



Saint Paul - Ramsey County Public Health

**Community Health Services Advisory Committee**

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*Marina McManus, Director*

**Community Health Services Advisory Committee**

**Summary Meeting Minutes**

**August 6, 2014**

**Members Present**

Maridee Bain  
Maureen Dempsey  
Thomas Kottke (Mayor)  
Madonna McDermott (Mayor)  
Dave Muhovich (Mayor)  
Caitlyn Nystedt  
Regina Rippel (Mayor)  
Kerri-Elizabeth Sawyer (Mayor)  
Bob Tracy (Mayor)  
Mary Yackley (Mayor)

**Speaker:**

Sanne Magnan, MD, PhD, President, CEO  
Institute for Clinical Systems Improvement (ICSI)

**Staff / Guests Present:**

Rina McManus	Zoe Hansen	} Nursing Students
Zack Hansen	Bri Gladitsch	
Diane Holmgren	Chris Lee	
Joan Brandt	Kepha Kinge	
Mary Peick	Daniel Mbola	
Julie Seiber		
Jocelyn Ancheta		
Neal Holtan		
Patricia Barney		

The meeting was called to Order at 5:30 by Vice-Chairperson Thomas Kottke. Tom welcomed everyone to the meeting and introductions were made of two new members; Caitlyn Nystedt and Maureen Dempsey.

Agenda item:	Speaker/Discussion:
Population Medicine and Population Health for Better Care, Better Health and Lower Costs.	<p>Sanne Magnan, MD, PhD, President, CEO, Institute for Clinical Systems Improvement (ICSI)</p> <p>Presentation on the intersect of clinical care and population health. The provisions of the Affordable Care Act change the focus of treatment (medical care) of chronic disease to prevention of disease. ICSI is leading discussions with physicians about the challenges and opportunities to improve quality of health, improve patient experience and lower costs by adopting a population medicine approach. (see attached copy of presentation)</p>
Department Updates:	<p>Rina McManus reported;</p> <ul style="list-style-type: none"> <li>Distributed Public Health Strategic Plan and CHIP (Community Health Improvement Plan) final copies. Thanked the committee for the work on the process of these documents. Electronic version can be accessed at <a href="http://www.co.ramsey.mn.us/ph/pc/planning">http://www.co.ramsey.mn.us/ph/pc/planning</a></li> <li>Introduced Jocelyn Ancheta, new Policy and Planning Manager for our department. Jocelyn will be working with the Community Action Teams. Jocelyn gave an update on organizing the Community Action Teams.</li> <li>Nutrition Action Team, Health Care access and use of services, Violence Prevention, Social Determinants of Health. Behavior/Mental Health/Disorders. Working on process to bring feedback to CHSAC.</li> <li>Accreditation application has been submitted to National Public Health Accreditation Board (PHAB). We will need to provide all of the required documentation by year end. A site visit will be scheduled in 2015.</li> <li>Quality Improvement Plan to be submitted to County Board and the State in September.</li> <li>Review of 2014 Legislative session accomplishments related to public health (see attached summary).</li> </ul>

Agenda item:	Speaker/Discussion:
	<ul style="list-style-type: none"><li>• Tom Kottke asked members to contact legislators regarding placing restrictions on the sale of small cigars. These items are cheap and targeted toward youth. Note: Saint Paul City Council to consider policy.</li><li>• Bob Tracy inquired about how we are looking at policies related to our goal of social determinates of health. Rina stated that Ramsey County's Economic Prosperity goal – includes the social determinates of health, demographics, education, jobs, transportation, and environmental concerns. Will have further discussion as the legislative platform is developed.</li></ul>
Other:	Ramsey County Attorney's Office and Public Health are sponsoring a Violence Prevention presentation by Ted Bunch co-founder of A Call To Men, who will talk about how we raise our boys in America and how that socialization can contribute to a culture that perpetrates physical and sexual violence against women and children.

**Tom Kottke Motion to adjourn (7:30 PM) passed by affirmation of the committee.**

Next meeting: September 3<sup>rd</sup>, Agenda; Climate Change and Public Health, Healthy Homes.

# Population Medicine *and* Population Health for the Triple Aim

August 2014

Community Health Services Advisory Committee  
Saint Paul – Ramsey County Public Health

Presentation by

Sanne Magnan, MD, PhD

President & CEO, ICSI

**ICSI** Institute for Clinical  
Systems Improvement  
Transforming health care, together

# Clinical Story - Adult

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85-year-old male with a history of chronic heart failure, diabetes, depression, early stage dementia, hypertension, and COPD, who has been hospitalized three times earlier in the year....

# Clinical Story - Child

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A young child with a regular check-up at a local hospital clinic had an elevated lead screening level of 35 (> 5 is elevated). The nurse practitioner called the local health department....

# Objectives

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- Explore the differences between population medicine/health care and population health
- Illustrate how population medicine can impact population health
- Illustrate how health care is exploring health - - and the challenges
- Provide examples for bridging between health care and the community for better health care outcomes

# Targeting the Triple Aim\*

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- Improve patient experience of care, including quality
- Improve the health of populations
- Improve affordability by decreasing per capita costs



\*The Triple Aim: Care, Health, And Cost. Berwick DM, Nolan TW and Whittington J., Health Affairs, May 2008, Vol. 27, No. 3, 759-769.

# National Quality Strategy Three Broad Aims

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- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

<http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf>

Report to Congress, March 2011

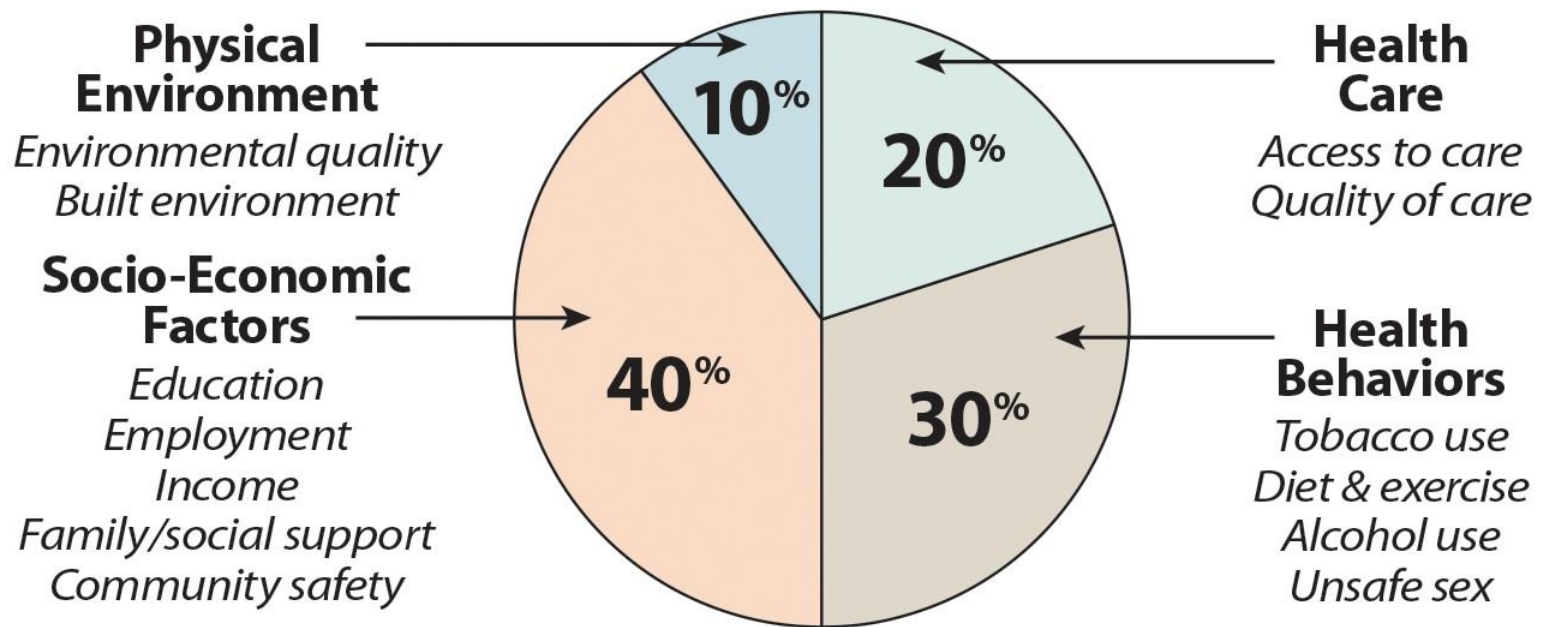


# Population Medicine & Population Health

- *Population Medicine or Population Health Care*
  - Patients in a clinic/hospital OR “attributed patients”
  - Focused on problem solving and care
  - May or may not use resources outside the clinical walls
  - Influenced by place and the social determinants of health
- *Population Health*
  - People in a geographic area OR an “attributed” group
  - Focused on well-being and functionality, includes care
  - Uses resources outside clinical walls
  - Influenced by place and the social determinants of health

# What Makes Us Healthy

## Population Health



Source: Authors' analysis and adaption from the University of Wisconsin

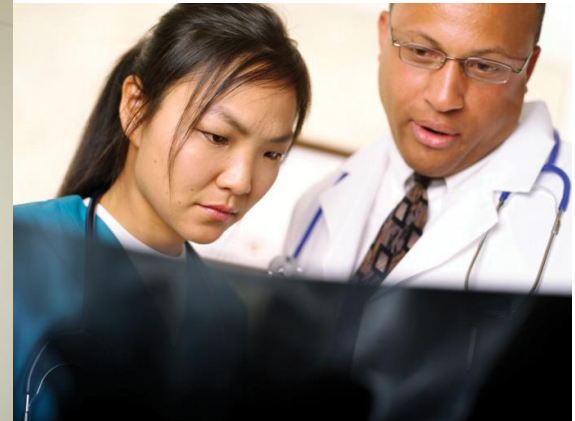
# Examples of Populations in Health Care

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- Populations with
  - Underuse
  - Overuse
  - Misuse
- Populations with disparities
- Populations that require us to reach outside our walls to solve these patients' “clinical” problems
- Racial or ethnic populations
- Geographic populations

# High Tech Diagnostic Imaging

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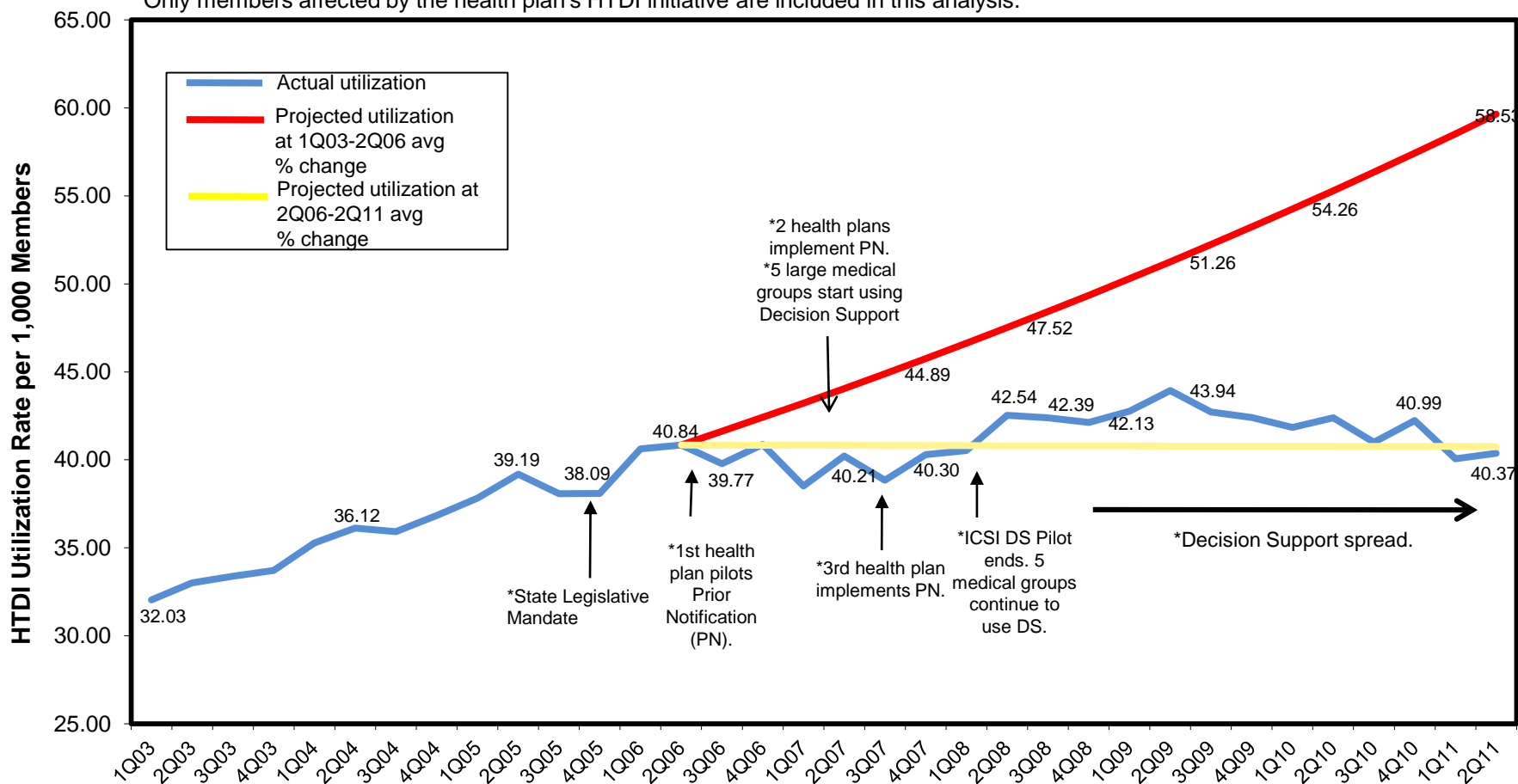
# Institute for Clinical Systems Improvement (ICSI) High Tech Diagnostic Imaging Initiative

**Aggregate HTDI Utilization Rate per 1,000 Members, 1Q03-2Q11**

**Aggregate Data Include: BCBSMN, HealthPartners, Medica, UCare and MN DHS Medicaid FFS  
Claims and Membership Data (Hospital Inpatient and ER Claims Excluded)**

\*Membership profile differs across health plans.

\*\*Only members affected by the health plan's HTDI initiative are included in this analysis.



# New Imperative

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## Perspective

### What Business Are We In? The Emergence of Health as the Business of Health Care

David A. Asch, M.D., M.B.A., and Kevin G. Volpp, M.D., Ph.D.

N Engl J Med 2012; 367:888-889 | [September 6, 2012](#)



# Building *Accountable Health Communities* for Accountable Care



Source: Magnan S, Fisher E, Kindig D, Isham G, Wood D, Eustis M, Backstrom C and Leitz S.  
Achieving Accountability for Health and Health Care. A White Paper Developed from the State  
Quality Improvement Institute 2008-2012 in Minnesota. Found at: <http://bit.ly/V3Xvt0>

# White Paper on Global Health Measures Used in MN Clinical Care

**ICSI** Institute for Clinical  
Systems Improvement  
Transforming health care, together

**MEASURING HEALTH IN MINNESOTA:  
IMPORTANCE, CHALLENGES AND FUTURE DIRECTIONS**

[https://www.icsi.org/\\_asset/cwd6c8/measuringpophealth.pdf](https://www.icsi.org/_asset/cwd6c8/measuringpophealth.pdf)





# MN Community Measurement Framework 3-5 Year Vision

MEASUREMENT FRAMEWORK AIM	CATEGORY	MNCM CURRENT CLINIC/AMBULATORY MEASURES	Opportunity 3-5 years
Health Care	Patient experience/engagement	1. CG CAHPS	Patient activation Shared decision making
	Safety	1. ASC/hospital transfer/admission 2. ASC appropriate surgical site hair removal 3. ASC Prophylactic antibiotic timing	Complications Dosing
	Effectiveness, Quality, Outcome	<b>Process</b> 1. Controlling high blood pressure 2. Spirometry testing COPD 3. Depression use of PHQ9 4. Depression PHQ9 follow-up 6 and 12 months <b>Outcome</b> 1. Optimal vascular care 2. Optimal diabetes care 3. Optimal asthma care 4. Depression 6 month remission 5. Depression 12 month remission 6. Depression 6 and 12 month response 7. Total knee replacement 8. (In pilot Spine surgery)	Specialty Physician Other Clinician care Post Acute Care Patient Activation
	Coordination of care, timeliness, communication	1. Health care home care coordination 2. HIT survey	Post Acute Care Advanced Directives
	Appropriateness, Utilization, overuse, use of resources	1. C-Section rate 2. (In development-Colonoscopy surveillance and quality)	Overuse measures Specialty elective procedures
Cost	Total cost of care	1. In pilot TCOC with actual cost.	Implementation
	Relative resource use (TCOC with standardized cost)		Relative Resource Use
	Expenditures by type of care	Per unit cost for top common procedures	Cost by Episode of Care Additional Price disclosure
Individual and Community Population Health	Prevention	1. Breast cancer screening 2. Childhood immunization status 3. Cervical cancer screening 4. Colorectal cancer screening 5. Chlamydia cancer screening in women 6. Immunizations for adolescents 7. Pediatric preventive care	Retire high performing
	Healthy behaviors	1. (Under development- tobacco use, obesity) 2. Tobacco use embedded in some disease specific measures	Physical activity Risky substance use
	Community health		Global Health Measures
	Social, Economic factors	1. Race, ethnicity, language	Income in risk adjustment



## Trends in Minnesota Health Care Spending and Rate of Growth



Source: MDH Health Economics Program

<http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2013.pdf>

# Reframing Conversations

*“Going Beyond Clinical Walls”*

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- RWJF grant to ICSI for communications to healthcare audience(s) for starting a conversation about connecting with community resources
- Minimum of four communications in *Going Beyond Clinical Walls*:
  - .....Solving Complex Problems
  - .....Identifying Examples of Resources
  - .....Sharing Knowledge and Using Data
  - .....Aligning with Leadership

# Examples of Resources Widely Available

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- Public Health Departments, e.g., lead programs
- Social services agencies, e.g., United Way, Area Agencies on Aging
- Adult day services
- Community activities, e.g., YMCAs, Silver Sneakers, etc
- Faith organizations

# Examples for Potential Replication

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- New workforces
  - Community health workers
  - Interns, e.g., social work interns working with care coordinators
  - Trained lay people or college graduates, e.g., lay navigators or Health Leads workers
- Medical legal partnerships
- “Everyone Swims” Program
- “Active Living by Design” – community design
- Public Health Playbook

# Clinical Story - Adult

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85-year-old male with a history of chronic heart failure, diabetes, depression, early stage dementia, hypertension, and COPD, who has been hospitalized three times earlier in the year....

- MN Day Services center two days per week
  - Health monitoring, socializes and eats a nutritious meal
  - Exercises twice a week at the YMCA.
- No subsequent hospitalizations.
- Increased strength and balance - -put his cane away - -new lease on life.

# Clinical Story - Child

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- A young child with a regular check-up at a local hospital clinic had an elevated lead screening level of 35 (> 5 is elevated). The NP called the local health department....
  - Lead case manager did a home assessment
  - Resources offered: remediation grants, HealthyStart/Healthy Families Program, and a free HEPA Vacuum cleaner loan program
  - Environmental specialist assessed for other hazards, and followed-up with the property owner to ensure that the remediation was completed

What are the possibilities for population  
medicine/health care to bridge to  
community resources for population  
health?

And vice versa?

What new relationships can we build?

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Local Public Health Association  
*of Minnesota*

# 2014 Legislative Session Summary



**Public Health**  
Prevent. Promote. Protect.

**Local Public Health  
Association of Minnesota**

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**Thanks to LPHA's partners who provided content for this session summary!**  
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Anne Kilzer, Minnesota Workforce Council Association  
Nancy Silesky, Minnesota Inter-County Association  
Melissa Finnegan, Minnesota Department of Health

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# 2014 Legislative Session Overview

Governor Dayton branded 2014 as the “UnSession.” His vision and challenge to legislators was to focus on reform by restricting passage of new legislation and instead working to “eliminate unnecessary or redundant laws, rules and regulations.” With the full House up for re-election, a \$1.2 billion surplus (including \$2.6 billion in the planning years or “tails”), and many controversial policy issues drawing attention, this shorter-than-usual bonding year quickly became anything but an “UnSession.” Over 2,800 bills were introduced in total with 23 more sent to the governor than last year.

The supplemental budget spent all but \$30 million of the \$1.2 billion in the current biennium and committed over \$2 billion of the \$2.6 billion for next session. However, apart from a 4% wage increase to home- and community-based service workers, much of the spending was not memorable. Health and human services (HHS) fared well overall. With a \$1.1 billion deficit in 2013, HHS was the only spending target with a significant decrease; this year, DFL leadership made up for it by assigning HHS the biggest increase of all budget areas.

On the policy side, in contrast to relatively benign UnSession changes, the DFL also pushed through a minimum wage bill lingering from last session and made Minnesota the only state other than Washington that builds in an inflationary factor (set to begin in 2018). The Women's Economic Security Act, anti-bullying legislation, e-cigarette regulation, and legalization of medical cannabis all passed, as well.

Despite a fast pace and Republican party seeking to take back the House in 2015, it was surprising that the minority did not put up more barriers in the process. They ultimately supported a fairly large, bipartisan bonding bill costing \$846 million, and a second capital investment bill spending \$199 million from the general fund for building projects. Even more surprising was that no legislation from either side was heard addressing MNsure, the new health insurance exchange.

Among the things “undone” this session was the loss of a number of longstanding legislative leaders, including Rep.

Tom Huntley – current Democratic HHS Finance Chair – who plans to retire and has served in the House since 1992, and Rep. Jim Abeler – former Republican HHS Finance Chair – who is retiring to run for the federal congressional seat of U.S. Representative Michele Bachmann.

With the full Minnesota House and Gov. Dayton up for re-election, the political machine has not slowed since adjournment. Many are speculating the House will flip back to GOP control in 2015 since the Republicans only need to pick up seven seats. Meanwhile, the gubernatorial race seems to be Mark Dayton's to lose. The presidential party typically does worse in off elections, especially during a second term, so voter turnout will be a significant factor in November. Combine this with a lack of constitutional amendments or other local ballot initiatives driving people to the polls, and the House may well switch. No matter the make-up, the 2015 legislative session will convene at noon on Tuesday, January 6.

***With the full House up for re-election, a \$1.2 billion surplus, and many controversial policy issues drawing attention, this shorter-than-usual bonding year quickly became anything but an “UnSession.”***

# Local Public Health Association Priority Issues

## Strengthen and Streamline the Local Public Health Act

- Since 1976, Minnesota's local public health system has delivered essential services that protect the public's health and safety while allowing flexibility to local governments to identify and address community needs.
- Minn. Stat. 145A – the Local Public Health Act ("LPH Act") – is the primary governing law that is central to the day-to-day operations of local public health departments across Minnesota.
- While the LPH Act was innovative for its time, much has changed over the past 37 years and there is a need to update and enhance the statute in the following ways to align with current public health practice:
  - Define core public health services;
  - Clearly describe the duties of community health boards (CHBs);
  - Strengthen public health leadership; and
  - Articulate expectations regarding performance management.
- The local public health grant is a critical source of flexible, state funding for services delivered under the LPH Act. Since its inception this funding has decreased from \$3 to \$1 per capita. Minnesota now ranks 46th (below almost all other states) in overall public health funding.

**Action Taken:** Changes to the Local Public Health Act, which MDH developed in close collaboration with LPHA, passed successfully as part of the health and human services omnibus policy package.

## Invest in Healthy Families and Healthy Communities

- The Statewide Health Improvement Program (SHIP) aims to reduce health care costs and chronic disease rates through partnerships led by local health departments that make healthy choices easier related to tobacco use and obesity. Statewide, stable funding for this program needs to be maintained to help all Minnesotans live healthier, longer lives. **Action Taken:** SHIP was featured prominently in the Governor's State of the State Address. LPHA thanked many legislators for their support of SHIP last year and informed them that SHIP 3 was off to a good start.
- A healthy homes approach to housing-based health threats identifies and mitigates exposure to hazards like lead, radon, mold, and pests in an efficient and comprehensive manner. Approximately 90% of time is spent indoors with the largest percentage of that time within homes. Local jurisdictions are best able to prioritize health concerns, identify high risk housing, and communicate with residents. **Action Taken:** A healthy housing grant program administered by MDH, which includes community health boards (CHBs) as potential recipients, was established and funded at \$300,000 per year ongoing.
- Local public health departments offer evidence-based family home visiting services which lower public expenditures, help families become healthier and more self-sufficient, and prepare children to succeed in school, stay out of trouble, and enter the workforce. **Action Taken:** Funding to MDH to develop a family home visiting standards and outcomes framework did not pass.

# Omnibus Health and Human Services Policy Bill

The HHS omnibus policy bill ([HF2402/SF2087/CH291](#)) provisions are effective August 1, 2014, unless otherwise specified in the bill language.

**Alcohol and Other Drug Abuse Advisory Council.** Effective immediately, a council is created to advise DHS concerning the problems of alcohol and other drug dependency and abuse. It will consist of ten members, five with interest or training in the field of alcohol dependency and abuse and five with interest or training in dependency and abuse of drugs other than alcohol. Terms ending in even-numbered years will be appointed by the commissioner of human services and terms ending in odd-numbered years will be appointed by the commissioner of health. The council expires June 30, 2018.

**Alzheimer's Training in Housing with Services.** Effective January 1, 2016, housing with services establishment employees are required to fulfill new dementia care training requirements. Each establishment is also required to have a written and posted emergency disaster plan, provide emergency exit diagrams to all tenants upon lease signing and post them on each floor, and have a written policy and procedure regarding missing tenants. MDH must report to the Legislature by February 15, 2015 on an evaluation of the 2014 training requirements, available dementia education options, existing dementia training mandates under state and federal law, and any enforceability concerns after consulting with named stakeholder groups and others.

**Autism Spectrum Disorder Statewide Strategic Plan Implementation.** Effective immediately, the Minnesota Legislative Autism Spectrum Disorder Task Force strategic plan will be implemented collaboratively by the commissioners of education, employment and economic development, health, and human services. Progress reports will be made available to the public twice per year. Two opportunities per year will be provided for interested parties to give input on implementation of the strategic plan. No new money is provided for this effort.

**Automatic External Defibrillator (AED) Registration.** All AEDs displayed for use by the public must be registered with an approved AED Registry and meet certain requirements, including regular maintenance. An emergency response plan related to AEDs must also be developed. Local public safety agencies may inspect public access AEDs during regular business hours and may direct the owners to comply with the new law or remove the AED from a location of public access if it is not ready for immediate use. Liability for a local public safety agency if they know of a malfunctioning or unregistered AED and do not intervene is unclear. The law does not apply to mobile AEDs or those intended for private use, such as those in public safety agency vehicles, or owned or used by hospitals or clinics.

## Child Maltreatment.

- **Common Entry Point.** The Minnesota Vulnerable Adults Act is modified to require county boards to designate a common entry point for reports of suspected maltreatment until the commissioner of human services establishes a common entry point effective July 1, 2015.
- **Report Retention.** For reports alleging child maltreatment that were not accepted for assessment or investigation, counties must maintain sufficient information for 365 days to identify repeat reports



pertaining to the same child or children. The commissioner of human services will specify to counties the minimum information needed to accomplish this, and counties will enter the data into the state social services information system.

**Chronic Conditions.** The commissioner of human services is required to incorporate strategies and activities that address chronic medical or behavioral health conditions complicated by socioeconomic factors such as race, ethnicity, age, immigration or language into DHS planning efforts and design of the state Medicaid plan option under the Affordable Care Act.

**E-cigarette Regulation.** Changes in law restrict the sale and use of electronic cigarettes.

- **Licensing and Sales.** A tobacco license is required to sell e-cigarettes or nicotine and lobelia delivery products. They cannot be sold in open displays or in vending machines, unless the retail store makes 90% of its revenue from the sale of such products. Child resistant packaging is required for the sale of any liquid that is intended for use in an electronic delivery device, and kiosk sales are prohibited (effective January 1, 2015). The sale of e-cigarettes to minors is prohibited.
- **Local Preemption.** Political subdivisions or businesses may adopt stronger prohibitions on the use of e-cigarettes.
- **Vape-free Spaces.** The use of e-cigarettes, or "vaping," is prohibited in: public schools; day care centers or group family day care provider homes; hospitals; health care clinics; doctor's offices; licensed residential facilities for children; other health care-related facilities; buildings owned or operated by the state, home rule charter or statutory cities, counties, townships, school districts, or other political subdivisions; any facility owned by the Minnesota State Colleges and Universities or the University of Minnesota; any facility licensed by DHS; and, any facility that is both licensed by MDH and subject to federal licensing requirements.

**Human Services Administrative Simplification.** Eligibility is simplified across income and support programs including the Minnesota Family Investment Program, the Diversionary Work Program, General Assistance, Minnesota Supplemental Assistance, and Group Residential Housing. This streamlining will align how assets, earned income disregards, reinstatement requirements, and self-employment income are treated across the various programs. The provisions were developed by a DHS-led interim working group, which included AMC and MACSSA members. One benefit of making these rules more uniform is that it will position DHS better to fully leverage the technology modernization investments from last session by enhancing the ability to automate. The simplification will additionally reduce error rates, enhance program integrity, and reduce costs. The process should be easier both for clients and the county case workers assisting them.

## **Immunizations.**

- **Dentists.** Qualified licensed dentists may administer influenza vaccinations to patients over 19 years old. The dentists must have received training in the administration of immunizations and must report the administration of an influenza vaccination to the Minnesota Immunization Information Connection or the patient's primary physician or clinic.
- **Pharmacists.** The Minnesota Practice of Pharmacy Act is aligned with national immunization best practice standards by specifying protocols for immunization administration in a pharmacy.

**Indoor Tanning.** It is now unlawful for a tanning facility or operator to allow a person under age 18 to use any tanning equipment. Signage to this effect must be conspicuously posted on site. Violation is a petty misdemeanor.

**Local Public Health Act.** Revisions to the Local Public Health Act, Minn. Stat. 145A, passed which update confusing and unclear sections, clarify or remove “legacy language,” and align the statute with current practice. Members of LPHA and AMC – along with MDH staff – participated in a working group to develop these changes, which passed almost entirely as written. One amendment was approved which ensures that those programs (city or county) that currently have environmental health delegations with the commissioner of health may continue to be delegated to perform these services in the future even if they are not linked to a community health board.

**Mammogram Results Notice to Patient.** A facility that conducts breast cancer screening or diagnosis through mammograms must provide notice to a patient who is categorized via screening as having dense breasts.

**Minnesota Family Investment Program (MFIP) Recertification.** A county agency must end benefits when the participant fails to submit the recertification form and verifications, and complete the interview process before the end of the certification period. If the participant submits the recertification form by the last day of the certification period, benefits may be reinstated back to the date of closing when the recertification process is completed during the first month after benefits ended.

**Minority Run Health Care Professional Associations.** MDH is required to award grants to minority run health care professional associations to provide collaborative mental health and health care services to minority residents and to collaborate on recruitment, training, and placement of minorities with health care providers.

**Smoke-free Child Foster Care.** Providing a smoke-free environment is now a factor in determining foster care placement for children. A smoke-free home is not required, but smoking behavior in the house must be considered. Great flexibility is granted to counties in determining the proper balance regarding placements. Nothing will delay the placement of a child with a relative unless immediate health needs for that child are threatened. Additionally, if a child's best interests would most effectively be served by placement in a home which does not meet the non-smoking requirements, smoking behavior will not be sufficient to deny placement. A list of settings is delineated in which a foster child must not be exposed to second hand smoke and the home study must now include a plan to maintain a smoke-free environment. The child-placing agency must ask foster parents who do not provide a smoke-free environment to comply with a plan that includes training on the health risks of exposure to second hand smoke. The law does not apply to traditional or spiritual Native American or religious ceremonies involving tobacco use.

**Statewide Procurement.** A statewide procurement and competitive bidding process is instituted in 2015 for contracts effective in 2016 for managed care under the Basic Health Plan/MinnesotaCare. This includes an emphasis on consultation with counties and attention to special needs and concerns of the diverse populations to be served.

**Suicide Intervention in Adult Foster Care.** Additional training requirements for adult foster homes



that serve people with mental illness are to be approved by the commissioner of human services in the areas of suicide intervention, identifying suicide warning signs, and appropriate responses. Foster care homes will be required to have a crisis plan for each resident.

**Temporary Assistance for Needy Families (TANF) Expenditures Task Force.** A task force is established that will look at past TANF expenditures and make recommendations as to which, if any, programs currently receiving TANF funding should be funded by the general fund so that a greater portion of TANF funds can go directly to families receiving assistance through MFIP.

Membership of this task force includes:

- One representative of DHS, appointed by the commissioner.
- One representative of Management and Budget, appointed by the commissioner;
- One representative of MDH, appointed by the commissioner;
- One representative of the Local Public Health Association;
- Two representatives of county government appointed by AMC, one representing counties in the seven-county metropolitan area and one representing all other counties;
- One representative of the Minnesota Legal Services Coalition;
- One representative of the Children's Defense Fund of Minnesota;
- One representative of the Minnesota Coalition for the Homeless;
- One representative of the Welfare Rights Coalition;
- Two members of the House of Representatives, one appointed by the speaker of the house and one appointed by the minority leader; and
- Two members of the Senate including one member of the minority party, appointed according to the rules of the Senate.

The task force will consider:

- The purpose of the TANF block grant under federal regulations;
- The potential overlap of the population eligible for the MFIP cash grant and the other programs currently receiving TANF funds;
- The impact of past expenditures on families who may be eligible for assistance through TANF; and
- The role of noncash assistance expenditures in maintaining compliance with federal law.

The task force will submit an initial report on past expenditures of the TANF block grant in Minnesota to the Legislature by November 30, 2014. A final report, including any draft legislation necessary for implementation, is due by February 1, 2015.

**Triclosan Health Risks.** MDH is directed to develop recommendations on ways to minimize triclosan health risks. Triclosan is an antibacterial and antifungal agent found in numerous consumer products which has raised questions in recent studies as to its effect on both individual health and the environment since it may disrupt hormone regulation, harm the immune system, and/or perpetuate antibiotic-resistance in germs.

# Omnibus Supplemental Appropriations Bill

The supplemental appropriations omnibus bill ([HF3172](#)/[SF2785](#)/[CH312](#)) provisions are effective July 1, 2014, unless otherwise specified in the bill language.

## Autism.

- **Medical Assistance (MA) Benefits.** There is a new benefit under MA called the Autism Early Intensive Intervention Benefit, costing \$12.7 million. Covered services will seek to improve communication skills, increase capacity for social interactions, and reduce maladaptive behaviors for children with autism spectrum disorder at a critical time in their development. After approval of the benefit by the Centers for Medicare and Medicaid Services, training for providers is also established for culturally and linguistically diverse communities. The training for families, lead agencies, advocates, and other interested parties must provide information about the benefit and how to access it.
- **Resource Website.** \$769,000 is appropriated one time, expiring on June 30, 2017, for development of an interagency (education, employment and economic development, health, and human services) website with autism-related resources for children and adults with autism spectrum disorder, their family members, and other interested parties.

**Detoxification Services Medical Assistance (MA) Coverage.** \$75,000 is allocated to DHS to develop a plan to include detoxification services as a covered MA benefit. The plan must be presented to the Legislature at the end of 2014.

**Early Childhood Family Education (ECFE).** An ECFE program that levies for home visiting must incorporate evidence-informed parenting education practices designed to support the healthy growth and development of children, with a priority focus on children with high needs. They must also provide information about and assist in making arrangements for an early childhood health and developmental screening. Finally, it recommends that the home visiting program be provided by licensed parenting educators, certified family life educators, or professionals with an equivalent license that reflect community demographics to the extent possible. Public health evidence-based models and Head Start home visiting are called out as examples of existing agencies and community-based organizations with which ECFE should strive to collaborate.

**Food, Pools and Lodging in St. Paul.** \$670,000 in FY14 is appropriated to cover the cost of regulating food, pool and lodging establishments in the City of Saint Paul. Existing fee revenue covers the cost of the appropriation.

**Health Care Grants for Uninsured Individuals.** \$1.7 million is appropriated in FY15 and \$1 million per year starting in FY16 for grants to safety net providers who serve low-income and uninsured individuals. Providers eligible for the grants include dentists, community mental health centers, hospitals serving Emergency Medical Assistance clients, and community health centers.

**Health Equity.** \$501,000 in FY15 is appropriated for MDH to make grants to address health equity and health disparities. A portion of the funds must be used to: address health equity issues facing East African communities; conduct a conference focused on mental health in immigrant and refugee communities; and fund women's reproductive health and dementia outreach projects.

**Healthy Housing Grants.** \$300,000 in FY15 is appropriated for healthy homes activities including \$60,000 for lead poisoning prevention and \$240,000 for healthy housing implementation grants. \$600,000 is appropriated for FY16-17 and is added to the base. MDH will administer the grants which can go to community health boards, non-profits, and CAP agencies to: implement and maintain primary prevention programs to reduce housing-based health threats; provide training; provide technical assistance on the implementation of mitigation measures; promote adoption of evidence-based best practices for mitigation; develop work practices for addressing housing-based health threats; identify hazards in housing that contribute to adverse health outcomes; ensure screening services are provided to high-risk populations; establish local or regional collaborative groups to ensure that resources are coordinated; and develop model programs for addressing housing-based health threats.

**Home- and Community-Based Services (HCBS) Rate Increase.** \$80.3 million for FY14-15 and \$192.7 million for FY16-17 passed to increase compensation for those who serve the elderly and disabled in their homes through HCBS waivers. Under the measure, 80% of the increase must go to workers' wages.

**Homeless Youth Act.** An additional \$1 million in grants is given to support the Homeless Youth Act, which provides funding to non-profits that offer street outreach, drop-in centers, emergency shelter, transitional living programs and/or supportive housing for runaway, at-risk and homeless youth. Grants to 30 nonprofit agencies and tribal governments currently fund these services.

**Human Services Administrative Simplification.** \$385,000 is appropriated for FY14-15 and \$11.139 million for FY16-17 to implement the policy changes outlined above around streamlining eligibility requirements for human services.

**MinneMinds.** Early learning scholarships intended to increase access to high-quality early childhood programs for three- to five-year-old children with the highest needs received an additional \$4.65 million this year. The base for FY16 and later will be \$27,884,000.

**Minnesota Family Investment Program (MFIP) Family Cap Repeal Date.** The MFIP family cap repeal will now be implemented July 1, 2014 rather than January 1, 2015. The Housing Allowance goes into effect on July 1, 2015.

**Nonemergency Medical Transportation (NEMT).** An advisory committee on NEMT, which included representatives from AMC and MACSSA, agreed to a two-year delay for implementation of a single administrative structure to allow time for the state to design a web-based system. DHS is directed to complete the task by July 1, 2016. Until then, the state will continue to do level of need assessments and manage assisted rides. Counties will continue to manage unassisted rides. Counties have flexibility to manage their own systems and choose whether or not to work with a broker. Four county representatives will sit on the advisory committee, which will continue to meet on a quarterly basis. Two of the appointments will be made by the Minnesota Inter-County Association, and two will be made by AMC. The Legislature did not appropriate necessary funding for the program. DHS will include the advisory committee's funding recommendations in its budget recommendations in 2015. The recommendations will address no-load miles, increased reimbursement rates for volunteer drivers, reclassification of ATS and STS modes, and restoration of the providers' rate.

**Obesity Pilot.** \$50,000 is granted to the Amateur Sports Commission to develop a pilot program to prevent and reduce childhood obesity. The appropriation is one time, available until June 30, 2017.

**Oral Health Delivery and Reimbursement System.** DHS, in consultation with MDH, will convene a work group to develop a new delivery and reimbursement system for oral health and dental services provided to enrollees of the state public health care programs. The new system must ensure cost-effective delivery and an increase in access to services. DHS will submit a report by January 15, 2015.

**Parent Aware Quality Rating and Improvement System Accessibility Report.** DHS, in consultation with stakeholders including MDH, will make recommendations to the Legislature on increasing statewide accessibility for child care providers to the Parent Aware quality rating and improvement system and for increasing access to Parent Aware-related programs for families with children. DHS will submit a report to the Legislature by February 15, 2015.

**Physical Education (PE) Study.** The commissioner of education will prepare a written report on K-12 students' experience with PE. The report will include:

- The number of minutes per day and frequency per week students in each grade level, kindergarten through grade 8, receive PE;
- The measures and data used to assess students' level of fitness and the uses made of the fitness data;
- The educational preparation of PE instructors and the proportion of time certified PE teachers provide PE instruction;
- The amount of time and number of days per week each grade level, kindergarten through grade 6, receives recess;
- Whether high school students are allowed to substitute other activities for required PE and, if so, which activities qualify;
- The number or percentage of high school students who earn required PE credits online;
- Whether schools offer before or after school physical activities opportunities in each grade level, kindergarten through grade 8, and in high school and, if so, what are the opportunities; and
- The extent to which schools coordinate with developmentally adaptive PE specialists when needed.

No new money is appropriated to develop the report.

**Safe Harbor for Sexually Exploited Youth.** An additional \$1 million is appropriated for grants for Safe Harbor programming for comprehensive services, including trauma-informed, culturally specific services for youth who are sexually exploited. The commissioner of health may use up to \$100,000 to administer these grants.

**Safe Routes to School.** \$250,000 for FY14-15 and \$500,000 for FY16-17 is appropriated for non-infrastructure grants to local jurisdictions for uses like training and SRTS planning. In addition, in the omnibus capital investment cash bill ([HF1068/SF882/CH295](#)), the Legislature appropriates \$1 million for infrastructure grants for uses like sidewalks and safer crossings.

**School Lunch Reimbursement.** The state lunch reimbursement rate is increased for reduced-price school lunches, covering the entire cost for eligible students. Approximately 61,500 low-income children

and teens will be impacted by this change. The cost to the state is an additional \$3.5 million in fiscal year 2015, with the cost slightly ramping up over ensuing years.

# Other Bills Signed Into Law Impacting Public Health

## All Payer Claims Database Modifications. [HF2656/SF2106/CH178](#)

The All Payer Claims Database (APCD), a database of claims paid by Minnesota health plans and third-party administrators, was established in 2008 as part of Minnesota's bipartisan health reform efforts. At that time, use of the APCD was limited to MDH's Provider Peer Grouping (PPG) program and a study of the feasibility of developing a state-specific risk adjustment system. The new law suspends the PPG program. It also creates new allowable uses of the APCD for MDH which include evaluating the Health Care Home program and the MDH/DHS State Innovation Model grant, studying readmission trends, and analyzing variations in cost, quality, utilization and illness burden by geography or population. Finally, it directs MDH to establish a work group to make recommendations to the Legislature on a range of issues related to data access, privacy/security, types of projects that could use APCD data, and financial sustainability. A report is due to the Legislature on February 1, 2015.

## Data Security.

- **Government Breaches.** [HF183/SF211/CH284](#) The law imposes essentially the same duties on local government as now exist for state government when a breach of private data occurs. Those duties include written notice to the victims and a subsequent report following final disposition of any disciplinary action including exhaustion of all rights of appeal under any applicable collective bargaining agreement. The report must include: 1) a description of the types of data that were accessed or acquired; 2) the number of individuals whose data was improperly accessed or acquired; 3) the name of each employee determined to be responsible for the unauthorized access or acquisition, unless the employee was performing duties under the Safe at Home Act; and 4) the final disposition of any disciplinary action taken against each employee. The knowing, unauthorized acquisition of not public data is made a misdemeanor as well as just cause for suspension from employment. The responsible authority must establish procedures for ensuring that data that are not public are only accessible to persons whose work assignment reasonably requires access to the data, and is only being accessed by those persons for purposes described in the procedure. Further, the responsible authority must develop a policy incorporating these procedures, which may include a model policy governing access to the data if sharing of the data with other government entities is authorized by law.
- **Legislative Commission on Data Practices and Personal Data Privacy.** [HF2120/SF2066/CH193](#) The Legislative Commission on Data Practices and Personal Data Privacy is established to study issues relating to government data practices and individuals' personal data privacy rights, and to review legislation on these issues. The commission consists of five senators and five representatives, with no more than three from the majority caucus in each chamber. The commission must convene its first meeting by June 15, 2014.
- **Private Entities.** [HF2167/SF1770/CH293](#) Statute will now effectively preempt application of the 2013 Minnesota Supreme Court's ruling in *Helmsberger v. Johnson Controls*. It provides that a private contractor performing a government function under a contract is subject to the Data Practices Act regardless of whether those specific terms are included in the contract. The law reads, "All contracts entered into by a government entity must include a notice that the requirements of this

subdivision apply to the contract. Failure to include the notice in the contract does not invalidate the application" of this statute.

### **Drug Overdose Prevention and Assistance ("Steve's Law").** [HF2307/SF1900/CH232](#)

Steve's Law was proposed in response to the increasing number of deaths caused by heroin overdose. The law permits certain individuals including emergency medical responders, peace officers, and staff of community-based health disease prevention or social service programs, to administer opiate antagonists (such as naloxone hydrochloride or Narcan) to a person experiencing a drug overdose. A standing order or individual protocol must be in place and the administering individual must have training recognition of opiate overdose and use of antagonists as a part of emergency response. Good faith administration of an opiate antagonist by someone who is not a health professional is immune from criminal prosecution and civil damages. There is a release from liability for health professionals, as well. Immunity is also provided for someone seeking medical assistance for another person who is experiencing a drug-related overdose. They can't be charged with possession, sharing, or use of a controlled substance, or possession of paraphernalia. The reporting individual must remain on the scene, provide a name, cooperate with authorities, and be the first person to seek assistance. The same immunity applies to the individual experiencing the overdose. However, it does not preclude prosecution if other independent evidence is available.

### **Farmers' Market Regulation.** [HF2178/SF2060/CH163](#)

A definition of "farmers' market" is provided. Food sampling and demonstrations at a farmers' market or community event are exempt from being licensed. Food safety rules (Chapter 4626) still apply. Seasonal temporary food stands may now operate for more than 21 days annually at one place with the approval of the regulatory authority. Finally, a statutory exemption is carved out for chili or soup cook-off fundraisers conducted by a community-based nonprofit organization. The sponsoring organization must develop food safety rules and ensure that participants follow these rules and place a sign or placard stating "These products are homemade and not subject to state inspection." Foods exempt under this clause must be labeled to accurately reflect the name and address of the person preparing the foods.

### **Incarcerated Pregnant Women.** [HF2833/SF2423/CH234](#)

Specific standards are put in place related to women who are pregnant or have recently given birth in an effort to improve the birth outcomes of pregnant women in jails and prisons and to help ensure the health of babies born in those settings. Among the provisions are limits on use of certain restraints on pregnant women, required pregnancy and STD testing, educational materials related to child birth, and mental health assessment and treatment, if needed, while pregnant and immediately postpartum.

### **Joint Powers.** [HF2939/SF2490/CH223](#)

The Public Employee Labor Relations Act is modified to set out new rules that impact public employees and public employers whenever a new joint powers entity is formed that has its own governing board and the authority to hire its own employees. The new law does not impact when one local government entity contracts with another entity, nor does it apply to the formation of a Service Delivery Authority. These changes will apply to entities formed after January 15, 2015. The law sets out a specific process to determine whether local government employees that are assigned to a new joint powers entity



choose an employee representative (union), and how that employee representative is chosen if employees represented by multiple unions are assigned to the new entity. The law also grants employers the authority to discipline an employee for just cause who, at the time the joint powers entity was formed, would have been subject to discipline by a member of the entity. The new entity will also have the authority to receive access to private and confidential data relating to employees of the governmental units who become employees of the entity.

**Local Government Sales Tax Exemption.** The omnibus supplemental tax bill ([HF3167/SF2726/CH308](#)) contains important changes to the county and city sales tax exemption that was approved in 2013, and took effect January 1, 2014. Currently, the sales tax exemption for local governments covers purchases made by cities, counties and towns. Under the new law, the exemption will be expanded to include:

- Special districts (under M.S. 6.465);
- Any instrumentality of a city, county, or township (under M.S. 471.59); and
- Any joint powers board or organization (under M.S. 471.59).

These new entities will become exempt on January 1, 2016, except the Metropolitan Council will become exempt on January 1, 2017. In addition, local government groups worked to modify the provision in current law that prohibits local governments from taking advantage of the sales tax exemption on purchases made as inputs to "goods and services generally provided by a private business." The new law strikes the "private business" clause, and replaces it with a definitive list of purchases that will remain taxable. This list will include purchases by local governments for: a liquor store; gas or electric utility; solid waste hauling service; solid waste recycling service; landfill; golf course; marina; campground; café; and/or laundromat. This new definitive list, and the striking of the "private business clause," will take effect on June 30, 2014.

### **Medical Cannabis.** [HF2846/SF2470/CH311](#)

Minnesota is now the 22nd state to grant some legal level of access to marijuana for medicinal purposes. Approximately 5,000 patients will have access to medicinal cannabis by July 1, 2015. Conditions eligible for treatment include:

- Cancer associated with severe or chronic pain, nausea or severe vomiting, or severe wasting;
- Glaucoma;
- HIV/AIDS;
- Tourette's syndrome;
- ALS (Lou Gehrig's disease);
- Seizure-inducing epilepsy;
- Severe and persistent muscle spasms brought on by Multiple Sclerosis;
- Crohn's disease; and
- Terminal illness with a life expectancy of less than a year or that causes severe pain, nausea, severe vomiting or wasting.



The health commissioner has the authority to add additional medical conditions to the eligibility list in the future. MDH will oversee manufacture of the drug at two sites and set up a distribution center in each of the state's eight congressional districts. Private contractors will bid for the manufacture and distribution. Patients will be enrolled in a patient registry supervised by MDH and pay a \$200 annual fee to help cover program costs, or \$50 for those on Social Security disability or enrolled in Medical Assistance or MinnesotaCare. To obtain the drug, patients will need to be certified as eligible by a doctor, physician assistant or advanced practice nurse. Health care providers are required to provide ongoing reports to the state on the patient's health status and condition for what is technically being called "observational research." Patients will get the drug in liquid, pill or by vaporized delivery method. Smoking of marijuana is not permitted. Participants found guilty of transferring medical marijuana to anyone who is not a registered patient can be fined up to \$3,000.

### **Minimum Wage.** [HF2091/SF1775/CH166](#)

The minimum wage for large employers (more than \$500,000 in annual sales) is increased to \$8 per hour on August 1, 2014, \$9 per hour on August 1, 2015, and \$9.50 per hour on August 1, 2016. The minimum wage for small employers is increased to \$6.50 per hour on August 1, 2014, \$7.25 per hour on August 1, 2015, and \$7.75 per hour on August 1, 2016. Beginning in 2018, all wages will increase each year on January 1 by the rate of inflation measured by the implicit price deflator, with a cap of 2.5%. The indexed increase could be suspended for one year by the commissioner of labor and industry if leading economic indicators suggest the possibility of a substantial downturn in the economy. The suspension could only be implemented after a public hearing and public comment period. In better economic times, the suspended inflationary increase or a lesser amount could be added back into the minimum wage rate in a subsequent year.

### **Newborn Screening.** [HF2526/SF2047/CH203](#)

MDH has regained authority to retain blood samples from newborn babies indefinitely for public health and research purposes unless a parent refuses permission. The new law effectively reverses a 2011 Minnesota Supreme Court order, which had required MDH to destroy millions of blood samples that tested negative for disease after 71 days and samples that tested positive after two years, unless parents "opted in" and gave written consent to keep them. The state can now retain the samples unless parents opt out. Newborn screening information must now be provided to legal guardians (in addition to parents) and be made available to childbirth education programs (in addition to prenatal health care providers). MDH is required to promote information materials about the program and encourage providers/education programs to thoroughly discuss with new parents and expectant parents. The law is clear that a parent or legal guardian can ask for the screening, but have the right to still refuse storage. They can also authorize in writing that the blood samples and test results may be used for public health studies or research. The child may also make these requests upon turning 18 (requirements to discontinue storage after 18 years were removed). The "operations" the stored spots can be used for are expanded to include follow-up services for those with heritable and congenital disorders and the development of new tests. If consent to store is withdrawn at any time, MDH has 30 days to destroy the spots and test results from receipt of the request.

### **Safe and Supportive Schools Act.** [HF826/SF783/CH160](#)

Bullying is more formally prohibited in Minnesota schools by requiring each district and school to consult with students, parents, and the community at-large to put in place and implement a written policy to prevent and prohibit student bullying. A state model policy is provided. They also must establish research-based best practices around prevention, remediation, and discipline for bullying behavior. These policies must be made available to the public on the school or district website. Staff training related to bullying is required at regular intervals. A 23-member multiagency leadership council is established to improve school climate and school safety across Minnesota. The commissioner of education is required to establish a school safety technical assistance center at the department (expiring June 30, 2019). The bill defines bullying, including cyber-bullying, and would specifically prohibit it on the basis of sexual orientation, race or religion, among other characteristics. It would apply to actions on school premises, at school functions, on school transportation or by use of school technology.

**Supplemental County Program Aid.** In the omnibus tax bill ([HF1777/SF75/CH150](#)), the eleven counties that received a program aid reduction in 2014 (because of rising tax bases) will receive a one-time supplemental aid equal to the drop in aid between 2013 and 2014. This supplemental aid will be paid to the following 11 counties: Big Stone; Chippewa; Faribault; Grant; Lac qui Parle; Marshall; Martin; Norman; Pipestone; Stevens; and Yellow Medicine.

### **Synthetic Drug Regulation.** [HF2446/SF2028/CH285](#)

In an effort to combat the ever changing world of synthetic drug manufacture and sale, the Board of Pharmacy is given broader authority to identify and classify substances as synthetic drugs for the purposes of applying existing statute that prohibits the production and distribution of these substances. The new law focuses on stopping the retail sale of synthetic drugs and educating the public regarding the dangers of the product. The Board of Pharmacy is permitted to issue cease and desist orders to businesses selling synthetic drugs that contain a banned substance. The Board can now use expedited rulemaking authority to ban newly identified substances used to make synthetic drugs and have that decision later ratified by the Legislature. However, that authority is set to expire on August 1, 2014. The law makes the Board's action final, but permits the Legislature to overturn a decision. Sellers of synthetic drugs offering the drug under the false pretense that the substance is legal would be ordered by a court to pay restitution for the costs and expenses resulting from the sale. This could include emergency response and potential long-term care costs for the victim. Other provisions include providing \$163,000 in fiscal year 2014 from the general fund to have DHS work to increase public awareness about the dangers of synthetic drugs and expanding the statutory definition of drug to include "any compound, substance, or derivative which is not approved for human consumption by the United States Food and Drug Administration or specifically permitted by Minnesota law."

### **Triclosan in Retail Products.** [HF2542/SF2192/CH277](#)

Retail sale of some consumer cleaning products containing triclosan is prohibited. Individual products already approved by the FDA for consumer use are exempted. The provisions go into effect on January 1, 2017. The measure was part of a larger environmental bill regulating mercury and lead.

## **Women's Economic Security Act.** [HF2536/SF2050/CH239](#)

Among other things, this law:

- Expands unpaid leave under the Minnesota Parental Leave Act from six to 12 weeks and allows use of leave for pregnancy-related needs. The leave must begin within six months of the birth or adoption. The parental or pregnancy leave may be reduced by any period of paid parental, disability, personal, medical or sick leave, accrued vacation, or leave taken for the same purpose under federal law.
- Expands the use of personal sick leave to cover the care of a mother-in-law, father-in-law, or grandchildren; and for use in circumstances of domestic abuse, sexual assault, and stalking.
- Requires employers to provide reasonable accommodations for employees for health conditions related to pregnancy or childbirth if the employee requests accommodation with the advice of her licensed health care provider or certified doula, unless the accommodation would impose an undue hardship on the operation of the employer's business. It specifies that a pregnant employee is not required to obtain the advice of her health care provider or doula, and that an employer cannot claim undue hardship for the following accommodations: more frequent restroom, food, and water breaks; seating; and limits on lifting over 20 pounds.
- Modifies language related to nursing mothers to add that the space an employer must make a reasonable effort to provide must be other than a bathroom, be shielded from view and free from intrusion from coworkers and the public, and must include access to an electrical outlet.
- Prohibits employment discrimination on the basis of familial status.
- Adds sexual assault and stalking to the list of reasons that provide an exception to the denial of unemployment benefits to applicants that quit employment.

# Public Health Items That Did Not Become Law

## Did Not Pass

### **Asthma Best Practices.** [HF1479/SF1317](#)

The House bill would have provided coverage for asthma management interventions under early and periodic screening, diagnosis, and treatment services and coverage for enhanced asthma care services under Medical Assistance. The Senate bill would have required DHS to develop a comprehensive, statewide asthma care plan.

### **Cancer Surveillance System Data Reporting.** [HF2878/SF2545](#)

This bill would have required the commissioner of health to include data in the cancer surveillance system on all previous occupations, dates, and places of work, and time and place of any military service of a cancer patient.

### **Genetically Modified Organisms (GMOs).** [HF3349/SF2865](#)

A bill requiring the labeling of GMO foods received only an informational hearing this year.

### **MFIP Random Drug Testing Repeal.** [HF1987/SF1738](#)

Bills were introduced in both the House and Senate which would have removed the 2012 requirement that counties perform random drug testing on recipients of general assistance who had been previously convicted of a drug related offense. The bill proposed would have allowed counties the flexibility to conduct this type of screening, but not have required it.

### **Tobacco Tax Repeal.** [HF3303/SF2910](#)

This bill would have eliminated the higher tax rate on large cigarettes and repeal annual indexing of the cigarette tax.

### **Toxic Free Kids Act.** [HF605/SF466](#)

This bill would have provided a process for manufacturers to report to the Pollution Control Agency regarding priority chemicals contained in children's products, and would require that the presence, concentration, and total amount of any priority chemical in a specific children's product be classified as public data. It would have additionally required manufacturers to disclose the presence of toxic chemicals in toys, school supplies, and personal care products.