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction; or

~~(2) the county attorney has filed a determination not to proceed with a termination of parental rights petition on these grounds was made under section 260C.301, subdivision 3, paragraph (b), and a permanency hearing is held within 30 days of the determination; or~~

~~(3) a termination of parental rights petition or other petition according to section 260C.201, subdivision 11, has been filed alleging a prima facie case that~~

(5) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable under the circumstances.

(b) When the court makes one of the prima facie determinations under paragraph (a), either permanency pleadings under section 260C.201, subdivision 11, or a termination of parental rights petition under sections 260C.141 and 260C.301 must be filed. A permanency hearing under section 260C.201, subdivision 11, must be held within 30 days of this determination.

(c) In the case of an Indian child, in proceedings under sections 260B.178 or 260C.178, 260C.201, and 260C.301 the juvenile court must make findings and conclusions consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901 et seq., as to the provision of active efforts. If a child is under the court's delinquency

jurisdiction, it shall be the duty of the court to ensure that reasonable efforts are made to reunite the child with the child's family at the earliest possible time, consistent with the best interests of the child and the safety of the public.

~~(b)~~ (d) "Reasonable efforts to prevent placement" means:

(1) the agency has made reasonable efforts to prevent the placement of the child; or

(2) given the particular circumstances of the child and family at the time of the child's removal, there are no services or efforts available which could allow the child to safely remain in the home.

(e) As appropriate under the particular circumstances and stage of the case, "reasonable efforts to finalize a permanent plan for the child" means reasonable efforts by the responsible social services agency to:

(1) reunify the child with the parent or guardian from whom the child was removed;

(2) assess a noncustodial parent's ability to provide day-to-day care for the child and, where appropriate, provide services necessary to enable the noncustodial parent to safely provide the care; and

(3) finalize a safe and legally permanent home for the child, preferably through adoption or transfer of permanent legal and physical custody of the child, when the child cannot return to the parent or guardian from whom the child was removed.

(f) Reasonable efforts are made upon the exercise of due diligence by the responsible social services agency to use appropriate and available services to meet the needs of the child and the child's family ~~in order to prevent removal of the child from the child's family; or upon removal, services to eliminate the need for removal and reunite the family~~. ~~(1)~~ Services may include those provided by the responsible social services agency and other appropriate services available in the community. ~~(2)~~ At each stage of the proceedings where the court is required to review the appropriateness of the responsible social services agency's reasonable efforts, the social services

agency has the burden of demonstrating that:

(1) it has made reasonable efforts~~,-or-that-provision-of services-or-further-services-for-the-purpose-of-rehabilitation and-reunification-is-futile-and-therefore-unreasonable-under-the circumstances-or-that-reasonable-efforts-aimed-at-reunification are-not-required-under-this-section~~ to prevent placement;

(2) it has made reasonable efforts to finalize the permanent plan for the child; or

(3) reasonable efforts to prevent placement and to reunify the child with the parent or guardian are not required. The agency may meet this burden by stating facts in a sworn petition filed under section 260C.141, ~~or~~ by filing an affidavit summarizing the agency's reasonable efforts or facts the agency believes demonstrate there is no need for reasonable efforts to reunify the parent and child, or through testimony or a certified report required under juvenile court rules.

~~(3) No~~ (g) Once the court determines that reasonable efforts for reunification are not required ~~when-the-court-makes a-determination~~ because the court has made one of the prima facie determinations under paragraph (a) ~~unless~~, the court may only require reasonable efforts for reunification after a hearing according to section 260C.163, where the court finds there is not clear and convincing evidence of the facts upon which the court based its prima facie determination. In this case, the court may proceed under section 260C.312. Reunification of a surviving child with a parent is not required if the parent has been convicted of:

~~(i)~~ (1) a violation of, or an attempt or conspiracy to commit a violation of, sections 609.185 to 609.20; 609.222, subdivision 2; or 609.223 in regard to another child of the parent;

~~(ii)~~ (2) a violation of section 609.222, subdivision 2; or 609.223, in regard to the surviving child; or

~~(iii)~~ (3) a violation of, or an attempt or conspiracy to commit a violation of, United States Code, title 18, section 1111(a) or 1112(a), in regard to another child of the parent.

~~(c)~~ (h) The juvenile court, in proceedings under sections 260B.178 or 260C.178, 260C.201, and 260C.301 shall make findings and conclusions as to the provision of reasonable efforts. When determining whether reasonable efforts have been made, the court shall consider whether services to the child and family were:

(1) relevant to the safety and protection of the child;

(2) adequate to meet the needs of the child and family;

(3) culturally appropriate;

(4) available and accessible;

(5) consistent and timely; and

(6) realistic under the circumstances.

In the alternative, the court may determine that provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances or that reasonable efforts are not required as provided in paragraph (a).

~~(d)~~ (i) This section does not prevent out-of-home placement for treatment of a child with a mental disability when the child's diagnostic assessment or individual treatment plan indicates that appropriate and necessary treatment cannot be effectively provided outside of a residential or inpatient treatment program.

~~(e)~~ (j) If continuation of reasonable efforts ~~described in paragraph (b)~~ to prevent placement or reunify the child with the parent or guardian from whom the child was removed is determined by the court to be inconsistent with the permanent plan for the child~~, or upon a determination~~ or the court making one of the prima facie determinations under paragraph (a), reasonable efforts must be made to place the child in a timely manner in ~~accordance with the permanent plan ordered by the court~~ a safe and permanent home and to complete whatever steps are necessary to legally finalize the permanent ~~plan for~~ placement of the child.

~~(f)~~ (k) Reasonable efforts to place a child for adoption or in another permanent placement may be made concurrently with reasonable efforts ~~as described in paragraphs (a) and (b)~~ to

prevent placement or to reunify the child with the parent or guardian from whom the child was removed. When the responsible social services agency decides to concurrently make reasonable efforts for both reunification and permanent placement away from the parent under ~~paragraphs~~ paragraph (a) ~~and (b)~~, the agency shall disclose its decision and both plans for concurrent reasonable efforts to all parties and the court. When the agency discloses its decision to proceed on both plans for reunification and permanent placement away from the parent, the court's review of the agency's reasonable efforts shall include the agency's efforts under ~~paragraphs (a) and (b)~~ both plans.

Sec. 10. Minnesota Statutes 2004, section 260C.001, subdivision 3, is amended to read:

Subd. 3. [PERMANENCY AND TERMINATION OF PARENTAL RIGHTS.] The purpose of the laws relating to permanency and termination of parental rights is to ensure that:

(1) when required and appropriate, reasonable efforts have been made by the social services agency to reunite the child with the child's parents in a home that is safe and permanent; and

(2) if placement with the parents is not reasonably foreseeable, to secure for the child a safe and permanent placement, preferably with adoptive parents or a fit and willing relative through transfer of permanent legal and physical custody to that relative.

Nothing in this section requires reasonable efforts to prevent placement or to reunify the child with the parent or guardian to be made in circumstances where the court has determined that the child has been subjected to egregious harm ~~or~~, when the child is an abandoned infant, the parent has involuntarily lost custody of another child through a proceeding under section 260C.201, subdivision 11, or similar law of another state, the parental rights of the parent to a sibling have been involuntarily terminated, or the court has determined that reasonable efforts or further reasonable efforts to reunify the child with the parent or guardian would be futile.

The paramount consideration in all proceedings for permanent placement of the child under section 260C.201, subdivision 11, or the termination of parental rights is the best interests of the child. In proceedings involving an American Indian child, as defined in section 260.755, subdivision 8, the best interests of the child must be determined consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et seq.

Sec. 11. Minnesota Statutes 2004, section 260C.007, subdivision 8, is amended to read:

Subd. 8. [COMPELLING REASONS.] "Compelling reasons" means an individualized determination by the responsible social services agency, which is approved by the court, related to a request by the agency not to initiate proceedings to terminate parental rights or transfer permanent legal and physical custody of a child to the child's relative or former noncustodial parent under section 260C.301, subdivision 3.

Sec. 12. Minnesota Statutes 2004, section 260C.151, subdivision 6, is amended to read:

Subd. 6. [IMMEDIATE CUSTODY.] If the court makes individualized, explicit findings, based on the notarized petition or sworn affidavit, that there are reasonable grounds to believe the child is in surroundings or conditions which endanger the child's health, safety, or welfare that require that responsibility for the child's care and custody be immediately assumed by the ~~court~~ responsible social services agency and that continuation of the child in the custody of the parent or guardian is contrary to the child's welfare, the court may order that the officer serving the summons take the child into immediate custody for placement of the child in foster care. In ordering that responsibility for the care, custody, and control of the child be assumed by the responsible social services agency, the court is ordering emergency protective care as that term is defined in the juvenile court rules.

Sec. 13. Minnesota Statutes 2004, section 260C.178, is amended to read:

260C.178 [~~DETENTION~~ EMERGENCY REMOVAL HEARING.]

Subdivision 1. [HEARING AND RELEASE REQUIREMENTS.] (a) If a child was taken into custody under section 260C.175, subdivision 1, clause (a) or (b)(2), the court shall hold a hearing within 72 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue in custody.

(b) Unless there is reason to believe that the child would endanger self or others, not return for a court hearing, run away from the child's parent, guardian, or custodian or otherwise not remain in the care or control of the person to whose lawful custody the child is released, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1. If the court determines there is reason to believe that the child would endanger self or others; not return for a court hearing; run away from the child's parent, guardian, or custodian or otherwise not remain in the care or control of the person to whose lawful custody the child is released; or that the child's health or welfare would be immediately endangered, the court shall order the child into foster care under the responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of protective care as that term is used in the juvenile court rules. In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

(c) The court, before determining whether a child should be placed in or continue in ~~custody~~ foster care under the protective care of the responsible agency, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts~~,--or~~ were made to prevent placement or whether

reasonable efforts to prevent placement are not required. In the case of an Indian child, the court shall determine whether active efforts, according to the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement. The court shall ~~also determine whether there are available services that would prevent the need for further detention. In the alternative,~~ enter a finding that the responsible social services agency has made reasonable efforts to prevent placement when the agency establishes either:

(1) that it has actually provided services or made efforts in an attempt to prevent the child's removal but that such services or efforts have not proven sufficient to permit the child to safely remain in the home; or

(2) that there are no services or other efforts that could be made at the time of the hearing that could safely permit the child to remain home or to return home. When reasonable efforts to prevent placement are required and there are services or other efforts that could be ordered which would permit the child to safely return home, the court shall order the child returned to the care of the parent or guardian and the services or efforts put in place to ensure the child's safety. When the court makes a prima facie determination that one of the circumstances under paragraph (e) exists, the court shall determine that reasonable efforts to prevent placement and to return the child to the care of the parent or guardian are not required ~~if the court makes a prima facie determination that one of the circumstances under paragraph (e) exists~~.

If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(d) The court may not order or continue the foster care placement of the child unless the court makes explicit, individualized findings that continued custody of the child by the parent or guardian would be contrary to the welfare of the

child.

(e) At the ~~detention~~ emergency removal hearing, or at any time during the course of the proceeding, and upon notice and request of the county attorney, the court shall ~~make-the following-determinations:~~

~~(1)~~ determine whether a ~~termination-of-parental-rights~~ petition has been filed stating a prima facie case that:

~~(i)~~ (1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

~~(ii)~~ (2) the parental rights of the parent to another child have been involuntarily terminated; ~~or~~

~~(iii)~~ (3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

~~(2) that~~ (4) the parents' custodial rights to another child have been involuntarily transferred to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction; or

(5) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable.

(f) When a petition to terminate parental rights is required under section 260C.301, subdivision 3 or 4, but the county attorney has determined not to proceed with a termination of parental rights petition ~~under-section-260C.307,-or~~

~~(3)-whether-a-termination-of-parental-rights-petition-or other-petition-according-to-section-260C.201,-subdivision-11, has-been-filed-alleging-a-prima-facie-case-that-the-provision-of services-or-further-services-for-the-purpose-of-rehabilitation and-reunification-is-futile-and-therefore-unreasonable-under-the circumstances.~~

~~If-the-court-determines-that-the-county-attorney-is-not proceeding-with-a-termination-of-parental-rights-petition-under section-260C.307,-but-is-proceeding-with-a-petition-under section-260C.201,-subdivision-11,-the-court-shall-schedule-a permanency-hearing-within-30-days.~~, and has instead filed a petition to transfer permanent legal and physical custody to a relative under section 260C.201, subdivision 11, the court shall

schedule a permanency hearing within 30 days of the filing of the petition.

(g) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260C.201, subdivision 3.

~~(f)~~ (h) If the court determines the child should be ordered into ~~out-of-home placement~~ foster care and the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the responsible social services agency for the purpose of complying with the requirements of sections 260C.151, 260C.212, and 260C.215.

~~(g)~~ (i) If a child ordered into ~~out-of-home placement~~ foster care has siblings, whether full, half, or step, who are also ordered into ~~placement~~ foster care, the court shall inquire of the responsible social services agency of the efforts to place the children together as required by section 260C.212, subdivision 2, paragraph (d), if placement together is in each child's best interests, unless a child is in placement due solely to the child's own behavior or a child is placed with a previously noncustodial parent who is not parent to all siblings. If the children are not placed together at the time of the hearing, the court shall inquire at each subsequent hearing of the agency's efforts to place the siblings together. If any sibling is not placed with another sibling or siblings, the agency must develop a plan for visitation among the siblings as required under section 260C.212, subdivision 1.

~~Subd. 2. [DURATION.] If the court determines that the child should continue in detention, it may order detention continued for eight days, excluding Saturdays, Sundays and holidays, from and including the date of the order. The court shall include in its order the reasons for continued detention~~

~~and the findings of fact which support these reasons.~~

Subd. 3. [PARENTAL VISITATION.] If a child has been taken into custody under section 260C.151, subdivision 5, or 260C.175, subdivision 1, clause (b)(2), and the court determines that the child should continue in ~~detention~~ foster care, the court shall include in its order reasonable rules for supervised or unsupervised parental visitation of the child in the ~~shelter~~ foster care facility unless it finds that visitation would endanger the child's physical or emotional well-being.

Subd. 4. [MENTAL HEALTH TREATMENT.] (a) Except as provided in paragraph (b), a child who is ~~held~~ ordered placed in ~~detention~~ foster care as an alleged victim of child abuse as defined in section 630.36, subdivision 2, may not be given mental health treatment specifically for the effects of the alleged abuse until the court finds that there is ~~probable cause~~ a prima facie basis to believe the abuse has occurred.

(b) A child described in paragraph (a) may be given mental health treatment prior to a ~~probable cause~~ prima facie finding of child abuse if the treatment is either agreed to by the child's parent or guardian in writing, or ordered by the court according to the standard contained in section 260C.201, subdivision 1.

Subd. 5. [COPIES OF ORDER.] Copies of the court's order shall be served upon the parties, including the ~~supervisor of the detention~~ placement facility, ~~who~~ which shall release the child or continue to hold the child as the court orders.

When the court's order is served upon these parties, notice shall also be given to the parties of the subsequent reviews provided by subdivision 6. ~~The notice shall also inform each party of the right to submit to the court for informal review any new evidence regarding whether the child should be continued in detention and to request a hearing to present the evidence to the court.~~

Subd. 6. [REVIEW.] ~~If a child held in detention under a court order issued under subdivision 2 has not been released prior to expiration of the order, the court or referee shall~~

~~informally review the child's case file to determine, under the standards provided by subdivision 1, whether detention should be continued. If detention is continued thereafter, informal reviews such as these shall be held within every eight days, excluding Saturdays, Sundays, and holidays, of the child's detention.~~ When a child is placed in foster care, the child's placement shall be periodically reviewed as required under the juvenile court rules including notice to the parties required to be served with a copy of the order under subdivision 4.

A hearing, ~~rather than an informal review of the child's case file,~~ shall be held at the request of any one of the parties notified pursuant to subdivision 5, if that party notifies the court of a wish to present to the court new evidence concerning whether the child should be continued in detention or notifies the court of a wish to present an alternate placement arrangement to provide for the safety and protection of the child.

In addition, if a child was taken into ~~detention~~ custody under section 260C.151, subdivision 5, or 260C.175, subdivision 1, clause (c)(2), and is ~~held~~ placed in ~~detention~~ foster care or placed in another facility under a court order issued under subdivision 2, the court shall schedule and hold an adjudicatory hearing on the petition within 60 days of the ~~detention~~ emergency removal hearing upon the request of any party to the proceeding. However, if good cause is shown by a party to the proceeding why the hearing should not be held within that time period, the hearing shall be held within 90 days, unless the parties agree otherwise and the court so orders.

Subd. 7. [OUT-OF-HOME PLACEMENT PLAN.] (a) An out-of-home placement plan required under section 260C.212 shall be filed with the court within 30 days of the filing of a petition alleging the child to be in need of protection or services under section 260C.141, subdivision 1, or filed with the petition if the petition is a review of a voluntary placement under section 260C.141, subdivision 2.

(b) Upon the filing of the out-of-home placement plan which

has been developed jointly with the parent and in consultation with others as required under section 260C.212, subdivision 1, the court may approve implementation of the plan by the responsible social services agency based on the allegations contained in the petition. The court shall send written notice of the approval of the out-of-home placement plan to all parties and the county attorney or may state such approval on the record at a hearing. A parent may agree to comply with the terms of the plan filed with the court.

~~(c) Upon notice and motion by a parent who agrees to comply with the terms of an out-of-home placement plan, the court may modify the plan and order the responsible social services agency to provide other or additional services for reunification, if reunification efforts are required, and the court determines the agency's plan inadequate under section 260.012.~~ If, after reasonable attempts by the responsible social services agency to engage a parent in case planning, the parent refuses to cooperate in the development of the out-of-home placement plan or disagrees with the services recommended by the responsible social service agency, the agency shall note such refusal or disagreement for the court in the out-of-home placement plan filed with the court. The agency shall notify the court of the services it will provide or efforts it will attempt under the plan notwithstanding the parent's refusal to cooperate or disagreement with the services, and the court may approve the plan based on the content of the petition.

(d) Unless the parent agrees to comply with the terms of the out-of-home placement plan, the court may not order a parent to comply with the provisions of the plan until the court ~~makes a determination~~ finds the child is in need of protection or services and orders disposition under section 260C.201, subdivision 1. However, the court may find that the responsible social services agency has made reasonable efforts for reunification if the agency makes efforts to implement the terms of an out-of-home placement plan approved under this section.

Sec. 14. Minnesota Statutes 2004, section 260C.201,

subdivision 1, is amended to read:

Subdivision 1. [DISPOSITIONS.] (a) If the court finds that the child is in need of protection or services or neglected and in foster care, it shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, he must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in his home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In ~~placing~~ making a foster care placement for a child whose custody has been transferred under this ~~paragraph~~ subdivision, the ~~agencies~~ agency shall make an individualized determination of how the placement is in the child's best interests using the consideration for relatives and the best interest factors in section 260C.212, subdivision 2, paragraph (b); or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed

for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit and remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order which describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or conduct a permanency hearing under subdivision 11 or 11a. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months.

(4) If the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental

disability, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

~~(4)~~ (5) If the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents,

guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child; or with the consent of the commissioner of corrections, place the child in a group foster care facility which is under the commissioner's management and supervision;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child and of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public

safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to

monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

Sec. 15. Minnesota Statutes 2004, section 260C.201, subdivision 10, is amended to read:

Subd. 10. [COURT REVIEW OF ~~OUT-OF-HOME PLACEMENTS~~ FOSTER CARE.] (a) If the court ~~places~~ orders a child placed in ~~a residential facility, as defined in section 260C.212, subdivision 1~~ foster care, the court shall review the out-of-home placement at least every 90 days as required in juvenile court rules to determine whether continued out-of-home placement is necessary and appropriate or whether the child should be returned home. This review is not required if the court has returned the child home, ordered the child permanently placed away from the parent under subdivision 11, or terminated rights under section 260C.301. Court review for a child permanently placed away from a parent, including where the child is under guardianship and legal custody of the commissioner, shall be governed by subdivision 11 or section 260C.317, subdivision 3, whichever is applicable.

(b) No later than six months after the child's ~~out-of-home~~ placement in foster care, the court shall review agency efforts pursuant to section 260C.212, subdivision 2, and order that the efforts continue if the agency has failed to perform the duties under that section.

(c) The court shall review the out-of-home placement plan and may modify the plan as provided under subdivisions 6 and 7.

(d) When the court orders ~~out-of-home placement~~ transfer of custody to a responsible social services agency resulting in foster care or protective supervision with a noncustodial parent under subdivision 1, the court shall notify the parents of the provisions of subdivisions 11 and 11a as required under juvenile court rules.

Sec. 16. Minnesota Statutes 2004, section 260C.201, subdivision 11, is amended to read:

Subd. 11. [REVIEW OF COURT-ORDERED PLACEMENTS; PERMANENT

PLACEMENT DETERMINATION.] (a) This subdivision and subdivision 11a do not apply in cases where the child is in placement due solely to the child's developmental disability or emotional disturbance, where legal custody has not been transferred to the responsible social services agency, and where the court finds compelling reasons under section 260C.007, subdivision 8, to continue the child in foster care past the time periods specified in this subdivision. Foster care placements of children due solely to their disability are governed by section 260C.141, subdivision 2b. In all other cases where the child is in foster care or in the care of a noncustodial parent under subdivision 1, the court shall ~~conduct a hearing~~ commence proceedings to determine the permanent status of a child not later than 12 months after the child is placed in foster care or in the care of a noncustodial parent. At the admit-deny hearing commencing such proceedings, the court shall determine whether there is a prima facie basis for finding that the agency made reasonable efforts, or in the case of an Indian child active efforts, required under section 260.012 and proceed according to the rules of juvenile court.

For purposes of this subdivision, the date of the child's placement in foster care is the earlier of the first court-ordered placement or 60 days after the date on which the child has been voluntarily placed in foster care by the child's parent or guardian. For purposes of this subdivision, time spent by a child under the protective supervision of the responsible social services agency in the home of a noncustodial parent pursuant to an order under subdivision 1 counts towards the requirement of a permanency hearing under this subdivision or subdivision 11a. Time spent on a trial home visit does not count towards the requirement of a permanency hearing under this subdivision or subdivision 11a.

For purposes of this subdivision, 12 months is calculated as follows:

(1) during the pendency of a petition alleging that a child is in need of protection or services, all time periods when a

child is placed in foster care or in the home of a noncustodial parent are cumulated;

(2) if a child has been placed in foster care within the previous five years under one or more previous petitions, the lengths of all prior time periods when the child was placed in foster care within the previous five years are cumulated. If a child under this clause has been in foster care for 12 months or more, the court, if it is in the best interests of the child and for compelling reasons, may extend the total time the child may continue out of the home under the current petition up to an additional six months before making a permanency determination.

(b) Unless the responsible social services agency recommends return of the child to the custodial parent or parents, not later than 30 days prior to ~~this~~ the admit-deny hearing required under paragraph (a) and the rules of juvenile court, the responsible social services agency shall file pleadings in juvenile court to establish the basis for the juvenile court to order permanent placement of the child, including a termination of parental rights petition, according to paragraph (d). Notice of the hearing and copies of the pleadings must be provided pursuant to section 260C.152. ~~If a termination of parental rights petition is filed before the date required for the permanency planning determination and there is a trial under section 260C.163 scheduled on that petition within 90 days of the filing of the petition, no hearing need be conducted under this subdivision.~~

(c) The permanency proceedings shall be conducted in a timely fashion including that any trial required under section 260C.163 shall be commenced within 60 days of the admit-deny hearing required under paragraph (a). At the conclusion of the ~~hearing~~ permanency proceedings, the court shall:

(1) order the child returned to the care of the parent or guardian from whom the child was removed; or

(2) order a permanent placement or termination of parental rights if permanent placement or termination of parental rights is in the child's best interests. The "best interests of the

child" means all relevant factors to be considered and evaluated. Transfer of permanent legal and physical custody, termination of parental rights, or guardianship and legal custody to the commissioner through a consent to adopt are preferred permanency options for a child who cannot return home.

(d) If the child is not returned to the home, the court must order one of the following dispositions:

(1) permanent legal and physical custody to a relative in the best interests of the child according to the following conditions:

(i) an order for transfer of permanent legal and physical custody to a relative shall only be made after the court has reviewed the suitability of the prospective legal and physical custodian;

(ii) in transferring permanent legal and physical custody to a relative, the juvenile court shall follow the standards applicable under this chapter and chapter 260, and the procedures set out in the juvenile court rules;

(iii) an order establishing permanent legal and physical custody under this subdivision must be filed with the family court;

(iv) a transfer of legal and physical custody includes responsibility for the protection, education, care, and control of the child and decision making on behalf of the child;

(v) the social services agency may bring a petition or motion naming a fit and willing relative as a proposed permanent legal and physical custodian. The commissioner of human services shall annually prepare for counties information that must be given to proposed custodians about their legal rights and obligations as custodians together with information on financial and medical benefits for which the child is eligible; and

(vi) the juvenile court may maintain jurisdiction over the responsible social services agency, the parents or guardian of the child, the child, and the permanent legal and physical custodian for purposes of ensuring appropriate services are

delivered to the child and permanent legal custodian or for the purpose of ensuring conditions ordered by the court related to the care and custody of the child are met;

(2) termination of parental rights when the requirements of sections 260C.301 to 260C.328 are met or according to the following conditions:

(i) ~~unless~~ order the social services agency ~~has already filed~~ to file a petition for termination of parental rights ~~under section 260C.307, the court may order such a petition filed and~~ in which case all the requirements of sections 260C.301 to 260C.328 remain applicable; and

(ii) an adoption completed subsequent to a determination under this subdivision may include an agreement for communication or contact under section 259.58;

(3) long-term foster care according to the following conditions:

(i) the court may order a child into long-term foster care only if it ~~finds~~ approves the responsible social service agency's compelling reasons that neither an award of permanent legal and physical custody to a relative, nor termination of parental rights is in the child's best interests; ~~and~~

(ii) further, the court may only order long-term foster care for the child under this section if it finds the following:

(A) the child has reached age 12 and ~~reasonable efforts by~~ the responsible social services agency ~~have failed~~ has made reasonable efforts to locate and place the child with an adoptive family ~~for the child~~ or with a fit and willing relative who will agree to a transfer of permanent legal and physical custody of the child, but such efforts have not proven successful; or

(B) the child is a sibling of a child described in subitem (A) and the siblings have a significant positive relationship and are ordered into the same long-term foster care home; and

(iii) at least annually, the responsible social services agency reconsiders its provision of services to the child and the child's placement in long-term foster care to ensure that:

(A) long-term foster care continues to be the most appropriate legal arrangement for meeting the child's need for permanency and stability, including whether there is another permanent placement option under this chapter that would better serve the child's needs and best interests;

(B) whenever possible, there is an identified long-term foster care family that is committed to being the foster family for the child as long as the child is a minor or under the jurisdiction of the court;

(C) the child is receiving appropriate services or assistance to maintain or build connections with the child's family and community;

(D) the child's physical and mental health needs are being appropriately provided for; and

(E) the child's educational needs are being met;

(4) foster care for a specified period of time according to the following conditions:

(i) foster care for a specified period of time may be ordered only if:

(A) the sole basis for an adjudication that the child is in need of protection or services is the child's behavior;

(B) the court finds that foster care for a specified period of time is in the best interests of the child; and

(C) the court ~~finds~~ approves the responsible social services agency's compelling reasons that neither an award of permanent legal and physical custody to a relative, nor termination of parental rights is in the child's best interests;

(ii) the order does not specify that the child continue in foster care for any period exceeding one year; or

(5) guardianship and legal custody to the commissioner of human services under the following procedures and conditions:

(i) there is an identified prospective adoptive home agreed to by the responsible social services agency that has agreed to adopt the child and the court accepts the parent's voluntary consent to adopt under section 259.24, except that such consent executed by a parent under this item shall be irrevocable unless

fraud is established and an order issues permitting revocation as stated in item (vii);

(ii) if the court accepts a consent to adopt in lieu of ordering one of the other enumerated permanency dispositions, the court must review the matter at least every 90 days. The review will address the reasonable efforts of the agency to achieve a finalized adoption;

(iii) a consent to adopt under this clause vests all legal authority regarding the child, including guardianship and legal custody of the child, with the commissioner of human services as if the child were a state ward after termination of parental rights;

(iv) the court must forward a copy of the consent to adopt, together with a certified copy of the order transferring guardianship and legal custody to the commissioner, to the commissioner; ~~and~~

(v) if an adoption is not finalized by the identified prospective adoptive parent within 12 months of the execution of the consent to adopt under this clause, the commissioner of human services or the commissioner's delegate shall pursue adoptive placement in another home unless the commissioner certifies that the failure to finalize is not due to either an action or a failure to act by the prospective adoptive parent;

(vi) notwithstanding item (v), as soon as the commissioner or commissioner's delegate determines that finalization of the adoption with the identified prospective adoptive parent is not possible, that the prospective adoptive parent is not cooperative in completing the steps necessary to finalize the adoption, or upon the commissioner's determination to withhold consent to the adoption under chapter 259, the commissioner or commissioner's delegate shall pursue adoptive placement in another home; and

(vii) unless otherwise required by the Indian Child Welfare Act, United States Code, title 25, section 1913, a consent to adopt executed under this section shall be irrevocable upon acceptance by the court except upon order permitting revocation

issued by the same court after written findings that consent was obtained by fraud.

(e) In ordering a permanent placement of a child, the court must be governed by the best interests of the child, including a review of the relationship between the child and relatives and the child and other important persons with whom the child has resided or had significant contact.

(f) Once a permanent placement determination has been made and permanent placement has been established, further court reviews are necessary if:

(1) the placement is long-term foster care or foster care for a specified period of time;

(2) the court orders further hearings because it has retained jurisdiction of a transfer of permanent legal and physical custody matter;

(3) an adoption has not yet been finalized; or

(4) there is a disruption of the permanent or long-term placement.

(g) Court reviews of an order for long-term foster care, whether under this section or section 260C.317, subdivision 3, paragraph (d), ~~or foster care for a specified period of time~~ must be conducted at least yearly and must review the child's out-of-home placement plan and the reasonable efforts of the agency to finalize the permanent plan for the child including the agency's efforts to:

(1) ensure that long-term foster care continues to be the most appropriate legal arrangement for meeting the child's need for permanency and stability or, if not, to identify and attempt to finalize another permanent placement option under this chapter that would better serve the child's needs and best interests;

(2) identify a specific long-term foster home for the child ~~or a specific foster home for the time the child is specified to be out of the care of the parent~~, if one has not already been identified;

~~(2)~~ (3) support continued placement of the child in the

identified home, if one has been identified;

~~(3)~~ (4) ensure appropriate services are provided to address the physical health, mental health, and educational needs of the child during the period of long-term foster care ~~or foster care for a specified period of time~~ and also ensure appropriate services or assistance to maintain relationships with appropriate family members and the child's community; and

~~(4)~~ (5) plan for the child's independence upon the child's leaving long-term foster care living as required under section 260C.212, subdivision 1~~, and~~

~~(5) where placement is for a specified period of time, a plan for the safe return of the child to the care of the parent~~.

(h) In the event it is necessary for a child that has been ordered into foster care for a specified period of time to be in foster care longer than one year after the permanency hearing held under this section, not later than 12 months after the time the child was ordered into foster care for a specified period of time, the matter must be returned to court for a review of the appropriateness of continuing the child in foster care and of the responsible social services agency's reasonable efforts to finalize a permanent plan for the child; if it is in the child's best interests to continue the order for foster care for a specified period of time past a total of 12 months, the court shall set objectives for the child's continuation in foster care, specify any further amount of time the child may be in foster care, and review the plan for the safe return of the child to the parent.

(i) An order ~~under this subdivision~~ permanently placing a child out of the home of the parent or guardian must include the following detailed findings:

(1) how the child's best interests are served by the order;

(2) the nature and extent of the responsible social service agency's reasonable efforts, or, in the case of an Indian child, active efforts to reunify the child with the parent or ~~parents~~ guardian where reasonable efforts are required;

(3) the parent's or parents' efforts and ability to use

services to correct the conditions which led to the out-of-home placement; and

(4) ~~whether~~ that the conditions which led to the out-of-home placement have not been corrected so that the child can safely return home.

~~(i)~~ (j) An order for permanent legal and physical custody of a child may be modified under sections 518.18 and 518.185. The social services agency is a party to the proceeding and must receive notice. A parent may only seek modification of an order for long-term foster care upon motion and a showing by the parent of a substantial change in the parent's circumstances such that the parent could provide appropriate care for the child and that removal of the child from the child's permanent placement and the return to the parent's care would be in the best interest of the child. The responsible social services agency may ask the court to vacate an order for long-term foster care upon a prima facie showing that there is a factual basis for the court to order another permanency option under this chapter and that such an option is in the child's best interests. Upon a hearing where the court determines that there is a factual basis for vacating the order for long-term foster care and that another permanent order regarding the placement of the child is in the child's best interests, the court may vacate the order for long-term foster care and enter a different order for permanent placement that is in the child's best interests. The court shall not require further reasonable efforts to reunify the child with the parent or guardian as a basis for vacating the order for long-term foster care and ordering a different permanent placement in the child's best interests. The county attorney must file pleadings and give notice as required under the rules of juvenile court in order to modify an order for long-term foster care under this paragraph.

~~(j)~~ (k) The court shall issue an order required under this section within 15 days of the close of the proceedings. The court may extend issuing the order an additional 15 days when necessary in the interests of justice and the best interests of

the child.

Sec. 17. Minnesota Statutes 2004, section 260C.312, is amended to read:

260C.312 [DISPOSITION; PARENTAL RIGHTS NOT TERMINATED.]

(a) If, after a hearing, the court does not terminate parental rights but determines that the child is in need of protection or services, or that the child is neglected and in foster care, the court may find the child is in need of protection or services or neglected and in foster care and may enter an order in accordance with the provisions of section 260C.201.

(b) When a child has been in placement 15 of the last 22 months after a trial on a termination of parental rights petition, if the court finds that the petition is not proven or that termination of parental rights is not in the child's best interests, the court must order the child returned to the care of the parent unless the court ~~finds~~ approves the responsible social services agency's determination of compelling reasons why the child should remain out of the care of the parent. If the court orders the child returned to the care of the parent, the court may order a trial home visit, protective supervision, or monitoring under section 260C.201.

Sec. 18. Minnesota Statutes 2004, section 260C.317, subdivision 3, is amended to read:

Subd. 3. [ORDER; RETENTION OF JURISDICTION.] (a) A certified copy of the findings and the order terminating parental rights, and a summary of the court's information concerning the child shall be furnished by the court to the commissioner or the agency to which guardianship is transferred. The orders shall be on a document separate from the findings. The court shall furnish the individual to whom guardianship is transferred a copy of the order terminating parental rights.

(b) The court shall retain jurisdiction in a case where adoption is the intended permanent placement disposition until the child's adoption is finalized, the child is 18 years of age,

or the child is otherwise ordered discharged from the jurisdiction of the court. The guardian ad litem and counsel for the child shall continue on the case until an adoption decree is entered. A hearing must be held every 90 days following termination of parental rights for the court to review progress toward an adoptive placement and the specific recruitment efforts the agency has taken to find an adoptive family or other placement living arrangement for the child and to finalize the adoption or other permanency plan.

(c) ~~When adoption is not the intended disposition~~ The responsible social services agency may make a determination of compelling reasons for a child to be in long-term foster care when the agency has made exhaustive efforts to recruit, identify, and place the child in an adoptive home, and ~~if~~ the child continues in ~~out-of-home placement~~ foster care for ~~12~~ at least 24 months after the court has issued the order terminating parental rights ~~and~~. Upon approving the agency's determination of compelling reasons, the court may order the child placed in long-term foster care. At least every 12 months thereafter as long as the child continues in out-of-home placement, the court shall conduct a permanency review hearing to determine the future status of the child~~, including, but not limited to, whether the child should be continued in out-of-home placement, should be placed for adoption, or should, because of the child's special needs and for compelling reasons, be ordered into long-term out-of-home placement~~ using the review requirements of section 260C.201, subdivision 11, paragraph (g).

(d) The court shall retain jurisdiction through the child's minority in a case where long-term foster care is the permanent disposition whether under paragraph (c) or section 260C.201, subdivision 11. ~~All of the review requirements under section 260C.201, subdivision 11, paragraph (g), apply.~~

ARTICLE 3

CHILD CARE

Section 1. Minnesota Statutes 2004, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. [FACTORS WHICH MUST BE VERIFIED.] (a) The county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) If a family did not use the universal application or child care addendum to apply for child care assistance, the family must complete the universal application or child care addendum at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application or child care addendum, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations. Eligibility must be redetermined at least every six months. If a family reports a change in an eligibility factor before the family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change.

(c) The commissioner shall develop a ~~recertification~~ redetermination form to redetermine eligibility and a change report form to report changes that ~~minimizes~~ minimize paperwork for the county and the participant.

Sec. 2. Minnesota Statutes 2004, section 119B.03,

subdivision 6, is amended to read:

Subd. 6. [ALLOCATION FORMULA.] The basic sliding fee state and federal funds shall be allocated on a calendar year basis. Funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 8, with any remaining available funds allocated according to the following formula:

(a) One-fourth of the funds shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation.

(b) One-fourth of the funds shall be allocated based on the number of families participating in the transition year child care program as reported during the most recent quarter completed at the time of the notice of allocation.

(c) One-fourth of the funds shall be allocated in proportion to each county's most recently reported first, second, and third priority waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1.

(d) One-fourth of the funds must be allocated in proportion to each county's most recently reported waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1.

Sec. 3. Minnesota Statutes 2004, section 119B.09, subdivision 4, is amended to read:

Subd. 4. [ELIGIBILITY; ANNUAL INCOME; CALCULATION.] Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family. Self-employment income must be calculated based on gross receipts less operating expenses. Income must be ~~redetermined~~ recalculated when the family's income changes, but no less often than every six

months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

Sec. 4. Minnesota Statutes 2004, section 119B.09, subdivision 9, is amended to read:

Subd. 9. [LICENSED AND LEGAL NONLICENSED FAMILY CHILD CARE PROVIDERS; ASSISTANCE.] Licensed and legal nonlicensed family child care providers are not eligible to receive child care assistance subsidies under this chapter for their own children or children in their ~~custody.~~ family during the hours they are providing child care or being paid to provide child care. Child care providers are eligible to receive child care assistance subsidies for their children when they are engaged in other activities that meet the requirements of this chapter and for which child care assistance can be paid. The hours for which the provider receives a child care subsidy for their own children must not overlap with the hours the provider provides child care services.

ARTICLE 4

CHILD SUPPORT

Section 1. Minnesota Statutes 2004, section 256.978, subdivision 2, is amended to read:

Subd. 2. [ACCESS TO INFORMATION.] (a) A request for information by the public authority responsible for child support of this state or any other state may be made to:

(1) employers when there is reasonable cause to believe that the subject of the inquiry is or was an employee or independent contractor of the employer. Information to be released by employers of employees is limited to place of residence, employment status, wage or payment information, benefit information, and Social Security number. Information to be released by employers of independent contractors is limited to place of residence or address, contract status, payment information, benefit information, and Social Security number or identification number;

(2) utility companies when there is reasonable cause to

believe that the subject of the inquiry is or was a retail customer of the utility company. Customer information to be released by utility companies is limited to place of residence, home telephone, work telephone, source of income, employer and place of employment, and Social Security number;

(3) insurance companies when there is reasonable cause to believe that the subject of the inquiry is or was receiving funds either in the form of a lump sum or periodic payments. Information to be released by insurance companies is limited to place of residence, home telephone, work telephone, employer, Social Security number, and amounts and type of payments made to the subject of the inquiry;

(4) labor organizations when there is reasonable cause to believe that the subject of the inquiry is or was a member of the labor association. Information to be released by labor associations is limited to place of residence, home telephone, work telephone, Social Security number, and current and past employment information; and

(5) financial institutions when there is reasonable cause to believe that the subject of the inquiry has or has had accounts, stocks, loans, certificates of deposits, treasury bills, life insurance policies, or other forms of financial dealings with the institution. Information to be released by the financial institution is limited to place of residence, home telephone, work telephone, identifying information on the type of financial relationships, Social Security number, current value of financial relationships, and current indebtedness of the subject with the financial institution.

(b) For purposes of this subdivision, utility companies include telephone companies, radio common carriers, and telecommunications carriers as defined in section 237.01, and companies that provide electrical, telephone, natural gas, propane gas, oil, coal, or cable television services to retail customers. The term financial institution includes banks, savings and loans, credit unions, brokerage firms, mortgage companies, insurance companies, benefit associations, safe

deposit companies, money market mutual funds, or similar entities authorized to do business in the state.

(c) For purposes of this section, the public authority may request or obtain information from any person or entity enumerated in this section, or from any third party who contracts with any such person or entity to obtain or retain information that may be requested by the public authority.

Sec. 2. Minnesota Statutes 2004, section 518.551, subdivision 5, is amended to read:

Subd. 5. [NOTICE TO PUBLIC AUTHORITY; GUIDELINES.] (a) The petitioner shall notify the public authority of all proceedings for dissolution, legal separation, determination of parentage or for the custody of a child, if either party is receiving public assistance or applies for it subsequent to the commencement of the proceeding. The notice must contain the full names of the parties to the proceeding, their Social Security account numbers, and their birth dates. After receipt of the notice, the court shall set child support as provided in this subdivision. The court may order either or both parents owing a duty of support to a child of the marriage to pay an amount reasonable or necessary for the child's support, without regard to marital misconduct. The court shall approve a child support stipulation of the parties if each party is represented by independent counsel, unless the stipulation does not meet the conditions of paragraph (i). In other cases the court shall determine and order child support in a specific dollar amount in accordance with the guidelines and the other factors set forth in paragraph (c) and any departure therefrom. The court may also order the obligor to pay child support in the form of a percentage share of the obligor's net bonuses, commissions, or other forms of compensation, in addition to, or if the obligor receives no base pay, in lieu of, an order for a specific dollar amount.

(b) The court shall derive a specific dollar amount for child support by multiplying the obligor's net income by the percentage indicated by the following guidelines:

Net Income Per Month of Obligor	Number of Children						
	1	2	3	4	5	6	7 or more
$550 and Below	Order based on the ability of the obligor to provide support at these income levels, or at higher levels, if the obligor has the earning ability.						
$551 - 600	16%	19%	22%	25%	28%	30%	32%
$601 - 650	17%	21%	24%	27%	29%	32%	34%
$651 - 700	18%	22%	25%	28%	31%	34%	36%
$701 - 750	19%	23%	27%	30%	33%	36%	38%
$751 - 800	20%	24%	28%	31%	35%	38%	40%
$801 - 850	21%	25%	29%	33%	36%	40%	42%
$851 - 900	22%	27%	31%	34%	38%	41%	44%
$901 - 950	23%	28%	32%	36%	40%	43%	46%
$951 - 1000	24%	29%	34%	38%	41%	45%	48%
$1001- 5000 or the amount in effect under paragraph (k)	25%	30%	35%	39%	43%	47%	50%

Guidelines for support for an obligor with a monthly income in excess of the income limit currently in effect under paragraph (k) shall be the same dollar amounts as provided for in the guidelines for an obligor with a monthly income equal to the limit in effect.

Net Income defined as:

Total monthly income less

*(i) Federal Income Tax

*(ii) State Income Tax

(iii) Social Security Deductions

(iv) Reasonable Pension Deductions

	*Standard Deductions apply- use of tax tables recommended	(v) Union Dues (vi) Cost of Dependent Health Insurance Coverage (vii) Cost of Individual or Group Health/Hospitalization Coverage or an Amount for Actual Medical Expenses (viii) A Child Support or Maintenance Order ~~that is currently being paid~~, not including payments or orders for child support or maintenance debts or arrears.

"Net income" does not include:

(1) the income of the obligor's spouse, but does include in-kind payments received by the obligor in the course of employment, self-employment, or operation of a business if the payments reduce the obligor's living expenses; or

(2) compensation received by a party for employment in excess of a 40-hour work week, provided that:

(i) support is nonetheless ordered in an amount at least equal to the guidelines amount based on income not excluded under this clause; and

(ii) the party demonstrates, and the court finds, that:

(A) the excess employment began after the filing of the petition for dissolution;

(B) the excess employment reflects an increase in the work schedule or hours worked over that of the two years immediately preceding the filing of the petition;

(C) the excess employment is voluntary and not a condition of employment;

(D) the excess employment is in the nature of additional, part-time or overtime employment compensable by the hour or

fraction of an hour; and

(E) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation.

The court shall review the work-related and education-related child care costs paid and shall allocate the costs to each parent in proportion to each parent's net income, as determined under this subdivision, after the transfer of child support and spousal maintenance, unless the allocation would be substantially unfair to either parent. There is a presumption of substantial unfairness if after the sum total of child support, spousal maintenance, and child care costs is subtracted from the obligor's income, the income is at or below 100 percent of the federal poverty guidelines. The cost of child care for purposes of this paragraph is 75 percent of the actual cost paid for child care, to reflect the approximate value of state and federal tax credits available to the obligee. The actual cost paid for child care is the total amount received by the child care provider for the child or children of the obligor from the obligee or any public agency. The court shall require verification of employment or school attendance and documentation of child care expenses from the obligee and the public agency, if applicable. If child care expenses fluctuate during the year because of seasonal employment or school attendance of the obligee or extended periods of parenting time with the obligor, the court shall determine child care expenses based on an average monthly cost. The amount allocated for child care expenses is considered child support but is not subject to a cost-of-living adjustment under section 518.641. If a court order provides for child care expenses and the public authority provides child support enforcement services, the collection of the amount allocated for child care expenses ~~terminates~~ must be suspended when either party ~~notifies~~ informs the public authority that ~~the~~ no child care costs ~~have ended and without any legal action on the part of either party~~ are being incurred and the public authority verifies the accuracy of the information with the other party.

The public authority shall ~~verify the information received under this provision before authorizing termination. The termination is effective as of the date of the notification.~~ resume collection of the amount allocated for child care expenses when either party provides information that child care costs have resumed. If the parties provide conflicting information to the public authority regarding whether or not child care expenses are being incurred, the collection of the amount allocated for child care expenses must continue or resume. Either party, through motion to the court, may challenge the suspension or resumption of the collection of the amount allocated for child care expenses. All provisions of the court order remain in effect even though the public authority suspends collection activities for the amount allocated for child care expenses. In these and other cases where there is a substantial increase or decrease in child care expenses, the parties may modify the order under section 518.64.

The court may allow the obligor parent to care for the child while the obligee parent is working, as provided in section 518.175, subdivision 8, but this is not a reason to deviate from the guidelines.

(c) In addition to the child support guidelines, the court shall take into consideration the following factors in setting or modifying child support or in determining whether to deviate from the guidelines:

(1) all earnings, income, and resources of the parents, including real and personal property, but excluding income from excess employment of the obligor or obligee that meets the criteria of paragraph (b), clause (2)(ii);

(2) the financial needs and resources, physical and emotional condition, and educational needs of the child or children to be supported;

(3) the standard of living the child would have enjoyed had the marriage not been dissolved, but recognizing that the parents now have separate households;

(4) which parent receives the income taxation dependency

exemption and what financial benefit the parent receives from it;

(5) the parents' debts as provided in paragraph (d); and

(6) the obligor's receipt of public assistance under the AFDC program formerly codified under sections 256.72 to 256.82 or 256B.01 to 256B.40 and chapter 256J or 256K.

(d) In establishing or modifying a support obligation, the court may consider debts owed to private creditors, but only if:

(1) the right to support has not been assigned under section 256.741;

(2) the court determines that the debt was reasonably incurred for necessary support of the child or parent or for the necessary generation of income. If the debt was incurred for the necessary generation of income, the court shall consider only the amount of debt that is essential to the continuing generation of income; and

(3) the party requesting a departure produces a sworn schedule of the debts, with supporting documentation, showing goods or services purchased, the recipient of them, the amount of the original debt, the outstanding balance, the monthly payment, and the number of months until the debt will be fully paid.

(e) Any schedule prepared under paragraph (d), clause (3), shall contain a statement that the debt will be fully paid after the number of months shown in the schedule, barring emergencies beyond the party's control.

(f) Any further departure below the guidelines that is based on a consideration of debts owed to private creditors shall not exceed 18 months in duration, after which the support shall increase automatically to the level ordered by the court. Nothing in this section shall be construed to prohibit one or more step increases in support to reflect debt retirement during the 18-month period.

(g) If payment of debt is ordered pursuant to this section, the payment shall be ordered to be in the nature of child support.

(h) Nothing shall preclude the court from receiving evidence on the above factors to determine if the guidelines should be exceeded or modified in a particular case.

(i) The guidelines in this subdivision are a rebuttable presumption and shall be used in all cases when establishing or modifying child support. If the court does not deviate from the guidelines, the court shall make written findings concerning the amount of the obligor's income used as the basis for the guidelines calculation and any other significant evidentiary factors affecting the determination of child support. If the court deviates from the guidelines, the court shall make written findings giving the amount of support calculated under the guidelines, the reasons for the deviation, and shall specifically address the criteria in paragraph (c) and how the deviation serves the best interest of the child. The court may deviate from the guidelines if both parties agree and the court makes written findings that it is in the best interests of the child, except that in cases where child support payments are assigned to the public agency under section 256.741, the court may deviate downward only as provided in paragraph (j). Nothing in this paragraph prohibits the court from deviating in other cases. The provisions of this paragraph apply whether or not the parties are each represented by independent counsel and have entered into a written agreement. The court shall review stipulations presented to it for conformity to the guidelines and the court is not required to conduct a hearing, but the parties shall provide the documentation of earnings required under subdivision 5b.

(j) If the child support payments are assigned to the public agency under section 256.741, the court may not deviate downward from the child support guidelines unless the court specifically finds that the failure to deviate downward would impose an extreme hardship on the obligor.

(k) The dollar amount of the income limit for application of the guidelines must be adjusted on July 1 of every even-numbered year to reflect cost-of-living changes. The

Supreme Court shall select the index for the adjustment from the indices listed in section 518.641. The state court administrator shall make the changes in the dollar amount required by this paragraph available to courts and the public on or before April 30 of the year in which the amount is to change.

(l) In establishing or modifying child support, if a child receives a child's insurance benefit under United States Code, title 42, section 402, because the obligor is entitled to old age or disability insurance benefits, the amount of support ordered shall be offset by the amount of the child's benefit. The court shall make findings regarding the obligor's income from all sources, the child support amount calculated under this section, the amount of the child's benefit, and the obligor's child support obligation. Any benefit received by the child in a given month in excess of the child support obligation shall not be treated as an arrearage payment or a future payment.

Sec. 3. Minnesota Statutes 2004, section 518.68, subdivision 2, is amended to read:

Subd. 2. [CONTENTS.] The required notices must be substantially as follows:

IMPORTANT NOTICE

1. PAYMENTS TO PUBLIC AGENCY

According to Minnesota Statutes, section 518.551, subdivision 1, payments ordered for maintenance and support must be paid to the public agency responsible for child support enforcement as long as the person entitled to receive the payments is receiving or has applied for public assistance or has applied for support and maintenance collection services. MAIL PAYMENTS TO:

2. DEPRIVING ANOTHER OF CUSTODIAL OR PARENTAL RIGHTS -- A FELONY

A person may be charged with a felony who conceals a minor child or takes, obtains, retains, or fails to return a minor child from or to the child's parent (or person with custodial or visitation rights), according to Minnesota Statutes, section 609.26. A copy of that section is

available from any district court clerk.

3. NONSUPPORT OF A SPOUSE OR CHILD -- CRIMINAL PENALTIES

A person who fails to pay court-ordered child support or maintenance may be charged with a crime, which may include misdemeanor, gross misdemeanor, or felony charges, according to Minnesota Statutes, section 609.375. A copy of that section is available from any district court clerk.

4. RULES OF SUPPORT, MAINTENANCE, PARENTING TIME

(a) Payment of support or spousal maintenance is to be as ordered, and the giving of gifts or making purchases of food, clothing, and the like will not fulfill the obligation.

(b) Payment of support must be made as it becomes due, and failure to secure or denial of parenting time is NOT an excuse for nonpayment, but the aggrieved party must seek relief through a proper motion filed with the court.

(c) Nonpayment of support is not grounds to deny parenting time. The party entitled to receive support may apply for support and collection services, file a contempt motion, or obtain a judgment as provided in Minnesota Statutes, section 548.091.

(d) The payment of support or spousal maintenance takes priority over payment of debts and other obligations.

(e) A party who accepts additional obligations of support does so with the full knowledge of the party's prior obligation under this proceeding.

(f) Child support or maintenance is based on annual income, and it is the responsibility of a person with seasonal employment to budget income so that payments are made throughout the year as ordered.

(g) If the obligor is laid off from employment or receives a pay reduction, support may be reduced, but only if a motion to reduce the support is served and filed with the court. Any reduction will take effect only if ordered by the court and may only relate back to the time that the motion is filed. If a motion is not filed, the support

obligation will continue at the current level. The court is not permitted to reduce support retroactively, except as provided in Minnesota Statutes, section 518.64, subdivision 2, paragraph (c).

(h) Reasonable parenting time guidelines are contained in Appendix B, which is available from the court administrator.

(i) The nonpayment of support may be enforced through the denial of student grants; interception of state and federal tax refunds; suspension of driver's, recreational, and occupational licenses; referral to the department of revenue or private collection agencies; seizure of assets, including bank accounts and other assets held by financial institutions; reporting to credit bureaus; interest charging, income withholding, and contempt proceedings; and other enforcement methods allowed by law.

(j) The public authority may suspend or resume collection of the amount allocated for child care expenses if the conditions of Minnesota Statutes, section 518.551, subdivision 5, paragraph (b), are met.

5. PARENTAL RIGHTS FROM MINNESOTA STATUTES, SECTION 518.17, SUBDIVISION 3

Unless otherwise provided by the Court:

(a) Each party has the right of access to, and to receive copies of, school, medical, dental, religious training, and other important records and information about the minor children. Each party has the right of access to information regarding health or dental insurance available to the minor children. Presentation of a copy of this order to the custodian of a record or other information about the minor children constitutes sufficient authorization for the release of the record or information to the requesting party.

(b) Each party shall keep the other informed as to the name and address of the school of attendance of the minor children. Each party has the right to be informed by school officials about the children's welfare, educational

progress and status, and to attend school and parent teacher conferences. The school is not required to hold a separate conference for each party.

(c) In case of an accident or serious illness of a minor child, each party shall notify the other party of the accident or illness, and the name of the health care provider and the place of treatment.

(d) Each party has the right of reasonable access and telephone contact with the minor children.

6. WAGE AND INCOME DEDUCTION OF SUPPORT AND MAINTENANCE

Child support and/or spousal maintenance may be withheld from income, with or without notice to the person obligated to pay, when the conditions of Minnesota Statutes, section 518.6111 have been met. A copy of those sections is available from any district court clerk.

7. CHANGE OF ADDRESS OR RESIDENCE

Unless otherwise ordered, each party shall notify the other party, the court, and the public authority responsible for collection, if applicable, of the following information within ten days of any change: the residential and mailing address, telephone number, driver's license number, Social Security number, and name, address, and telephone number of the employer.

8. COST OF LIVING INCREASE OF SUPPORT AND MAINTENANCE

Child support and/or spousal maintenance may be adjusted every two years based upon a change in the cost of living (using Department of Labor Consumer Price Index ....., unless otherwise specified in this order) when the conditions of Minnesota Statutes, section 518.641, are met. Cost of living increases are compounded. A copy of Minnesota Statutes, section 518.641, and forms necessary to request or contest a cost of living increase are available from any district court clerk.

9. JUDGMENTS FOR UNPAID SUPPORT

If a person fails to make a child support payment, the payment owed becomes a judgment against the person

responsible to make the payment by operation of law on or after the date the payment is due, and the person entitled to receive the payment or the public agency may obtain entry and docketing of the judgment WITHOUT NOTICE to the person responsible to make the payment under Minnesota Statutes, section 548.091. Interest begins to accrue on a payment or installment of child support whenever the unpaid amount due is greater than the current support due, according to Minnesota Statutes, section 548.091, subdivision 1a.

10. JUDGMENTS FOR UNPAID MAINTENANCE

A judgment for unpaid spousal maintenance may be entered when the conditions of Minnesota Statutes, section 548.091, are met. A copy of that section is available from any district court clerk.

11. ATTORNEY FEES AND COLLECTION COSTS FOR ENFORCEMENT OF CHILD SUPPORT

A judgment for attorney fees and other collection costs incurred in enforcing a child support order will be entered against the person responsible to pay support when the conditions of section 518.14, subdivision 2, are met. A copy of section 518.14 and forms necessary to request or contest these attorney fees and collection costs are available from any district court clerk.

12. PARENTING TIME EXPEDITOR PROCESS

On request of either party or on its own motion, the court may appoint a parenting time expeditor to resolve parenting time disputes under Minnesota Statutes, section 518.1751. A copy of that section and a description of the expeditor process is available from any district court clerk.

13. PARENTING TIME REMEDIES AND PENALTIES

Remedies and penalties for the wrongful denial of parenting time are available under Minnesota Statutes, section 518.175, subdivision 6. These include compensatory parenting time; civil penalties; bond requirements; contempt; and reversal of custody. A copy of that

subdivision and forms for requesting relief are available from any district court clerk.

Sec. 4. Minnesota Statutes 2004, section 548.091, subdivision 1a, is amended to read:

Subd. 1a. [CHILD SUPPORT JUDGMENT BY OPERATION OF LAW.] (a) Any payment or installment of support required by a judgment or decree of dissolution or legal separation, determination of parentage, an order under chapter 518C, an order under section 256.87, or an order under section 260B.331 or 260C.331, that is not paid or withheld from the obligor's income as required under section 518.6111, or which is ordered as child support by judgment, decree, or order by a court in any other state, is a judgment by operation of law on and after the date it is due, is entitled to full faith and credit in this state and any other state, and shall be entered and docketed by the court administrator on the filing of affidavits as provided in subdivision 2a. Except as otherwise provided by paragraph (b), interest accrues from the date the unpaid amount due is greater than the current support due at the annual rate provided in section 549.09, subdivision 1, plus two percent, not to exceed an annual rate of 18 percent. A payment or installment of support that becomes a judgment by operation of law between the date on which a party served notice of a motion for modification under section 518.64, subdivision 2, and the date of the court's order on modification may be modified under that subdivision.

(b) Notwithstanding the provisions of section 549.09, upon motion to the court and upon proof by the obligor of ~~36~~ 12 consecutive months of complete and timely payments of both current support and court-ordered paybacks of a child support debt or arrearage, the court may order interest on the remaining debt or arrearage to stop accruing. Timely payments are those made in the month in which they are due. If, after that time, the obligor fails to make complete and timely payments of both current support and court-ordered paybacks of child support debt or arrearage, the public authority or the obligee may move the court for the reinstatement of interest as of the month in which

the obligor ceased making complete and timely payments.

The court shall provide copies of all orders issued under this section to the public authority. The state court administrator shall prepare and make available to the court and the parties forms to be submitted by the parties in support of a motion under this paragraph.

(c) Notwithstanding the provisions of section 549.09, upon motion to the court, the court may order interest on a child support debt or arrearage to stop accruing where the court finds that the obligor is:

(1) unable to pay support because of a significant physical or mental disability;

(2) a recipient of Supplemental Security Income (SSI), Title II Older Americans Survivor's Disability Insurance (OASDI), other disability benefits, or public assistance based upon need; or

(3) institutionalized or incarcerated for at least 30 days for an offense other than nonsupport of the child or children involved, and is otherwise financially unable to pay support.

(d) If the conditions in paragraph (c) no longer exist, upon motion to the court, the court may order interest accrual to resume retroactively from the date of service of the motion to resume the accrual of interest.

ARTICLE 5

FAMILY SUPPORTS

Section 1. Minnesota Statutes 2004, section 119A.43, subdivision 2, is amended to read:

Subd. 2. [ESTABLISHMENT AND ADMINISTRATION.] A transitional housing program is established to be administered by the commissioner. The commissioner may make grants to eligible recipients or enter into agreements with community action agencies or other public or private nonprofit agencies to make grants to eligible recipients to initiate, maintain, or expand programs to provide transitional housing and support services for persons in need of transitional housing, which may include up to six months of follow-up support services for

persons who complete transitional housing as they stabilize in permanent housing. The commissioner must ensure that money appropriated to implement this section is distributed as soon as practicable. The commissioner may make grants directly to eligible recipients. The commissioner may use up to ten percent of the appropriation available for this program for persons needing assistance longer than 24 months.

Sec. 2. Minnesota Statutes 2004, section 144D.025, is amended to read:

144D.025 [OPTIONAL REGISTRATION.]

An establishment that meets all the requirements of this chapter except that fewer than 80 percent of the adult residents are age 55 or older, or a supportive housing establishment developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness required under Laws 2003, chapter 128, article 15, section 9, may, at its option, register as a housing with services establishment.

Sec. 3. Minnesota Statutes 2004, section 256D.02, subdivision 17, is amended to read:

Subd. 17. [PROFESSIONAL CERTIFICATION.] "Professional certification" means~~:~~ ~~(1)~~ a statement about a person's illness, injury, or incapacity that is signed by a ~~licensed physician, psychological practitioner, or licensed psychologist, qualified by professional training and experience to diagnose and certify the person's condition, or~~

~~(2) a statement about an incapacity involving a spinal subluxation condition that is signed by a licensed chiropractor qualified by professional training and experience to diagnose and certify the condition~~ "qualified professional" as defined in section 256J.08, subdivision 73a.

Sec. 4. Minnesota Statutes 2004, section 256D.051, subdivision 6c, is amended to read:

Subd. 6c. [PROGRAM FUNDING.] ~~(a)~~ Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training

service providers for the provision of food stamp employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's food stamp employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of food stamp cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

~~(b) This subdivision expires effective June 30, 2005.~~

Sec. 5. Minnesota Statutes 2004, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. [LICENSE REQUIRED.] A county agency may not enter into an agreement with an establishment to provide group residential housing unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a residential care home; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265, or certified by a county human services agency prior to July 1,

1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; ~~or~~

(3) the establishment is registered under chapter 144D and provides three meals a day, ~~except that~~ or is an establishment voluntarily registered under section 144D.025 ~~is not eligible for an agreement to provide group residential housing~~ as a supportive housing establishment; or

(4) an establishment voluntarily registered under section 144D.025, other than a supportive housing establishment under clause (3), is not eligible to provide group residential housing.

The requirements under clauses (1), (2), (3), and ~~(3)~~ (4) do not apply to establishments exempt from state licensure because they are located on Indian reservations and subject to tribal health and safety requirements.

Sec. 6. Minnesota Statutes 2004, section 256I.05, is amended by adding a subdivision to read:

Subd. 1g. [SUPPLEMENTARY SERVICE RATE FOR CERTAIN FACILITIES.] On or after July 1, 2005, a county agency may negotiate a supplementary service rate for recipients of assistance under section 256I.04, subdivision 1, paragraph (b), who relocate from a homeless shelter licensed and registered prior to December 31, 1996, by the Minnesota Department of Health under section 157.17, to a supportive housing establishment developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness required under Laws 2003, chapter 128, article 15, section 9, not to exceed $456.75.

Sec. 7. Minnesota Statutes 2004, section 256J.626, subdivision 6, is amended to read:

Subd. 6. [BASE ALLOCATION TO COUNTIES AND TRIBES; DEFINITIONS.] (a) For purposes of this section, the following terms have the meanings given ~~them:~~.

(1) "2002 historic spending base" means the commissioner's determination of the sum of the reimbursement related to fiscal year 2002 of county or tribal agency expenditures for the base programs listed in clause ~~(4)~~ (6), items (i) through (iv), and

earnings related to calendar year 2002 in the base program listed in clause ~~(4)~~ (6), item (v), and the amount of spending in fiscal year 2002 in the base program listed in clause ~~(4)~~ (6), item (vi), issued to or on behalf of persons residing in the county or tribal service delivery area.

(2) "Adjusted caseload factor" means a factor weighted:

(i) 47 percent on the MFIP cases in each county at four points in time in the most recent 12-month period for which data is available multiplied by the county's caseload difficulty factor; and

(ii) 53 percent on the count of adults on MFIP in each county and tribe at four points in time in the most recent 12-month period for which data is available multiplied by the county or tribe's caseload difficulty factor.

(3) "Caseload difficulty factor" means a factor determined by the commissioner for each county and tribe based upon the self-support index described in section 256J.751, subdivision 2, clause (7).

~~(2)~~ (4) "Initial allocation" means the amount potentially available to each county or tribe based on the formula in paragraphs (b) through ~~(d)~~ (h).

~~(3)~~ (5) "Final allocation" means the amount available to each county or tribe based on the formula in paragraphs (b) through ~~(d)~~ (h), after adjustment by subdivision 7.

~~(4)~~ (6) "Base programs" means the:

(i) MFIP employment and training services under Minnesota Statutes 2002, section 256J.62, subdivision 1, in effect June 30, 2002;

(ii) bilingual employment and training services to refugees under Minnesota Statutes 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

(iii) work literacy language programs under Minnesota Statutes 2002, section 256J.62, subdivision 7, in effect June 30, 2002;

(iv) supported work program authorized in Laws 2001, First Special Session chapter 9, article 17, section 2, in effect June

30, 2002;

(v) administrative aid program under section 256J.76 in effect December 31, 2002; and

(vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48, in effect June 30, 2002.

(b) ~~(1) Beginning July 1, 2003,~~ The commissioner shall:

(1) beginning July 1, 2003, determine the initial allocation of funds available under this section according to clause (2) ~~.~~ ;

(2) allocate all of the funds available for the period beginning July 1, 2003, and ending December 31, 2004, ~~shall be allocated~~ to each county or tribe in proportion to the county's or tribe's share of the statewide 2002 historic spending base ~~.~~ ;

~~(c)~~ (3) determine for calendar year 2005 ~~, the commissioner shall determine~~ the initial allocation of funds to be made available under this section in proportion to the county or tribe's initial allocation for the period of July 1, 2003, to December 31, 2004 ~~.~~ ;

~~(d) The formula under this subdivision sunsets December 31, 2005.~~ (4) determine for calendar year 2006 the initial allocation of funds to be made available under this section based 90 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and ten percent on the proportion of the county or tribe's share of the adjusted caseload factor;

(5) determine for calendar year 2007 the initial allocation of funds to be made available under this section based 70 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 30 percent on the proportion of the county or tribe's share of the adjusted caseload factor; and

(6) determine for calendar year 2008 and subsequent years the initial allocation of funds to be made available under this section based 50 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 50 percent on the proportion of the county or tribe's share of

the adjusted caseload factor.

~~(e)~~ (c) With the commencement of a new or expanded tribal TANF program or an agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of the responsibilities of particular counties under this section are transferred to a tribe, the commissioner shall:

(1) in the case where all responsibilities under this section are transferred to a tribal program, determine the percentage of the county's current caseload that is transferring to a tribal program and adjust the affected county's allocation accordingly; and

(2) in the case where a portion of the responsibilities under this section are transferred to a tribal program, the commissioner shall consult with the affected county or counties to determine an appropriate adjustment to the allocation.

~~(f)~~ (d) Effective January 1, 2005, counties and tribes will have their final allocations adjusted based on the performance provisions of subdivision 7.

Sec. 8. Minnesota Statutes 2004, section 256J.626, subdivision 7, is amended to read:

Subd. 7. [PERFORMANCE BASE FUNDS.] (a) Beginning calendar year 2005, each county and tribe will be allocated 95 percent of their initial calendar year allocation. Counties and tribes will be allocated additional funds based on performance as follows:

(1) for calendar year 2005, a county or tribe that achieves a 30 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) for calendar year 2006, a county or tribe that achieves a 40 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the

measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(3) for calendar year 2007, a county or tribe that achieves a 50 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(4) for calendar year 2008 and yearly thereafter, a county or tribe that achieves a 50 percent MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(5) for calendar years 2005 and thereafter, a county or tribe that performs above the top of its annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), ~~in both measurements in the preceding year~~ will receive an additional allocation equal to five percent of its initial allocation; or

(6) for calendar years 2005 and thereafter, a county or tribe that performs within its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (7), ~~in both measurements in the preceding year, or above the top of its range of expected performance in one measurement and within its expected range of performance in the other measurement,~~ will receive an additional allocation equal to 2.5 percent of its initial allocation.

(b) Performance-based funds for a federally approved tribal TANF program in which the state and tribe have in place a contract under section 256.01, addressing consolidated funding, will be allocated as follows:

(1) for calendar year 2006 and yearly thereafter, a tribe that achieves the participation rate approved in its federal

TANF plan using the average of four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) for calendar years 2005 and thereafter, a tribe that performs above the top of its annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), will receive an additional allocation equal to five percent of its initial allocation; or

(3) for calendar years 2005 and thereafter, a county or tribe that performs within its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (7), will receive an additional allocation equal to 2.5 percent of its initial allocation.

~~(b)~~ (c) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

~~(c)~~ (d)(1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.

(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).

Sec. 9. Minnesota Statutes 2004, section 256J.626, subdivision 8, is amended to read:

Subd. 8. [REPORTING REQUIREMENT AND REIMBURSEMENT.] (a) The commissioner shall specify requirements for reporting according to section 256.01, subdivision 2, clause (17). Each county or tribe shall be reimbursed for eligible expenditures up to the limit of its allocation and subject to availability of funds.

(b) Reimbursements for county administrative-related

expenditures determined through the income maintenance random moment time study shall be reimbursed at a rate of 50 percent of eligible expenditures.

(c) The commissioner of human services shall review county and tribal agency expenditures of the MFIP consolidated fund as appropriate and may reallocate unencumbered or unexpended money appropriated under this section to those county and tribal agencies that can demonstrate a need for additional money~~.~~ as follows:

(1) to the extent that particular county or tribal allocations are reduced from the previous year's amount due to the phase-in under subdivision 6, paragraph (b), clauses (4) to (6), those tribes or counties would have first priority for reallocated funds; and

(2) to the extent that unexpended funds are insufficient to cover demonstrated need, funds will be prorated to those counties and tribes in relation to demonstrated need.

Sec. 10. Minnesota Statutes 2004, section 256J.751, subdivision 2, is amended to read:

Subd. 2. [QUARTERLY COMPARISON REPORT.] The commissioner shall report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) federal participation requirements as specified in Title 1 of Public Law 104-193;

(5) median placement wage rate;

(6) caseload by months of TANF assistance;

(7) percent of MFIP and diversionary work program (DWP) cases off cash assistance or working 30 or more hours per week at one-year, two-year, and three-year follow-up points from a baseline quarter. This measure is called the self-support index. ~~Twice-annually,~~ The commissioner shall report quarterly an expected range of performance for each county, county

grouping, and tribe on the self-support index. The expected range shall be derived by a statistical methodology developed by the commissioner in consultation with the counties and tribes. The statistical methodology shall control differences across counties in economic conditions and demographics of the MFIP and DWP case load; and

(8) the MFIP work participation rate, defined as the participation requirements specified in title 1 of Public Law 104-193 applied to all MFIP cases except child only cases and cases exempt under section 256J.56.

Sec. 11. Minnesota Statutes 2004, section 256J.751, subdivision 5, is amended to read:

Subd. 5. [FAILURE TO MEET FEDERAL PERFORMANCE STANDARDS.] (a) If sanctions occur for failure to meet the performance standards specified in title 1 of Public Law 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, the state shall pay 88 percent of the sanction. The remaining 12 percent of the sanction will be paid by the counties. The county portion of the sanction will be distributed across all counties in proportion to each county's percentage of the MFIP average monthly caseload during the period for which the sanction was applied.

(b) If a county fails to meet the performance standards specified in title 1 of Public Law 104-193 of the Personal Responsibility and Work Opportunity Act of 1996 for any year, the commissioner shall work with counties to organize a joint state-county technical assistance team to work with the county. The commissioner shall coordinate any technical assistance with other departments and agencies including the Departments of Employment and Economic Development and Education as necessary to achieve the purpose of this paragraph.

(c) For state performance measures, a low-performing county is one that:

(1) performs below the bottom of their expected range for the measure in subdivision 2, clause (7), in ~~both measurements during the~~ an annualized measurement reported in October of each

year; or

(2) performs below 40 percent for the measure in subdivision 2, clause (8), as averaged across the four quarterly measurements for the year, or the ten counties with the lowest rates if more than ten are below 40 percent.

(d) Low-performing counties under paragraph (c) must engage in corrective action planning as defined by the commissioner. The commissioner may coordinate technical assistance as specified in paragraph (b) for low-performing counties under paragraph (c).

Sec. 12. [REPEALER.]

Minnesota Rules, part 9500.1206, subparts 20, 26d, and 27, are repealed.

APPENDIX
Repealed Minnesota Statutes for 05-0376

626.5551 ALTERNATIVE RESPONSE PROGRAMS FOR CHILD PROTECTION ASSESSMENTS OR INVESTIGATIONS.

Subdivision 1. **Programs authorized.** (a) A county may establish a program that uses alternative responses to reports of child maltreatment under section 626.556, as provided in this section.

(b) The alternative response program is a voluntary program on the part of the family, which may include a family assessment and services approach under which the local welfare agency assesses the risk of abuse and neglect and the service needs of the family and arranges for appropriate services, diversions, referral for services, or other response identified in the plan under subdivision 4.

(c) This section may not be used for reports of maltreatment in facilities required to be licensed under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B, or in a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10, or in a nonlicensed personal care provider association as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

Subd. 2. **Use of alternative response or investigation.** (a) Upon receipt of a report under section 626.556, the local welfare agency in a county that has established an alternative response program under this section shall determine whether to conduct an investigation using the traditional investigative model under section 626.556 or to use an alternative response as appropriate to prevent or provide a remedy for child maltreatment.

(b) The local welfare agency may conduct an investigation of any report using the traditional investigative model under section 626.556. However, the local welfare agency must use the traditional investigative model under section 626.556 to investigate reports involving substantial child endangerment. For purposes of this subdivision, substantial child endangerment includes when a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) sexual abuse as defined in section 626.556, subdivision 2, paragraph (a);

(3) abandonment under section 260C.301, subdivision 2;

(4) neglect as defined in section 626.556, subdivision 2, paragraph (c), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(5) murder in the first, second, or third degree under section 609.185; 609.19; or 609.195;

(6) manslaughter in the first or second degree under section 609.20 or 609.205;

(7) assault in the first, second, or third degree under section 609.221; 609.222; or 609.223;

(8) solicitation, inducement, and promotion of prostitution under section 609.322;

(9) criminal sexual conduct under sections 609.342 to 609.3451;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378; or

(12) use of minor in sexual performance under section 617.246.

(c) Nothing in this section gives a county any broader authority to intervene, assess, or investigate a family other than under section 626.556.

(d) In addition, in all cases the local welfare agency shall notify the appropriate law enforcement agency as provided in section 626.556, subdivision 3.

(e) The local welfare agency shall begin an immediate investigation under section 626.556 if at any time when it is using an alternative response it determines that an investigation is required under paragraph (b) or would otherwise be appropriate. The local welfare agency may use an alternative response to a report that was initially referred for an investigation if the agency determines that a complete investigation is not required. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and consult with:

(1) the local law enforcement agency, if the local law enforcement is involved, and notify the county attorney of the decision to terminate the investigation; or

(2) the county attorney, if the local law enforcement is not involved.

Subd. 3. **Documentation.** When a case in which an alternative response was used is closed, the local welfare agency shall document the outcome of the approach, including a description of the response and services provided and the removal or reduction of risk to the child, if it existed. Records maintained under this section must contain the documentation and must be retained for at least four years.

Subd. 4. **Plan.** The county community social service plan required under section 256E.09 must address the extent that the county will use the alternative response program authorized under this section, based on the availability of new federal funding that is earned and other available revenue sources to fund the additional cost to the county of using the program. To the extent the county uses the program, the county must include the program in the community social service plan and in the program evaluation under section 256E.10. The plan must address alternative responses and services that will be used for the program and protocols for determining the appropriate response to reports under section 626.556 and address how the protocols comply with the guidelines of the commissioner under subdivision 5.

Subd. 5. **Commissioner of human services to develop guidelines.** The commissioner of human services, in consultation with county representatives, may develop guidelines defining alternative responses and setting out procedures for family assessment and service delivery under this section. The commissioner may also develop guidelines for counties regarding the provisions of section 626.556 that continue to apply when using an alternative response under this section. The commissioner may also develop forms, best practice guidelines, and training to assist counties in implementing alternative responses under this section.

Senator ..... moves to amend S.F. No. 1710 as follows:

Page 95, line 5, delete "2005" and insert "2006"

Page 95, line 10, delete "2005" and insert "2006" and delete "county or"

Page 96, line 27, strike everything after "(4)"

Page 96, strike line 28

Page 96, line 29, strike "(5)"

Page 96, line 30, strike "(6)" and insert "(5)"

Page 96, line 31, strike "(7)" and insert "(6)"

Page 97, line 7, strike "(8)" and insert "(7)"

S. F. 1710 Lourey **H.F. 1889 Wilkin**

TITLE: Children and Family Services Policy Bill

This proposal has no fiscal implications but is substantive policy change and clarification. The policy changes are relatively non controversial, yet important to children, families and program services delivery. Many provisions were heard and approved by the House of Representatives in 2004 but did not meet Senate deadline.

Article 1 Child Welfare: Alternative Response

- Integrates a new approach for dealing with less serious cases that works with families to develop or restore a safe and nurturing home environment for the child. It preserves the investigative approach in existing law for more serious cases. An assessment and supports approach will be used for families in the child protection system that has less serious problems. In 2000, 20 Minnesota counties began a pilot project that provided workers the flexibility to offer a broad range of supportive services to families reported to the child protection system in cases where children were not in imminent danger. The project, called Alternative Response, was so successful that all 87 counties voluntarily implemented it as of January 2004.
- Clarifies the time frame for face to face contact with a child reported to be maltreated and with the child's primary care giver to five calendar days To assure the safety and well-being of children a timely contact with the child and care giver. This change aligns Minnesota with the clear and prompt timelines that are required under federal standards for initiating a response to a report of child maltreatment.
- Reduces the time frame to complete an investigation or family assessment from 90 days to 45 days and changes the time frame for creating protective services plans from 60 days to 30 days. This change assures that the intervention is applied at the point in time most likely to prevent subsequent maltreatment.

Article 2 – Child Welfare: Permanency

- Expands relative custody and adoption laws to include relatives gaining permanent legal custody of children under the order of a tribal court to participate in the relative custody program, minimize competing adoption proceedings in different court districts, bring the background check requirement for adoptive parents in line with foster care licensing

standards, clarify adoption record retention responsibilities and identify the families that are eligible for postadoption service grants.

- Amends juvenile court statutes to:
    - Achieve compliance with federal Title IV-E requirements for judicial determinations for reasonable efforts, agency responsibility, permanency planning and permanency hearings;
    - Clarify service and permanency requirements when a child is removed due to egregious harm;
    - Make the requirement for "compelling reasons" consistent throughout 260C;
    - Make review requirements consistent with juvenile court rules;
    - Change terms to be consistent with juvenile court rules and Title IV-E; and
    - Clarify requirements related to the agency's duties to implement a case plan prior to adjudication and to the court's authority to order the delivery of services under the plan once it is filed

- Brings state law into compliance with federal Title IV-E requirements for permanency hearings, allows a new disposition option called "trial home visit" that is allowable under federal law, clarifies the agency's role and responsibilities for children ordered into long-term foster care, clarifies due process protections for the parent and child, makes consent to adoption irrevocable except as that is prohibited by ICWA and permits the Commissioner to identify and make an alternative adoptive placement without having to wait 12 months when the identified prospective adoptive home is not viable.

- Clarifies the requirements related to termination of parental rights, permits the court to order a trial home visit after a denial of a termination of rights petition when the child has been in placement 15 of the last 22 months and prohibits the agency from asking the court to order long-term foster care for a state ward until there have been exhaustive efforts to place the child for adoption for at least two years following termination.

Article 3 – Child Care

- Allows counties to have families fill out a streamlined Change Report Form rather than requiring a full re-determination if a family reports a change. A full re-determination of eligibility for child care will still be required every six months; however, a simplified process will be used when small changes occur during the interim;
- Expands the types of families who are included in the reallocation formula used to redistribute BSF funds among counties. The current formula includes families who are on the waiting list but does not include families whose cases have been closed due to a reduction in the county allocation. By modifying the reallocation formula to include these cases, funds could be redistributed more quickly to the counties with greatest need; and
- Revises current law to allow child care providers to be eligible for child care assistance for their own children during authorized activities.

Article 4 - Child Support

- Clarifies that the public authority can ask for location and asset information about program participants of third party contractors of employers, financial institutions, utility companies, etc. who hold, administer or distribute such information;
- Makes changes to the way other orders are considered in determining net income for guidelines support calculations;
- Improves and makes administrative the process for suspending and reinstating collection of child care child support amounts; and
- Changes current law to 12 months of consecutive payments, from 36 months, before the obligor may bring a motion to stop interest charging on overdue child support.

Article 5 - Family Supports

- Authorizes the use of up to 10% of Transitional Housing Program funding for more than 24 months in order to better serve long-term homeless currently assisted by transitional housing;
- Changes the housing with services statute to allow supportive housing participants, as defined in the Governor's Initiative to End Homelessness, to voluntarily register as housing with services participants;
- Allows registered supportive housing to contract to receive Group Residential Housing (GRH) payments so that eligible homeless adults will be able to use GRH to pay for permanent supportive housing and a GRH client to continue to receive a GRH service payment if relocating from a shelter to supportive housing;
- Continues allowing flexibility in the amount used per participant with Food Stamp Employment and Training (FSET) funds;
- Deletes obsolete language and uses more recent definitions of professionals qualified to determine a person's illness, injury or incapacity ; and
- Improves the MFIP Consolidated Fund formula by phasing-in an adjusted caseload factor that takes into consideration caseload difficulty.

Contact:

Anne Martineau 651-296-0310

Senators Lourey, Fischbach, Kelley and Nienow introduced--
S.F. No. 1872: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; lowering the blood lead level needed to trigger a lead risk assessment; amending Minnesota Statutes 2004, section 144.9504, subdivision 2.

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

Section 1. Minnesota Statutes 2004, section 144.9504, subdivision 2, is amended to read:

Subd. 2. [LEAD RISK ASSESSMENT.] (a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to ~~(5)~~ (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~70~~ 60 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~20~~ 15 micrograms of lead per deciliter of whole blood;

(4) ~~within ten working days of a child in the residence~~

~~being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification; or~~

~~(5)~~ within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

(d) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least ~~20~~ 15 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or

pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

(f) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose

lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9509 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

2004 Legislative Lead Study
Final Report to the Legislature

Despite recent progress in reducing childhood lead poisoning rates, lead exposure remains one of the leading environmental health risks facing Minnesota children. A state model lead poisoning prevention bill was considered in 2004. A focal point of this legislative activity was the proposal to lower the required environmental intervention level. Because of the significant fiscal impact that this change would have had on state and local lead assessing agencies (especially Minneapolis, St. Paul/Ramsey Co), compromise language resulted in the requirement for the MDH to conduct a study of lead issues. The enabling text, as included in the Laws of Minnesota 2004 Ch 288, Section 31 is:

> *The commissioner of health, in consultation with the Department of Employment and Economic Development, the Minnesota Housing Finance Agency, and the Department of Human Services, shall develop and evaluate the best strategies to reduce the number of children endangered by lead paint. The study shall examine:*
>
> *(1) how to promote and encourage primary prevention;*
> *(2) how to ensure that all children at risk are tested;*
> *(3) whether or not to reduce the state mandatory intervention from 20 to ten micrograms of lead per deciliter of whole blood and if a reduction is not recommended whether to develop guidelines on intervention for children with blood levels between ten and 20 micrograms of lead per deciliter of whole blood;*
> *(4) how to provide incentives and funding support to property owners for lead hazard prevention and reduction; and*
> *(5) ways to provide resources for local jurisdictions to conduct outreach.*
>
> *The commissioner shall submit the results of the study and any recommendations, including any necessary legislative changes to the legislature by January 15, 2005.*

This report constitutes submission of the results of the study along with recommendations to the legislature.

Lead poisoning prevention partners have been actively involved in collaborative lead reduction strategies over the past several years. The State of Minnesota 2010 Childhood Lead Poisoning Elimination Plan is the result of one such effort. It adopted a goal of creating a lead-safe Minnesota where no child would have elevated blood lead levels by the year 2010. The so called "2010 report" recommended using a collaborative, housing-based approach to promote primary prevention of lead exposure. The City of Minneapolis has also developed a comprehensive plan to guide efforts to eliminate childhood lead poisoning by the year 2010. These plans are in concert with federal goals of eliminating childhood lead poisoning by 2010 and formed the basis for much of the discussion of the work group convened to address the study required by the 2004 legislature. In this way, the legislative study workgroup had the benefit of previous planning and did not have to duplicate the "2010 plan" efforts.

Meetings were held at the MDH Snelling Office Park on September 2, October 7, and November 18, 2004. Agendas and pertinent background materials were prepared and distributed via email prior to meetings. The first meeting was designed to provide a brief background on each of the

five targeted topic areas. Speakers were solicited from a variety of partners, including the Sustainable Resources Center, Medica Health Plans, Minnesota Visiting Nurses Association, St. Paul/Ramsey County Lead Program, Minneapolis Housing Inspections, Minnesota Housing Finance Agency, and Countryside Public Health Department. Subsequent meetings were used to generate ideas, identify areas of consensus, and propose possible specific steps to "reduce the number of children endangered by lead paint".

Table 1: Work group participants. Staff support provided by the MDH Environmental Health Division.

Minnesota Department of Health (MDH) Aggie Leitheiser, Chair	**Countryside Public Health Department** Elizabeth Auch
Minnesota Department of Human Services (DHS) Brian Osberg Susan Castellano	**Minnesota Multi-Housing Association** Jack Horner
Minnesota Housing Finance Agency (MHFA) Tonja Orr Jim Cegla	**Project 504** Greg Luce
Minnesota Department of Employment and Economic Development (DEED) Louis Jambois Leona Humphry	**Medica Health Plans** Sandy Lien
Hennepin County Department of Housing, Community Works, and Transit Jim Graham	**Greater Minneapolis Daycare Association** Ed Petcshe
Hennepin County Community Health Department Susan Palchick Joe Jurusik	**National Paint Coatings Association** Jennifer Breitinger
Minneapolis Department of Health and Family Support Ken Dahl Megan Ellingson Patricia Bowler	**Local Public Health Association** Laura LaCroix
Minneapolis Comm. Planning and Econ. Development Lee Pao Xiong	**Minnesota Council of Health Plans** Joan Mailander
Minneapolis Housing Inspections JoAnn Velde Lisa Smested	**Community Action for Suburban Hennepin County** Bill O'Meara
St. Paul Ramsey County Public Health Rob Fulton Jim Yanarelly Mary Ellen Smith	**Sustainable Resources Center (SRC)** Sue Gunderson Megan Curran Samuel Walseth
Association of Minnesota Counties Patricia Coldwell	**MedTox, Inc.** Vernan Herman
Duluth Housing Redevelopment Agency Richard Ball John Miller	**Minnesota Visiting Nurse Agency** Cheryl Lanigan
Minnesota House of Representatives Keith Ellison Karen Clark Bud Nornes	**St. Louis County Public Health** Dale Schroeder
Minnesota Senate Becky Lourey Carrie Ruud	

Topic Area #1: Primary Prevention

Background

The specific task for topic area #1 was to examine how to promote and encourage primary prevention. Primary prevention for lead is defined in Minnesota statute as "preventing toxic lead exposure before blood levels become elevated." This requires focusing on high-risk populations and activities, rather than toxic exposures to individuals (which is secondary prevention). An exposure is defined as "elevated" when a blood lead test result is greater than 10 micrograms of lead per deciliter of whole blood (ug/dL).

The most important risk factors related to lead poisoning risk in Minnesota are poverty and living in a home containing lead-based paint. Lead was banned from residential paint in the U.S. in 1978. Homes built before 1950 have been shown to have the highest levels of lead-based paint. Based on 2000 census information there are about 1.35 million homes in Minnesota built before 1978, and 560,000 built before 1950.

During the course of the meetings creation of a lead housing registry was discussed. There was not consensus on the usefulness and maintenance of a registry due to costs, accuracy and accessibility of such a list.

Action Steps Considered

A. Increase incentives to the clinics/providers for primary prevention/education, with special emphasis on getting lead information in pre-natal classes.
B. Disseminate new research to physicians showing health effects at levels once thought to be safe (e.g. Lanphear, et. al., 2000; Canfield, et. al., 2003).
C. Target lead hazard reduction method awareness for all re-hab activities on pre-1950 homes; this should focus on raising awareness in both consumers (to use "market forces" to promote lead safety) and contractors.
D. Perform outreach to high-risk populations to raise awareness of risk factors.
E. Increase collaboration with grass roots organizations.
F. Develop educational message for lead results less than 10 ug/dL.
G. Promote the use of capillary tests as an easy to administer, quick screening tool.
H. Promote a "healthy homes" approach and deal with all health/housing issues at once.

Consensus Items

The group agreed that primary prevention should be the main long-term approach used to eliminate childhood lead poisoning. Implementation of primary prevention strategies for lead will require using current agency programs proactively to address elimination of housing-based lead. It will also require a blend of education, regulation, and incentives to mobilize both governmental and private sector resources.

Discussions emphasized the need to increase education and awareness of the general public on lead hazards, including getting lead information included in current home inspections, being added to first-time home-buyer classes, and being added to trade school training classes for certification. The overall goal is to get lead-safe work practices incorporated into daily routines for contractors, home buyers, local public health, inspectors, and others offering direct services to the public. Contractor education should be expanded to include more lead hazard reduction awareness. Credentialing of painters and remodelers as "lead safe" could be a useful tool for marketing their services.

Topic Area #2: Screening

Background

The specific task for topic area #2 was to examine how to ensure that all children at risk are tested. That test involves screening for exposure to lead by analyzing a blood sample. Screening can be done using capillary methods (e.g. finger-stick), but elevated results must be confirmed using venous sample. Results are classified as private data. The test is typically performed when the child is one and two years old, but may be done at any time if the parent is concerned or if a high-risk activity (e.g. remodeling a home built before 1950) has recently occurred.

MDH has issued statewide screening guidelines for children and pregnant women. Since not all Minnesota children have a high risk for lead exposure, targeted screening is currently recommended for most areas of the state rather than universal screening. The guidelines do, however, recommend universal screening for children residing in Minneapolis and St. Paul, those recently arriving from other major metropolitan areas, and for children receiving Medicaid.

There was a recommendation for MDH to re-convene the Case Management Guideline workgroup to examine current timelines for screening and follow-up, the role of capillary tests, and the incorporation of new research and data on test reliability. The group felt that ongoing efforts towards physician education have had mixed results. While screening and lead awareness continues to increase, individual practitioners are still encountered who resist screening/testing for lead. Most successful efforts have focused on administrative points (e.g. providing continuing education credits; targeted to clinic directors) and financial incentives. Use of professional organizations such as the Minnesota Medical Association and the University of Minnesota Medical School were encouraged.

Action Steps Considered

A. Promote screening at Child &Teen Checkup (C&TC)/Women Infant Child (WIC) Clinics.
B. Reduce tenants' fear of eviction and immigrant/refugees fear of government.
C. Link lead screening to school admittance and/or immunization schedule.
D. Maintain DHS withhold (5% on Prepaid Medical Assistance Program contracts).
E. Encourage collaborative relationship between health plans and public health.
F. Promote screening by physicians using non-monetary incentives.
G. Increase screening in potentially high exposure groups [remodeling contractors].

Consensus Items

The group agreed that lead professionals in Minnesota, both public and private, have been very successful in increasing the number of children screened for lead annually from just under 36,000 in 1998 to almost 70,000 in 2004. Current efforts should be continued, and additional outreach to coordinate with currently underutilized health care contact points for high-risk populations (WIC Clinics, C&TC).

Topic Area #3: Lower Intervention Level

Background

The specific task for topic area #3 was to examine whether or not to reduce the state mandatory intervention from 20 to 10 ug/dL. If a reduction was not recommended, the task would be whether or not to develop guidelines on intervention for children with blood levels between 10 and 20 ug/dL.

Current CDC case management recommendations, issued in 2002, are to "conduct an environmental investigation for all children with blood lead level above 20 ug/dL or 15 ug/dL persistently". Requirement in M.S. 144.9504 are consistent with this recommendation. In general, the MDH Lead Program responds to results as shown in Table 2.

Table 2: Responses to blood lead test reports to MDH for children less than 6 years old:

Blood lead result	Response
Less than 10 ug/dL	Reports entered into MDH database
10 – 15 ug/dL	Same as previous, plus: MDH also notifies local health agency, which contacts the family and provides education on hazard reduction. Environmental intervention may be ordered, at discretion of assessing agency.
15 – 20 ug/dL	Same as previous, plus: if level over 15 ug/dL for 90 days, environmental intervention mandatory.
20 – 45 ug/dL	Same as previous, plus: environmental intervention mandatory
Greater than 45 ug/dL	Same as previous, plus: child is recommended for chelation therapy to reduce level
Greater than 60 ug/dL	Same as previous, plus: considered a medical emergency. Immediate action is taken

The MDH Childhood Blood Lead Case Management Guidelines serve as minimum guidelines for providing services to children with lead test results greater than 10 µg/dL. The objective is to ensure that a qualified medical case manager oversees the treatment and recovery and that steps are taken to prevent further exposure to lead. The case management guidelines work in concert with the MDH Screening Guidelines to identify and manage lead exposure in children. The MDH is also developing recommendations on public health implications of lead levels below 10 ug/dL in collaboration with a physician workgroup. These should be available in 2005.

State statute requires specific steps to be taken when a mandatory environmental intervention is conducted. An environmental intervention involves conducting lead testing in the residence and issuing orders for corrective actions to eliminate identified lead hazards. Lowering the mandatory intervention level to 10 ug/dL would increase the burden to assessing agencies to

provide environmental interventions, property owners to improve property conditions, and bring enforcement action into play. However, a number of studies have shown that any exposure to lead can result in adverse health effects.

Action Steps Considered

A. Within current funding sources, drop the intervention to 15 ug/dL. Most jurisdictions are trying to intervene at this level currently. It is not feasible to drop the level lower because of funding constraints at both state and local levels.
B. Avoid condemnation of housing.
C. Issue recommendations for lead hazard reduction instead of orders at levels lower than 15 ug/dL.
D. Use existing training programs to establish additional hands-on, practical primary prevention by worker/contractor training that targets lead hazard reduction.

Consensus Items

There was general consensus that lowering the mandatory environmental intervention level to 10 ug/dL would be most consistent with current public health research. However, the associated costs of that change cannot be supported by current budgets and would seriously disrupt current efforts toward primary prevention. As a result, it was recommended that current statute (MS 144.9504 be amended to read (underline is new text, strike-out is deleted):

Subd. 2. Lead risk assessment.(a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (5) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~7~~60 micrograms of lead per deciliter of whole blood;
(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;
(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~20~~ 15 micrograms of lead per deciliter of whole blood;
~~(4) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification;~~ or
(~~5~~ 4) within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) [no change]

(d) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least ~~20~~ 15 micrograms per deciliter .....

This change recognizes the developing scientific information supporting a lower intervention level and would result in all venous reports greater than 15 ug/dL receiving an environmental intervention (for the house/exposure route) and associated medical case management (for the

child). Conducting an enforceable environmental intervention is allowable for levels equal to or greater than 10 ug/dL at the discretion of the assessing agency (see (b) above). However, members felt it was important to have the statute clearly state the required intervention level was 15 ug/dL and above. There also was agreement to seek additional resources for local governments to intervene at levels of 10 ug/dL and above.

This change would provide a more consistent approach state wide to dealing with elevated blood lead levels in children. Current federal funding does provide the necessary resources for property owners for lead hazard reduction activities when children with elevated blood lead levels are identified. These federal funds are available through April 2007, after which, additional competitive federal or alternative funds will need to be secured to support this lower intervention level. Absent that support, the cost of lead hazard reduction will be borne by private property owners. In addition, the emergency reporting level should be lowered from 70 ug/dL to 60 ug/dL based on the MDH Childhood Blood Lead Clinical Treatment Guidelines for Minnesota, which represent the consensus opinion of eight physicians experienced in treating patients with an elevated blood lead level.

Topic Area #4: Funding for Lead Hazard Reduction

Background

The specific task for topic area #4 was to examine how to provide incentives and funding support to property owners for lead hazard prevention and reduction actions. Lead hazard reduction is implemented through various federal, state and local housing programs. Programs receiving federal assistance through HUD are required to implement various levels of lead hazard reduction actions. Programs may adopt similar requirements when dealing with non-federal funding sources.

The following Minnesota agencies receive competitive federal HUD funds for lead hazard reduction activities: Minneapolis/Hennepin County, St. Paul/Ramsey County (includes Duluth/St. Louis County), and DEED.

Assessing agencies include MDH, Minneapolis, St. Paul/Ramsey County, City of Richfield, City of Bloomington, Hennepin County, Dakota County, St. Louis County, and Stearns County. These agencies provide resources for mandatory environmental interventions. A number of state agencies have responsibility for various aspects of controlling home-based lead exposure, including MDH, MHFA, and DEED. There also are other state agencies that deal with other possible lead exposure routes. At the local level, cities of the first class and counties/local public health agencies have responsibilities for lead risk assessment and case management. Non-governmental advocacy organizations also perform essential tasks regarding education, training, and primary prevention.

Action Steps Considered

A. Institute a tax credit for performing lead abatement.
B. Impose a fee on the retail sale of residential paint.

C. Use the petroleum storage tank fund for lead work.
D. Impose a tax on gasoline sales.
E. Enforce housing codes with rental property owners.
F. Target current housing rehabilitation funds and modify programs to ensure lead safe practices are employed.

Consensus Items

The group agreed that current Minnesota funding streams, which rely almost exclusively on competitive federal grants, need to be monitored to ensure a stable revenue source for lead hazard reduction activities. Possible supplemental sources are presented in "Resources" below. Any additional resources received should be applied to the existing state and local programs, and should be targeted towards primary prevention and housing-based activities.

Topic Area #5: Resources for Local Agencies

Background

The specific task for topic area #5 was to examine ways to provide resources for local jurisdictions to conduct outreach and education. These activities are essential to informing parents and others of possible risks to children. The MDH has prepared the "Protecting Families from Lead: The Lead Poisoning Prevention Workshop" manual to assist lead case managers and health educators in spreading the word about childhood lead poisoning prevention. There are a host of other lead-related materials available, both directly and through links, at the MDH website at: www.health.state.mn.us/divs/eh/lead.

MDH hired a full-time case monitor to provide case management technical assistance to local public health case managers in 2001. The state case monitor provides technical assistance on lead cases to 85 of the 87 counties within the state of Minnesota. Primary responsibility for daily case management of lead poisoned children rests with the local public health agency and is a collaborative effort with available health care providers in the area. In addition, the Sustainable Resources Center, as part of its CLEARCorps program, Project 504, and other private providers regularly conduct education and training on lead hazard reduction statewide.

Action Steps Considered

A. Incorporate lead primary prevention awareness into daily activities of local public health and into other units of local government such as housing.
B. Promote lead prevention as an incentive for building relationships with different segments of government, with a focus on housing and health.
C. Create homebuyer incentives to becoming informed about lead.
D. Link lead information into the general home inspection process.
E. Recognize and address non-metro needs with regard to training and resources.
F. Enforce existing federal disclosure requirements.
G. Promote use of lead identification techniques available to the general public.

Consensus Items

As with Topic Area #4, the group agreed that sustainable funding is essential to maintaining a high-quality lead poisoning prevention and mitigation program, and that local health and housing agencies have critical roles to play. Fostering the relationship between health and housing agencies is an important first step in coordinating services to children exposed to lead and to eliminating the source of future exposures.

Resources

Economic information surrounding the financial burdens of lead poisoning to society has been detailed in the literature for more than a decade. For example, Landrigan et al. (2002) quantifies the total annual costs of lead poisoning nationally at $43.4 billion. They indicate that the estimate is likely to be low because it only addresses reduction in lifetime expected earnings and does not account for costs of pain and suffering or medical-related costs.

Schwartz (1994) assessed the potential cost savings with decreased blood lead levels. He estimated that "a 1 ug decrease in mean blood level concentrations in the population would produce at least $3.5 billion per year in benefits from reduced health effects of lead." Grosse et al. (2002) provides information surrounding the economic benefits in worker productivity as a result of reduction in lead levels in children related to cognitive abilities. The decline in blood lead level between 1976 and 1999 resulted in an estimate of $3.8 million increase in productivity for each annual cohort of 2 year olds, which equals between $110 billion and $319 billion.

To help quantify resources needed to address lead caseload in Minnesota and to address whether the intervention level should be lowered to 15 ug/dL, the number of children with various blood lead levels in 2003 was compiled (Table 3). There were 311 children under 6 years old statewide reported to MDH in 2003 with venous blood lead levels >15 ug/dL. There are 668 children to be addressed if all reported venous cases > 10 ug/dL are considered. Therefore, there is a significant difference in the resources needed to address all children over 15 ug/dL versus over 10 ug/dL. Although Minnesota has mandatory reporting of all tests, it is important to recognize that blood lead testing is not universal and that the data are not representative of all Minnesota children. The data include only children for whom a family member has requested a test or for whom a health care provider has ordered a test.

Table 3: Number of children with blood lead tests reported to MDH in 2003

Blood Lead Level	Test Type		Total
	Venous	Cap/Unknown	
Greater than 20 ug/dl	154	125	279
15-19.9 ug/dl	157	125	282
10-14.9 ug/dl	357	741	1,098
5-10 ug/dl	1,635	6,364	7,999
<5 ug/dl	11,941	40,111	52,052
Total	14,244	47,466	61,710
Population (2000 Census): 396,389			
Percent Tested: 16%			

During meetings the group arrived at a consensus value of $12,500 necessary to address each statutory elevated lead case. This cost included maintaining the state lead database, screening, public health follow-up, risk assessment and lead hazard reduction and clearance on the child's residence. This per-case cost may be used to estimate the total cost of addressing lead cases at various required environmental intervention levels. As the intervention level is lowered, the number of cases, and associated cost, increases dramatically (Table 4). Because the data reported to MDH is only from residents who requested a blood lead test (and, therefore, does not represent the entire population), the values from 2003 were adjusted to account for increasing accuracy in capillary testing and for populations not currently receiving lead screens. This adjustment attempts to reflect the cost to address the problem in the entire state, rather than just the cost to address the residents who are screened.

Table 4: Estimated costs associated with response to various blood lead levels. Amounts based on an assumption of $12,500 per elevated blood lead case/child. The estimated number of cases is based on 2003 results (Table 3), and assumes that 50% of the capillary tests will become actionable cases, and that there are 20% of additional cases beyond the current venous caseload (e.g. for greater than 20 ug/dL, 154 + (125)(.5) + (154)(.2) = 247). Cumulative cost is the amount needed to address all cases greater than the specified interval. These numbers are presented as rough estimates for comparative purposes only and should NOT be interpreted as definitive resource requirements.

Blood lead result	Estimate of number of state-wide cases	Cost to address result interval	Cumulative cost
Greater than 20 ug/dL	247	$3,091,250	$3,091,250
15 – 20 ug/dL	251	$3,136,250	$6,227,500
10 - 15 ug/dL	799	$9,986,250	$16,213,750
5 – 10 ug/dL	5144	$64,300,000	$80,513,750

Another way of looking at the resource need is based on the number of houses eventually needing attention. If there are 560,000 homes in Minnesota built before 1950 (2000 Census), and the estimated cost for lead hazard reduction in each unit is estimated to be $7,500 (consensus of the work group), there then is estimated to be a need for $4.2 billion to address all homes in Minnesota with lead threats.

The bulk of funding for the Minnesota lead program comes from federal sources via competitive grants and cooperative agreements. The State also contributes general fund resources to the effort, as shown in Table 5.

Table 5: Rough estimates of current annual contributions

Source	Estimated annual amount
HUD (all MN grants combined)	$5 million
CDC	$750,000
EPA	$270,000
State General Fund	$250,000

These figures do not include financial support to mitigate lead hazards from a range of partners, including health plans, health care providers, non-profit organizations, individual home owners, concerned parents, and industry groups. The funding from HUD, CDC, and EPA must be renewed via competitive applications on a regular (typically every three years) basis. While the federal agencies have committed their support to the elimination of childhood lead poisoning by

2010, their financial support is dictated by the federal budget. For example, the EPA cooperative agreement has declined 20 percent over the past two years. Minnesota must compete with states across the country (many of which have significantly more cases and higher poisoning rates) for these funds. The consensus of the group was that the currently available resources as described above are sufficient to support lowering the intervention level down to a single venous test of 15 ug/dL. This is consistent with the estimates in Table 4. However, there was concern over the sustainability of current federal support beyond the current grant cycles (which end in 2006 or 2007) and recognition that securing additional funding in the State's current fiscal climate would be very difficult.

The following is a brief description of potential funding sources (in addition to those listed in Table 5 above) for supplemental funding for lead hazard reduction activities and the associated public health infrastructure.

- State Petro Fund - Divert 5% of an established fee to a lead hazard reduction fund, in addition to a fee imposed on paint sales. Petro Fund is currently used for petroleum tank cleanup and associated supporting activities. The fee is imposed on tanks, dependent on the balance in the fund.
- Business-sector contributions: Incentives to promote collaboration with the insurance industry, philanthropy (e.g. Anderson Windows), current landlord efforts, National Paint & Coating Association, and States' Attorney General agreement.
- Community Reinvestment Act: The federal Community Reinvestment Act (Title 12, Ch 30:2901-2908) encourages depository institutions to help meet the credit needs of the communities, including low- and moderate-income neighborhoods.
- "This Old House" Property Tax Reduction – A market value exclusion on property tax of up to 50% of the cost of lead hazard reduction, not to exceed $10,000. Each county would determine if it will participate.
- Medicaid: Continue the "withhold" for meeting screening targets and incentives for increased screening and ongoing "corrective action" planning.
- MHFA Grants and Deferred Loan: Promote risk assessments, lead safe work practice professionals and clearance sampling for all non-federal housing rehab programs.
- Multiple Dwellings Inspection Fee: For example, in New Jersey the Department of Community Affairs is required to inspect every multiple dwelling for lead hazards and imposes a $20/unit inspection fee to support the lead hazard reduction fund.
- Fee on Retail Sale of Paint – A fund supported by the sale of paint in Minnesota established to yield $2 million/year to be used for reimbursing a portion of the cost of lead hazard reduction costs. For reference, MN has 1.94% of US housing stock (2000 Census) and architectural paint coating sales in US are 620 million gal/year (NPCA data). Another variation is the New Jersey "Lead Hazard Control Assistance Fund" (2002) supported through a dedicated portion of the existing sales tax collected on retail sale of architectural paint coatings.
- Fee for services related to property maintenance [Chicago implemented this approach in May 2004]: All facilities must be maintained so they are free of lead hazards. Fee for local agency that determines the lead-free status (Risk assessment $450, Clearance $150, Plan Review $25)

The group did not come to consensus on which, if any, of the above alternatives should be pursued legislatively or administratively.

The Minnesota 2010 Childhood Lead Poisoning Elimination Plan

This plan for eliminating childhood lead poisoning in Minnesota was developed in 2004. It advocates for a collaborative, housing-based approach to promoting primary prevention of childhood lead exposure, while still incorporating ongoing programs that are based on secondary prevention models. This is consistent with the federal elimination strategy to act before children are poisoned (primary prevention), identify and care for lead poisoned children (secondary prevention), conduct research, and measure progress to refine prevention strategies. The goals of the plan were to eliminate childhood lead poisoning by developing strategies:

I. For lead education and training.
II. For identifying at-risk properties and children.
III. To better coordinate health and housing enforcement.
IV. To identify resources to increase the supply of lead-safe housing.
V. To assess the availability of lead liability insurance for single-family property owners, rental property owners, and contractors.

The details of the plan are presented in a table organized by goal and specific objectives. Objectives are then examined by current strategies and new strategies. Many of these strategies mirror the recommendations of the legislative study group, as shown in Table 6 below.

Table 6: Goals from the State of Minnesota 2010 Childhood Lead Poisoning Elimination Plan that were also discussed during study meetings.

Goal	Common Objectives between 2010 Plan and Legislative Study
lead education and training	• increasing compliance with federal disclosure laws with the general public, home buyers, renters, and contractors, • informing health care providers about anticipatory guidance for lead poisoning prevention, • providing training on lead-safe work practices and maintenance.
identify at-risk properties and children	• maintaining state-wide blood lead surveillance system, • structuring incentives and disincentives promoting blood lead screening for at-risk children and pregnant women, • collaborating to identify at-risk properties, and • performing primary prevention risk assessments to address lead hazards before a child is exposed
coordinate health and housing enforcement	• collaboration with housing agencies to assure compliance through existing enforcement tools • coordination with home-visiting agencies to incorporate lead safe work practices into their routines
identify resources to increase the supply of lead-safe housing	• improving access and coordination with housing and health organizations with respect to lead, • leveraging current private and non-federal funds to control lead paint hazards, • linking access to public housing funds with lead-safe practices
availability of lead liability insurance	• Assess status of lead liability insurance in Minnesota to encourage lead-safe work practices

Summary

In general, the group concurred that lead remains a significant environmental health threat to certain high-risk populations in Minnesota, and that continued efforts to eliminate exposures and reduce lead hazards are justified at both the state and local level. The approaches developed as part of both the 2010 Elimination Plan effort and this study were complementary and should be given serious consideration. Specific recommendations fall into three basic categories:

Actions requiring legislative action and approval:

> Amending MS 144.9504 so that all venous reports greater than 15 ug/dL receive an environmental intervention and changing the emergency reporting level from 70 ug/dL to 60 ug/dL.

Actions for current lead programs:

> Promotion of primary prevention as the strategy of choice for eliminating childhood lead poisoning, using current resources to address lower blood lead levels for at-risk populations where feasible.
>
> Education and training targeted to both professionals and the public based on current research that reflects the position that there is no "safe" level of lead in children.
>
> Collaboration between health and housing agencies, continued information sharing between public, private and non-profit organizations, and joint efforts locally and regionally towards the common goal of reducing lead hazards.
>
> Implementation of State 2010 Childhood Lead Poisoning Elimination Plan.

Considerations for future:

> Review comprehensive lead funding biennially to identify likely sustainable sources and help ensure federal and state resources are available to meet future demand.

References

Canfield R.L., Henderson M.A., Cory-Slechta D.A., Cox C, Jusko T.A., Lanphear B.P. (2003). Intellectual impairment in children with blood lead concentrations below 10 μg per deciliter. *N. Engl. J. Med.* 348:1517-1525.

Grosse, S. D., Matte, T. D., Schwartz, J., & Jackson, R. J. (2002). Economic gains resulting from the reduction in children's exposure to lead in the United States. *Environ Health Perspect,* 110(6), 563-69.

Landrigan, P. J., Schechter, C. B., Lipton, J. M., Fahs, M. C., & Schwartz, J. (2002). Environmental pollutants and disease in American children: Estimates of morbidity, mortality, and costs for lead poisoning, asthma, cancer, and developmental disabilities. *Environ Health Perspect,* 110(7), 721-28.

Lanphear B.P., Dietrich K, Auinger P, Cox C. (2000). Cognitive deficits associated with blood lead concentrations <10 microg/dl in US children and adolescents. *Public Health Rep. 2000* 115:521-529.

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Agenda No: 90

Hennepin County, Minnesota
RESOLUTION NO. 05-175

The following Resolution was offered by Commissioner Dorfman, seconded by Commissioner Stenglein:

WHEREAS, childhood lead poisoning is a serious, but preventable, public health threat to the children of Hennepin County; and

WHEREAS, Hennepin County partners in the Joint City/County Lead Task Force, which aims to coordinate lead reduction efforts between the City of Minneapolis, Hennepin County and other government, business and nonprofit sectors; and

WHEREAS, Hennepin County staff participated in a workgroup commissioned by the State Legislature and convened by the Minnesota Department of Health (MDH), resulting in recommendations to the Legislature detailed in the Minnesota Department of Health Biennial Report to the Legislature on Minnesota's Lead Poisoning Prevention Programs; and

WHEREAS, the Joint Lead Task Force recommended by unanimous vote, to support the language in the MDH report, lowering the mandatory environmental intervention blood lead level from 20 ug/dl down to 15 ug/dl, and to support the policy recommendations listed in the report; and

WHEREAS, funds are already in place from the U.S. Department of Housing and Urban Development and other sources to provide testing, intervention and lead remediation for children whose blood lead levels would mandate intervention; therefore

BE IT RESOLVED, that the Hennepin County Board of Commissioners supports the Minnesota Department of Health recommendation lowering the mandatory environmental intervention blood lead level from 20 ug/dl down to 15 ug/dl, within current funding sources.

Lead poisoning prevention

Lead poisoning is one of the most common childhood health problems in the United States today. Lead is highly toxic and can harm almost all of the systems in the body. Exposure to lead and lead poisoning can cause serious irreversible health and learning problems in children. Because lead poisoning often occurs with no obvious symptoms, it frequently goes unrecognized. And yet, lead poisoning is entirely preventable.

All children living in Minneapolis or Saint Paul and all children on Medicaid should be tested for lead at ages one and two, or up to age six if they have never been tested before. In 2003, only 29 percent of Minnesota children on medical assistance between nine- and 30-months old received a lead test. In the same year, only 55 percent of Minneapolis one- and two-year-olds were tested for lead. Other children in the state should be tested for lead up to age six if they live in or regularly visit a home built before 1978.

How are children exposed to lead?

The major source of lead exposure is lead-based paint and lead-contaminated dust found in deteriorating buildings. Lead-based paints were banned for use in housing in 1978, so older housing stock, which is often found in urban environments, is more likely to have lead-based paints.

- Approximately 1.3 million homes throughout Minnesota contain lead paint — that's 65 percent of the state's rural, suburban and urban housing stock.
- Low-income communities and communities of color are most impacted by lead poisoning, but any older home that is deteriorating or being remodeled puts people at risk.

How prevalent is the problem?

In 2003, 1,659 Minnesota children (542 from Minneapolis) had elevated blood lead levels (more than 10 micrograms per deciliter). Of these, 154 children (91 from Minneapolis) had high enough blood lead levels (more than 20 micrograms per deciliter) to trigger mandatory intervention.

What can we do to solve the problem?

Minneapolis has been a leader among major U.S. cities in removing and cleaning up lead hazards and educating residents.

- Support policies that help achieve Minnesota's goal of having a lead-safe state by 2010.
- Support policies that promote early intervention to remove lead hazards in homes before children are poisoned.
- Support policies to lower the blood lead level for mandatory environmental intervention.
- Support continued efforts to promote universal lead screening for all urban children.
- Support legislation to hold managed health care plans and health care providers accountable for lead screening for children on medical assistance.

Minneapolis
City of Lakes

Intergovernmental Relations Department
350 South 5th Street - Room 301 M
Minneapolis, MN 55415
(612) 673-2043

Properties with lead and lead poisoned children in Minnesota counties

City/County	# and % of properties likely to contain some lead (built pre-1978)	# of children with elevated lead levels in 2003[1]
Moorhead	8,749 (72%)	5 children in all of Clay County
Rochester	20,649 (59%)	28 children in all of Olmsted County
St. Cloud	13,862 (60%)	10 children in all of Stearns County
Anoka County	53,143 (49%)	27
Dakota County	56,914 (43%)	29
Washington County	31,742 (43%)	15
Hennepin County	338,054 (72%)	606
Ramsey County	161,329 (78%)	473
St. Louis County	77,910 (81%)	87
Total for these areas	762,352 (66%)	1,280
Total for remainder of state (rural areas)	596,154 (66%)	379
Minnesota Total	**1,358,506 (66%)**	**1,659**

[1] The Centers for Disease Control and Prevention consider a level of 10 micrograms per deciliter to be elevated.

A bill for an act

relating to health occupations; authorizing a psychologist to release information to law enforcement without the consent of the client; amending Minnesota Statutes 2004, sections 13.384, subdivision 3; 13.46, subdivision 7; proposing coding for new law in Minnesota Statutes, chapter 148.

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

Section 1. Minnesota Statutes 2004, section 13.384, subdivision 3, is amended to read:

Subd. 3. [CLASSIFICATION OF MEDICAL DATA.] Unless the data is summary data or a statute specifically provides a different classification, medical data are private but are available only to the subject of the data as provided in section 144.335, and shall not be disclosed to others except:

(a) pursuant to section 13.05;

(b) pursuant to section 253B.0921;

(c) pursuant to a valid court order;

(d) to administer federal funds or programs;

(e) to the surviving spouse, parents, children, and siblings of a deceased patient or client or, if there are no surviving spouse, parents, children, or siblings, to the surviving heirs of the nearest degree of kindred;

(f) to communicate a patient's or client's condition to a family member or other appropriate person in accordance with acceptable medical practice, unless the patient or client

directs otherwise; or

(g) as otherwise required or permitted by law.

Sec. 2. Minnesota Statutes 2004, section 13.46, subdivision 7, is amended to read:

Subd. 7. [MENTAL HEALTH DATA.] (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision; ~~or~~

(4) with the consent of the client or patient; or

(5) as otherwise permitted by law.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, the responsible authority for a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. Disclosure under this paragraph may include, but is not limited to, the name and telephone number of the psychiatrist, psychologist, therapist, mental health

professional, practitioner, or case manager of the client or patient. A law enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the information, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (4), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order

or any other means allowed by law.

Sec. 3. [148.977] [CRIMES AGAINST A PROVIDER.]

Notwithstanding section 144.335, if the provider has been the victim of a crime and knows that the crime was committed by a client or former client, the provider may disclose the identity of the client or former client, and acknowledge the professional relationship to the appropriate law enforcement agency. The provider shall not disclose any private information contained in the client's health record that is not specifically related to the crime.

Senator ..... moves to amend the committee engrossment (SCS0722CE1) of S.F. No. 722 as follows:

Page 2, line 1, strike "or"

Page 2, line 2, after "(g)" insert "when an individual providing mental health services is believed to be the victim of a crime committed by a client, patient, or former client or patient and the disclosure is limited to the data authorized by Code of Federal Regulations, title 45, section 164.512(f)(2); or (h)"

Page 2, line 14, after the semicolon, insert:

"(5) when an individual providing mental health services is believed to be the victim of a crime committed by a client, patient, or former client or patient and the disclosure is limited to the data authorized by Code of Federal Regulations, title 45, section 164.512(f)(2);"

Page 2, line 15, delete "(5)" and insert "(6)"

SF 0722 "Crimes Against a Provider" Situation Analysis by James A. Klein, Ph.D. Feb. 24, 2005

Situation	Example	Current Law/Ethics		Effect of SF0722	Negative Impacts and Other Issues				
		OK to Report Crime and Name Offender?	OK to Disclose the Therapeutic Relationship?						
Crime committed outside of therapeutic context - evidence exists	Mugging "on the street"; Break-in to house; etc.	Yes - not privileged	No - not pertinent	Relationship now OK to disclose	Non-pertinent disclosure authorized		"Cat Out of the Bag" Syndrome - non-regulated people have unnecessary access to privileged information	Certain allegations may gain credibility: "I am/was his therapist and I know that...(fill in the blank)"	
Crime comitted outside but confessed within therapeutic context	"I'm the one who slashed your tires last week"	No - privileged like any other disclosure except for the mandatory reporting issues	Not Applicable	Crime and Relationship now OK to disclose	Disclosure of the Relationship is not necessarily always pertinent or needed	Establishes providers as a privileged class of crime victim in the therapy session	"Cat Out of the Bag" Syndrome - non-regulated people have unnecessary access to privileged information	Certain allegations may gain credibility: "I am his therapist and he told me that...(fill in the blank)"	What stops an unethical or impaired provider from fabricating a "confession", or acting on mis-construal?
Crime committed within therapeutic context	Stealing from office; Violence committed in office	Gray area. Probably "No", but there are practical problems	Almost certainly "No", but there are practical problems	Crime and Relationship now OK to disclose					What stops an unethical or impaired provider from fabrication or simple error?

Gary Schoener is a Licensed Psychologist and the Executive Director of the Walk-In Counselling Centre in Minneapolis, Minnesota. For over 30 years, he has consulted and presented internationally on ethical and professional practice issues, including workshops and presentations for practitioners of various health disciplines. Mr. Schoener has testified in legal cases related to boundaries in both the USA and Canada. In addition to co-authoring books on assisting impaired psychologists and on psychotherapists' sexual involvement with clients, he has also authored seven journal articles, twenty-eight book chapters, and hundreds of monographs.

****

Re: A Bill Before the Legislature - SF0722

Jim,

The strongest argument, in my opinion, and one I think most professionals would agree with is:

There may be an issue here, and additional remedies may be needed. That remains to be seen. **But what is crystal clear is that when the public goes for personal therapy, marriage counseling, or family therapy, etc. they may end up seeing a licensed psychologist, social worker, marriage & family therapist, professional counselor, psychiatrist, alcoholism or substance abuse counselor, or unlicensed mental health therapist.**

All are regulated by the state. The client is often unclear who they are seeing. But even more central is the fact that a sizeable number of professionals hold two licenses or certificates. For example, many Licensed Marriage & Family Therapists also hold a social work license or a psychology license.

SO, WHAT'S THE PROBLEM WITH THIS? Well, the standards for such things as the duty to breach confidentiality to protect third parties from violent acts by the client are currently (like this proposed bill), inside of the various licensure laws. The standards are different.

The same is true of standards for reporting of misconduct by health care professionals. For example, a psychologist must report all sorts of misconduct by other licensed health care professionals to their boards, but when the offender is a psychologist, NO reporting is required if learned of

from the offender during a therapy session, and even then only three things are mandated reports.

So, if a Licensed Marriage & Family Therapist who is also a Licensed Psychologist comes in for help and admits to the psychologist that he is horribly impaired and has done damage to a number of clients, the psychologist has NO duty to report to the Board of Psychology but has to report to the Board of Marriage & Family Therapy. If a psychologist admits the same things to a licensed marriage and family counselor, there is no reporting duty to the board of psychology. But if the psychologist also holds a social work or nursing license, a report is mandated to the social work or nursing board.

CONFUSING? You bet! The state needs to ask the boards to get together and try to develop statutes or language that apply across the board. To have literally dozens of standards benefits nobody. As a professional who teaches in this area, I can tell you that I spend a good deal of time just answering professional's questions about these duties.

Also, it is nearly impossible to explain things to consumers when getting informed consent. The consumer comes for help, but to actually try to explain all of this is going to take an hour of valuable time.

You can quote me on this.

Since there is no urgency for this Bill, perhaps this is as good a time as any to get the boards to work out similar rules and language for standards of confidentiality and its limits, for the duty to warn, and for duties to report other professionals.

Gary

EXHIBIT: One Real-Life Example of false "knowing" by an L.P. of a crime

BEFORE THE MINNESOTA BOARD OF PSYCHOLOGY

STIPULATION AND CONSENT ORDER

May 7, 1999

In the Matter of

Renee Fredrickson, Ph.D., L.P.

License No. LP2653

IT IS HEREBY STIPULATED AND AGREED by Renee Fredrickson, Ph.D., L.P. (Licensee) and the Minnesota Board of Psychology (Board) as follows:

.....

.....

III. _Providing Psychological Services to Clients When Licensee's Objectivity and Effectiveness were Impaired_

.....

.....

Exhibiting Signs of a Possible Mental Dysfunction

37. Beginning in September 1996, and continuing through December 1996, Licensee repeatedly contacted the St. Paul Police Department to report incidents of alleged stalking. Licensee believed she was being stalked based on a certain number of these incidents. She exhibited symptoms of a possible mental dysfunction, her objectivity was impaired, and she failed to protect the privacy of clients. For example, Licensee reported the following incidents to the police:

a. Licensee made numerous complaints to the police, including that persons had broken into her home; cultic ritual marks were left by these persons; her mail had been tampered with; clothing or personal items had been stolen, moved, or misplaced in her home; items had been mysteriously damaged and then repaired. She expressed concern that naturally occurring incidents, such as a large tree branch caught upside down in wires next to her home and the presence of a large eviscerated bug with a fresh carapace found on her step might be related to stalking. These complains were investigated by the police and were not confirmed.

.....

.....

Investigating Officer's Observations and Conclusions

54. On October 8, 1996, the police sergeant interviewed clients #2 and #3. In a memorandum prepared after the interview, the sergeant noted that although Licensee had told him the clients were survivors of satanic/ritual abuse by their parents and a satanic cult form Oregon, their report to him of abuse was vague and lacked detail of occult-specific data. The sergeant concluded: "While it is evident these women believe the reported incidents themselves, there is neither physical evidence, nor reported evidence to substantiate a belief in the accuracy of the incidents recalled."

55. In his December 26, 1996, report, the sergeant noted the following: "Most of the reports of unusual occurrences have a logical explanation... These occurrences most often are normal actions or results of same.... While the complainant does not appear to accept any of these explanations, there is insufficient evidence to proceed further at this time."

.....

.....

IV. _Failure to Obtain Informed Written Consent to Disclose Private Information_

68. In September 1996, Licensee failed to protect the privacy of client #2 and client #3 in that she reveled their full names as well a certain therapy issues to police officers without permission from the clients. Licensee also discussed client #2 with client #4 without having obtained informed written consent from client #2 to do so.

.....

.....

BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE

RENEE FREDRICKSON, Ph.D., L.P. NORMAN L. JAMES, Ph.D., L.P.

Licensee

Dated: May 3, 1999 Dated: May 7, 1999

SAMUEL ALBERT, Ph.D., L.P.

Dated: May 7, 1999

THOMAS SANNER	ROSELLEN CONDON
Hinshaw & Culbertson	Assistant Attorney General
3200 Piper Jaffray Tower	500 Capitol Office Building
222 South Ninth Street	535 Park Street
Minneapolis, MN 55402	St. Paul. MN 55103-2106
Telephone: (612)	Telephone: (651) 297-1050
Attorney for Licensee	Attorney for Committee
Dated: 5/3, 1999	Dated: 5-7, 1999

ORDER

Upon consideration of this stipulation and all the files, record, and proceedings herein,

IT IS HEREBY ORDERED that the Licensee is placed in a RESTRICTED AND CONDITIONAL status and that all other terms of this stipulation are adopted and implemented by the Board this 7th day of May, 1999.

MINNESOTA BOARD OF PSYCHOLOGY

PAULINE WALKER-SINGLETON

Executive Director

Reasons to Oppose SF0722 (v.1 – e-mailed to Sen. H&FS Comm. 2/22/05)

The proposed Statute is not needed.

No prohibition. There is nothing in the Statutes barring a provider who has been the victim of a crime from naming the alleged violator to law enforcement.

Relationship not pertinent. There are no actions that a client might take that would be crimes *because* of the existence of a therapist-client relationship. The existence of the professional relationship is not pertinent to any crime.

The proposed Statute replaces a tested standard with a dangerous new precedent.

First Discretionary Exception. Ethical psychologists NEVER voluntarily breach client confidence. Several provisions of existing statutes create for providers a DUTY to breach confidentiality in specific circumstances, and one provision permits providers to comply with a subpoena. SF0722 would create the first entirely discretionary exception to client-therapist confidentiality.

Slippery Slope. SF0722 singles out providers as a privileged class of crime victim. Why shouldn't providers be allowed to report all client crimes of which they have knowledge, regardless of the victim?

False Sense of Security. It may seem that the provider is allowed by the Bill to disclose very little. However, the three most sensitive items of confidential information in a therapeutic relationship are the fact that the client is "in therapy"; the diagnosis; and the identity of the therapist. In the case where the therapist is a "specialist", the disclosure of the therapist's identity approaches disclosure of diagnosis. SF0722 authorizes a provider to disclose very sensitive information.

Once the Cat Is Out of the Bag... SF0722 authorizes the disclosure of confidential client information to individuals who are not, in turn, bound by any expectations for confidentiality. One shudders to consider a prominent citizen's psychotherapeutic relationship being divulged to personnel in law enforcement, who are not bound in any effective way to protect against wider dissemination.

The proposed Statute will have a dangerous and unintended effect.

Creating a Prejudice in Law Enforcement. Since the professional relationship is not pertinent, the primary effect of permitting a provider to acknowledge the relationship to law enforcement will be to attach to a provider's accusations a level of credibility and authority they might not have on their merits alone.

The proposed Statute is misplaced and inappropriate in its scope.

Protect the Public. The Minnesota Psychology Practice Act (Sections 148.88-148.98) is to "protect the public from the practice of psychology by unqualified persons and from unethical or unprofessional conduct by persons licensed to practice psychology". Proper regulation of a profession seeks to protect the public against the acts of the few. SF0722 provides a new way in which an unethical provider can harm a client without providing any new protections.

Why Only Psychologists? If there is a need, the need should apply as well at least to all regulated health care professionals for whom there is an expectation of client confidentiality, such as MDs, LMFTs, LPCs, and others.

What Do Other Professions Think? The proposed statute would impact public perception of all health care professionals. The input of the other regulated professions should be sought by the Legislature before such a statute is enacted.

The proposed Statute is further flawed.

Over-broad. SF0722 applies to "a crime". There are many acts defined as crimes that, occurring within the context of a therapeutic relationship, would not be viewed as criminal by most ethical providers. For example, a verbal exchange which might be construed "on the street" as assault might be construed during a therapy session by a therapist as "grist for the mill". We understand that SF0722 is largely motivated by a desire to protect providers against violent crimes and stalking. To minimize the danger to the client public of the proposed statute, however, such major crimes should be called out specifically.

Lacks Definition. SF0722 prohibits disclosure from the "health record" that is "not specifically related to the crime". Is a diagnosis (e.g. kleptomania) "specifically related" to a crime (e.g. theft of a book from a provider's office)? Better definition of this term is clearly needed.

Neglects the Client. SF0722 fails to deal with the important therapeutic process of Termination. A provider should not continue to provide care to an active client whose confidentiality he has compromised via a criminal complaint. The proposed statute should mandate Termination, and require that it be carried out according to the ethical standards of the profession.

Liability. If the proposed statute is to be a part of Section 148, it should specifically point out that the provider continues to have ethical responsibilities. These should include, at least, a responsibility to take all reasonable steps to be certain that a crime has in fact been committed and that the client is the perpetrator. It should make explicit that a provider who acts in bad faith, acts on mere suspicion, or fails in any way to make reasonable efforts may still be guilty of one or more violations of the Minnesota Psychology Practice Act.

S.F. No. 722, as introduced 84th Legislative Session (2005-2006) Posted on Feb 02, 2005

A bill for an act

relating to health occupations; authorizing a psychologist to release information to law enforcement without the consent of the client; proposing coding for new law in Minnesota Statutes, chapter 148.

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

Section 1. [148.977] [CRIMES AGAINST A PROVIDER.]

Notwithstanding section 144.335, if the provider has been the victim of a crime and knows that the crime was committed by a client or former client, the provider may disclose the identity of the client or former client, and acknowledge the professional relationship to the appropriate law enforcement agency. The provider shall not disclose any private information contained in the client's health record that is not specifically related to the crime.