

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED RULES OF THE MINNESOTA DEPARTMENT OF HEALTH RELATING TO THE APPROVAL OF EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS.

ORDER OF THE CHIEF HEARING EXAMINER

The above-entitled matter was submitted to the Chief Hearing Examiner for review pursuant to the provisions of Minn. Stat. § 15.052, Subd. 4, and Minn. Rule HE 107, on Friday, September 15, 1978. This review is limited to ensuring compliance with Minn. Stat. § 15.0412, Subd. 4, to determine whether or not the rules as finally adopted are substantially different from those proposed prior to hearing.

Based upon a review of the record, the Chief Hearing Examiner makes the following:

FINDINGS OF FACT

1. A Notice of Hearing was published in the State Register and mailed to all persons who had registered with the Secretary of State at least 30 days prior to the hearing. The Report of the Hearing Examiner, at Finding 3, indicated that the Department mailed the Notice of Hearing on January 6, 1978. The Affidavit of Mailing, which is found as Agency Exhibit No. 8, indicates that the Notice was mailed on December 28, 1977.

2. The full text of the proposed rules was published at least 30 days prior to the first day of hearing.

3. All documents required to be filed prior to the hearing pursuant to Minn. Rule HE 103 were filed on January 6, 1978, which is more than 25 days prior to the hearing.

4. During the hearing, the Department of Health proposed to amend the rules as originally proposed in several areas and the Hearing Examiner issued his report on the rules as amended at the time of hearing.

5. Rule 7 MCAR § 1.175 A.2.b., as originally proposed, contained a footnote which read: "It is recommended that approved programs provide immunizations on site." The rule as amended at the hearing deleted the footnoted recommendation and adds language which makes on-site immunizations mandatory with certain exceptions which includes a proviso that the local agency can obtain medical supervision of this service.

6. Rule 7 MCAR § 1.175 A.2.g.(2) and 7 MCAR § 1.176 D. 2.a. use the word "may" which provides for agency discretion but without including criteria or standards by which the agency will exercise this discretion.

Based upon the foregoing Findings of Fact, the Chief Hearing Examiner makes the following:

CONCLUSIONS

1. The Minnesota Department of Health has complied with the procedural provisions of Minn. Stat. § 15.0412, Subd. 4, and the procedural requirements of the Rules of the Office of Hearing Examiners.

2. The use of the term "may" in the rules cited in Finding 6 above without having enumerated standards or criteria by which the agency will exercise its discretion has been determined by the Attorney General to be contrary to law and, therefore, unreasonable. The Chief Hearing Examiner must then conclude that for purposes of these two rules, as drafted, the agency has failed to make an affirmative presentation of facts showing the reasonableness of the utilization of the term "may". The Chief Hearing Examiner further concludes that should the agency amend these two rules to establish sufficient standard and criteria, that it would not result in a "substantial change" necessitating further review by the Chief Hearing Examiner.

3. That the amendment to Rule 7 MCAR 1.175 A.2.b. is a substantial change in that it changes the rule from a recommendation to a mandatory requirement which is a major substantive change that was not raised by the original Notice of Hearing in such a way as to invite reaction at the hearing.

NOW, THEREFORE, pursuant to the provisions of Minn. Stat. § 15.052, Subd. 4, and Minn. Rule HE 108, the Minnesota Department of Health shall either withdraw the proposed final rules discussed in the conclusions above, amend those discussed in conclusion 2, or reconvene the rule hearing.

Dated this 18th day
of September, 1978.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

#482 Dept of Health

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 11-8 Temporary Rule _____

Resubmitted and Received 12-21

DUE DATE 11-28 / 12-29

a. Returned to Agency w/o filing w/Secy of State 11-21-78
b. Approved _____ Date Sent Back to Agency _____

- -

1. Rules as Adopted ✓
2. Rules as Proposed ✓
3. Certificate of Board's Authorizing Resolution, where applicable _____
4. Order for Hearing ✓
5. Notice of Hearing ✓
   (i) Sufficiency ✓
6. Secretary of State's List ✓
7. Certificate of Acquisition of Secretary of State's List ✓
8. Affidavit of Mailing ✓
   (i) At least 30 days prior to hearing ✓
9. Statement of Need and Evidence ✓
10. Hearing Examiner's Report ✓ (supplem findings too:)
11. Agency's Findings of Fact ✓
12. Certificate of Board's Resolution Adopting Rules, where applicable _____
13. Order Adopting ✓ attached to findings
14. Report of Chief Hearing Examiner ✓
    (i) Finding of No Substantial Change No - But Ag recanted so its O.K.
    (ii) Permission to Incorporate by Reference, where applicable ✓ (done before hearing)
15. Certificate of Compliance with Rulemaking Procedures ✓
16. Copy of Notice of Intent to Solicit Outside Opinion, where applicable ✓
17. Petition by Public, where applicable _____.

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : Joanne Hinderaker
Special Assistant
Attorney General
Department of Administration

DATE: December 18, 1978

FROM : Terry P. O'Brien
Special Assistant
Attorney General

PHONE: 5371

SUBJECT: Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

Pursuant to your memo of November 21, 1978, with regard to the above-referenced topic, I am enclosing for your review three copies of an amended order adopting the rules and three copies of the amended rules. It is my understanding that the other requisite documents have been retained by your office.

Thank you for the time you have expended in reviewing the file for these rules. I apologize for the hassle.

If you have any questions with regard to these new documents, please do not hesitate to contact me. Thank you.

TPO:cs

Enclosures

RECEIVED
DEC 2 1 1978
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Terry P. O'Brien
Special Assistant
Attorney General

DATE: November 21, 1978

FROM : Joanne Hinderaker JH
Special Assistant
Attorney General

PHONE: 296-4692

SUBJECT: Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

The above-captioned rules have not been approved by this office for the following reasons:

1. In 7 MCAR § 1.175 A.2.g.(1) there is a reference to the Denver Prescreening Developmental Questionnaire (PDQ) with its manual. No such manual was incorporated by reference in the proposed rule prior to the hearing. It appears that no such manual exists, in which case any reference to it should be deleted.

2. In 7 MCAR § 1.175 A.2.h.(1) there is a reference to the 1977 Edition of VASC Manual which is apparently a reference to the 1977 Edition of the "Minnesota Fortunate Fours" Handbook which was incorporated by reference upon the approval of the Chief Hearing Examiner prior to the hearing on these rules. This rule should be amended so as to refer to the appropriate document title.

3. Finally, it is suggested that the citations to DPW and SDE rules in 7 MCAR § 1.174 should be made more specific and reference the rules in their codified MCAR form if such citations are available. Furthermore, it is advisable to change the statutory citation in 7 MCAR § 1.174B.13 to Minn. Stat. § 123.701 et seq.

Upon the Health Department's consideration of this decision, and after any action taken in this regard, please resubmit three copies of amended order adopting the rules together with three copies of the amended rules to this office.

Copies of the other requisite documents from the file have been retained by our office.

JH:mb

Enclosure

cc: Duane Harves

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of Proposed Rules
Relating to Approval of Early and
Periodic Health and Developmental
Screening Programs

AMENDED ORDER
ADOPTING RULES

The Supplemental Findings of Fact, Conclusions and Order issued on November 2, 1978, which adopted the above-referenced rules, are confirmed and continued except as such order may be inconsistent with this AMENDED ORDER ADOPTING RULES. The Rules approved in the Supplemental Findings of Fact, Conclusions and Order issued November 2, 1978, shall be adopted except that such rules shall be modified in accordance with changes as recommended by the Office of the Attorney General. The changes as set forth herein are as follows:

1. 7 MCAR § 1.175A.2.g.(1) originally referred to " . . . the Denver Prescreening Developmental Questionnaire (PDQ) with its manual . . . . " Inasmuch as there is no manual for this test, the phrase "with its manual" is deleted from the rule as finally adopted. The rule as finally adopted shall read as follows:

> (1) In order to access these developmental areas, MDH recommends the use of the Denver Prescreening Developmental Questionnaire (PDQ) and the Denver Developmental Screening Tests (DDST) with this manual or an acceptable alternative meeting the criteria of rule 7 MCAR § 1.175A.2.g.(2).

2. 7 MCAR § 1.175A.2.h.(1) references the "1977 Edition of VASC Manual" as descriptive of the Verbal Auditory Screening for Children (VASC). Inasmuch as this manual was authorized to be incorporated by reference by order of the Chief Hearing Examiner on December 6, 1977, under a different name, reference to the "VASC Manual" shall be deleted and substituted with the more accurate title, "Fortunate Fours: Preschool Medical Survey of Vision and Hearing." Thus, the rule as adopted shall read as follows:

h.(1) MDH approved programs must use the Pure-Tone audiometric screening procedure. A Verbal Auditory Screening for Children (VASC) hearing procedure as described in the 1977 Edition of Fortunate Fours: Preschool Medical Survey of Vision and Hearing, may be used for four-year-old children.

3. 7 MCAR § 1.174A refers generally to rules of the Department of Public Welfare and rules of the Department of Education which relate to these rules. Inasmuch as a specific citation may now be provided for the rules of these other agencies, such citations shall be provided in the rule as finally adopted. The rules as finally adopted shall provide the specific citation to a rule of the Department of Public Welfare as "12 MCAR § 2.061" and a rule of the Department of Education as "5 MCAR §§ 1.0720-1.0725."

4. 7 MCAR § 1.174B.13 references "Minnesota Laws 1977, ch. 437." Inasmuch as this session law as now been codified, the rule as finally adopted shall delete reference to the session law and substitute in its place the citation "Minnesota Statutes, section 123.701 et seq."

Dated: December 18, 1978.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

WARREN R. LAWSON, M.D.
Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of Proposed Rules Relating to Approval of Early and Periodic Health and Developmental Screening Program

SUPPLEMENTAL FINDINGS OF FACT, CONCLUSIONS AND ORDER

The above-entitled matter came on for hearing at 9:00 a.m. on February 2, 1978, in Room 105 of the Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota. The Hearing Examiner, Peter Erickson, submitted his report to the Commissioner of Health on April 3, 1978. Consistent with the Report of the Hearing Examiner, the Commissioner of Health issued Findings of Fact, Conclusions and Order with regard to this matter on September 5, 1978. Pursuant to the provisions of Minn. Stat. § 15.052, subd. 4, and Minn. Rule HE 107, the Commissioner submitted the record in support of the above-referenced matter to the Chief Hearing Examiner on September 15, 1978. On September 18, 1978, the Chief Hearing Examiner issued an Order with respect to these rules. These Supplemental Findings of Fact, Conclusions and Order adopting the rules are now issued so as to comply with the Order of the Chief Hearing Examiner issued on September 18, 1978.

Based upon all the testimony, exhibits and written comments, the Report of the Hearing Examiner dated April 3, 1978, and the Order of the Chief Hearing Examiner dated September 18, 1978 (hereinafter "Order of the Chief Hearing Examiner"), the Commissioner of Health now makes the following:

FINDINGS OF FACT

The Commissioner adopts and reaffirms the Findings of Fact which he issued on September 5, 1978, with the following exceptions:

1. A footnote to Rule 7 MCAR § 1.175A.2.b. as originally proposed recommended that approved programs provide immunizations on site. A subsequent amendment mandated provision of on site immunizations by approved programs under certain circumstances. In Conclusion 3 of the Order of the Chief Hearing Examiner, the amendments were determined to constitute a substantial change.

2. The Order of the Chief Hearing Examiner issued September 18, 1978, states in Finding 6 that rules 7 MCAR § 1.175A.2.g.(2) and 7 MCAR § 1.176D.2.a. use the word "may" which provides for agency discretion but do not include criteria or standards by which the agency will exercise this discretion.

CONCLUSIONS

The Commissioner adopts and reaffirms the Conclusions which he issued on September 5, 1978, and adopts, as his own, the Conclusions incorporated into the Order of the Chief Hearing Examiner, except that the Commissioner does not adopt such Conclusions to the extent that they are inconsistent with the following:

1. Finding of Fact B relating to the amendment of 7 MCAR § 1.175A.2.b., on page 2 of the Findings of Fact, Conclusions and Order issued by the Commissioner on September 5, 1978, is deleted and shall cease to have effect.

Inasmuch as Conclusion 3 of the Order of the Chief Hearing Examiner states that a change in proposed rule 7 MCAR § 1.175A.2.b. from that which was originally proposed constituted a substantial change which was not raised by the original Notice of Hearing in such a way as to invite reaction at the hearing, the rule as adopted shall be that as originally proposed.

2. Consistent with Conclusion 2 of the Order of the Chief Hearing Examiner, the use of the verb "may" is ill-advised in rules 7 MCAR § 1.175A.2.g.(2) and 7 MCAR § 1.176D.2.a. and shall be deleted and substituted with the verb "shall." The Commissioner concludes that 7 MCAR § 1.175A.2.g.(2)(a)(b)i., ii. and iii. state the criteria under which alternative tests shall be approved by the Commissioner. These criteria are the submission of narratives which describe alternative tests with respect to content and construction of the test, norms, administration, scoring and interpretation of the test, validity and reliability of the test, as well as maintenance of written procedures for administration and scoring of the test,

evidence of validated norms for the age range being tested and a requirement that the test provide the same information regarding the child's development as would be provided through the use of the Denver Developmental Screening Test. All of these items offer clear standards by which the Commissioner shall exercise his discretion. The use of the verb "may" in 7 MCAR § 1.176D.2.a. shall be deleted and substituted with the verb "shall." The Commissioner concludes that the statement in this rule requiring the completion of application, training, the initial screening session and a satisfactory EPS consultant report provide sufficient standards by which applicants will know whether or not the Commissioner of Health shall grant provisional approval to the program prior to any other screening of children by the applicant.

ORDER

The rules relating to the approval of early and periodic health and developmental screening programs are found to be reasonable, necessary, and supported by the evidence contained in the records, and are hereby approved and adopted pursuant to the authority vested in me by Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (Supp. 1977), 144.07(1), 144.09 (1976), and 123.702-703, subds. 1 and 3 (Supp. 1977) except that such rules shall be modified in accordance with the changes as are set forth in the Commissioner's Findings of Fact dated September 14, 1978, and as set forth in the Commissioner's Supplemental Findings, Conclusions and Order, herein. The changes as set forth herein are as follows:

1. 7 MCAR § 1.175A.2.g.(2) which originally read, "alternative tests may be substituted for the Denver Developmental Screening Test (DDST) upon approval by MDH," is deleted. In its place the following language shall be used:

(2) Alternative tests shall be approved as substitutes for the Denver Developmental Screening Test (DDST) provided the following criteria in (a) and (b) herein are fulfilled:

2. 7 MCAR § 1.176D.2.a. shall have the verb "may" in the first sentence deleted and substituted with the verb "shall" so that the rule shall read as follows:

a. Upon completion of application, training, the initial screening session, and a satisfactory EPS consultant report, the commissioner of health shall grant provisional approval to the applicant prior to any other screening of children by the applicant.

3. 7 MCAR § 1.175A.2.b. is adopted as originally proposed and not as later amended. Thus, it is ordered that this rule shall read as follows:

b. An immunization assessment which shall include a review of the immunization status of the child in relation to the following immunizations: diptheria, pertussis, tetanus, polio, measles, mumps, rubella.[1/]

Footnote 1 shall read as originally proposed that, "[i]t is recommended that approved programs provide immunizations on site."

Dated: November 2, 1978

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

WARREN R. LAWSON, M.D.
Commissioner of Health

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL-HEALTH

Office Memorandum

TO : Lee E. Sheehy
Special Assistant
Attorney General
G19K Administration

DATE: Nov. 6, 1978

FROM : Terry P. O'Brien
Special Assistant
Attorney General

PHONE: 8-6-5371

SUBJECT: Documents Filed in Support of Proposed Rules Relating to Approval of Early and Periodic Health and Developmental Screening Programs

Enclosed for your review are two files containing documents to support the above-referenced rules.

Although the substance of these rules were not particularly controversial to the public, the Chief Hearing Examiner did have some problems. As stated in his order issued September 15, 1978, in Conclusion number three, the Chief Hearing Examiner concluded that the amendment to rule 7 MCAR § 1.175A.2.d. constituted a substantial change from the rule as initially proposed. The Supplemental Findings of Fact, Conclusions and Order issued by the Commissioner of Health on November 2, 1978, address the Chief Hearing Examiner's concern in Conclusion number 1. Essentially, the Commissioner agreed with the Chief Hearing Examiner, and the rule was adopted as initially proposed in the Notice of Hearing.

The Chief Hearing Examiner in Conclusion number 2 of his order dated September 18, 1978, took issue with the use of the verb "may" in rule 7 MCAR § 1.175A.2.g.(2) and 7 MCAR § 1.176D.2.a. inasmuch as he found this verb conferred too much discretion upon the Commissioner. Dr. Lawson addressed the Chief Hearing Examiner's concern in Conclusion number 2 of the Supplemental Findings of Fact, Conclusions and Order which he issued on November 2, 1978. The rule as finally adopted deletes the verb "may" and substitutes for it the verb "shall." Inasmuch as both rules already provided specific criteria under which alternative tests shall be approved or under which provisional approval shall be granted, further amendments were not made. We would agree with the Chief Hearing Examiner that the amendments do not constitute a "substantial change" requiring his further review.

The documents within the two files submitted for your review have been ordered as follows:

1. Rules as finally adopted;
2. Rules as proposed;
3. Order for Hearing;
4. Notice of Hearing;
5. Statement of Number of Persons and Estimated Length of Hearing;
6. Notice of Hearing as mailed;
7. Notice of Hearing as published;
8. Affidavit of Receipt of Secretary of State's List;

9. Affidavit of Mailing, with attached Certificate and Lists;
10. Statement of Evidence, which statement includes an attached Statement of Need and Statement of Justification, as well as listing the witnesses to appear on behalf of the Commissioner at the hearing;
11. Report of the Hearing Examiner;
12. Report of the Chief Hearing Examiner regarding incorporation by reference;
13. Findings, Conclusions and Order with accompanying rules issued by the Commissioner of Health on September 5, 1978;
14. Order of the Chief Hearing Examiner;
15. Supplemental Findings of Fact, Conclusions and Order dated November 2, 1978;
16. Notice of Intent to Solicit Outside Information as published;
17. Notice of Intent to Solicit Outside Information as mailed with Affidavit and accompanying records;
18. Transcript and Exhibits; and
19. Statement of Compliance with Manual of Rule Making Procedures

If you have any questions with regard to these rules, their supporting documentation or authority, please do not hesitate to contact me. Thank you.

TPO:ss

enclosures

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

In the Matter of Proposed Rules Relating to Approval of Early and Periodic Health and Developmental Screening Program

FINDINGS OF FACT, CONCLUSIONS, AND ORDER

The above-entitled matter came on for hearing at 9:00 a.m. on February 2, 1978, in Room 105 of the Minnesota Department of Health, 717 Delaware Street S.E. On April 3, 1978 the Commissioner of Health received the Report of the Hearing Examiner, submitted by Peter Erickson, Hearing Examiner, which report was dated on April 3, 1978.

Based upon all the testimony, exhibits and written comments, and the Report of the Hearing Examiner, the Commissioner now makes the following:

FINDINGS OF FACT

The Commissioner adopts, as his own, the findings of fact contained in the Report of the Hearing Examiner of April 3, 1978, said report being fully incorporated into and made a part of these findings as if set forth by the Commissioner, except that the Commissioner does not adopt such findings of fact to the extent they are inconsistent with the following:

A. In accordance with the recommendation of the Hearing Examiner, in Finding of Fact number 10.c., of the Report of the Hearing Examiner, dated April 3, 1978 (hereinafter "Report") which suggest deletion of the definition "Screening and Referral Form" in §§ 1.174, 16. (renumbered 15.) as this form has been replaced by the DPW invoice, the term defined in §§ 1.174, B.16. (renumbered 15.) "Screening and Referral Form" has been deleted and replaced by the term "EPSDT Invoice", the name of the defined form.

B. In accordance with the recommendation of the Hearing Examiner, in Finding of Fact number 11.a. of the Report which states in part, "the child who is thus found to have deficiencies in his immunization status shall be offered appropriate immunization services as part of the EPS service . . . "

§ 1.175, A.2.B. is amended by deleting the footnote and adding the following:

> The child who is thus found to have deficiencies in his immunization status shall be offered appropriate immunization services on-site as part of the EPS service, if there is legal consent from the parent(s)/ guardian or from the emancipated minor and there are no medical or religious contradictions to the administration of the vaccine, and provided the local agency can obtain medical supervision of this service.

The rationale for this change is substantiated on page 2 of a memorandum to Mr. Erickson from Ms. Swaiman, dated February 17, 1978, which was entered into the Hearing Record. This states that it is desirable to provide on-site immunizations "because the federal requirements of Title XIX SSA relative to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) will be changed in the near future to require availability of vaccination services at the time of the screening service rather than at another site and time through referral. It is our intent to maintain the compatibility of EPS and the EPSDT federal requirements to obtain Title XIX reimbursements for the EPS programs" Furthermore, in the above referenced memorandum, testimony by Ms. Diane Peterson, Supervisor, Minnesota Department of Health, Immunization Unit, indicated in part, "A random sample of referrals made during the report period of FY 1977 showed that referral for immunization was the number one reason for referrals identified during the screening process. A full three months after referrals had been made, one-third of the needed immunizations had not been provided. This situation would not have existed if the immunization services had been made available on-site as part of the screening package in EPS clinics."

The last phrase "and provided the local agency can obtain medical supervision of this service", assures that an approved program may continue to provide EPS services even if it is unable, through circumstances beyond its control, to obtain medical supervision for on-site provision of immunizations.

C. In accordance with the recomendation of the Hearing Examiner in Finding of Fact 12.a. of the Report which states: "The use of volunteers is encouraged in the screening program and volunteer vision and hearing technicians, clinical assistants, and clerical personnel are suggested as appropriate use of volunteers, providing they meet the qualifications as defined in § 1.175, B.1.d., e,, and f." § 1.175 B.1. is amended to state:

> The use of volunteers is encouraged in the screening program, provided they meet the qualifications as defined in § 1.175, B.1., a. - f.

This language expands the use of volunteers to include other health professionals. This provides more local program options, better reflects the intent of the Department and the practice of approved programs. It also permits the provision of a less expensive service.

D. In accordance with the recommendation of the Hearing Examiner in Finding of Fact, 14.a. of the Report which states: "F. The identification of existing and ongoing health care services, including personal physicians, in the community to prevent the duplication of services and care and how this program will coordinate and utilize existing network." § 1.176, C.1. is amended to add a part "f." which reads the same as recommended part "F." above. This editorial change enhances the clarity of the rule.

E. In accordance with the recommendation of the Hearing Examiner in Finding of Fact, 16.a., which suggests deletion of § 1.178, B. and its accompanying footnote because of the elimination of the EPS Manual from the rules, § 1.178, B. is amended to delete the footnote and the first sentence which reads: "The criteria for referral resulting from the screening tests and assessments are outlined in the 1977 EPS Procedures Manual.[3]"

The second sentence of § 1.178, B., which states: "Approved programs shall refer children to an appropriate resource for evaluation, diagnosis, and treatment." is retained. This latter sentence is necessary to maintain clarity of the rule.

F. In accordance with the recommendation of the Hearing Examiner in Finding of Fact, 16.b., which suggests an addition to §§ 1.178 which reads: "The EPS health and developmental report of the child shall be provided to the child's personal physician." §§ 1.178, B., is amended by addition after the sentence ending " . . . diagnosis and treatment." of the following:

> Whenever a child identifies a personal physician, that person shall be provided a copy of the screening results with the approval of the parent, guardian or emancipated child.

This language maintains the intent of the recommended language, but deletes the name of a non-existent report and reaffirms privacy rights of the EPS service participant.

The Commissioner finds that several revisions of the proposed rules are needed to provide additional clarity and to provide consistency with the latest medical practices and, therefore, the following revisions are made.

A. 7 MCAR §§ 1.175, A.2.e., "An unclothed physical assessment which shall include an inspection of pulse, respiration . . ." shall be amended to "An unclothed physical assessment which shall include pulse, respiration, blood pressure . . ." The words "an inspection" are deleted for the purpose of enhancing clarity. The use of the word "inspection" may be considered redundant.

B. 7 MCAR § 1.175, A.2.i. (1), "Observe and examine the child's pupils and light following reflex, presence or absence of nystagmus, muscle balance and external inspection of the eye . . ." is amended to delete the word "external" and read, "Observe and examine the child's pupils and light following reflex, presence or absence of nystagmus, muscle balance and an inspection of the eyes." The deletion of the word "external" is for the purposes of clarity. It can be assumed an inspection of the eye is only external.

C. 7 MCAR § 1.175 A.2.i.(2)

"Muscle balance screening procedures include at least observation, cover test, Hirschberg Test and the Worth 4-Dot Test. The Worth 4-Dot may be used for children who are five or older." This is amended by deleting "and the Worth 4-Dot Test" in the first sentence to read: "Muscle balance screening procedures include at least observation, cover test, and Hirschberg Test. The Worth 4-D may be used for children who are five or older." This phrase and the Worth 4-Dot," is deleted for the purpose of clarity and to avoid unnecessary repetition.

D. 7 MCAR § 1.175, A.2.i.(3)

"Test for visual actuity. A test, as appropriate for the child's age, such as the Screening Test for Young Child Retardates (STYCAR), the Snellen E Cube, the Snellen E Chart, and plus lenses shall be used." This is amended to capitalize the words Plus Lenses and reads ". . . and the Plus Lenses shall be used." This capitalization is for purposes of clarity and to delineate Plus Lenses as a separate test.

E. 7 MCAR § 1.175, A.2.j., "(1) Tuberculin tests indicate exposure to active tuberculosis and may indicate need for medication" shall be deleted and subsequent parts of j., renumbered beginning with "(1) Urine . . ."

In a communique received by the Department after these rules were proposed, we were informed that the Federal Center for Disease Control Tuberculosis Control Division recommends discontinuation of screening of children who live in communities which have a low prevalence of infection, as evidenced by a tuberculin skin test reaction rate in children of less than 1%. In Minnesota, the skin test reactor rate is less than .5%. Accordingly, routine screening of children is unwarranted.

F. 7 MCAR § 1.175, A.2.j.(2)

"Anemia (Microhematocrit), Hemoglobin tests for anemia and also indicates other blood abnormalities" has been amended to "Anemia (Microhematocrit, Hemoglobin) tests." The amendment is necessary to more accurately define the tests being utilized because the Microhematocrit and Hemoglobin procedures do not test for or indicate other blood abnormalities.

G. 7 MCAR § 1.175, A.3., the EPS Periodicity Chart shall be revised as follows:

Delete "Review" in "Immunization Review." This change is necessary to keep consistency with the change made in 7 MCAR §§ 1.175, A.2.b.

Delete the line "Tuberculin." This change is necessary to keep consistency with the change made in 7 MCAR §§ 1.175, A.2.j.

Add a footnote symbol (*) before "Bacteriuria" at the bottom of the same page, add:

> *The local agency may wish to consult with the local medical society regarding use of this procedure.

The recommendation of this test assumes that referred children will receive further evaluation and treatment. However, some community's physicians may consider treatment as not indicated for asymptomatic bacteriuria and, hence, that this condition is not appropriate for screening. If treatment is not provided, screening should not be performed.

H. 7 MCAR §§ 1.175, B.1., "b. EPS trained nurse shall be either a Pediatric Nurse Associate who is a graduate of an accredited university post-graduate program in pediatric nursing or meet all of the following criteria" shall be amended to delete "be either a

F. 7 MCAR § 1.175, A.2.j.(2)

"Anemia (Microhematocrit), Hemoglobin tests for anemia and also indicates other blood abnormalities" has been amended to "Anemia (Microhematocrit, Hemoglobin) tests." The amendment is necessary to more accurately define the tests being utilized because the Microhematocrit and Hemoglobin procedures do not test for or indicate other blood abnormalities.

G. 7 MCAR § 1.175, A.3., the EPS Periodicity Chart shall be revised as follows:

Delete "Review" in "Immunization Review." This change is necessary to keep consistency with the change made in 7 MCAR §§ 1.175, A.2.b.

Delete the line "Tuberculin." This change is necessary to keep consistency with the change made in 7 MCAR §§ 1.175, A.2.j.

Add a footnote symbol (*) before "Bacteriuria" at the bottom of the same page, add:

> *The local agency may wish to consult with the local medical society regarding use of this procedure.

The recommendation of this test assumes that referred children will receive further evaluation and treatment. However, some community's physicians may consider treatment as not indicated for asymptomatic bacteriuria and, hence, that this condition is not appropriate for screening. If treatment is not provided, screening should not be performed.

H. 7 MCAR §§ 1.175, B.1., "b. EPS trained nurse shall be either a Pediatric Nurse Associate who is a graduate of an accredited university post-graduate program in pediatric nursing or meet all of the following criteria" shall be amended to delete "be either a

Pediatric Nurse Associate who is a graduate of an accredited university post-graduate program in pediatric nursing or . . ." This change is necessary to make clear that the Pediatric Nurse Associate (PNA) skills are not the minimum required. These skills are, however, still acceptable because the PNA skills exceed those required in the amended rule. § 1.175, B.1.b.(2) refers to nursing personnel who have participated in equivalent programs designated by MDH. PNAs would come under this category, and their training would, in fact, exceed the requirements of the rule and this change would have no effect upon them.

I. 7 MCAR § 1.175, B.1.b. "(4) Have the ability to work effectively with children based on recommendations from the EPS clinic coordinator, agency nurse supervisor, or the EPS consultant under contract with MDH" shall be deleted. This criterion is self-evident to all affected parties; its inclusion is considered offensive to many professional nurses.

J. 7 MCAR § 1.175, B.1.f.

"EPS clerk shall have responsibility for clerical and receptionist functions and shall have acquired clerical and human relation skills through paid employment or voluntary activity." This section shall be deleted as it is self-evident that clerical personnel will be necessary and that a description of such is not needed in Rule.

K. 7 MCAR § 1.175, C.1.

"Separate areas shall be provided for the various screening procedures, as well as waiting and play areas" shall be amended to "As appropriate, areas shall be provided for the screening procedures, waiting, and play areas." This amendment is to clearly indicate that flexibility in arranging the clinic site is permitted allowing for local adaptations of screening patterns.

L. 7 MCAR §§ 1.175, E., ". . . a screening and referral form . . ." shall be deleted and replaced with the expression "EPSDT Invoice." This change is necessary to keep consistency with the change made in 7 MCAR § 1.174, B.15. (previously numbered 16)

M. 7 MCAR §§ 1.176, B.

"Upon receipt of the letter of intent, MDH shall transmit an application and instructions to the applicant." This has been amended by deleting "an" and "and" to read "Upon receipt of the letter of intent, MDH shall transmit application instructions to the applicant." This has been amended because MDH does not wish to provide an application form which may be confining in its structure, but rather simply provides written instructions to be utilized in submitting an application.

N. 7 MCAR § 1.176 B.2.(c) and (d) and 1.176, B.3.

Reads in part . . . "staff shall notify the applicant in writing at least 33 days prior to submission . . ." This is amended from 33 days to 35 days to read . . . "staff shall notify the applicant in writing at least 35 days prior to submission . . ." This amendment is for purposes of establishing a convenient legally acceptable number.

CONCLUSIONS OF LAW

The Commissioner adopts as his own, the conclusions contained in the Report of Hearing Examiner, April 3, 1978, said conclusion being fully incorporated and made a part of Commissioner's conclusions as if set forth by the Commissioner.

ORDER

The rules relating to Early and Periodic Health and Developmental Screening Program requirements for approval are found to be reasonable, necessary, and

supported by the evidence contained in the records, and are hereby approved and adopted pursuant to authority vested in me by Minnesota Statute 144.10, 144.11 (1976), 144.12 (supp. 1977), 144.07 (1), 144.09 (1976), 123.702-703 (supp. 1977), subds. 1 and 3 (supp. 1977), except that said rules shall be modified in accordance with non-substantial changes as are set forth in the Commissioner's Findings of Fact herein.

Minnesota Department of Health
Warren R. Lawson, M.D., Commissioner

9/5/78
Date

RULES AS FINALLY ADOPTED

DEPARTMENT OF HEALTH

Working copy

RULES OF THE MINNESOTA DEPARTMENT OF HEALTH
RELATING TO THE APPROVAL OF
EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS

CHAPTER ELEVEN: 7 MCAR §§ 1.174 - 1.178

7 MCAR § 1.174 General

A. Declaration of Purpose, Scope and Applicability

The purpose and scope of these Rules is to establish minimum standards and procedures for MDH approved nurse-administered local provision of comprehensive health screening of children.

These Rules apply to those organizations seeking MDH approval in order to qualify for reimbursement by third parties for which such reimbursement requires MDH approval; and constitutes standards for the nurse-supervised EPSDT programs as prescribed in Department of Public Welfare (DPW) Rule and Preschool Screening Program as prescribed in Department of Education (SDE) Rule.

B. Definitions

For the purposes of these Rules the following terms have the meanings given them:

1. "Applicant" means a local organization, such as but not limited to a community health agency, hospital, voluntary nonprofit group or school, which is seeking approval and has submitted for approval a completed plan for an Early and Periodic Screening (EPS) program.

2. "Application" means a written request for MDH program approval in a format as specified by the MDH. This format shall require submission of the information required by Rule 7 MCAR § 1.176 (A)(B)(C), herein.

3. "Approved program" means a screening program which offers regularly scheduled comprehensive health screening for children from birth through 20 years of age, in accordance with the standards contained in Rule 7 MCAR § 1.175, and which has been approved by MDH.

4. "Children" means those individuals from birth through 20 years of age.

5. "Diagnosis" means the systematic classification of the nature or the cause of physical or mental disease or abnormality through the combined use of health history, physical, developmental and psychological assessments and laboratory tests and x-rays.

6. "Early" means the entrance of a child to the health care system at his/her youngest possible age.

7. "EPS" means Early and Periodic Screening.

~~8. "EPS Procedures Manual" (1977 Edition) means the document written by MDH staff in which the concepts and method for program administration and screening procedures are specified and can be promulgated and utilized by local health programs. The screening procedures and referral criteria contained in the Manual are based on Academy of Pediatrics standards and specific scientific criteria for a given test.~~

8. ~~9.~~ "EPS trained nurse" means the nurse who is trained to perform the screening assessments and tests in an approved program inasmuch as she meets the qualifications as contained in Rule 7 MCAR § 1.175 (B)(1)(b).

9. ~~10.~~ "MDH" means the Minnesota Department of Health.

10. ~~11.~~ "Periodic" means health screening occurring at predetermined intervals.

11. ~~12.~~ "Periodicity schedule" means the schedule set out in Rule 7 MCAR § 1.175 (A)(3), and which specifies the frequency and age ranges at which the specified screening assessments and tests are to be administered to a child.

12. ~~13.~~ "Physician Integration Plan" means the option whereby an MDH approved program seeks to extend its services by substituting a physician-administered health history, physical examination and laboratory services, and immunizations for the nurse-administered health history, physical assessment and laboratory services.

13. ~~14.~~ "Preschool Screening Program" means the health and developmental screening program under the auspices of the Department of Education, whereby children are screened once before they enter kindergarten, pursuant to Minnesota Laws 1977, Chapter 437. 123.702 .703

14. ~~15.~~ "Screening" means the use of those simple and quick procedures as outlined in Rule 7 MCAR § 1.175 (A)(2) to sort out apparently well children from those in need of more definitive study of possible physical or developmental problems.

15. ~~16.~~ "EPSDT Invoice" ~~"Screening and referral form"~~ means a report when completed by approved programs and submitted to MDH provides a summary of results of screening for each child and contains data which can be used for MDH and local program analysis and evaluation pursuant to Rule 7 MCAR § 1.178 (E). Sense?

16. ~~17.~~ "Sliding fee scale" means a predetermined schedule which identifies the amount to be paid by the parent(s) or guardian(s) toward the cost of screening. The sliding fee scale is developed by the applicant or approved program and is based on such factors as average incomes for the region, individual family income and the number of persons in the family.

17. ~~18.~~ "Third party reimbursement" means payment to approved programs, by sources other than the child, or his/her parent(s) or guardian(s) and

which is applied to the cost of screening. The sources of this reimbursement may include Title XIX (Medical Assistance), other federal, state or local monies, insurance benefits or in-kind contributions converted into dollar equivalency.

18. ~~19.~~ "Title XIX (Medical Assistance)" means the program authorized under the Social Security Act, USC 42, Title XIX - Sec. 1901-1910, and rules promulgated thereunder, to provide medical care for individuals whose resources do not enable them to purchase such care.

19. ~~20.~~ "Tracking" means documenting the results of diagnosis and treatment resulting from the screening of a child. This data also may be used to evaluate the type and appropriateness of referrals.

20. ~~21.~~ "Treatment" means medical, dental, nursing, preventive, rehabilitative or other relevant services to prevent, correct, or ameliorate disease or disability detected by diagnostic services for a qualified professional.

7 MCAR §§ 1.175 Minimum Standards to Qualify for MDH Approval

A. Applicants seeking MDH program approval shall develop a screening program containing the following components:

1. An outreach component which shall include a demonstrated ability to stimulate or encourage participation in the screening program.

a. Information about a screening program may be disseminated by a variety of methods such as the following:

(1) Person-to-person communication.

(2) Public information outreach such as, but not limited to, planned meetings with groups, contacts with agencies such as schools or Head Start, in order to obtain assistance with regard to their specific child populations, distribution of pamphlets, use of the mass media.

b. Outreach efforts shall be coordinated with the outreach function of local welfare departments in relation to children under the Title XIX (Medical Assistance) Program and with local school districts in relation to children under the Preschool Screening Program.

2. A screening component which shall include a demonstrable ability to provide at least the following assessments and tests which must be available at the frequency and age ranges as specified in the Periodicity Schedule found in Rule 7 MCAR § 1.175 (A) (3). ~~Referrals resulting from the assessment and testing shall be based on referral criteria as stated in 1977 EPS Procedures Manual.~~

a. A health history assessment which shall include at least an individual review of past and present health status including perinatal, psychosocial and family health.

b. An immunization assessment which shall include a review of the immunization status of the child in relation to the following immunizations: diptheria, pertussis, tetanus, polio, measles, mumps, rubella.~~‡~~[1]

c. A nutrition status assessment which shall include at least a review of the child's food intake for a 24-hour period preceding screening.

d. A physical growth assessment which shall include measurement of the child's height, weight, and head circumference and comparison with the ranges considered normal for children of that age.

e. An unclothed physical assessment which shall include ~~an inspection of~~ pulse, respiration, blood pressure, head, eyes, ears, nose, pharynx, neck, chest, heart, lungs, genitals, abdomen, spine, extremities, joints, muscle tone, skin and neurologic reaction.

f. A dental inspection which shall include inspection of the child's mouth for any evident oral or dental abnormalities.

g. Developmental screening tests which shall assess the child's development in the areas of fine and gross motor skills, speech and language, social-emotional behavior and self-help skills.

(1) In order to assess these developmental areas, MDH recommends the use of the Denver Prescreening Developmental Questionnaire (PDQ) with its manual and the Denver Developmental Screening Test (DDST) with its manual or an acceptable alternative meeting the criteria of Rule 7 MCAR §§ (A)(2)(g)(2).

incomplete ref?

(2) Alternative tests ~~may be substituted for the Denver Developmental Screening Test (DDST) upon approval by MDH.~~ shall be approved as substitutes for the Denver Developmental Screening Test (DDST) provided the following criteria in (a)(b) herein are fulfilled:

(a) An applicant considering substitution for the Denver Prescreening Developmental Questionnaire (PDQ) and the Denver Developmental Screening Test (DDST) shall submit a narrative which describes the alternative test in the following areas: content and construction of the test, norms, administration, scoring and interpretation, validity and reliability.

(b) In order to secure approval of an alternative test, such a test must be standardized and able to provide at a minimum:

~~‡It is recommended that approved programs provide immunizations on site.~~

[1]It is recommended that approved programs provide immunizations on site.

i. Written procedures for administration and scoring.
ii. Evidence of validated norms for age range being tested.
iii. The same information regarding the child's development as would be provided through the use of the Denver Developmental Screening Test (DDST).

h. A hearing assessment shall include procedures which test for deviations from the normal range of auditory acuity.

(1) MDH approved programs must use the puretone audiometric screening procedure. A Verbal Auditory Screening for Children (VASC) hearing procedure as described in the 1977 Edition of VASC Manual, may be used for four year old children.

i. A vision assessment shall include procedures which test for eye health deviations, including the normal range of visual acuity and muscle balance in the child. Approved programs must:

(1) Observe and examine the child's pupils and light following reflex, presence or absence of nystagmus, muscle balance, and an ~~external~~ inspection of the eyes.

(2) Muscle balance screening procedures include at least observation, cover test, Hirschberg Test.~~and the Worth 4 Dot Test.~~ The Worth 4-Dot may be used for children age five or over who are cooperative.

(3) Test for visual acuity. A test, as appropriate for the child's age, such as the Screening Test for Young Children and Retardates (STYCAR), the Snellen E Cube, the Snellen E Chart, and the Plus Lenses, shall be used.

j. Laboratory tests: The following tests shall be administered according to the Periodicity Schedule found in Rule 7 MCAR § 1.175 (A) (3).

~~(1) Tuberculin tests indicate exposure to active tuberculosis and may indicate need for medication.~~

(1) ~~(2)~~ Urine and bacteriuria (Bililabstix and Culturia Assay) test for bacteria and other abnormal substances in the urine.

(2) ~~(3)~~ Anemia (Microhematocrit, Hemoglobin) tests.~~for anemia and also indicates other blood abnormalities.~~

(3) ~~(4)~~ A Blood Lead test for increased lead absorption and for lead poisoning in children whose history indicates the possibility of exposure to undue levels of lead in the environment or atmosphere.

(4) ~~(5)~~ A Sickle Cell test shall be administered only with the consent of the parent(s), or guardian(s), or the child, if he/she is over 18 years, and only to those children at risk for the sickle cell trait or disease.

3. The assessment and tests listed above shall be available on the following periodic schedule.

EPS PERIODICITY CHART

INTERVALS (1)	MONTHS					YEARS					
	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
History											
Health	X	X	X	X	X	X	X	X	X	X	X
Perinatal	X	←	←	←	←	←					
Psychosocial	X	X	X	X	X	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X	X	X	X	X	X
Immunization ~~Review~~	X	X	X	X	←	←	X	←	←	X	←
Developmental											
DDST	X	X	←	←	←	X					
PDQ			X	X	X						
Assessment											
Height	X	X	X	X	X	X	X	X	X	X	X
Weight	X	X	X	X	X	X	X	X	X	X	X
OFC	X	X	X	X	X	←	←				
Physical Inspection	X	X	X	X	X	X	X	X	X	X	X
Oral Inspection	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure						X	X	X	X	X	X
Tests											
Hearing	X	←	X	X	X	X	X	X	X	X	X
Vision	X	←	X	←	X	X	X	X	X	X	X
Urine (BiliLabstix)						X	←	←	←	←	←
* Bacteriuria (females)						X	←	X	←	←	←
Microhematocrit or Hgb.	X	←	X	←	X	X	←	←	←	X	←
Blood Lead (Only if history positive)			X	←	X	X					
Sickle Cell (Upon parental request)	X	←	←	←	←	←	←	←	←	←	←
~~Tuberculin~~		X	←	←	←	←	←	←	←	←	←

(1) The period, birth to six months, is not addressed in the program based upon the assumption that nearly all children of this age interval are receiving ongoing physical care.

← Procedure to be completed if not done at the previous visit; or on the first visit.

* The local agency may wish to consult with the local medical society regarding use of this procedure.

4. An interpretation and parent education component which shall include discussions aimed at sharing with the family and child information collected during screening. These discussions must incorporate guidance regarding sound health practices, normal growth and development, and the clarification of any concerns on the part of the child or family. A copy of the screening results shall be given to the parents.

5. A referral component which shall include an organized system of arranging for children with problems identified through screening to be seen by an appropriate resource for evaluation, diagnosis or treatment. Arrangements shall be made to establish all children who have been screened with on-going health care services. Whenever a child identifies a personal physician, that person shall be notified of the referral.

6. A follow-up component which shall include an organized system for securing information on children who are referred to another resource for evaluation, diagnosis and treatment. Follow-up efforts are to assure that the required services were made available and to evaluate the effectiveness of the screening program.

   a. A follow-up plan shall consist of at least the following:

      (1) Written and formal arrangements with other agencies such as the county welfare departments, Head Start, Developmental Achievement Centers, community action councils, public health nursing services, and school services to define and coordinate each agency's responsibilities with respect to follow-up.

      (2) A description of activities such as personal contact with the child, family or referral resource. At least two attempts shall be made to contact parent(s) or provider(s) concerning diagnosis and treatment results.

      (3) A written identification of nursing personnel who shall have supervisory responsibility for follow-up.

B. Personnel for EPS Screening of Children

1. Qualifications and/or responsibilities of the screening personnel: An individual may perform one or more of the functions in the screening program provided that the appropriate qualifications are met. The use of volunteers is encouraged in the screening program, providing they meet the qualifications as defined in § 1.175 (B) (1) (a-f).

   a. EPS clinic coordinator shall have the responsibility for coordination and management of the local screening program. These responsibilities include management as well as specific organization of activity in the clinics.

   b. EPS trained nurse shall ~~be either a Pediatric Nurse Associate who is a graduate of an accredited university postgraduate program in Pediatric Nursing or~~ meet all of the following criteria:

      (1) Be currently licensed as a professional nurse by the Minnesota Board of Nursing.

(2) Have successfully completed EPS training seminars provided by MDH, or have participated in equivalent training programs designated by MDH.

(3) Demonstrate ability to satisfactorily perform to an EPS Consultant designated by MDH, those child assessments as required in Rule 7 MCAR § 1.175 (A) (2) (a-j).

(4) ~~Have the ability to work effectively with children based on recommendations from the EPS clinic coordinator, agency nurse supervisor, or the EPS consultant under contract with MDH.~~

c. EPS Laboratory Assistant shall be:

(1) A lab technician or an assistant who can document training in performing the specific tests used in the screening session under the supervision of the EPS nurse.

d. EPS Vision and Hearing Technician shall:

(1) Have documentation of the successful completion of a course in vision and hearing screening offered by MDH and demonstrate ability to satisfactorily perform the vision and hearing screening as required in Rule 7 MCAR § 1.175 (A) (2) (h) (i) and;

(2) If the VASC is used, have documentation of the completion of training to perform the Verbal Auditory Screening of Children (VASC).

e. EPS Clinic Assistant shall:

(1) Be able to document the completion of training in the administration of the developmental tests selected for use in the screening program. Such training may be provided by the EPS nurse or consultant who has documented training in developmental testing from institutions such as, but not limited to area mental health centers, or community colleges and schools.

(2) Have experience in working with children either through paid employment or volunteer activity.

~~f. EPS clerk shall have responsibility for clerical and receptionist functions and shall have acquired clerical and human relations skills through paid employment or voluntary activity.~~

C. The physical facility shall meet the following requirements:

1. ~~Separate areas shall be provided for the various screening procedures, as well as waiting and play areas.~~ As appropriate, areas shall be provided for screening procedures, waiting, and play areas.
2. Physical privacy shall be maintained for interviewing and physical assessment.
3. Equipment needed for the assessments and tests shall be available to the program and maintained in servicable and reliable condition so as to insure the integrity of the tests specified in Rule 7 MCAR § 1.175 (A) (2) (a-j).

7 MCAR § 1.176 Application Procedures for EPS Program Approval

A. Local organizations shall notify MDH in writing of their intent to establish an EPS program and to apply for MDH program approval in accordance with the standards specified in these Rules. The sections of the application addressing Statement of Need, and Evaluation and Fiscal Management, shall be considered for purposes of program planning at state and local level and, if necessary, for provision of technical consultation by MDH. The section of the application relating to the Methods of Accomplishing Program Components, and Personnel shall be applicable to the approval process as defined in Rule 7 MCAR § 1.176 (D).

B. Upon receipt of the letter of intent, MDH shall transmit an application ~~and~~ instructions to the applicant.

C. Submission of Application. The applicant shall submit the completed application to MDH and to the MDH District Nursing Consultant for the district in which the applicant is located. The application shall include at least the following information.

1. A Statement of Need for EPS - The applicant shall provide a general statement of the extent of the need for this kind of preventive health service in the community to be served and includes information on the following:

   a. The geographic area of the proposed program.

   b. The age range and numbers of children to be served in each age group.[21]

   c. The estimate of the number of Title XIX (Medical Assistance) eligible children identified in each age group.

   d. The identification of all the school districts within the geographic area of the proposed program.

   e. The identification of other child and adolescent health screening programs in the area and specification of how the proposed program will coordinate with these programs.

   f. The identification of existing and on-going health services in the community to prevent duplication of services and care, and how this proposed program will coordinate and utilize the existing network.

2. A description of the method of accomplishing each of the program components: outreach, screening and interpretation, education, referral and follow-up.

3. Personnel - Outline the number and type of personnel necessary to implement each component and the plans for training personnel.

[21] An applicant may elect to serve only one age group of children.

4. Evaluation - Outline the methods other than those specified in this Rule, by which the applicant will evaluate its own program. Such methods may include parent surveys, and/or analysis of the use of referral resources, and numbers of children screened.

5. Fiscal Management - include the following:

   a. The method for determining unit cost.

   b. The plan for implementing a sliding fee scale and for collecting third-party reimbursements and a copy of the sliding fee scale except where prohibited by Minnesota Laws, 1977, Chapter 437, the Preschool Screening Act.

   c. The copy of the authorization from the duly constituted authority (such as county commissioners, city councils) to charge fees for services, except as prohibited by Minnesota Laws 1977, Chapter 437, the Preschool Screening Act.

D. Review and Disposition of Application

There shall be a two stage approval process.

1. With regard to the first stage of approval:

   a. Upon receipt, the application shall be reviewed by MDH staff in order to determine that it contains the information specified in Rule 7 MCAR § 1.176 (C) (1-5).

   b. The MDH staff shall make arrangements for the local EPS personnel to be trained in EPS seminars.

   c. An initial screening session shall be scheduled by the applicant. An EPS Consultant, as designated by MDH will be assigned to the applicant for on-site consultation to assist the applicant to develop adequate skills. A subsequent consultation may be provided as necessary.

2. Provisional Approval

   a. Upon completion of application, training, the initial screening session, and a satisfactory EPS consultant report, the Commissioner of Health ~~may~~ shall grant provisional approval to the applicant prior to any other screening of children by the applicant. Provisional approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third-party reimbursement.

   b. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of provisional approval, the staff shall notify the applicant in writing of the conditions necessary to gain approval. Technical assistance and consultation shall be offered by MDH to the applicant.

c. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health denial of provisional approval the staff shall notify the applicant at least ~~33~~ 35 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny provisional approval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

3. With regard to the final stage of approval:

a. A second visit shall be made by the EPS Consultant within the first six months of the program's operation to evaluate the screening program and staff performance to assure implementation and fulfillment of the program components as specified in Rule 7 MCAR §§ 1.175 (A) (B) (C).

b. The MDH staff shall make a final staff review of the screening program. This review consists of the EPS Consultant's evaluation of the ability of program personnel to adequately perform the screening procedures as outlined in the Rule, the MDH District Nursing Consultant's evaluation of the overall program administration and a review of the application in accordance with standards as specified in Rule 7 MCAR §§ 1.175 (A) (B) (C).

c. If the Commissioner of Health concurs with staff comments and recommendation, the Commissioner shall notify the applicant within 30 days of final approval.

Such approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third-party reimbursement.

d. If not in substantial compliance:

(1) The conditions necessary to gain approval shall be stated in writing by MDH staff to the applicant. Technical assistance and consultation shall be offered by MDH staff to the applicant.

(2) If following the offer of consultation and reconsideration, MDH staff intends to recommend to the Commissioner of Health a denial of final approval, the staff shall notify the applicant in writing of the reasons therefore, at least ~~33~~ 35 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny approval, it shall request in writing a hearing, within 30 days of the receipt of the proposed staff recommendation or otherwise, it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

E. Annual Reapproval

1. An approved program shall be reviewed annually by the MDH staff to determine if approval status shall continue. Reapproval shall be based on the program's continued compliance with the standards specified in Rule 7 MCAR § 1.175 (A) (B) (C).

2. The Commissioner of Health shall notify the program within 30 days after receipt of the staff recommendation of reapproval.

3. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of reapproval, the staff shall notify the program in writing of the conditions necessary to gain reapproval. Technical assistance and consultation shall be offered by MDH to the program. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health, denial of reapproval, the staff shall notify the program at least ~~33~~ 35 days prior to the submission of the recommendation to the Commissioner of Health. If the program contests the proposed staff recommendation to deny reapproval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

7 MCAR § 1.177 MDH Responsibilities in Relation to Applicants and Approved Programs

A. The MDH shall provide technical assistance and consultation for the planning, implementing and administering of EPS programs and those programs seeking approval.

B. The MDH shall survey and evaluate approved programs on a periodic basis to assure compliance with the standards contained in these Rules.

C. The MDH shall provide in-service EPS training seminars for local staff based upon the needs as determined jointly by approved programs and MDH staff. This training shall address at least the following areas:

1. Administration of EPS.

2. Pediatric nursing skills in relation to the specific screening assessments and tests of children.

7 MCAR § 1.178 Approved Program Responsibilities

A. Approved programs shall provide EPS service in accordance with or exceeding the standards contained in these Rules.

B. ~~The criteria for referral resulting from the screening tests and assessments are outlined in the 1977 EPS Procedures Manual.[3]~~ Approved programs shall refer children to an appropriate resource for evaluation, diagnosis and treatment. Whenever a child identifies a personal physician that person shall be provided a copy of the screening results with the approval of the parent/guardian or emancipated child.

[3] ~~The EPS Procedures Manual is available to the public and may be obtained from the Minnesota Department of Health.~~

C. Approved programs shall assure that EPS personnel obtain continuing education in order to maintain or improve clinical skills. This training may be provided by MDH or the University of Minnesota, School of Public Health. The content shall relate to child ambulatory health care, screening principles and clinical skills.

D. Approved programs shall coordinate the EPS program with schools or other community child health programs and health care providers.

E. Approved programs shall participate in evaluation of their programs and submit evaluation data as requested by MDH. This data includes at least ~~a screening and referral form~~ EPSDT Invoice and forms for tracking diagnosis and treatment results. Data provided to MDH by approved programs may be summarized and the child's identity shall remain anonymous.

F. Approved Program Option

Approved programs may include the Physician Integration Plan, provided such a plan meets or exceeds the standards contained in these Rules. If this plan is included, the health history, physical examination and the laboratory tests shall be performed on the child, under a physician's supervision. This examination shall be performed within the previous 6 months if the child is under the age of 2, within 12 months if the child is 2 years or older, or 60 days after the provision of the other EPS screening tests (vision, hearing, and developmental). There shall be a mutual exchange of information to assure that each provider has the complete health and developmental profile of the child.

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing before Hearing Examiner Peter C. Erickson of the State Office of Hearing Examiners at 9:00 a.m. on Thursday, February 2, 1978 in the Department of Health Building, Minneapolis, Minnesota.

Terry O'Brien, Special Assistant Attorney General, appeared as counsel for the Minnesota Department of Health; Grace Gumnit, Acting Director of the Division of Personal Health Services; Sheila Swaiman, Supervisor of Comprehensive Child Health Screening; and Ronald Campbell, M.D., Chief of the Maternal and Child Health Section, testified in support of the rule on behalf of the Department. The hearing continued until all interested groups or persons had an opportunity to be heard concerning the adoption of the proposed rules.

Pursuant to Minn. Stat. § 15.0412, subd. 4, this Report shall be available for review to all affected individuals upon request for at least five days.

The Department of Health shall, if it proposes to adopt the rules as originally proposed or amended, submit the complete hearing record, including its Findings and Order, to the Chief Hearing Examiner no earlier than five days subsequent to the receipt of this Report. This submission shall clearly indicate any changes made to the rules as originally proposed, preferably in the format that will be submitted to the State Register for publication. The Chief Hearing Examiner shall complete his review and submit his report to the Department on the issues of substantial changes in the rule and compliance with Minn. Stat. § 15.0412 within ten calendar days. Thereafter, the Department of Health shall be responsible for filing the rules with the

Attorney General and for notifying persons who have indicated that they wish to be notified of such filing.

Based upon all the records and proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

1. On December 12, 1977, the Department filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules;
(b) A proposed Order for Hearing;
(c) A proposed Notice of Hearing; and
(d) A Statement of the estimated length and number of people attending the hearing.

2. On December 26, 1977, a Notice of Hearing and a copy of the proposed rules were published at 2 State Register 1252.

3. On January 6, 1978, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. On January 6, 1978, the Department filed the following documents:

(a) The Order for Hearing;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Affidavit of Mailing;
(e) The Secretary of State's Certificate and list;
(f) The Statement of Need;
(g) The Statement of Evidence, including the names of witnesses to be called; and
(h) The names of Department personnel who will represent the agency.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

5. The record remained open through February 22, 1978 for the receipt of written comments and statements.

6. Pursuant to Minn. Stat. § 15.0412, the Chief Hearing Examiner gave approval to the Department of Health for the incorporation by reference of the following documents:

(a) Minnesota Fortunate Fours, Fourth Ed., 1977;
(b) Early and Periodic Screening Procedures Manual, 1977;
(c) Denver Developmental Screening Test Reference Manual, Revised, 1975 Ed.

7. Pursuant to Minn. Stat. § 15.0412, both the Hearing Examiner and the Department of Health requested that an extension be granted through April 14, 1978, for the completion of the Report herein. The Chief Hearing Examiner ordered that an extension be granted through April 14, 1978.

8. The Department of Health asserts that statutory authority to promulgate the proposed rules is contained in Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (1977 Supp.), 144.06, 144.07 and 144.09 (1976), 123.702-703 (1977 Supp.) and 15.0412, subds. 1 and 3 (1977 Supp.).

a. David Peterson, Polk County Attorney, and Donna Anderson, Minnesota Public Health Association, commented that statutory authority was lacking for the promulgation of the proposed rules.

b. Minn. Stat. §§ 144.10-.12 give the Department broad authority to adopt rules for the "preservation of the public health." The sections specifically speak to the implementation of federally funded programs for maternal and child welfare services. The Examiner concludes that the Department has documented its statutory authority to promulgate the proposed rules.

9. These proposed rules for Early and Periodic Health and Developmental Screening Programs address the requirements, standards and procedures necessary for local early and periodic health screening organizations to secure approved status from the Commissioner of Health.

10. Proposed Rule 7 MCAR § 1.174 A. sets out the general purpose and scope of the rules. § 1.174 B. provides definitions of 21 terms used in the rules.

a. The School Nurses' Organization of Minnesota (SNOM) suggest that the definition of "diagnosis" be deleted. SNOM stated that these proposed rules deal with screening procedures only.

b. Because of public misunderstanding as to the effect of incorporating the EPS Manual, and printing delays resulting in the unavailability of the Manual prior to hearing, the Department has withdrawn the EPS Manual from consideration as a part of the proposed rules. Consequently, the definition of "EPS Procedures Manual" will also be deleted.

c. The Ramsey County Nursing Service; EPS Physical Assessors and the Ramsey County Child Health Consortium suggest the deletion of the definition "Screening and Referral Form" in 1.174(16), as this form has been replaced by the DPW Invoice.

d. The Minnesota Medical Association recommended that the word "immunizations" be added to § 1.174 B.13. The Department concurred in the recommendation.

e. Betty Hubbard suggested that identical definitions be used by all departments proposing rules for early and periodic screening. Ms. Hubbard also recommended that a definition for "referral" be added to these rules.

f. The Examiner concludes that proposed § 1.174 is both needed and reasonable. However, the Examiner recommends that the proposed rule be amended as set forth in paragraphs b., c. and d. above.

11. Proposed Rule 7 MCAR § 1.175 A. sets out the essential ingredients for a local program to qualify for MDH approval.

a. The Department proposed the following amendment to § 1.175A.2.b.:

> The child who is thus found to have deficiencies in his immunization status shall be offered appropriate immunization services as part of the EPS service rather than through referral, if there is legal consent from the parent(s)/guardian or from the emancipated minor and there are no medical or religious contradictions to administration of vaccine.

The Department proposed that the footnote recommending on-site immunization be deleted if the amendment is adopted. This amendment is supported by Nancy Feldman, EPSDT Coordinator, Department of Public Welfare; Fred Aden, Co-chairperson, Interagency Committee on Child Health Screening, and Elaine Saline, Ramsey County Child Health Consortium.

b. Thomas Lombard, State Department of Education, proposed that § 1.175 A.2.g.(2)(b) be amended to include "In order to secure approval of an alternative test, such a test must be standardized and able to provide at a minimum." The Department concurred in this recommendation and proposed its adoption.

c. The Department proposed to amend § 1.175 A.2.i.(2) as follows based on suggestions by Drs. Letson and Anderson:

> Muscle balance screening procedures include at least observation, cover test and the Hirschberg test. The Worth 4-Dot test may be used for children age 5 or over who are co-operative.

Also, the Department proposed to amend § 1.175 A.2.i.(3) to read "Snellen E Chart."

d. The Department concurred with a change to § 1.175 A.5. as recommended by the Minnesota Medical Association (MMA). The following language would be added: Whenever the child identifies a personal physician, that person shall be notified of the referral.

e. Elaine Saline recommended that § 1.175 A.4. be amended by specifying that a copy of the Summary and Referral Form be given to the parents. Thomas Olson suggested that "Developmental Achievement Centers" be inserted after Head Start in § 1.175 A.6. a.(1). The Department concurred with both of these proposed amendments.

f. The Examiner concludes that proposed § 1.175 A. is both needed and reasonable. However, the Examiner recommends that the proposed rule be amended as set out in paragraphs a. - e. above.

12. Proposed Rule 7 MCAR § 1.175 B. sets out standards for the qualifications and responsibilities of EPS screening personnel.

a. Representatives James Swanson and Peggy Byrne expressed concerns regarding the utilization of volunteers as mandated by Minn. Stat. § 123.702, subd. 5 (1977 Supp.), for preschool screening. The Department proposed that § 1.175 B.1. be amended by adding the following language:

The use of volunteers is encouraged in the screening program and volunteer vision and hearing technicians, clinic assistants and clerical personnel are suggested as appropriate use of volunteers, providing they meet the qualifications as defined in § 1.175 B.1.d., e. and f.

b. The examiner concludes that proposed § 1.175 B. is both needed and reasonable. However, the Examiner recommends that the rule be amended as set out in paragraph a. above.

13. Proposed Rule 7 MCAR § 1.175 C. descrribes the requirements of the physical facility to ensure adequate space and privacy for those being screened.

a. Elaine Saline and Anita Hoffman proposed that the "separate areas" requirement be deleted because of the space or room requirement.

b. The Examiner concludes that proposed § 1.175 C. is both needed and reasonable.

14. Proposed Rule 7 MCAR § 1.176 sets out the application procedures for local organizations to seek EPS Program approval from the Department of Health.

a. The MMA proposed that § 1.176 be amended by adding the following paragraph:

F. The identification of existing and ongoing health care services, including personal physicians, in the community to prevent duplication of services and care and how this proposed program will coordinate and utilize the existing network.

The Department concurred in that proposed amendment.

b. The Examiner concludes that proposed § 1.176 is both needed and reasonable. However, the Examiner recommends that the rule be amended as set forth in paragraph a. above.

15. Proposed Rule 7 MCAR § 1.177 describes the supervisory duties and assistance provided by MDH to applicants for EPS approval and on-going programs.

a. The Examiner concludes that proposed § 1.177 is both needed and reasonable.

16. Proposed Rule 7 MCAR § 1.178 sets out the continuing responsibilities and standards for approved EPS programs.

a. The Department proposed to delete § 1.178 B. and its accompanying footnote because of the elimination of the EPS Manual from the rules.

b. The Department proposed that the following additional language be added to § 1.178:

The EPS Health and Developmental report of the child shall be provided to the child's personal physician.

c. The Examiner concludes that proposed § 1.178 is both needed and reasonable. However, the Examiner recommends that the rule be amended as set out in paragraphs a. and b. above.

17. Because the EPS Manual has been withdrawn from the proposed rules, there are no referral criteria contained therein.

Based upon the foregoing Findings of Fact, the Hearing Examiner makes the following:

CONCLUSIONS

1. Due, timely and adequate legal notice of the hearing was properly served and filed by the Department of Health. All other substantive and procedural requirements of statute or rule have been complied with.

2. Pursuant to Minn. Stat. § 15.052, subd. 3, it is the duty of the Hearing Examiner to: ". . . (4) make a report on each proposed agency action . . . taking notice of the degree to which the agency has (i) documented its statutory authority to take the proposed action; (ii) fulfilled all relevant, substantive and procedural requirements of law or rule; and (iii) demonstrated the need for and reasonableness of its proposed action with an affirmative presentation of facts."

3. The Department of Health has documented its statutory authority to promulgate the proposed rules.

4. The Department of Health has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts.

5. The Hearing Examiner suggests that the proposed rules be amended as recommended in Findings 10.f., 11.f., 12.b., 14.b.,

and 16.c. The Department should further examine the entire record in this matter before final action is taken.

6. The Examiner concludes that the amendments he is suggesting make the proposed rules more reasonble and do not constitute a substantial change.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATION

That the Department of Health adopt the proposed rules as recommended to be amended in this Report and on the basis of the record made herein.

Dated this 3 day of April, 1978.

Peter C. Erickson

PETER C.ERICKSON
Hearing Examiner

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS
ROOM 300 – 1745 UNIVERSITY AVENUE
ST. PAUL, MINNESOTA 55104
(612) 296-6910

September 18, 1978

Mr. Terry P. O'Brien
Special Assistant Attorney General
232 Minnesota Health Department Bldg.
717 Delaware Street SE
Minneapolis, Minnesota 55440

Re: Proposed Rules of the Minnesota Department of Health
Relating to the Approval of Early and Periodic Health
and Developmental Screening Programs
HLTH-78-013-PE

Dear Mr. O'Brien:

Pursuant to Minn. Rule HE 108, enclosed is the Order of the Chief Hearing Examiner together with the file in the above-entitled rules hearing.

Yours very truly,

/S/ Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

DRH:sh
Enc.
✓cc: Lee Sheehy

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ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED RULES OF THE MINNESOTA DEPARTMENT OF HEALTH RELATING TO THE APPROVAL OF EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS.

ORDER OF THE CHIEF HEARING EXAMINER

The above-entitled matter was submitted to the Chief Hearing Examiner for review pursuant to the provisions of Minn. Stat. § 15.052, Subd. 4, and Minn. Rule HE 107, on Friday, September 15, 1978. This review is limited to ensuring compliance with Minn. Stat. § 15.0412, Subd. 4, to determine whether or not the rules as finally adopted are substantially different from those proposed prior to hearing.

Based upon a review of the record, the Chief Hearing Examiner makes the following:

FINDINGS OF FACT

1. A Notice of Hearing was published in the State Register and mailed to all persons who had registered with the Secretary of State at least 30 days prior to the hearing. The Report of the Hearing Examiner, at Finding 3, indicated that the Department mailed the Notice of Hearing on January 6, 1978. The Affidavit of Mailing, which is found as Agency Exhibit No. 8, indicates that the Notice was mailed on December 28, 1977.

2. The full text of the proposed rules was published at least 30 days prior to the first day of hearing.

3. All documents required to be filed prior to the hearing pursuant to Minn. Rule HE 103 were filed on January 6, 1978, which is more than 25 days prior to the hearing.

4. During the hearing, the Department of Health proposed to amend the rules as originally proposed in several areas and the Hearing Examiner issued his report on the rules as amended at the time of hearing.

5. Rule 7 MCAR § 1.175 A.2.b., as originally proposed, contained a footnote which read: "It is recommended that approved programs provide immunizations on site." The rule as amended at the hearing deleted the footnoted recommendation and adds language which makes on-site immunizations mandatory with certain exceptions which includes a proviso that the local agency can obtain medical supervision of this service.

6. Rule 7 MCAR § 1.175 A.2.g.(2) and 7 MCAR § 1.176 D. 2.a. use the word "may" which provides for agency discretion but without including criteria or standards by which the agency will exercise this discretion.

Based upon the foregoing Findings of Fact, the Chief Hearing Examiner makes the following:

CONCLUSIONS

1. The Minnesota Department of Health has complied with the procedural provisions of Minn. Stat. § 15.0412, Subd. 4, and the procedural requirements of the Rules of the Office of Hearing Examiners.

2. The use of the term "may" in the rules cited in Finding 6 above without having enumerated standards or criteria by which the agency will exercise its discretion has been determined by the Attorney General to be contrary to law and, therefore, unreasonable. The Chief Hearing Examiner must then conclude that for purposes of these two rules, as drafted, the agency has failed to make an affirmative presentation of facts showing the reasonableness of the utilization of the term "may". The Chief Hearing Examiner further concludes that should the agency amend these two rules to establish sufficient standard and criteria, that it would not result in a "substantial change" necessitating further review by the Chief Hearing Examiner.

3. That the amendment to Rule 7 MCAR 1.175 A.2.b. is a substantial change in that it changes the rule from a recommendation to a mandatory requirement which is a major substantive change that was not raised by the original Notice of Hearing in such a way as to invite reaction at the hearing.

NOW, THEREFORE, pursuant to the provisions of Minn. Stat. § 15.052, Subd. 4, and Minn. Rule HE 108, the Minnesota Department of Health shall either withdraw the proposed final rules discussed in the conclusions above, amend those discussed in conclusion 2, or reconvene the rule hearing.

Dated this 18th day
of September, 1978.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs.

NOTICE OF HEARING

Notice is hereby given that a public hearing in the above-entitled matter will be held pursuant to Minn. Stat. § 15.0412 subd. 4 (Supp. 1977), in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Thursday, February 2, 1978, commencing at 9:00 a.m.

All interested or affected persons will have an opportunity to participate concerning the adoption of the proposed rules captioned above. Statements may may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted by mail to Peter Erickson, Hearing Examiner, at Room 300, 1745 University Avenue, Saint Paul, Minensota 55104, telephone (612) 296-8118, either before the hearing or within five days after the close of the hearing. All such statements will be entered into and become part of the record. Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand. For those wishing to submit written statements or exhibits, it is requested that at least three (3) copies be furnished. In addition, it is suggested, to save time and avoid duplication, that those persons, organizations, or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests.

The conduct of the hearing shall be governed by the rules of the Office of Hearing Examiners.

A copy of the proposed rules is attached hereto and made a part hereof.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing.

A Statement of Need explaining the Commissioner of Health's position relative to the necessity for the proposed rules and a Statement of Evidence outlining the testimony and evidence which will be introduced on behalf of the Commissioner in support of the proposed rules will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection. The statutory authority of the Commissioner of Health to promulgate and adopt these rules is contained in Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (Supp. 1977), 144.07(1), 144.09 (1976) and 15.0412 subds. 1 and 3 (Supp. 1977).

In addition, please be advised that Minn. Stat. ch. 10A requires each loggyist to register with the State Ethical Practices Board within five (5) days after he commences lobbying. Lobbying includes attempting to influence rule making by communicating or urging others to communicate with public officials. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 a year or five (5) hours per month for lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, Saint Paul, Minnesota 55155, telephone (612) 296-5615.

Dated: December 8, 1977

STATE OF MINNESOTA

COMMISSIONER OF HEALTH



WARREN R. LAWSON, M.D.
Commissioner of Health

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED RULES OF THE MINNESOTA DEPARTMENT OF HEALTH RELATING TO THE APPROVAL OF EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS.

REPORT OF THE CHIEF HEARING EXAMINER RELATING TO INCORPORATION BY REFERENCE

Pursuant to Minnesota Statutes, 1976, Section 15.0412, as amended by Laws of Minnesota, Chapter 443, Section 2, the Minnesota Department of Health, on November 28, 1977, requested prior approval of the Chief Hearing Examiner to be allowed to incorporate by reference certain documents in the above-entitled proposed rules. The documents are as follows:

1. "Minnesota Fortunate Fours", a handbook sponsored by the Minnesota State Medical Association in cooperation with the Minnesota Society for the Prevention of Blindness, Fourth Edition, 1977.

2. "Early and Periodic Screening Procedures Manual, 1977", published and distributed free of charge by the Minnesota Department of Health.

3. "Denver Developmental Screening Test, Reference Manual", Revised 1975 Edition.

The Chief Hearing Examiner, having reviewed all of the aforementioned documents, has found that each of the documents exceeds 3,000 words in length and would exceed five printed pages in the Minnesota State Register. Additionally, the Chief Hearing Examiner finds that all of the documents are readily available at the Minnesota Department of Health, free of charge, and are otherwise readily available and accessible to the public.

NOW, THEREFORE, the Chief Hearing Examiner herewith gives approval to the Minnesota Department of Health for the incorporation by reference of the above-entitled documents in their proposed rules relating to the approval of early and periodic health and developmental screening programs.

Dated this 6th day of December, 1977.

DUANE R. HARVES
Chief Hearing Examiner

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EXAMINERS

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEATLH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

STATEMENT OF EVIDENCE

Agents of the State Commissioner of Health (hereinafter "Commissioner") will introduce the following evidence at the hearing in the above-entitled matter scheduled for Thursday, February 2, 1978, commencing at 9:00 a.m. in the Board Room, Minnesota Department of Health Building, 717 Delaware Street S.E., Minneapolis, Minnesota.

Documents attached hereto and made a part hereof constituting the Commissioner's affirmative presentation of facts establishing the need for and reasonableness of the proposed rule and evidencing the Commissioner's compliance with substantive requirements for rule making:

(a) Statement of Need; and

(b) Statement of Justification Establishing the Reasonableness of Rule

The following witnesses will represent the Commissioner at the hearing:

Ronald C. Campbell, M.D.
Grace Gumnit
Sheila Swaiman

Said witnesses will be available to answer questions as they might relate to the Commissioner's affirmative presentation of facts as set forth through the previously listed and attached documents.

The Statement of Need attached hereto contains the citations to the Commissioner's statutory authority to promulgate the proposed rules.

STATE OF MINNESOTA

COMMISSIONER OF HEATLH

Dated: January 6, 1978

WARREN R. LAWSON, M.D.
Commissioner

9a)

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

STATEMENT OF NEED

The above-captioned rules are new rules of the Commissioner of Health (hereinafter "Commissioner") and address those requirements, standards and procedures necessary for local early and periodic health screening organizations to secure approval status from the Commissioner.

The need to adopt these rules arises primarily to bring the Department of Health into compliance with existing state and federal legislation concerning screening programs for children and to provide notice of criteria and clarification of procedures to those organizations applying for screening program approval.

The legal authority for adopting these rules is found in Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (Supp. 1977), 144.06, 144.07 and 144.09 (1976), 123.702-703 (Supp. 1977) and 15.0412 subds. 1 and 3 (Supp. 1977).

Minn. Stat. § 144.11 (1976) authorizes the Commissioner to promulgate rules enforcing Minn. Stat. § 144.10 (1976), which relates to federally funded child welfare and public health services. Minn. Stat. § 144.10 (1976) states in relevant part as follows:

> The state treasurer is hereby appointed as the custodian of all monies received, or which may hereafter be received, by the state by reason of any federal aid granted for maternal and child welfare service and for public health services, . . . which money shall be expended in accordance with the purposes expressed in the acts of congress granting such aid and solely in accordance with plans to be prepared by the State Board of Health. . . such plans shall include the training of personnel for both state and local health work and conform with all the requirements governing federal aid for these purposes. Such plans shall be designed to secure for the state the maximum amount of federal aid which is possible to be secured on the basis of the available state, county, and local appropriations for such purposes.

The State of Minnesota has received federal monies for maternal and child welfare services and public health services pursuant to 42 U.S.C.A. §§ 701-703, 705-713 (1974) (also referred to as Title V of the Social Security Act, enacted August 14, 1935, ch. 531, Title V, 49 Stat. 629 and amended thereafter) and the regulations promulgated thereunder, 42 CFR §§ 51a.101-51a.143. More specifically, the Minnesota Department of Health is the state agency as described in 42 CFR §§ 51a.101 to administer and supervise the administration of a state plan for maternal and child health, which plan provides, among other things, educational and preventive health services to children and training to personnel dealing with children. The Minnesota Department of Health developed a maternal and child health state plan which includes provision for early and periodic screening of children up to 21 years of age under this federal program. In 1975, the United States Government accepted the Minnesota plan and has accordingly been transferring monies to the State of Minnesota..

Thus, the Minnesota Department of Health, as an agency of the state, has received and expended federal monies in accordance with the purposes expressed in acts of Congress granting such aid and in accordance with plans prepared by the Department of Health. Minn. Stat. § 144.11 (1976) states as follows: "The Board may make such reasonable rules and regulations as may be necessary to carry into effect the provisions of sections 144.10 and alter, amend, suspend or repeal any such rules and regulations."*/ These rules are proposed in order to expend monies needed by the state from the United States Government in accordance with 42 U.S.C.A. §§ 701-703, 705-713 (1974) and to promulgate into rule those parts of the state plan which affect the rights of the public.

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*/ The legislature through amendments to Minn. Stat. § 144.011 (1976), enacted in Minn. Laws 1977, ch. 305 § 39, abolished the Board of Health and transferred all its powers to the Commissioner of Health. Although the statutes cited and quoted herein refer to the Board of Health as empowered to promulgate and enforce regulations, reference is made to the Commissioner of Health throughout this Statement of Need and other documents filed in support of these rules.

Similar authority for the Commissioner's promulgation of these rules is found in Minn. Stat. §§ 144.06 and 144.09 (1976) when read in conjunction with Minn. Stat. § 144.07 (1976). Minn. Stat. § 144.06 (1976) authorizes the Commissioner of Health to provide instruction and advice to mothers and their infants after child birth. Minn. Stat. § 144.09 specifies that the state, through its legislative authority, accepts any congressional acts providing for cooperation between the United States government and the states in protecting infants and empowers and directs the Commissioner to cooperate with the Federal Childrens Bureau to carry out the purposes of such acts. Minn. Stat. § 144.07(3) permits the Commissioner to cooperate with agencies, whether federal, state or local, which carry on work for maternal and infant hygiene. Minn. Stat. § 144.07(1) (1976) then authorizes the Commissioner to "make all reasonable rules and regulations necessary to carry into effect the provisions of sections 144.06, 144.07 and 144.09, . . ." referenced in this paragraph. As is evident from these proposed rules, the health criteria for screening programs, as well as qualifications for those personnel testing children, all relate to instruction and advice to mothers and children and require cooperation between federal, state and local levels in protecting children.

Minn. Stat. § 144.12 subd. 1 (Supp. 1977) states in relevant part as follows:

> The Board may adopt, alter, and enforce reasonable regulations of permanent application throughout the whole or any portion of the state, or for specified periods in parts thereof, for the preservation of the public health.

The proposed rules are needed to preserve the public health. The purpose of promulgating rules relating to the approval of early and periodic health screening and developmental screening programs is to facilitate the provision of such services and to provide quality assurance for such services. Health screening programs are necessary to bring needed health care to children who may not be receiving it. Screening programs accomplish this goal by identifying children with health problems or needs that have not been recognized or have not been fully cared for, and by insuring that these problems are adequately referred to others for diagnosis and treatment.

A child may fail to receive needed health care for any one or a combination of the following reasons:

1. Because the problem can be detected only by special tests or observations,

2. Because the health importance of a problem or symptom is not recognized,

3. Because appropriate care has not been sought for a recognized problem,

4. Because needed preventive services have not been used,

5. Because a child has been neglected or abused,

6. Because the parents or guardians of the child are unaware of referral sources within the community area.

If every child is to receive needed care, some person or persons must periodically survey him to be sure there are no hidden problems, that the medical significance of any symptoms is known, that evidence of neglect is identified and that necessary preventive and remedial measures are being taken. Early and periodic screening programs, and these rules dealing with the approval of such programs, are designed to accomplish these tasks.

A strategy for preserving the public health of children is to discover unmet health needs by evaluating children through use of relatively simple or inexpensive tests and observations. The screening tests outlined in these rules are designed to determine whether a child is healthy or is at health risk and therefore in need of referral. By this strategy, children who are healthy or are at low risk are spared the expense, discomfort and inconvenience of detailed medical evaluation, and scarce resources for diagnosis and treatment are concentrated on children with a high risk of having unmet needs.

The standards contained in these rules are proposed to address a perceived public health need. If there is any doubt as to whether or not these rules concern the preservation of the public health, one need only to refer to the legislative declaration found in Minn. Stat. § 123.701 (Supp. 1977) which states in relevant part as follows:

> The legislature finds that early detection of children's health and developmental problems can reduce their later need for costly care, minimize their physical and educational handicaps, and aid in their rehabilitation.

The purpose of sections 123.701 to 123.705 (Supp. 1977) [the preschool screening program] is to assist parents and communities in improving the health of Minnesota children and in planning educational and health programs.

Furthermore, these rules are necessary to provide a minimal degree of uniformity to screening programs consistent with efficient operation and qualitative standards as well as to provide a maximum degree of flexibility to local programs consistent with their determination of local needs and desires. Hopefully, promulgation of these rules will encourage those communities which do not have screening programs to institute the same. These rules are also designed to prevent wasteful duplication as well as possible fragmentation among local screening programs throughout the state. In Minnesota the first early and screening programs corresponding to those contemplated in the rules where instituted in September of 1974. Since 1974, there has been a steady growth of such programs. It is estimated that there are roughly 52 such programs in the state in January, 1978. According to statistics available in a report entitled, "EPS-Minnesota Department of Health-Annual Evaluation Report-1976-1977," it is stated that approximately 10,000 children were screened in FY 1977 by local early and periodic screening programs. In a statewide sample survey, it was noted that 19% of the parents, guardians or children could not identify a personal physician. Approximately 59% of those responding to the survey had not had their pre-school age child see a personal physician for a well child check-up in the year immediately preceding the survey. These statistics further demonstrate the public health need for rules related to early and periodic screening programs.

Minn. Stat. § 123.702 (Supp. 1977) mandates that every school board provide a health and developmental screening program for children and further requires that:

> All screening components shall be consistent with the standards of the State Board of Health for early and periodic screening programs.

Further, Minn. Stat. § 123.703 requires that the Department of Education consider Department of Health standards in drafting its own proposed rules. The Departments of Education and Health are to report to the legislature by February 1, 1979 on the results of the programs in accordance with the purposes specified in Minn. Stat. § 123.701, quoted hereinabove.

Finally, authority and need for these rules is found in Minn. Stat. § 15.0412 subd. 3 (Supp. 1977). Subdivision 1 of this statute requires that each agency adopt rules consistent with its duties and obligations. The law states that the administrative procedure act itself does not constitute authority for an agency to adopt rules, "except as provided in subdivision 3. . ." Subdivision 3 states as follows:

> Each agency shall adopt rules setting forth the nature and requirements of all formal and informal procedures related to the administration of official agency duties to the extent that those procedures directly affect the rights of or procedures available to the public.

The rights of those programs seeking approval are affected by the approval or nonapproval by the Commissioner. Surely, applicants for approval are entitled to notice as to what procedures shall be used with regard to securing such approval. Applicants are entitled to advance knowledge of the standards and criteria upon which their application shall be reviewed as well as the standards and procedures upon which they may continue to be approved. Remedies for those applicants who are denied approval or previously approved programs who have had approval removed should be stated in rule so as to preclude the possibility of too wide a path of bureaucratic discretion. Inasmuch as the administration of the approval system is an official duty of the Commissioner pursuant to those statutes referenced above, these rules are necessary to set forth the nature of his requirements and procedures with respect to the approval process. It is necessary to ensure that the Commissioner and those acting under his authority concentrate their reviewing efforts to those items within rules which relate to the ultimate public health

benefits of screening programs and which are within their expertise to review.

Further need is clarified and put forth in the Statement of Justification filed in support of these rules.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

WARREN R. LAWSON, M.D.
Commissioner

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STATEMENT OF JUSTIFICATION RELATING TO PROPOSED RULES
OF MINNESOTA DEPARTMENT OF HEALTH
EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS

Chapter Eleven: 7 MCAR 1.174 - 1.178

These proposed rules provide an explanation of the purpose of the rules, and deal with the subjects which are needed to give the reader precise knowledge of the Early and Periodic Health and Developmental Screening Program and the process of obtaining Minnesota Department of Health approval for local provision of program services.

7 MCAR § 1.174 GENERAL

MCAR § 1.174 (A) gives the general purpose of these rules. The authority to promulgate these rules resides in Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (supp. 1977), 144.07 (1), 144.09 (1976), 123.702 - 703 (supp. 1977), subds. 1 and 3 (supp. 1977).

MCAR § 1.174 (B) provides definitions of 21 separate terms used in the rules. These definitions, discussed individually below, are necessary to affect a uniform interpretation of these rules and to avoid uncertainty and ambiguity in utilizing the rules.

1. APPLICANT

This definition is necessary to clarify those portions of the rules which make reference to the "applicant". This definition defines when an organization becomes subject to these rules. Without this definition there may be ambiguity in distinguishing among the terms "applicant" and "approved program". Applicant is a term which refers to an organization, which may be at one of several stages in the process of obtaining the status of MDH approval to provide local Early and Periodic Health and Developmental Screening of children. This definition also provides examples of the type of organization that would be eligible to apply for approved program status.

2. APPLICATION

This definition clarifies those portions of the rules that deal with the application process. Organizations selecting MDH approved program status must submit written information in a specified format. The requirement that information be submitted in a specified format provides for uniformity and completeness in the applications. The information requested in writing the application is considered to be basic and essential to the review process.

3. APPROVED PROGRAM

This definition clarifies those portions of the rule that relate to an approved program and denotes that the local organization has obtained MDH approved program status and is operating in accordance with the standards specified in these rules.

4. CHILDREN

This definition is necessary in order to delineate the specific population that is to be served by this program. This definition includes the category of young adults 13 - 21 years, but for ease of reading and in order to avoid verbiage, the young adult category is incorporated within the term "children". This definition is established to be compatible with DPW definition of children, as found in Rule 12 MCAR § 2.061.

5. DIAGNOSIS

This definition refers to the process that may occur as a result of the screening process. Diagnosis distinguishes one disease from another and determines the nature and cause of a disease. Referral to a resource for diagnosis and possible treatment is a responsibility of an approved program under the section on follow-up, MCAR § 1.175 (6). Diagnosis is not a direct function of the MDH approved nurse-supervised program.

6. EARLY

This definition is necessary to convey the idea that a basic tenet of the EPS Program is to establish children in the health care system at the youngest possible age. It has been shown that early health care experience offers opportunity for health education and prevention of health problems. Early detection of health problems may reduce the possibility of more extensive treatment later and may minimize physical and emotional handicaps and aid in rehabilitation.[1]

7. EPS

This allows a short-hand reference to the Early and Periodic Health and Developmental Screening Program.

8. EPS MANUAL

This definition is necessary to describe the document which is incorporated in the rules by reference. It is a document which provides descriptive and instructional information to the staff of agencies seeking approval or who are approved. It provides uniformity of information about EPS and is compatible with these rules.

9. EPS TRAINED NURSES

This definition is needed to distinguish between any nurse and one who has received specific training in administering assessments and tests used in an approved program and who will have responsibility for utilizing those specific skills in an EPS program.

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[1] M. Wagner, Sweden's Health Screening Program for Four Year Old Children, DHEW Publication, No. (ADM) 72-282, 1975.

10. MDH

This acronym allows a short-hand reference to the Minnesota Department of Health.

11. PERIODIC

This definition is necessary to convey the idea that EPS should reoccur at specific intervals throughout the child's life, in order to assure that the child has not developed symptoms of a disease or disability which was formerly not present or not detected. Early intervention in a disease process is more effective if a child is screened at established intervals.

12. PERIODICITY SCHEDULE

This definition is necessary to delineate the chart MCAR 1.175 (3) which defines the frequency and age ranges at which specific assessments and tests are to be administered. This periodicity schedule is based on scientific evidence and professional judgments which indicates that certain health threatening conditions have an increased incidence based on age, sex, and race specific relationships.[2] Some tests need to be repeated at specific intervals and others will need to be administered only once or will be limited to a specific age range.

13. PHYSICIAN INTEGRATION PLAN

This definition is necessary to clarify the option available to an approved program of utilizing a physician-administered health history, physical examination and laboratory tests as part of EPS. The child may already be receiving ongoing medical care from a physician and by utilizing the physician-administered health history, physical examination and laboratory services in place of an EPS nursing assessment, health history and lab tests, duplication of efforts is avoided and supports the ongoing medical care by a physician.

14. PRESCHOOL SCREENING PROGRAM

This definition is necessary to describe a major statewide Preschool Screening Program as established in Minn. Stat. §§ 123.701 - 705 (supp. 1977). Minn. Stat. § 123.702 (supp. 1977) requires that all Preschool Screening Program standards be consistent with Minnesota Department of Health standards for EPS programs.

15. SCREENING

This definition is necessary to define those procedures utilized by the MDH approved programs for identifying those children in need of further evaluation, diagnosis and/or treatment and to delineate the difference between screening and diagnosis. Screening is a sorting process to separate children with possible problems from the general population of apparently well children.

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[2] See e.g. William K. Frankenberg, Fredrick A. North, A Guide to EPSDT Screening, U.S. Department of Health, Education, and Welfare, prepared under contract with American Academy of Pediatrics, June, 1974.

16. SCREENING AND REFERRAL FORM

This definition is necessary to describe the document for reporting the results of screening a child and the subsequent use of this information, on an aggregate basis, for purposes of program evaluation.

17. SLIDING FEE SCALE

This definition addresses the method by which persons, who are unable to pay the full cost for screening and who are not Title XIX eligible, are able to pay a partial cost towards the screening service. This definition is necessary to specify that sliding fee scales are developed at the local level.

18. THIRD PARTY REIMBURSEMENT

This definition is necessary to describe the umbrella term which delineates payment mechanisms other than parent fees that can be used to pay the full or partial cost of the screening service. Examples of third party reimbursement are: Title XIX or Department of Education Preschool Screening monies.

19. TITLE XIX

This definition is necessary to identify the federal program and the source of payment for the screening and medical care costs of those persons as defined under the 42 USC, Title XIX 1901-1910 (Social Security Act as ammended) who are eligible for such payment.

20. TRACKING

This definition is necessary to specify that there shall be a written process by which the approved program must obtain and record the results of diagnosis and treatment. This data is necessary to identify the outcomes that result from the screening and referral procedures.

21. TREATMENT

This definition is necessary to specify a process which may be initiated as a result of diagnosis. A basic premise in screening is to identify potential problems in order that those children who need treatment may be alterted to receive the necessary treatment. The local approved program is not directly responsible for treatment, but must have follow-up procedures to assure that appropriate treatment is arranged for those determined to need it.

7 MCAR § 1.175 MINIMUM STANDARDS TO QUALITY

1.175 (A)(1) Because EPS is a preventive health program and historically preventive health programs have not been accorded sufficient priority among the populations who could benefit from them, it is appropriate that there be a ~~systematic~~ method of acquainting the public with the program and its benefits to enhance participation in the program. These methods are best established at the level of the local approved program.

1.175 (A)(1)(a) is necessary to suggest possible methods of reaching and informing parents and children of program benefits. This is not an all inclusive list of methods and individual programs may use whatever method is the most effective, based on actual experience.

1.175 (A)(1)(b) This section is necessary to convey the idea that coordination is required in the outreach effort. Local welfare departments have a responsibility for outreach for the Title XIX population and the public schools have responsibilities for the preschool population under Preschool Screening Act. In order to avoid duplication and achieve a coordinated approach to child health screening, the outreach efforts of the local EPS program must be coordinated with these particular agencies.

1.176 (A)(1)(e) This proposed rule provides a description of the minimum technical aspects of the program that are necessary in order to qualify for MDH approval. The content in this rule eminates from a variety of sources which include:

1. Guidelines for EPSDT-Medicaid Program prepared by HEW in cooperation with the American Academy of Pediatrics, June, 1974.

2. The ongoing advice of various consultants, including physicians, psychologists, public health nurses, pediatric nurse associates and health program administrators.

3. Our ongoing review of pertinent publications.[3]

Each of the tests and assessment procedures described in this section were selected because the tests identify problems or diseases about which affirmative answers were obtained when most of the following questions were asked:

- Is the problem or disease to be detected important to the affected individual?
- Is the problem or disease to be detected important to the community?
- Is the problem or disease to be detected treatable?
- Does early detection and treatment improve the outcome or reduce the cost of treatment?
- Is there a substantial "lead time" between the time that the problem can first be discovered through screening and the time that it would ordinarily be detected without screening?
- Are adequate resources available to diagnose and treat persons discovered through screening or is there potential for their development?
- Are the total costs of screening, diagnosis and treatment for the problem justified by the benefits of early detection?
- Is there a safe, economical, simple, reliable, accurate and valid screening test for the problem or disease to be detected?

For most tests and assessments there are specific indicators or referral criteria for referral to a qualified resource trained to evaluate and/or diagnose, and as appropriate, to treat the condition. These referral criteria may be used alone or in combination with other indicators identified in the screening process. The nurse responsible for the screening is trained to couple professional judgment with the referral criteria outlined in the EPS Procedures Manual.

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[3]See e.g., Pediatrics - American Academy of Pediatrics, Supplement - Report of Task Force of Blood Pressure Control in Children, May 1977.

To assure that children who participate in the EPS Program receive high quality services, an EPS Procedures Manual has been developed by the Minnesota Department of Health. This manual, which describes in detail the tests and assessments, the methods by which they are performed and their referral criteria, has been incorporated into these rules by reference.

The following sections of this rule describe the screening component and justify the contents of the EPS Procedures Manual.

1.175 (A)(2)(a) A health history gathers information about the past and present health problems of the child and his/her family. This information is necessary to identify conditions which should be further evaluated during the screening process and possibly further evaluated through referral. This health history information is also necessary to assure that health problems previously known and treated are not inappropriately referred.

1.175 (A)(2)(b) is necessary so that the immunization needs of the child can be determined and the necessary immunizations can be provided. The objective in this regard is to insure that the child is protected from immunizable disease at the earliest appropriate age and that she/he remains protected. There are seven diseases for which immunization is currently recommended: diphtheria, tetanus, whooping cough, polio, measles, german measles, and mumps. Each of these diseases can cause serious consequences and immunization largely eliminates the risk of the child suffering from the disease or its consequences.

see letters on site Admin

1.175(A)(2)(c) is necessary to determine the presence of inadequate diet. It is resonable that a standard method of utilizing a 24 hour dietary intake be used to provide a basis for potential nutritional counseling. Inadequate diet can lead to health problems. However, when inadequate diet is detected early, health problems related thereto can be prevented.

1.175 (A)(2)(d) Physical growth assessments are necessary, because the abnormal results of these assessments lead to further evaluation of the child's health status. This evaluation may lead to the identification of health threatening conditions.

1.175 (A)(2)(e) The unclothed physical assessment is necessary to further evaluate abnormalities detected by other EPS tests and assessments and to identify otherwise undetected health problems which should be referred for further evaluation. The nurses do not perform a conventional physical examination. However, it is reasonable and necessary that nurses perform an unclothed physical assessment in order to detect gross deviations of growth and development from the norm. The physical assessment must be done in a systematic manner and includes physical inspection, and limited palpation and auscultation. It does not include diagnosis and treatment, this is provided in the established health care delivery system.

1.175 (A)(2)(f) Dental inspection is necessary to determine the oral health status of the child, and whether the child is receiving ongoing dental care.

see Dentist letter

1.175 (A)(2)(g)(1) It is necessary to administer a developmental screening test in order to detect gross abnormalities in the areas of fine and gross motor, speech, and personal social behavior. The Denver Developmental Screening Test

(DDST) is a short easily administered measure of physical motor, perceptual and cognitive development in preschool children. The DDST yield scores in four areas, gross motor, fine motor, adaptive speech and language, and personal-social. The PDQ is useful and necessary at age intervals 12 - 15 months, 16 - 19 months, and 30 - 35 months because a child's developmental status is changing during these age intervals. However, generally the changes are not of such magnitude that the more time consuming and in-depth DDST must be administered with this frequency. The PDQ requires less time and skill for administration and, thus, serves as an efficient tool to identify children in need of further testing with the DDST. The DDST is recommended by the MDH as a screening instrument for the following reasons:

1. The DDST is normed or standardized on broad socio-economic grouping of children ages 2 weeks to 6.4 years.[4]

2. The DDST has a standardized method of administration and scoring.

3. The DDST has programmed training materials available for training of personnel.

1.175 (A)(2)(g)(2) An alternative procedure for selecting a developmental screening test other than the PDQ/DDST has been developed because the state of the art in developmental testing is not fully developed (defined in absolutes) and there may be other tests now or in the future equal to or better than the DDST. However, if other tests are to be substituted they must conform to the criteria stated in 1.175 (A)(2)(g)(2) in order to assure a valid approach to developmental screening.

1.175 (A)(2)(h) Hearing assessment is necessary to identify children who are at risk for reduced hearing. Normal hearing, particularly during the first years of life, is essential to development of speech and learning.

1.175 (A)(2)(h)(1) Both the puretone and VASC tests are standardized and meet the criteria of appropriate screening tests.

1.175 (A)(2)(i) Vision screening is necessary to detect eye problems and visual impairments which may interfere with the development and education of the child. It is important to identify these problems as early as possible and to provide correction so that normal learning may take place. Tests described in this section of the rules, such as muscle balance procedures and the tests for visual acuity such as the Snellen Alphabet Chart, meet the criteria of appropriate screening tests.

see original letter

1.175 (A)(2)(j) Laboratory tests are necessary to provide information which supplements the results of other tests and assessments and leads to referral for further evaluation of possible health problems.

1.175 (A)(2)(j)(1) The purpose of the tuberculin test is to detect disease due to infection with tubercle bacillus. The incidence of this disease is so low in the United States that we have recommended that a child be screened no more than once for tuberculin sensitivity. Nonetheless, the incidence is sufficient that American Academy of Pediatrics includes this test in their recommended schedules for immunization and tuberculin testing.

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[4] The Denver Developmental Screening Test, William Frankenberg, M.D., Jacob B. Dodds, Ph.D., Journal of Pediatrics, August, 1967.

1.175 (A)(2)(j)(2) The purpose of the bacteriuria test is to identify individuals who have a symptommatic urinary tract infection. Children with positive results from this test may be at risk for permanent renal damage. It should be noted that this testing is confined to females, only at 3 to 4 years of age and again at 8 to 10 years of age. Males are generally not at risk for this problem. Urine testing (Bililabstix) determines abnormal substances in the urine, which may be indicators of problems in need of further evaluation. It is recommended that a child be tested only once.

1.175 (A)(j)(3) This test is needed to identify those persons who have anemia requiring medical evaluation and treatment. The results of this test can also support the findings of other nutrition assessments, thus, leading to the conclusion that the child's health may be improved or problems may be prevented through changes in dietary habits.

1.175 (j)(4) The purpose of screening for increased lead absorption is to prevent disability and possibly death due to absorption of excessive amounts of lead from the environment. When identified, this health problem can be alleviated by reducing the exposure to lead. Where absorbed lead levels are very high, excess lead can be chemically bound and discharged from the body. This test has been limited to children between 16 months and 4 years of age because the risk for increased blood lead is most prevalent in this age range. In addition, only children with a positive history receive a blood test. A positive history has affirmative responses to questions relating to oral consumption of paint chips and pencils or to residence in a house build before 1950 that has peeling paint.

1.175 (j)(5) The purpose of sickle cell screening is to detect sickle cell disease or sickle cell trait. Early detection of the disease permits early development of a care plan. Early detection of the disease or trait facilitates informed reproductive decisions by the child's parents and later by the child. Blacks and individuals of Mediterranean ancestory are chiefly those at risk for sickle cell disease. Appropriate counseling services must be available to expalin the screening results to the families. Sickle cell will be performed only upon parental request.

1.175 (A)(3) The periodicity schedule is necessary to concisely indicate the appropriate age ranges for administration of each of the tests and assessments. The specific age ranges, tests and assessments are based on the fact that the incidence of many diseases relates to the age, sex and race of the population to be screened. Some tests and assessments must be periodically repeated to detect changes in the health status of the population. Because change in health status of infants can change rapidly, screening is recommended twice before age one. In young adults, however, health status is relatively stable and hense, screening is only recommended every three years.

1.175 (A)(4) The interpretation and education component of the EPS Program is necessary to motivate parents and children to follow through if a referral is made. When abnormal findings are present their meaning should be carefully explained and a plan developed for any necessary further evaluation, diagnosis and treatment, if indicated. Plans should take into account any limitations of the family's ability to take time for medical care or health related support services. Normal findings should also be discussed and parents and children should be reassured of the strengths and good practices which they do possess. All families, whether or not their child has any problems, should be given information about how to protect their child's health in the future, how and when to seek medical care, and how to maintain a healthy nutritional and psychological atmosphere in their home.

1.175 (A)(5) This section, relating to the referral component of the EPS Program, is necessary to assure that there is an organized system for evaluation or diagnosis and treatment services for children with problems identified in the screening process. The primary source of referrals for medical problems should be to the family physician. Other problems are referred to resources as appropriate. For example, a child who is not receiving ongoing dental care should be referred to a dentist.

1.175 (6) This section, related to the follow-up component of the EPS Program, is necessary to assure that diagnosis and treatment services are obtained as a result of the referral. Most experts agree that a screening program that does not follow-up to assure evaluation, diagnosis and treament, is a failure.

1.175 (6)(a)(1) Due to the critical nature of this activity, a detailed description of the steps to be taken in the process of follow-up are essential. A plan for follow-up is reasonable in that it requires that program personnel give thoughtful consideration to precisely how they will implement follow-up procedures. Written and formal arrangements with other agencies who may have follow-up responsibility for the respective population they serve is necessary in order to avoid duplication and to assure each agency is clearly aware of their responsibility. Written and formal arrangements allow for enforcability of follow-up responsibilities at the local level and allow MDH to review such plans and arrangements to identify whether technical assistance is necessary and whether such plans meet the requirements of EPS Rule.

1.175 (6)(a)(2) It is reasonable to have a description of follow-up activities for purposes of MDH reviewal and to assure that local agency personnel are aware of the specific follow-up activities which must transpire. Two attempts to make contact with parent or provider is reasonable in that it does not place an undue burden on the agency and assumes that most parents are responsible and will arrange for the necessary diagnosis and treatment for the child.

1.175(a)(3) This section is necessary to assure that nursing personnel have the overall responsibility for follow-up because the skills of a nurse are needed to interpret the questions that parents may have, and they are perceived by the parents as a reliable resource.

1.176 (C) The Physical Facility. The facility is of importance because it provides the physical backdrop for the screening program. Such consideration as adequate space for screening and privacy affect both the parent and child, as well as the efficiency, screening personnel and clinic flow.

1.175 (C)(1) Separate areas for screening procedures are necessary for privacy and to assure clinic flow. Separate play and waiting areas provide a place to entertain children while they are waiting to be screened.

1.175 (C)(2) Physical privacy must be maintained for interviewing and the physical assessment in order to assure the integrity of the individual and maintain privacy for the purpose of patient modesty and confidentiality.

1.175 (C)(3) It is necessary for equipment to be available and serviceable to avoid inaccurate test results which will negatively impact the screening results.

1.175 (B)(1) Personnel for EPS Screening. The standards proposed for the qualifications and responsibilities of personnel are reasonable and they maintain program uniformity. The standards assure that the personnel have the appropriate preparation, skill and expertise to administer the tests and assessments, record and interpret the results of such tests and assessments to determine whether

further evaluation/diagnosis and/or treatment may be necessary.

The provision permitting individuals to perform one or more functions in the screening program is reasonable in order to allow for greater flexibility and more efficient clinic management. In addition, this may help reduce the unit cost of screening.

1.175 (B)(1)(a) The qualifications of EPS Clinic Coordinator and the Clerk positions are defined by responsibilities rather than specific academic preparation or training. This is reasonable because there is no specific academic preparation and criteria which determine managerial or clerical competency. It is also reasonable because these personnel do not have "hands on" responsibility for the screening of children and, therefore, their qualifications are not related to the specific screening skills and knowledge required by screening personnel in the program. They do not directly affect the results of screening as it relates to the children.

1.175 (B)(1)(b) The qualifications of the EPS nurse defined herein, are necessary to assure an adequate level of skill in performing child assessments. The Pediatric Nurse Associate who is a graduate of an accredited university postgraduate program is presumed to have acquired adequate knowledge and expertise in pediatric ambulatory care is not required additional training. Furthermore, nurses who are otherwise very competent but who have not completed a PNA program, will not have the benefit of a third party review of the specific skills necessary in an EPS program. However, it is reasonable that requirements for EPS nurses other than Pediatric Nursing Associate, preparation include:

1. That a nurse be licensed as professional nurse by Minnesota Board of Nursing as this provides a base line of academic preparation and skill.
2. It is necessary that nurses complete EPS training or its equivalent because at the present, licensed nurses may not have specialized academic preparation to assure skill level and expertise in child health screening principles required to perform and interpret the tests and assessments described in these rules.
3. It is reasonable that a nurse be able to demonstrate her ability to satisfactorily perform the necessary tests and assessment to an MDH consultant because this provides for further reinforcement of the skills obtained in EPS training programs and provides a mechanism for local MDH nurse to objectively assess whether the nurse is able to meet the requirement of 7 MCAR § 1.176 A (2)(a-j).
4. It is reasonable that the EPS nurse have the ability to function effectively with children: Children are unable to communicate verbally in the adult context. Therefore, anyone functioning as a pediatric screener is better able to establish rapport if they like, respect and have the ability to work with children.

1.175 (B)(1)(c) Wm. Frankenberg, M.D., states in "A Guide to EPSDT Screening" prepared for HEW, under contract with Academy of Pediatrics, June 1974, that the training required for administration of lab tests used in the screening program is relatively simple and anyone can be trained in a few hours to adequately perform the tests. It is reasonable that personnel performing these tests in an EPS program shall have documentation of having successfully completed training in the administration of the test in order to assure the quality and integrity of the tests. It is necessary to require documentation of ability to administer lab tests so that MDH can objectively evaluate the expertise of the lab assistant.

1.175 (B)(d)(1) It is reasonable that a Vision and Hearing Assistant has

successfully completed training provided by MDH Vision and Hearing Consultants so that they can adequately perform the Vision and Audiometric Hearing testing, as described in Rule 7 MCAR § 1.175 (A)(2). MDH cannot be responsible for monitoring all types of training programs. Therefore, it is reasonable that MDH provide the Vision and Hearing training. Thus, MDH is assured of uniform curriculum and the professional competency of the educators.

1.175 (B)(d)(2) MDH does not possess expertise in the use of the VASC. Since the Preschool Medical Survey of Vision and Hearing, Minnesota Medical Association, developed the VASC and has the necessary training expertise, it is reasonable that it should provide the training for the use of the VASC.

1.175 (B)(1)(e) It is not necessary that a clinic assistant be a licensed professional, as most developmental screening tests are specifically designed to be administered by para-profesionals. It is reasonable that an EPS nurse who has been trained in the use of the DDST in an MDH EPS training seminar is qualified to provide training in the administration of this test. Since the nurse has received EPS training, MDH is assured that there will be a relatively uniform method of training for clinic assistant in the administration of the DDST.

The provision for training of EPS personnel in the administration of the DDST and acceptable alternative tests by consultants from other institutions is necessary in order to expand the training capacity of an EPS program and to enlarge upon the core of expertise knowledge available to a program and its personnel.

7 MCAR § 1.176 APPLICATION PROCEDURES FOR PROGRAM APPROVAL

This section is necessary to describe the procedures to be approved as an EPS program. This information is necessary to give the applicant specific knowledge of how to seek MDH approval. The procedures outline an orderly manner for communications between the applicant and MDH, establish steps in the application process, outline applicant responsibilities and provide redress available to the applicant.

1.176 (A)- (B)

An EPS program is a multi-facited screening program requiring the coordination, cooperation and involvement of many individuals and programs in a community. The application will probably be the culmination of a community organizational process which includes the collaboration of individuals and groups who will have assessed the need and local commitment to such a new health program.

It is necessary to have an application procedure which encourages and permits the broad planning and community involvement required to develop, sustain and maintain such a program. This application process rests upon local organization and support which assures stability and continuity of the program. Therefore, the application process should permit careful planning.

The MDH application format raises questions which helps the community and the applicant agency look at the many dimensions required to provide such a screening service for children. Therefore, the aspects of the application related to Statement of Need, calculation and fiscal management are needed to assure the applicant has given consideration to these dimensions.

The MDH application also must be structured to permit the documentation of applicant plans and commitment related to the standards for screening and the personnel. These sections of the application are subject to the review and approval or disapproval by MDH.

In all instances, the application is viewed a communication device to identify areas in which MDH can and/or should provide technical consultation to the applicant.

1.176 (B) A letter of intent to MDH is reasonable as it initiates the application process and the possible provision of technical assistance by MDH staff to the applicant.

1.176 (C) It is necessary for the applicant to submit written information in the format specified, which allows for uniformity in the application and provides information that is necessary in terms of local program planning. It is necessary for a copy to be submitted to the District Nursing Consultant to expedite the provision of technical assistance to the applicant.

1.176 (C)(1) Descriptors stating the need for a program in a given community area are necessary to encourage applicants to plan for programming both in terms of the population to be served, including numbers and ages of children, and coordination with existing services. In order to avoid duplication of service and in the interests of a coordinated approach to screening, it is especially important that the Title XIX eligibles and school districts be identified.

1.176 (C)(2) It is necessary to describe the method of accomplishing the basic program components: outreach, screening, interpretation/education, referral and follow-up to assure that the applicant is in or will become in compliance with the standards as defined in 7 MCAR 1.175. By planning for these components and identifying the methods for accomplishing the tasks indicated, it is assumed that program effectiveness and efficacy will be enhanced. The public will be poorly served if the program is not well-conceived and planned.

1.176 (C)(3) Personnel - It is necessary that the number and type of personnel as well as plans for training personnel be stated to assure that applicant is in or will be in compliance with the standards relating to the qualification of personnel defined in 7 MCAR 1.176 (B).

1.176 (C)(4) It is necessary that local evaluation plans be developed and described so that the EPS Program may measure the strengths and weaknesses in achieving overall program goals and assuring that the specific needs of the particular population being served are met. Such evaluation should account for factors such as parental satisfaction, the number and type of referrals and the use of referral resources. In addition, this information can be useful for statewide program evaluation. Local evaluation information which is collected on a statistical sampling basis can be analyzed for statewide program evaluation purposes.

1.176 (C)(1)(5)(a) A description of the method of determining unit cost is necessary to identify if an applicant has developed procedures to ascertain unit cost. It is necessary to develop good unit cost figures to assure program costs are efficient and reasonable. If the application so indicates, technical assistance may be provided by MDH. Unit cost determination becomes the basis for reimbursement by Title XIX and other third party payment. MDH has no authority to approve the unit cost per se, but it can provide technical support for well-conceived methods to ascertain unit cost.

1.176 (C)(1)(5)(b) A description of plan for sliding fee scale is necessary to assure the local program is establishing procedures to serve the non-Title XIX eligible population as well as the eligible population. The principle of ability-to-pay permits local agencies to maximize public and private resources to this program.

1.176 (C)(5)(c) The copy of the authorization from the duly constituted authority to charge fees for services is necessary to assure official authority to charge fees is established for that program. Historically, there has been limited use of fee for service payment in the provision of public health service. It is necessary to avoid any misunderstanding between the local statutory authority and the local program personnel.

7 MCAR 1.176 D REVIEW AND DISPOSITION

This section provides a description of the manner in which MDH acts to review an application. This description is necessary to give the reader knowledge of the potential outcome of the review. The nature of the application process necessitates provisional approval which is based upon a two-stage review and disposition process. The first stage relates to the adequacy of written application, the manner in which the applicant documents information as indicated in MCAR 1.176 (C)(1-5), the completion of EPS training by local personnel and an initial screening session under the observation of a PNS Consultant.

The second stage relates to final approval and is based on the adequacy of the observed screening program performance at the end of 6 months to assure the quality of the total screening program in terms of the standards of these rules.

1.176 (D)(1)(a) is necessary and reasonable to determine whether the applicant has an understanding of and has the capability to meet the requirements of these rules. Fundamental fairness will prevail as the standard application information is reviewed.

1.176 (D)(1)(a) is necessary to assure that applicant staff are trained and adequately prepared to carry out the screening program in keeping with these rules.

1.176 (D)(c) This is necessary to assess the level of performance of the screening personnel and to ascertain if performance will adequately assure the public of quality service. The presence of an MDH Consultant at the first screening sessions provides support and on-site teaching to the screening staff, as well as identification of skills which need additional training. If additional technical consultation is indicated to assure at least minimum skill levels, the PNA Consultant can schedule the consultation.

This on-site participation is necessary to adequately assess performance levels.

1.176 (D)(2)(a) Provisional Approval.

1.176 (b) It is necessary and reasonable to inform applicant in writing if there is to be a recommendation of denial of provisional approval and outline conditions necessary to gain approval. Technical assistance and consultation shall be offered so as to provide the applicant with every opportunity to overcome deficiencies and meet the standards of these rules.

1.176 (c) It is reasonable and necessary that after reconsideration, if the MDH staff still intends to recommend a denial of provisional approval, an applicant should be notified in writing and given 30 days in which to consider and respond if they so desire, with request for a hearing. It is necessary to reference the statutes under which such a hearing shall be conducte-.

1.176 (D)(3)(a) Final Stage. It is reasonable that there shall be a second EPS consultant visit for purposes of evaluating performance after a few months of screening experience. The applicant will have conducted several clinics, and, therefore, will have had an opportunity to improve clinical and management skills. This improvement can be accrued only from actual experience in conducting screening clinics.

1.176 (b) It is reasonable and necessary that in the interest of fundamental fairness, MDH staff shall review and consider the EPS consultant's performance evaluation report and the District Nursing Consultant's report on the applicant's overall program administration and compare them with these rules. Upon assurance of compliance with these Rules a recommendation for approval can be made to the Commissioner.

1.176 (c) This provision is necessary so that local agencies may continue to be eligible for third party reimbursements.

1.176 (d)(1) It is necessary and in interest of fairness, if after a final review, the applicant is not in compliance with these rules, to inform the applicant in writing of the conditions necessary to gain approval. Technical assistance and consultation shall be offered so as to provide the applicant with every opportunity to meet the standards of these rules.

1.176 (3)(2) It is reasonable and necessary that if after reconsideration, the MDH staff still intends to recommend a denial of final approval, an applicant shall be informed in writing and have 30 days in which to consider and respond if they so desire, with a request for a hearing. It is necessary to reference the statutes under which such a hearing shall be conducted.

Reapproval:

1. This is necessary to assure continued compliance with these rules. With changes in personnel that tend to occur over time, it is necessary to review program compliance with these rules. It is necessary to assure that the physical arrangements and equipment continue to be in keeping with these rules.

2. It is necessary and reasonable if after review for reapproval, MDH staff intends to recommend a denial of reapproval, to inform the program in writing of the conditions necessary to gain reapproval. Technical assistance and consultation shall be offered so as to provide the program with every opportunity to meet the standards of the Rules.

3. It is reasonable and necessary that after due consideration, the MDH staff still intends to recommend a denial of reapproval, and program should have 30 days in which to consider and respond if they so desire, with a request for a hearing. It is necessary to reference the statute under which such a hearing shall be conducted.

7 MCAR §§ 1.177 MDH RESPONSIBILITIES IN RELATION TO APPLICANTS AND APPROVED PROGRAMS

A. It is necessary and reasonable that MDH should provide technical assistance in the form of written and oral communication about the program such as manuals, EPS rules, telephone conferences, person-to-person assistance and addressing local community meetings. In addition, it is necessary to provide specialized consultation such as nursing and hearing and vision consultation, both for programs seeking approval and on an ongoing basis to approved programs. Such assistance should allow for continuing program improvement and quality.

B. It is reasonable and necessary that MDH shall survey and evaluate approved programs. Such surveying for collection of data and its subsequent analysis provides information re: local programs and provides assurances that programs are operating in compliance with standards contained in these rules. In addition, such evaluation provides the overall to state program with evaluation statistics and statistical inferences that relate to the program. The information is used for purposes of reporting to the legislature and provides a description of the efficacy of the program.

C. It is reasonable and necessary that training requirements should respond to the needs of individual local programs, as well as to the program components. MDH staff and consultants shall be identified as necessary for purposes of training local screening personnel to upgrade skills to conduct screening programs in accordance with these rules.

7 MCAR § 1.178

A. It has been determined that the standards contained in these rules assure at least a minimum program for the screening of children. Therefore, it is reasonable for an agency approved under these rules to meet these standards.

B. Criteria for referral resulting from screening as contained in the EPS Manual are based on scientific evidence and are generally accepted by professionals in the field. It is a reasonable expectation that approved programs be familiar with and utilize these criteria in making referrals. This helps assure the validity of such referrals.

It is necessary that children who may have a problem identified as a result of screening are referred for evaluation/diagnosis and treatment, as it is a basic assumption in a screening program. As a result of the application process, local agencies are familiar with the resources in the area that are most appropriate and, therefore, are best able to act as case managers until child is into a care program.

C. Knowledge and practices relating to pediatric screening are continually expanding and developing. It is reasonable to require an involvement in continuing education to maintain an acceptable level of competence. Local program personnel need to have a method to become aware of current developments in their field to improve their existing skill level by participating in continuing education.

MDH continuing education and the University of Minnesota, School of Public Health currently are the only training available whose curriculum address the specific skills of the EPS nurse.

D. This is necessary to assure a coordinated integrated approach to child screening and to avoid duplication of efforts at the local level.

E. It is necessary that a new program of this kind have an anticipated built-in evaluation capacity. There is a long-term need to study the efficacy of the screening program. The screening and referral form provides appropriate data on numbers of children screened and types of problems identified. The tracking record provides information on results of diagnosis and treatment, allowing for evaluation of validity of nursing referrals and the effect of screening on the child's health. MDH needs at least this minimal amount of program data for the purposes of statewide screening program reporting, and can only obtain this data from the local program.

F. The necessity for including the option for approved program of utilizing the Physician Integration Plan is considered reasonable for following reasons:

1. To decrease possible duplication of services by providing more options for the physical assessment portion of the screening program as provided by MDH approved programs.

2. To increase the scope of services available to the consumer who has a regular source of health care.

3. To encourage continuity in the child health provider relationship.

4. To increase the number of children being screened by coordinating activities of providers of health services, thus, increasing efficacy and effectiveness of EPS in the community.

The time requirements on the provision of physical assessment portion take into account periodicity and requirements for provision of services to the Title XIX client. It is necessary that both the local approved program and the physician exchange information on tests in order that either may make diagnostic/referral judgments as it is necessary for both parties to have a complete profile of the child.

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General Terry P. O'Brien, do hereby declare that I have examined the proposed rules relating to approval of early and periodic health and developmental screening programs and all related documents and that, based on such examinations and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed.

Dated: November 6, 1978

TERRY P. O'BRIEN
Special Assistant
Attorney General

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DEPARTMENT OF HEALTH PROPOSED #1

RULES OF THE MINNESOTA DEPARTMENT OF HEALTH
RELATING TO THE APPROVAL OF
EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS

CHAPTER ELEVEN: 7 MCAR § § 1.174 - 1.178

7 MCAR § 1.174 General

A. Declaration of Purpose, Scope and Applicability

The purpose and scope of these rules is to establish minimum standards and procedures for MDH approved nurse-administered local provision of comprehensive health screening of children.

These rules apply to those organizations seeking MDH approval in order to qualify for reimbursement by third parties for which such reimbursement requires MDH approval; and constitutes standards for the nurse-supervised EPSDT programs as prescribed in Department of Public Welfare (DPW) Rule and Preschool Screening Program as prescribed in Department of Education (DPE) Rule.

B. Definitions

For the purposes of these rules the following terms have the meanings given them:

1. "Applicant" means a local organization, such as but not limited to a community health agency, hospital, voluntary nonprofit group or school, which is seeking approval and has submitted for approval a completed plan for an Early and Periodic Screening (EPS) program.
2. "Application" means a written request for MDH program approval in a format as specified by the MDH. This format shall require submission of the information required by Rule 7 MCAR § 1.176, (A) (B) (C), herein.
3. "Approved program" means a screening program which offers regularly scheduled comprehensive health screening for

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children from birth through 20 years of age, in accordance with the standards contained in Rule 7 MCAR § 1.175, and which has been approved by MDH.

4. "Children" means those individuals from birth through 20 years of age.
5. "Diagnosis" means the systematic classification of the nature or the cause of physicial or mental disease or abnormality through the combined use of health history, physical, developmental and psychological assessments and laboratory tests and x-rays.
6. "Early" means the entrance of a child to the health care system at his/her youngest possible age.
7. "EPS" means Early and Periodic Screening.
8. "EPS Procedures Manual" (1977 edition) means the document written by MDH staff in which the concepts and methods for program administration and screening procedures are specified and can be promulgated and utilized by local health programs. The screening procedures and referral criteria contained in the manual are based on Academy of Pediatrics standards and specific scientific criteria for a given test.
9. "EPS trained nurse" means the nurse who is trained to perform the screening assessments and tests in an approved program inasmuch as she meets the qualifications as contained in Rule 7 MCAR § 1.175, (B) (1) (b).
10. "MDH" means the Minnesota Department of Health.
11. "Periodic" means health screening occurring at predetermined intervals.

12. "Periodicity schedule" means the schedule set out in Rule 7 MCAR § 1.175, (A) (3), and which specifies the frequency and age ranges at which the specified screening assessments and tests are to be administered to a child.

13. "Physician Integration Plan" means the option whereby an MDH approved program seeks to extend its services by substituting a physician-administered health history, physical examination and laboratory services for the nurse-administered health history, physical assessment and laboratory services.

14. "Preschool Screening Program" means the health and developmental screening program under the auspices of the Department of Education, whereby children are screened once before they enter kindergarten, pursuant to Minnesota Laws 1977, Chapter 437.

15. "Screening" means the use of those simple and quick procedures as outlined in Rule 7 MCAR § 1.175, (A) (2), to sort out apparently well children from those in need of more definitive study of possible physical or developmental problems.

16. "Screening and referral form" means a report when completed by approved programs and submitted to MDH provides a summary of the results of screening for each child and contains data which can be used for MDH and local program analysis and evaluation pursuant to Rule 7 MCAR § 1.178,(E).

17. "Sliding fee scale" means a pre-determined schedule which identifies the amount to be paid by the parent(s) or guardian(s) toward the cost of screening. The sliding

fee scale is developed by the applicant or approved program and is based on such factors as average incomes for the region, individual family income and the number of persons in the family.

18. "Third-party reimbursement" means payment to approved programs, by sources other than the child, or his/her parent(s) or guardian(s) and which is applied to the cost of screening. The sources of this reimbursement may include Title XIX (Medical Assistance), other federal, state or local monies, insurance benefits or in-kind contributions converted into dollar equivalency.
19. "Title XIX (Medical Assistance)" means the program authorized under the Social Security Act, USC 42, Title XIX - Sec. 1901-1910, and rules promulgated thereunder, to provide medical care for individuals whose resources do not enable them to purchase such care.
20. "Tracking" means documenting the results of diagnosis and treatment resulting from the screening of a child. This data also may be used to evaluate the type and appropriateness of referrals.
21. "Treatment" means medical, dental, nursing, preventive, rehabilitative or other relevant services to prevent, correct, or ameliorate disease or disability detected by diagnostic services from a qualified professional.

7 MCAR § 1.175 Minimum Standards to Qualify for MDH Approval

A. Applicants seeking MDH program approval shall develop a screening program containing the following components:

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1. An outreach component which shall include a demonstrated ability to stimulate or encourage participation in the screening program.
   a. Information about a screening program may be disseminated by a variety of methods such as the following:
      1) Person-to-person communication.
      2) Public information outreach such as, but not limited to, planned meetings with groups, contacts with agencies such as schools or Head Start, in order to obtain assistance with regard to their specific child populations, distribution of pamphlets, use of the mass media.
   b. Outreach efforts shall be coordinated with the outreach function of local welfare departments in relation to children under the Title XIX (Medical Assistance) program and with local school districts in relation to children under the Preschool Screening Program.
2. A screening component which shall include a demonstrable ability to provide at least the following assessments and tests which must be available at the frequency and age ranges as specified in the Periodicity Schedule found in Rule 7 MCAR § 1.175, (A) (3). Referrals resulting from the assessment and testing shall be based on referral criteria as stated in 1977 EPS Procedures Manual.
   a. A health history assessment which shall include at least an individual review of past and present health status including perinatal, psychosocial and family health.

b. An immunization assessment which shall include a review of the immunization status of the child in relation to the following immunizations: Diptheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella.[1]

c. A nutrition status assessment which shall include at least a review of the child's food intake for a 24 hour period preceeding screening.

d. A physical growth assessment which shall include measurement of the child's height, weight and head circumference and comparison with the ranges considered normal for children of that age.

e. An unclothed physical assessment which shall include an inspection of pulse, respiration, blood pressure, head, eyes, ears, nose, pharynx, neck, chest, heart, lungs, genitals, abdomen, spine, extremities, joints, muscle tone, skin and neurologic reaction.

f. A dental inspection which shall include inspection of the child's mouth for any evident oral or dental abnormalities.

g. Developmental screening tests which shall assess the child's development in the areas of fine and gross motor skills, speech and language, social-emotional behavior and self-help skills.

1) In order to assess these developmental areas, MDH recommends the use of the Denver Prescreening Developmental Questionnaire (PDQ) with its manual

[1] It is recommended that approved programs provide immunizations on site.

and the Denver Developmental Screening Test (DDST) with its manual or an acceptable alternative meeting the criteria of Rule 7 MCAR § 1.175,(A) (2) (g) (2).

2) Alternative tests may be substituted for the Denver Developmental Screening Test (DDST) upon approval by MDH.

a) An applicant considering substitution for the Denver Prescreening Developmental Questionnaire (PDQ) and the Denver Developmental Screening Test (DDST) shall submit a narrative which describes the alternative test in the following areas: content and construction of the test, norms, administration, scoring and interpretation, validity and reliability.

b) In order to secure approval of an alternative test, such a test must be able to provide at a minimum:

i. Written procedures for administration and scoring.

ii. Evidence of validated norms for age range being tested.

iii. The same information regarding the child's development as would be provided through the use of the Denver Developmental Screening Test (DDST).

h. A hearing assessment shall include procedures which test for deviations from the normal range of auditory acuity.

1) MDH approved programs must use the puretone audiometric screening procedure. A Verbal Auditory Screening for Children (VASC) hearing procedure as described in the 1977 Edition of VASC Manual may be used for four year old children.

i. A vision assessment shall include procedures which test for eye health deviations, including the normal range of visual acuity and muscle balance in the child. Approved programs must:

1) Observe and examine the child's pupils and light following reflex, presence or absence of nystagmus, muscle balance, and an external inspection of the eyes.

2) Muscle balance screening procedures include at least observation, cover test, Hirschberg test and the Worth 4-Dot Test.

3) Test for visual acuity. A test, as appropriate for the child's age, such as the Screening Test for Young Children and Retardates (STYCAR), the Snellen E Cube, the Snellen Alphabet Chart, and plus lenses shall be used.

j. Laboratory tests: the following tests shall be administered according to the Periodicity Schedule found in Rule 7 MCAR § 1.175, (A) (3).

1) Tuberculin tests indicate exposure to active tuberculosis and may indicate need for medication.

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EPS PERIODICITY CHART

INTERVALS (1)	MONTHS					YEARS					
	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
History											
Health	X	X	X	X	X	X	X	X	X	X	X
Perinatal	X	←	←	←	←	←					
Psychosocial	X	X	X	X	X	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	←	←	X	←	←	X	←
Developmental											
DDST	X	X	←	←	←	X					
PDQ			X	X	X						
Assessment											
Height	X	X	X	X	X	X	X	X	X	X	X
Weight	X	X	X	X	X	X	X	X	X	X	X
OFC	X	X	X	X	X	←	←				
Physical Inspection	X	X	X	X	X	X	X	X	X	X	X
Oral Inspection	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure						X	X	X	X	X	X
Tests											
Hearing	X	←	X	X	X	X	X	X	X	X	X
Vision	X	←	X	←	X	X	X	X	X	X	X
Urine (BiliLabstix)						X	←	←	←	←	←
Bacteriuria (females)						X	←	X	←	←	←
Microhematocrit or Hgb.	X	←	X	←	X	X	←	←	←	X	←
Blood Lead (Only if history positive)			X	←	X	X					
Sickle Cell (Upon parental request)	X	←	←	←	←	←	←	←	←	←	←
Tuberculin		X	←	←	←	←	←	←	←	←	←

(1) The period, birth to six months, is not addressed in the program based upon the assumption that nearly all children of this age interval are receiving ongoing physical care.

← Procedure to be completed if not done at the previous visit; or on the first visit.

2) Urine and Bacteriuria (Bililabstix and Culturia Assay) test for bacteria and other abnormal substances in the urine.

3) Anemia (Microhematocrit, Hemoglobin) tests for anemia and also indicates other blood abnormalities.

4) A Blood Lead - test for increased lead absorption and for lead poisoning in children whose history indicates the possibility of exposure to undue levels of lead in the environment or atmosphere.

5) A Sickle Cell Test shall be administered only with the consent of the parent(s), or guardian(s), or the child, if he/she is over 18 years, and only to those children at risk for the sickle cell trait or disease.

3. The assessment and tests listed above shall be available on the following periodic schedule.

4. An interpretation and parent education component which shall include discussions aimed at sharing with the family and child information collected during screening. These discussions must incorporate guidance regarding sound health practices, normal growth and development, and the clarification of any concerns on the part of the child or family.

5. A referral component which shall include an organized system of arranging for children with problems identified through screening to be seen by an appropriate resource for evaluation, diagnosis or treatment. Arrangements shall be made to establish all children who have been screened with ongoing health care services.

6. A follow-up component which shall include an organized system for securing information on children who are referred to another resource for evaluation, diagnosis and treatment. Follow-up efforts are to assure that the required services were made available and to evaluate the effectiveness of the screening program.

   a. A follow-up plan shall consist of at least the following:

      1) Written and formal arrangements with other agencies such as the county welfare departments, Head Start, community action councils, public health nursing services, and school services to define and coordinate each agency's responsibilities with respect to follow-up.

2) A description of activities such as personal contact with the child, family or referral resource. At least two attempts shall be made to contact parent(s)or provider(s) concerning diagnosis and treatment results.

3) A written identification of nursing personnel who shall have supervisory responsibility for follow-up.

B. Personnel for EPS Screening of Children

1. Qualifications and/or responsibilities of the screening personnel: An individual may perform one or more of the functions in the screening program provided that the appropriate qualifications are met.

a. EPS clinic coordinator shall have responsibility for coordination and management of the local screening program. These responsibilities include management as well as specific organization of activity in the clinics.

b. EPS trained nurse shall be either a Pediatric Nurse Associate who is a graduate of an accredited university postgraduate program in Pediatric Nursing or meet all of the following criteria:

1) Be currently licensed as a professional nurse by the Minnesota Board of Nursing.

2) Have successfully completed EPS training seminars provided by MDH, or have participated in equivalent training programs designated by MDH.

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3) Demonstrate ability to satisfactorily perform to an EPS Consultant designated by MDH, those child assessments as required in Rule 7 MCAR § 1.175, (A) (2) (a-j).

4) Have the ability to work effectively with children based on recommendations from the EPS clinic coordinator, agency nurse supervisor, or the EPS Consultant under contract with MDH.

c. EPS Laboratory Assistant shall be:

1) A lab technician or an assistant who can document training in performing the specific tests used in the screening session under the supervision of the EPS nurse.

d. EPS Vision and Hearing Technician shall:

1) Have documentation of the successful completion of a course in vision and hearing screening offered by MDH and demonstrate ability to satisfactorily perform the vision and hearing screening as required in Rule 7 MCAR § 1.175, (A) (2) (h) (i), and;

2) If the VASC is used, have documentation of the completion of training to perform the Verbal Auditory Screening of Children (VASC).

e. EPS Clinic Assistant shall:

1) Be able to document the completion of training in the administration of the developmental tests selected for use in the screening program. Such training may be provided by the EPS nurse or

consultant who has documented training in developmental testing from institutions such as but not limited to area mental health centers, or community colleges and schools.

2) Have experience in working with children either through paid employment or volunteer activity.

f. EPS clerk shall have responsibility for clerical and receptionist functions, and shall have acquired clerical and human relations skills through paid employment or voluntary activity.

C. The physical facility shall meet the following requirements:

1. Separate areas shall be provided for the various screening procedures, as well as waiting and play areas.
2. Physical privacy shall be maintained for interviewing and physical assessment.
3. Equipment needed for the assessments and tests shall be available to the program and maintained in servicable and reliable condition so as to insure the integrity of the tests specified in Rule 7 MCAR § 1.175, (A) (2) (a-j).

7 MCAR § 1.176 APPLICATION PROCEDURES FOR EPS PROGRAM APPROVAL

A. Local organizations shall notify MDH in writing of their intent to establish an EPS program and to apply for MDH program approval in accordance with the standards specified in these rules. The sections of the application addressing Statement of Need, and Evaluation and Fiscal Management shall be considered for purposes of program planning at state and local level and if necessary, for provision of

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technical consultation by MDH. The section of the application relating to the Methods of Accomplishing Program Components, and Personnel shall be applicable to the approval process as defined in Rule 7 MCAR § 1.176, (D).

B. Upon receipt of the letter of intent, MDH shall transmit an application and instructions to the applicant.

C. Submission of Application. The applicant shall submit the completed application to MDH and to the MDH District Nursing Consultant for the district in which the applicant is located. The application shall include at least the following information:

1. A statement of need for EPS - The applicant shall provide a general statement of the extent of the need for this kind of preventive health service in the community to be served and includes information on the following:
   a. The geographic area of the proposed program.
   b. The age range and numbers of children to be served in each age group.[2]
   c. The estimate of the number of Title XIX (Medical Assistance) eligible children identified in each age group.
   d. The identification of all the school districts within the geographic area of the proposed program.
   e. The identification of other child and adolescent health screening programs in the area and specification of how the proposed program will coordinate with these programs.

[2]An applicant may elect to serve only one age group of children.

2. A description of the method of accomplishing each of the program components: outreach, screening and interpretation, education, referral and follow-up.
3. Personnel - Outline the number and type of personnel necessary to implement each component and the plans for training personnel.
4. Evaluation - Outline the methods other than those specified in this Rule, by which the applicant will evaluate its own program. Such methods may include parent surveys, and/or analysis of the use of referral resources, and numbers of children screened.
5. Fiscal Management - include the following:
   a. The method for determining unit cost.
   b. The plan for implementing a sliding fee scale and for collecting third-party reimbursements and a copy of the sliding fee scale except where prohibited by Minnesota Laws, 1977, Chapter 437, the Preschool Screening Act.
   c. The copy of the authorization from the duly constituted authority (such as county commissioners, city councils) to charge fees for service, except as prohibited by Minnesota Laws 1977, Chapter 437, the Preschool Screening Act.

D. Review and Disposition of Application

There shall be a two stage approval process.

1. With regard to the first stage of approval:
   a. Upon receipt, the application shall be reviewed by

MDH staff in order to determine that it contains the information specified in Rule 7 MCAR § 1.176, (C) (1-5).

b. The MDH staff shall make arrangements for the local EPS personnel to be trained in EPS seminars.

c. An initial screening session shall be scheduled by the applicant. An EPS Consultant, as designated by MDH will be assigned to the applicant for on-site consultation to assist the applicant to develop adequate skills. A subsequent consultation may be provided as necessary.

2. Provisional Approval

a. Upon completion of application, training, the initial screening session, and a satisfactory EPS Consultant report, the Commissioner of Health may grant provisional approval to the applicant prior to any other screening of children by the applicant. Provisional approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third party reimbursement.

b. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of provisional approval, the staff shall notify the applicant in writing of the conditions necessary to gain approval. Technical assistance and consultation shall be offered by MDH to the applicant.

c. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health denial of provisional approval the staff shall notify the applicant at least 33 days

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prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny provisional approval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

3. With regard to the final stage of approval:

   a. A second visit shall be made by the EPS Consultant within the first six months of the program's operation to evaluate the screening program and staff performance to assure implementation and fulfillment of the program components as specified in Rule 7 MCAR § 1.175, (A) (B) (C).

   b. The MDH staff shall make a final staff review of the screening program. This review consists of the EPS Consultant's evaluation of the ability of program personnel to adequately perform the screening procedures as outlined in the Rule, the MDH District Nursing Consultant's evaluation of the overall program administration and a review of the application in accordance with standards as specified in Rule 7 MCAR § 1.175, (A) (B) (C).

   c. If the Commissioner of Health concurs with staff comments and recommendation, the Commissioner shall notify the applicant within 30 days of final approval.

Such approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third-party reimbursement.

d. If not in substantial compliance:

1) The conditions necessary to gain approval shall be stated in writing by MDH staff to the applicant. Technical assistance and consultation shall be offered by MDH staff to the applicant.

2) If following the offer of consultation and reconsideration, MDH staff intends to recommend to the Commissioner of Health a denial of final approval, the staff shall notify the applicant in writing of the reasons therefore, at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny approval, it shall request in writing a hearing, within 30 days of the receipt of the proposed staff recommendation or otherwise, it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

E. Annual Reapproval

1. An approved program shall be reviewed annually by the MDH staff to determine if approval status shall continue. Reapproval shall be based on the program's continued compliance with the standards specified in Rule 7 MCAR §§ 1.175, (A) (B) (C).

2. The Commissioner of Health shall notify the program within 30 days after receipt of the staff recommendation of reapproval.

3. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of reapproval, the staff shall notify the program in writing of the conditions necessary to gain reapproval. Technical assistance and consultation shall be offered by MDH to the program. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health, denial of reapproval, the staff shall notify the program at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the program contests the proposed staff recommendation to deny reapproval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

7 MCAR § 1.177 MDH RESPONSIBILITIES IN RELATION TO APPLICANTS AND APPROVED PROGRAMS

A. The MDH shall provide technical assistance and consultation for the planning, implementing and administering of EPS programs and those programs seeking approval.

B. The MDH shall survey and evaluate approved programs on a periodic basis to assure compliance with the standards contained in these rules.

C. The MDH shall provide in-service EPS training seminars for local staff based upon the needs as determined jointly by approved programs and MDH staff. This training shall address at least the following areas:

1. Administration of EPS
2. Pediatric nursing skills in relation to the specific screening assessments and tests of children.

7 MCAR § 1.178 APPROVED PROGRAM RESPONSIBILITIES

A. Approved programs shall provide EPS service in accordance with or exceeding the standards contained in these rules.

B. The criteria for referral resulting from the screening tests and assessments are outlined in the 1977 EPS Procedures Manual.[3] Approved programs shall refer children to an appropriate resource for evaluation, diagnosis and treatment.

C. Approved programs shall assure that EPS personnel obtain continuing education in order to maintain or improve clinical skills. This training may be provided by MDH or the University of Minnesota, School of Public Health. The content shall relate to child ambulatory health care, screening principles and clinical skills.

D. Approved programs shall coordinate the EPS program with schools or other community child health programs and health care providers.

E. Approved programs shall participate in evaluation of their

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[3]The EPS Procedures Manual is available to the public and may be obtained from the Minnesota Department of Health.

programs and submit evaluation data as requested by MDH. This data includes at least a screening and referral form and forms for tracking diagnosis and treatment results. Data provided to MDH by approved programs may be summarized and the child's identity shall remain anonymous.

F. Approved Program Option

Approved programs may include the Physician Integration Plan, provided such a plan meets or exceeds the standards contained in these rules. If this plan is included, the health history, physical examination and the laboratory tests shall be performed on the child, under a physician's supervision. This examination shall be performed within the previous 6 months if the child is under the age of 2, within 12 months if the child is 2 years or older, or 60 days after the provision of the other EPS screening tests (vision, hearing, and developmental). There shall be a mutual exchange of information to assure that each provider has the complete health and developmental profile of the child.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs.

ORDER FOR HEARING

To effectively implement Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (Supp. 1977), 144.07(1), 144.09 (1976) and 15.0412 subds. 1 and 3 (Supp. 1977), the Minnesota Commissioner of Health deems it necessary to consider adoption of the proposed rules captioned above pursuant to the authority vested in it by the above-referenced statutes.

NOW, THEREFORE, IT IS ORDERED this 8th day of December, 1977, that a public hearing on the proposed rules captioned above be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street S.E., Minneapolis, Minnesota, on February 2, 1978, commencing at 9:00 a.m., and continuing until all persons or representatives of associations or other interested groups have had an opportunity to be heard.

IT IS FURTHER ORDERED, that notice of said hearing be published in the State Register and be given to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose and to all persons who are presently members of the Minnesota Legislature.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH



WARREN R. LAWSON, M.D.
Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs.

STATEMENT OF NUMBER OF PERSONS EXPECTED TO ATTEND AND LENGTH OF HEARING

The number of persons expected to attend the hearing in the above-captioned matter is 100.

It is estimated that the length of the hearing will be eight hours.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

Dated: December 8, 1977

WARREN R. LAWSON, M.D.
Commissioner of Health

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STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs.

NOTICE OF HEARING

Notice is hereby given that a public hearing in the above-entitled matter will be held pursuant to Minn. Stat. § 15.0412 subd. 4 (Supp. 1977), in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Thursday, February 2, 1978, Commencing at 9:00 a.m.

All interested or affected persons will have an opportunity to participate concerning the adoption of the proposed rules captioned above. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted by mail to Peter Erickson, Hearing Examiner, at Room 300, 1745 University Avenue, Saint Paul, Minnesota 55104, telephone (612) 296-8118, either before the hearing or within five days after the close of the hearing. All such statements will be entered into and become part of the record. Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand. For those wishing to submit written statements or exhibits, it is

requested that at least three (3) copies be furnished. In addition, it is suggested, to save time and avoid duplication, that those persons, organizations, or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests. The conduct of the hearing shall be governed by the rules of the Office of Hearing Examiners.

A copy of the proposed rules is attached hereto and made a part hereof.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing.

A Statement of Need explaining the Commissioner of Health's position relative to the necessity for the proposed rules and a Statement of Evidence outlining the testimony and evidence which will be introduced on behalf of the Commissioner in support of the proposed rules will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection. The statutory authority of the Commissioner of Health to promulgate and adopt these rules is contained in Minn. Stat. §§ 144.10, 144.11 (1976), 144.12 (Supp. 1977), 144.07(1), 144.09 (1976) and 15.0412 subds. 1 and 3 (Supp. 1977).

In addition, please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he commences lobbying.

Lobbying includes attempting to influence rule making by communicating or urging others to communicate with public officals. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 a year or five (5) hours per month for lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, Saint Paul, Minnesota 55155, telephone (612) 296-5615.

Dated: December 8, 1977

STATE OF MINNESOTA

COMMISSIONER OF HEALTH



WARREN R. LAWSON, M.D.
Commissioner of Health

RULES OF THE MINNESOTA DEPARTMENT OF HEALTH RELATING TO THE APPROVAL OF EARLY AND PERIODIC HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS

CHAPTER ELEVEN: 7 MCAR §§ 1.174 - 1.178

7 MCAR § 1.174 General

A. Declaration of Purpose, Scope and Applicability

The purpose and scope of these rules is to establish minimum standards and procedures for MDH approved nurse-administered local provision of comprehensive health screening of children.

These rules apply to those organizations seeking MDH approval in order to qualify for reimbursement by third parties for which such reimbursement requires MDH approval; and constitutes standards for the nurse-supervised EPSDT programs as prescribed in Department of Public Welfare (DPW) Rule and Preschool Screening Program as prescribed in Department of Education (DPE) Rule.

B. Definitions

For the purposes of these rules the following terms have the meanings given them:

1. "Applicant" means a local organization, such as but not limited to a community health agency, hospital, voluntary nonprofit group or school, which is seeking approval and has submitted for approval a completed plan for an Early and Periodic Screening (EPS) program.

2. "Application" means a written request for MDH program approval in a format as specified by the MDH. This format shall require submission of the information required by Rule 7 MCAR § 1.176, (A)(B)(C), herein.

3. "Approved program" means a screening program which offers regularly scheduled comprehensive health screening for children from birth through 20 years of age, in accordance with the standards contained in Rule 7 MCAR § 1.175, and which has been approved by MDH.

4. "Children" means those individuals from birth through 20 years of age.

5. "Diagnosis" means the systematic classification of the nature or the cause of physical or mental disease or

abnormality through the combined use of health history, physical, developmental and psychological assessments and laboratory tests and x-rays.

6. "Early" means the entrance of a child to the health care system at his/her youngest possible age.

7. "EPS" means Early and Periodic Screening.

8. "EPS Procedures Manual" (1977 edition) means the document written by MDH staff in which the concepts and methods for program administration and screening procedures are specified and can be promulgated and utilized by local health programs. The screening procedures and referral criteria contained in the manual are based on Academy of Pediatrics standards and specific scientific criteria for a given test.

9. "EPS trained nurse" means the nurse who is trained to perform the screening assessments and tests in an approved program inasmuch as she meets the qualifications as contained in Rule 7 MCAR § 1.175, (B)(1)(b).

10. "MDH" means the Minnesota Department of Health.

11. "Periodic" means health screening occurring at predetermined intervals.

12. "Periodicity schedule" means the schedule set out in Rule 7 MCAR § 1.175, (A)(3), and which specifies the frequency and age ranges at which the specified screening assessments and tests are to be administered to a child.

13. "Physician Integration Plan" means the option whereby an MDH approved program seeks to extend its services by substituting a physician-administered health history, physical examination and laboratory services for the nurse-administered health history, physical assessment and laboratory services.

14. "Preschool Screening Program" means the health and developmental screening program under the auspices of the Department of Education, whereby children are screened once before they enter kindergarten, pursuant to Minnesota Laws 1977, Chapter 437.

15. "Screening" means the use of those simple and quick procedures as outlined in Rule 7 MCAR § 1.175, (A)(2), to sort out apparently well children from those in need of more definitive study of possible physical or developmental problems.

16. "Screening and referral form" means a report when completed by approved programs and submitted to MDH provides a summary of the results of screening for each child and contains data which can be used for MDH and local program analysis and evaluation pursuant to Rule 7 MCAR § 1.178, (E).

17. "Sliding fee scale" means a pre-determined schedule which identifies the amount to be paid by the parent(s) or guardian(s) toward the cost of screening. The sliding fee scale is developed by the applicant or approved program and is based on such factors as average incomes for the region, individual family income and the number of persons in the family.

18. "Third-party reimbursement" means payment to approved programs, by sources other than the child, or his/her parent(s) or guardian(s) and which is applied to the cost of screening. The sources of this reimbursement may include Title XIX (Medical Assistance), other federal, state or local monies, insurance benefits or in-kind contributions converted into dollar equivalency.

19. "Title XIX (Medical Assistance)" means the program authorized under the Social Security Act, USC 42, Title XIX - Sec. 1901-1910, and rules promulgated thereunder, to provide medical care for individuals whose resources do not enable them to purchase such care.

20. "Tracking" means documenting the results of diagnosis and treatment resulting from the screening of a child. This data also may be used to evaluate the type and appropriateness of referrals.

21. "Treatment" means medical, dental, nursing, preventive, rehabilitative or other relevant services to prevent, correct, or ameliorate disease or disability detected by diagnostic services from a qualified professional.

7 MCAR §§ 1.175 Minimum Standards to Qualify for MDH Approval

A. Applicants seeking MDH program approval shall develop a screening program containing the following components:

1. An <u>outreach</u> component which shall include a demonstrated ability to stimulate or encourage participation in the screening program.

a. Information about a screening program may be disseminated by a variety of methods such as the following:
1) Person-to-person communication.

2) Public information outreach such as, but not limited to, planned meetings with groups, contacts with agencies such as schools or Head Start, in order to obtain assistance with regard to their specific child populations, distribution of pamphlets, use of the mass media.

b. Outreach efforts shall be coordinated with the outreach function of local welfare departments in relation to children under the Title XIX (Medical Assistance) program and with local school districts in relation to children under the Preschool Screening Program.

2. A screening component which shall include a demonstrable ability to provide at least the following assessments and tests which must be available at the frequency and age ranges as specified in the Periodicity Schedule found in Rule 7 MCAR § 1.175, (A)(3). Referrals resulting from the assessment and testing shall be based on referral criteria as stated in 1977 EPS Procedures Manual.

a. A health history assessment which shall include at least an individual review of past and present health status including perinatal, psychosocial and family health.

b. An immunization assessment which shall include a review of the immunization status of the child in relation to the following immunizations: Diptheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella.[1]

c. A nutrition status assessment which shall include at least a review of the child's food intake for a 24 hour period preceeding screening.

d. A physical growth assessment which shall include measurement of the child's height, weight and head circumference and comparison with the ranges considered normal for children of that age.

e. An unclothed physical assessment which shall include an inspection of pulse, respiration, blood pressure, head, eyes, ears, nose, pharynx, neck, chest, heart, lungs, genitals, abdomen, spine, extremities, joints, muscle tone, skin and neurologic reaction.

f. A dental inspection which shall include inspection of the child's mouth for any evident oral or dental abnormalities.

g. Developmental screening tests which shall assess the child's development in the areas of fine and gross motor skills, speech and language, social-emotional behavior and self-help skills.

1) In order to assess these developmental areas, MDH recommends the use of the Denver Prescreening Developmental Questionnaire (PDQ) with its manual

[1]It is recommended that approved programs provide immunizations on site.

and the Denver Developmental Screening Test (DDST) with its manual or an acceptable alternative meeting the criteria of Rule 7 MCAR § 1.175, (A)(2)(g)(2).

2) Alternative tests may be substituted for the Denver Developmental Screening Test (DDST) upon approval by MDH.

a) An applicant considering substitution for the Denver Prescreening Developmental Questionnaire (PDQ) and the Denver Developmental Screening Test (DDST) shall submit a narrative which describes the alternative test in the following areas: content and construction of the test, norms, administration, scoring and interpretation, validity and reliability.

b) In order to secure approval of an alternative test, such a test must be able to provide at a minimum:

i. Written procedures for administration and scoring.

ii. Evidence of validated norms for age range being tested.

iii. The same information regarding the child's development as would be provided through the use of the Denver Developmental Screening Test (DDST).

h. A hearing assessment shall include procedures which test for deviations from the normal range of auditory acuity.

1) MDH approved programs must use the puretone audiometric screening procedure. A Verbal Auditory Screening for Children (VASC) hearing procedure as described in the 1977 Edition of VASC Manual may be used for four year old children.

i. A vision assessment shall include procedures which test for eye health deviations, including the normal range of visual acuity and muscle balance in the child. Approved programs must:

1) Observe and examine the child's pupils and light following reflex, presence or absence of nystagmus, muscle balance, and an external inspection of the eyes.

2) Muscle balance screening procedures include at least observation, cover test, Hirschberg test and the Worth 4-Dot Test.

3) Test for visual acuity. A test, as appropriate for the child's age, such as the Screening Test for Young Children and Retardates (STYCAR), the Snellen E Cube, the Snellen Alphabet Chart, and plus lenses shall be used.

j. Laboratory tests: the following tests shall be administered according to the Periodicity Schedule found in Rule 7 MCAR § 1.175, (A)(3).
   1) Tuberculin tests indicate exposure to active tuberculosis and may indicate need for medication.
   2) Urine and Bacteriuria (Bililabstix and Culturia Assay) test for bacteria and other abnormal substances in the urine.
   3) Anemia (Microhematocrit, Hemoglobin) tests for anemia and also indicates other blood abnormalities.
   4) A Blood Lead - test for increased lead absorption and for lead poisoning in children whose history indicates the possibility of exposure to undue levels of lead in the environment or atmosphere.
   5) A Sickle Cell Test shall be administered only with the consent of the parent(s), or guardian(s), or the child, if he/she is over 18 years, and only to those children at risk for the sickle cell trait or disease.

3. The assessment and tests listed above shall be available on the following periodic schedule.

EPS PERIODICITY CHART

INTERVALS (1)	MONTHS					YEARS					
	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
History											
Health	X	X	X	X	X	X	X	X	X	X	X
Perinatal	X	←	←	←	←	←					
Psychosocial	X	X	X	X	X	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	←	←	X	←	←	X	←
Developmental											
DDST	X	X	←	←	←	X					
PDQ			X	X	X						
Assessment											
Height	X	X	X	X	X	X	X	X	X	X	X
Weight	X	X	X	X	X	X	X	X	X	X	X
OFC	X	X	X	X	X	←	←				
Physical Inspection	X	X	X	X	X	X	X	X	X	X	X
Oral Inspection	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure						X	X	X	X	X	X
Tests											
Hearing	X	←	X	X	X	X	X	X	X	X	X
Vision	X	←	X	←	X	X	X	X	X	X	X
Urine (BiliLabstix)						X	←	←	←	←	←
Bacteriuria (females)						X	←	X	←	←	←
Microhematocrit or Hgb.	X	←	X	←	X	X	←	←	←	X	←
Blood Lead (Only if history positive)			X	←	X	X					
Sickle Cell (Upon parental request)	X	←	←	←	←	←	←	←	←	←	←
Tuberculin		X	←	←	←	←	←	←	←	←	←

(1) The period, birth to six months, is not addressed in the program based upon the assumption that nearly all children of this age interval are receiving ongoing physical care.

← Procedure to be completed if not done at the previous visit; or on the first visit.

4. An interpretation and parent education component which shall include discussions aimed at sharing with the family and child information collected during screening. These discussions must incorporate guidance regarding sound health practices, normal growth and development, and the clarification of any concerns on the part of the child or family.

5. A referral component which shall include an organized system of arranging for children with problems identified through screening to be seen by an appropriate resource for evaluation, diagnosis or treatment. Arrangements shall be made to establish all children who have been screened with ongoing health care services.

6. A follow-up component which shall include an organized system for securing information on children who are referred to another resource for evaluation, diagnosis and treatment. Follow-up efforts are to assure that the required services were made available and to evaluate the effectiveness of the screening program.

   a. A follow-up plan shall consist of at least the following:
      1) Written and formal arrangements with other agencies such as the county welfare departments, Head Start, community action councils, public health nursing services, and school services to define and coordinate each agency's responsibilities with respect to follow-up.
      2) A description of activities such as personal contact with the child, family or referral resource. At least two attempts shall be made to contact parent(s) or provider(s) concerning diagnosis and treatment results.
      3) A written identification of nursing personnel who shall have supervisory responsibility for follow-up.

B. <u>Personnel for EPS Screening of Children</u>

1. Qualifications and/or responsibilities of the screening personnel: An individual may perform one or more of the functions in the screening program provided that the appropriate qualifications are met.

   a. EPS clinic coordinator shall have the responsibility for coordination and management of the local screening program. These responsibilities include management as well as specific organization of activity in the clinics.

b. EPS trained nurse shall be either a Pediatric Nurse Associate who is a graduate of an accredited university postgraduate program in Pediatric Nursing or meet all of the following criteria:
   1) Be currently licensed as a professional nurse by the Minnesota Board of Nursing.
   2) Have successfully completed EPS training seminars provided by MDH, or have participated in equivalent training programs designated by MDH.
   3) Demonstrate ability to satisfactorily perform to an EPS Consultant designated by MDH, those child assessments as required in Rule 7 MCAR § 1.175, (A)(2)(a-j).
   4) Have the ability to work effectively with children based on recommendations from the EPS clinic coordinator, agency nurse supervisor, or the EPS Consultant under contract with MDH.

c. EPS Laboratory Assistant shall be:
   1) A lab technician or an assistant who can document training in performing the specific tests used in the screening session under the supervision of the EPS nurse.

d. EPS Vision and Hearing Technician shall:
   1) Have documentation of the successful completion of a course in vision and hearing screening offered by MDH and demonstrate ability to satisfactorily perform the vision and hearing screening as required in Rule 7 MCAR § 1.175, (A)(2)(h)(i), and;
   2) If the VASC is used, have documentation of the completion of training to perform the Verbal Auditory Screening of Children (VASC).

e. EPS Clinic Assistant shall:
   1) Be able to document the completion of training in the administration of the developmental tests selected for use in the screening program. Such training may be provided by the EPS nurse or consultant who has documented training in developmental testing from institutions such as, but not limited to area mental health centers, or community colleges and schools.
   2) Have experience in working with children either through paid employment or volunteer activity.

f. EPS clerk shall have responsibility for clerical and receptionist functions, and shall have acquired clerical and human relations skills through paid employment or voluntary activity.

C. The physical facility shall meet the following requirements:

1. Separate areas shall be provided for the various screening procedures, as well as waiting and play areas.

2. Physical privacy shall be maintained for interviewing and physical assessment.

3. Equipment needed for the assessments and tests shall be available to the program and maintained in servicable and reliable condition so as to insure the integrity of the tests specified in Rule 7 MCAR § 1.175, (A)(2)(a-j).

7 MCAR § 1.176 Application Procedures for EPS Program Approval

A. Local organizations shall notify MDH in writing of their intent to establish an EPS program and to apply for MDH program approval in accordance with the standards specified in these rules. The sections of the application addressing Statement of Need, and Evaluation and Fiscal Management shall be considered for purposes of program planning at state and local level and, if necessary, for provision of technical consultation by MDH. The section of the application relating to the Methods of Accomplishing Program Components, and Personnel shall be applicable to the approval process as defined in Rule 7 MCAR § 1.176, (D).

B. Upon receipt of the letter of intent, MDH shall transmit an application and instructions to the applicant.

C. Submission of Application. The applicant shall submit the completed application to MDH and to the MDH District Nursing Consultant for the district in which the applicant is located. The application shall include at least the following information.

1. A Statement of Need for EPS - The applicant shall provide a general statement of the extent of the need for this kind of preventive health service in the community to be served and includes information on the following:

   a. The geographic area of the proposed program.
   b. The age range and numbers of children to be served in each age group.[2]
   c. The estimate of the number of Title XIX (Medical Assistance) eligible children identified in each age group.
   d. The identification of all the School districts within the geographic area of the proposed program.
   e. The identification of other child and adolescent health screening programs in the area and specification of how the proposed program will coordinate with these programs.

[2]An applicant may elect to serve only one age group of children.

2. A description of the method of accomplishing each of the program components: outreach, screening and interpretation, education, referral and follow-up.

3. Personnel - Outline the number and type of personnel necessary to implement each component and the plans for training personnel.

4. Evaluation - Outline the methods other than those specified in this rule, by which the applicant will evaluate its own program. Such methods may include parent surveys, and/or analysis of the use of referral resources, and numbers of children screened.

5. Fiscal Management - include the following:

   a. The method for determining unit cost.
   b. The plan for implementing a sliding fee scale and for collecting third-party reimbursements and a copy of the sliding fee scale except where prohibited by Minnesota Laws, 1977, Chapter 437, the Preschool Screening Act.
   c. The copy of the authorization from the duly constituted authority (such as county commissioners, city councils) to charge fees for services, except as prohibited by Minnesota Laws 1977, Chapter 437, the Preschool Screening Act.

D. Review and Disposition of Application

There shall be a two stage approval process.

1. With regard to the first stage of approval:

   a. Upon receipt, the application shall be reviewed by MDH staff in order to determine that it contains the information specified in Rule 7 MCAR § 1.176, (C)(1-5).
   b. The MDH staff shall make arrangements for the local EPS personnel to be trained in EPS seminars.
   c. An initial screening session shall be scheduled by the applicant. An EPS Consultant, as designated by MDH will be assigned to the applicant for on-site consultation to assist the applicant to develop adequate skills. A subsequent consultation may be provided as necessary.

2. Provisional Approval

   a. Upon completion of application, training, the initial screening session, and a satisfactory EPS Consultant report, the Commissioner of Health may grant provisional

approval to the applicant prior to any other screening of children by the applicant. Provisional approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third-party reimbursement.

b. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of provisional approval, the staff shall notify the applicant in writing of the conditions necessary to gain approval. Technical assistance and consultation shall be offered by MDH to the applicant.

c. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health denial of provisional approval the staff shall notify the applicant at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny provisional approval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

3. With regard to the final stage of approval:

a. A second visit shall be made by the EPS Consultant within the first six months of the program's operation to evaluate the screening program and staff performance to assure implementation and fulfillment of the program components as specified in Rule 7 MCAR § 1.175, (A)(B)(C).

b. The MDH staff shall make a final staff review of the screening program. This review consists of the EPS Consultant's evaluation of the ability of program personnel to adequately perform the screening procedures as outlined in the Rule, the MDH District Nursing Consultant's evaluation of the overall program administration and a review of the application in accordance with standards as specified in Rule 7 MCAR § 1.175, (A)(B)(C).

c. If the Commissioner of Health concurs with staff comments and recommendation, the Commissioner shall notify the applicant within 30 days of final approval.

Such approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third-party reimbursement.

d. If not in substantial compliance:
   1) The conditions necessary to gain approval shall be stated in writing by MDH staff to the applicant. Technical assistance and consultation shall be offered by MDH staff to the applicant.
   2) If following the offer of consultation and reconsideration, MDH staff intends to recommend to the Commissioner of Health a denial of final approval, the staff shall notify the applicant in writing of the reasons therefore, at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny approval, it shall request in writing a hearing, within 30 days of the receipt of the proposed staff recommendation or otherwise, it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

E. Annual Reapproval

1. An approved program shall be reviewed annually by the MDH staff to determine if approval status shall continue. Reapproval shall be based on the program's continued compliance with the standards specified in Rule 7 MCAR § 1.175, (A)(B)(C).

2. The Commissioner of Health shall notify the program within 30 days after receipt of the staff recommendation of reapproval.

3. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of reapproval, the staff shall notify the program in writing of the conditions necessary to gain reapproval. Technical assistance and consultation shall be offered by MDH to the program. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health, denial of reapproval, the staff shall notify the program at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the program contests the proposed staff recommendation to deny reapproval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

7 MCAR § 1.177 MDH Responsibilities in Relation to Applicants and Approved Programs

A. The MDH shall provide technical assistance and consultation for the planning, implementing and administering of EPS programs and those programs seeking approval.

B. The MDH shall survey and evaluate approved programs on a periodic basis to assure compliance with the standards contained in these rules.

C. The MDH shall provide in-service EPS training seminars for local staff based upon the needs as determined jointly by approved programs and MDH staff. This training shall address at least the following areas:

1. Administration of EPS

2. Pediatric nursing skills in relation to the specific screening assessments and tests of children.

7 MCAR § 1.178 Approved Program Responsibilities

A. Approved programs shall provide EPS service in accordance with or exceeding the standards contained in these rules.

B. The criteria for referral resulting from the screening tests and assessments are outlined in the 1977 EPS Procedures Manual.[3] Approved programs shall refer children to an appropriate resource for evaluation, diagnosis and treatment.

C. Approved programs shall assure that EPS personnel obtain continuing education in order to maintain or improve clinical skills. This training may be provided by MDH or the University of Minnesota, School of Public Health. The content shall relate to child ambulatory health care, screening principles and clinical skills.

D. Approved programs shall coordinate the EPS program with schools or other community child health programs and health care providers.

E. Approved programs shall participate in evaluation of their programs and submit evaluation data as requested by MDH. This data includes at least a screening and referral form and forms for tracking diagnosis and treatment results. Data provided to MDH by approved programs may be summarized and the child's identity shall remain anonymous.

[3]The EPS Procedures Manual is available to the public and may be obtained from the Minnesota Department of Health.

F. Approved Program Option

Approved programs may include the Physician Integration Plan, provided such a plan meets or exceeds the standards contained in these rules. If this plan is included, the health history, physical examination and the laboratory tests shall be performed on the child, under a physician's supervision. This examination shall be performed within the previous 6 months if the child is under the age of 2, within 12 months if the child is 2 years or older, or 60 days after the provision of the other EPS screening tests (vision, hearing, and developmental). There shall be a mutual exchange of information to assure that each provider has the complete health and developmental profile of the child.

dling, storage, disposal, application, use or misuse of any pesticide.

K. Reciprocal Agreement.

1. Reciprocal agreements shall apply to all non-residents licensed and certified to apply pesticides for restricted use as Commercial Applicators and Private Applicators so long as such license and certification has not been cancelled or suspended for cause by the jurisdiction issuing the license and certification on which issuance of the reciprocal license and certification is based.

2. In all cases, when a license and certification has been suspended or revoked by either jurisdiction in the Agreement, the appropriate official of the reciprocating jurisdiction shall be notified detailing the reasons for such suspension or revocation.

3. The Commissioner is authorized to enter into an informal reciprocal Agreement with any other state which has a similar state plan for certification of Pesticide Applicators. Under such Agreement, the designated person of the state party to the reciprocal Agreement is granted full authority, including reciprocal recognition of licensing and certification standards, training and testing procedures, and related matters in all states participating in such Agreements.

4. The Commissioner reserves the right to test any applicant from another state who is seeking certification in Minnesota.

Department of Health

Proposed Rules Regarding Early and Periodic Health and Developmental Screening Programs

Notice of Hearing

Notice is hereby given that a public hearing in the above-entitled matter will be held pursuant to Minn. Stat. § 15.0412, subd. 4 (Supp. 1977), in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Thursday, February 2, 1978, commencing at 9:00 a.m.

All interested or affected persons will have an opportunity to participate concerning the adoption of the proposed rules captioned above. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted by mail to Peter Erickson, Hearing Examiner, at Room 300, 1745 University Avenue, Saint Paul, Minnesota 55104, telephone (612) 296-8118, either before the hearing or within five days after the close of the hearing. All such statements will be entered into and become part of the record. Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand. For those wishing to submit written statements or exhibits, it is requested that at least three (3) copies be furnished. In addition, it is suggested, to save time and avoid duplication, that those persons, organizations, or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests. The conduct of the hearing shall be governed by the rules of the Office of Hearing Examiners.

A copy of the proposed rules is attached hereto and made a part hereof.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. Additional copies will be available at the door on the date of the hearing.

A Statement of Need explaining the Commissioner of Health's position relative to the necessity for the proposed rules and a Statement of Evidence outlining the testimony and evidence which will be introduced on behalf of the Commissioner in support of the proposed rules will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection. The statutory authority of the Commissioner of Health to promulgate and adopt these rules is contained in Minn. Stat. §§ 144.10, § 144.11 (1976), § 144.12 (Supp. 1977), § 144.07(1), § 144.09 (1976) and § 15.0412 subds. 1 and 3 (Supp. 1977).

In addition, please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he commences lobbying. Lobbying includes attempting to influence rulemaking by communicating or urging others to communicate with public officials. A lobbyist is generally any individual who spends more than $250 per year for lobbying or any individual who is engaged for pay or authorized to spend money by another individual or association and who spends more than $250 a year or five (5) hours per month for lobbying. The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, Saint Paul, Minnesota 55155, telephone (612) 296-5615.

Warren R. Lawson, M.D.
Commissioner of Health

Rules as Proposed

Chapter Eleven: 7 MCAR §§ 1.174-1.178

7 MCAR § 1.174 General.

A. Declaration of purpose, scope and applicability.

The purpose and scope of these rules is to establish minimum standards and procedures for MDH approved nurse-administered local provision of comprehensive health screening of children.

These rules apply to those organizations seeking MDH approval in order to qualify for reimbursement by third parties for which such reimbursement requires MDH approval; and constitutes standards for the nurse-supervised EPSDT programs as prescribed in Department of Public Welfare (DPW) Rule and Preschool Screening Program as prescribed in Department of Education (DPE) Rule.

B. Definitions.

For the purposes of these rules the following terms have the meanings given them:

1. "Applicant" means a local organization, such as but not limited to a community health agency, hospital, voluntary nonprofit group or school, which is seeking approval and has submitted for approval a completed plan for an Early and Periodic Screening (EPS) program.

2. "Application" means a written request for MDH program approval in a format as specified by the MDH. This format shall require submission of the information required by Rule 7 MCAR § 1.176 A, B, C, herein.

3. "Approved program" means a screening program which offers regularly scheduled comprehensive health screening for children from birth through 20 years of age, in accordance with the standards contained in Rule 7 MCAR § 1.175, and which has been approved by MDH.

4. "Children" means those individuals from birth through 20 years of age.

5. "Diagnosis" means the systematic classification of the nature or the cause of physical or mental disease or abnormality through the combined use of health history, physical, developmental and psychological assessments and laboratory tests and x-rays.

6. "Early" means the entrance of a child to the health care system at his/her youngest possible age.

7. "EPS" means Early and Periodic Screening.

8. "EPS Procedures Manual" (1977 edition) means the document written by MDH staff in which the concepts and methods for program administration and screening procedures are specified and can be promulgated and utilized by local health programs. The screening procedures and referral criteria contained in the manual are based on Academy of Pediatrics standards and specific scientific criteria for a given test.

9. "EPS trained nurse" means the nurse who is trained to perform the screening assessments and tests in an approved program inasmuch as she meets the qualifications as contained in Rule 7 MCAR § 1.175 B. 1. b.

10. "MDH" means the Minnesota Department of Health.

11. "Periodic" means health screening occurring at predetermined intervals.

12. "Periodicity schedule" means the schedule set out in Rule 7 MCAR § 1.175 A. 3., and which specifies the frequency and age ranges at which the specified screening assessments and tests are to be administered to a child.

13. "Physician Integration Plan" means the option whereby an MDH approved program seeks to extend its services by substituting a physician-administered health history, physical examination and laboratory services for the nurse-administered health history, physical assessment and laboratory services.

14. "Preschool Screening Program" means the health and developmental screening program under the auspices of the Department of Education, whereby children are screened once before they enter kindergarten, pursuant to Laws of 1977, ch. 437.

15. "Screening" means the use of those simple and quick procedures as outlined in Rule 7 MCAR § 1.175 A. 2., to sort out apparently well children from those in need of more definitive study of possible physical or developmental problems.

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16. "Screening and referral form" means a report when completed by approved programs and submitted to MDH provides a summary of the results of screening for each child and contains data which can be used for MDH and local program analysis and evaluation pursuant to Rule 7 MCAR § 1.178 E.

17. "Sliding fee scale" means a pre-determined schedule which identifies the amount to be paid by the parent(s) or guardian(s) toward the cost of screening. The sliding fee scale is developed by the applicant or approved program and is based on such factors as average incomes for the region, individual family income and the number of persons in the family.

18. "Third-party reimbursement" means payment to approved programs, by sources other than the child, or his/her parent(s) or guardian(s) and which is applied to the cost of screening. The sources of this reimbursement may include Title XIX (Medical Assistance), other federal, state or local monies, insurance benefits or in-kind contributions converted into dollar equivalency.

19. "Title XIX (Medical Assistance)" means the program authorized under the Social Security Act, USC 42, Title XIX — Sec. 1901-1910, and rules promulgated thereunder, to provide medical care for individuals whose resources do not enable them to purchase such care.

20. "Tracking" means documenting the results of diagnosis and treatment resulting from the screening of a child. This data also may be used to evaluate the type and appropriateness of referrals.

21. "Treatment" means medical, dental, nursing, preventive, rehabilitative or other relevant services to prevent, correct, or ameliorate disease or disability detected by diagnostic services from a qualified professional.

7 MCAR § 1.175 Minimum standards to qualify for MDH approval.

A. Applicants seeking MDH program approval shall develop a screening program containing the following components:

1. An outreach component which shall include a demonstrated ability to stimulate or encourage participation in the screening program.

a. Information about a screening program may be disseminated by a variety of methods such as the following:

(1) Person-to-person communication.

(2) Public information outreach such as, but not limited to, planned meetings with groups, contacts with agencies such as schools or Head Start, in order to obtain assistance with regard to their specific child populations, distribution of pamphlets, use of the mass media.

b. Outreach efforts shall be coordinated with the outreach function of local welfare departments in relation to children under the Title XIX (Medical Assistance) program and with local school districts in relation to children under the Preschool Screening Program.

2. A screening component which shall include a demonstrable ability to provide at least the following assessments and tests which must be available at the frequency and age ranges as specified in the Periodicity Schedule found in Rule 7 MCAR § 1.175 A..3. Referrals resulting from the assessment and testing shall be based on referral criteria as stated in 1977 EPS Procedures Manual.

a. A health history assessment which shall include at least an individual review of past and present health status including perinatal, psychosocial and family health.

b. An immunization assessment which shall include a review of the immunization status of the child in relation to the following immunizations: Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella.[1]

c. A nutrition status assessment which shall include at least a review of the child's food intake for a 24 hour period preceding screening.

d. A physical growth assessment which shall include measurement of the child's height, weight and head circumference and comparison with the ranges considered normal for children of that age.

e. An unclothed physical assessment which shall include an inspection of pulse, respiration, blood pressure, head, eyes, ears, nose, pharynx, neck, chest, heart, lungs, genitals, abdomen, spine, extremities, joints, muscle tone, skin and neurologic reaction.

f. A dental inspection which shall include inspection of the child's mouth for any evident oral or dental abnormalities.

g. Developmental screening tests which shall assess the child's development in the areas of fine and

[1] It is recommended that approved programs provide immunizations on site.

gross motor skills, speech and language, social-emotional behavior and self-help skills.

(1) In order to assess these developmental areas, MDH recommends the use of the Denver Prescreening Developmental Questionnaire (PDQ) with its manual and the Denver Developmental Screening Test (DDST) with its manual or an acceptable alternative meeting the criteria of Rule 7 MCAR § 1.175 A. 2. g.(2).

(2) Alternative tests may be substituted for the Denver Developmental Screening Test (DDST) upon approval by MDH.

(a) An applicant considering substitution for the Denver Prescreening Developmental Questionnaire (PDQ) and the Denver Developmental Screening Test (DDST) shall submit a narrative which describes the alternative test in the following areas: content and construction of the test, norms, administration, scoring and interpretation, validity and reliability.

(b) In order to secure approval of an alternative test, such a test must be able to provide at a minimum:

(i) Written procedures for administration and scoring.

(ii) Evidence of validated norms for age range being tested.

(iii) The same information regarding the child's development as would be provided through the use of the Denver Developmental Screening Test (DDST).

h. A hearing assessment shall include procedures which test for deviations from the normal range of auditory acuity.

(1) MDH approved programs must use the puretone audiometric screening procedure. A Verbal Auditory Screening for Children (VASC) hearing procedure as described in the 1977 Edition of VASC Manual may be used for four year old children.

i. A vision assessment shall include procedures which test for eye health deviations, including the normal range of visual acuity and muscle balance in the child. Approved programs must:

(1) Observe and examine the child's pupils and light following reflex, presence or absence of nystagmus, muscle balance, and an external inspection of the eyes.

(2) Muscle balance screening procedures include at least observation, cover test, Hirschberg test and the Worth 4-Dot Test.

(3) Test for visual acuity. A test, as appropriate for the child's age, such as the Screening Test for Young Children and Retardates (STYCAR), the Snellen E Cube, the Snellen Alphabet Chart, and plus lenses shall be used.

j. Laboratory tests: the following tests shall be administered according to the Periodicity Schedule found in Rule 7 MCAR § 1.175 A. 3.

(1) Tuberculin tests indicate exposure to active tuberculosis and may indicate need for medication.

(2) Urine and Bacteriuria (Bililabstix and Culturia Assay) test for bacteria and other abnormal substances in the urine.

(3) Anemia (Microhematocrit, Hemoglobin) tests for anemia and also indicates other blood abnormalities.

(4) A Blood Lead — test for increased lead absorption and for lead poisoning in children whose history indicates the possibility of exposure to undue levels of lead in the environment or atmosphere.

(5) A Sickle Cell Test shall be administered only with the consent of the parent(s), or guardian(s), or the child, if he/she is over 18 years, and only to those children at risk for the sickle cell trait or disease.

3. The assessment and tests listed above shall be available on the following periodic schedule.

4. An interpretation and parent education component which shall include discussions aimed at sharing with the family and child information collected during screening. These discussions must incorporate guidance regarding sound health practices, normal growth and development, and the clarification of any concerns on the part of the child or family.

5. A referral component which shall include an organized system of arranging for children with problems

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EPS PERIODICITY CHART

INTERVALS	MONTHS					YEARS					
(1)	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
History											
Health	X	X	X	X	X	X	X	X	X	X	X
Perinatal	X	←	←	←	←	←					
Psychosocial	X	X	X	X	X	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	←	←	X	←	←	X	←
Developmental											
DDST	X	X	←	←	←	X					
PDQ			X	X	X						
Assessment											
Height	X	X	X	X	X	X	X	X	X	X	X
Weight	X	X	X	X	X	X	X	X	X	X	X
OFC	X	X	X	X	X	←	←				
Physical Inspection	X	X	X	X	X	X	X	X	X	X	X
Oral Inspection	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure						X	X	X	X	X	X
Tests											
Hearing	X	←	X	X	X	X	X	X	X	X	X
Vision	X	←	X	←	X	X	X	X	X	X	X
Urine (BiliLabstix)						X	←	←	←	←	←
Bacteriuria (females)						X	←	X	←	←	←
Microhematocrit or Hgb.	X	←	X	←	X	X	←	←	←	X	←
Blood Lead (Only if history positive)			X	←	X	X					
Sickle Cell (Upon parental request)	X	←	←	←	←	←	←	←	←	←	←
Tuberculin		X	←	←	←	←	←	←	←	←	←

(1) The period, birth to six months, is not addressed in the program based upon the assumption that nearly all children of this age interval are receiving ongoing physical care.

Procedure to be completed if not done at the previous visit; or on the first visit.

identified through screening to be seen by an appropriate resource for evaluation, diagnosis or treatment. Arrangements shall be made to establish all children who have been screened with ongoing health care services.

6. A follow-up component which shall include an organized system for securing information on children who are referred to another resource for evaluation, diagnosis and treatment. Follow-up efforts are to assure that the required services were made available and to evaluate the effectiveness of the screening program.

a. A follow-up plan shall consist of at least the following:

(1) Written and formal arrangements with

other agencies such as the county welfare departments, Head Start, community action councils, public health nursing services, and school services to define and coordinate each agency's responsibilities with respect to follow-up.

(2) A description of activities such as personal contact with the child, family or referral resource. At least two attempts shall be made to contact parent(s) or provider(s) concerning diagnosis and treatment results.

(3) A written identification of nursing personnel who shall have supervisory responsibility for follow-up.

B. Personnel for EPS Screening of Children

1. Qualifications and/or responsibilities of the screening personnel: An individual may perform one or more of the functions in the screening program provided that the appropriate qualifications are met.

a. EPS clinic coordinator shall have responsibility for coordination and management of the local screening program. These responsibilities include management as well as specific organization of activity in the clinics.

b. EPS trained nurse shall be either a Pediatric Nurse Associate who is a graduate of an accredited university postgraduate program in Pediatric Nursing or meet all of the following criteria:

(1) Be currently licensed as a professional nurse by the Minnesota Board of Nursing.

(2) Have successfully completed EPS training seminars provided by MDH, or have participated in equivalent training programs designated by MDH.

(3) Demonstrate ability to satisfactorily perform to an EPS Consultant designated by MDH, those child assessments as required in Rule 7 MCAR § 1.175 A. 2. a-j.

(4) Have the ability to work effectively with children based on recommendations from the EPS clinic coordinator, agency nurse supervisor, or the EPS Consultant under contract with MDH.

c. EPS Laboratory Assistant shall be:

(1) A lab technician or an assistant who can document training in performing the specific tests used in the screening session under the supervision of the EPS nurse.

d. EPS Vision and Hearing Technician shall:

(1) Have documentation of the successful completion of a course in vision and hearing screening offered by MDH and demonstrate ability to satisfactorily perform the vision and hearing screening as required in Rule 7 MCAR § 1.175 A. 2. h., i, and;

(2) If the VASC is used, have documentation of the completion of training to perform the Verbal Auditory Screening of Children (VASC).

e. EPS Clinic Assistant shall:

(1) Be able to document the completion of training in the administration of the developmental tests selected for use in the screening program. Such training may be provided by the EPS nurse or consultant who has documented training in developmental testing from institutions such as but not limited to area mental health centers, or community colleges and schools.

(2) Have experience in working with children either through paid employment or volunteer activity.

f. EPS clerk shall have responsibility for clerical and receptionist functions, and shall have acquired clerical and human relations skills through paid employment or voluntary activity.

C. The physical facility shall meet the following requirements:

1. Separate areas shall be provided for the various screening procedures, as well as waiting and play areas.

2. Physical privacy shall be maintained for interviewing and physical assessment.

3. Equipment needed for the assessments and tests shall be available to the program and maintained in servicable and reliable condition so as to insure the integrity of the tests specified in Rule 7 MCAR § 1.175 A. 2. a-j.

7 MCAR § 1.176 Application procedures for EPS program approval.

A. Local organizations shall notify MDH in writing of

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their intent to establish an EPS program and to apply for MDH program approval in accordance with the standards specified in these rules. The sections of the application addressing Statement of Need, and Evaluation and Fiscal Management shall be considered for purposes of program planning at state and local level and if necessary, for provision of technical consultation by MDH. The section of the application relating to the Methods of Accomplishing Program Components, and Personnel shall be applicable to the approval process as defined in Rule 7 MCAR § 1.176 D.

B. Upon receipt of the letter of intent, MDH shall transmit an application and instructions to the applicant.

C. Submission of Application. The applicant shall submit the completed application to MDH and to the MDH District Nursing Consultant for the district in which the applicant is located. The application shall include at least the following information:

1. A statement of need for EPS — The applicant shall provide a general statement of the extent of the need for this kind of preventive health service in the community to be served and includes information on the following:

a. The geographic area of the proposed program.

b. The age range and numbers of children to be served in each age group.[2]

c. The estimate of the number of Title XIX (Medical Assistance) eligible children identified in each age group.

d. The identification of all the school districts within the geographic area of the proposed program.

e. The identification of other child and adolescent health screening programs in the area and specification of how the proposed program will coordinate with these programs.

2. A description of the method of accomplishing each of the program components: outreach, screening and interpretation, education, referral and follow-up.

3. Personnel — Outline the number and type of personnel necessary to implement each component and the plans for training personnel.

4. Evaluation — Outline the methods other than those specified in this Rule, by which the applicant will evaluate its own program. Such methods may include parent surveys, and/or analysis of the use of referral resources, and numbers of children screened.

5. Fiscal Management — include the following:

a. The method for determining unit cost.

b. The plan for implementing a sliding fee scale and for collecting third-party reimbursements and a copy of the sliding fee scale except where prohibited by Laws of 1977, ch. 437, the Preschool Screening Act.

c. The copy of the authorization from the duly constituted authority (such as county commissioners, city councils) to charge fees for service, except as prohibited by Laws of 1977, ch. 437, the Preschool Screening Act.

D. Review and Disposition of Application

There shall be a two stage approval process.

1. With regard to the first stage of approval:

a. Upon receipt, the application shall be reviewed by MDH staff in order to determine that it contains the information specified in Rule 7 MCAR § 1.176 C. 1-5.

b. The MDH staff shall make arrangements for the local EPS personnel to be trained in EPS seminars.

c. An initial screening session shall be scheduled by the applicant. An EPS Consultant, as designated by MDH will be assigned to the applicant for on-site consultation to assist the applicant to develop adequate skills. A subsequent consultation may be provided as necessary.

2. Provisional Approval

a. Upon completion of application, training, the initial screening session, and a satisfactory EPS Consultant report, the Commissioner of Health may grant provisional approval to the applicant prior to any other screening of children by the applicant. Provisional approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third party reimbursement.

b. In the event the MDH staff intends to recommend to the Commissioner of Health a denial of provisional approval, the staff shall notify the applicant in writing of the conditions necessary to gain approval.

[1] An applicant may elect to serve only one age group of children.

Technical assistance and consultation shall be offered by MDH to the applicant.

c. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health denial of provisional approval the staff shall notify the applicant at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny provisional approval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

3. With regard to the final stage of approval:

a. A second visit shall be made by the EPS Consultant within the first six months of the program's operation to evaluate the screening program and staff performance to assure implementation and fulfillment of the program components as specified in Rule 7 MCAR § 1.175 A., B., C.

b. The MDH staff shall make a final staff review of the screening program. This review consists of the EPS Consultant's evaluation of the ability of program personnel to adequately perform the screening procedures as outlined in the Rule, the MDH District Nursing Consultant's evaluation of the overall program administration and a review of the application in accordance with standards as specified in Rule 7 MCAR § 1.175 A., B., C.

c. If the Commissioner of Health concurs with staff comments and recommendation, the Commissioner shall notify the applicant within 30 days of final approval. Such approval by MDH shall constitute approval for purposes of other governmental agencies and their provision of third-party reimbursement.

d. If not in substantial compliance:

(1) The conditions necessary to gain approval shall be stated in writing by MDH staff to the applicant. Technical assistance and consultation shall be offered by MDH staff to the applicant.

(2) If following the offer of consultation and reconsideration, MDH staff intends to recommend to the Commissioner of Health a denial of final approval, the staff shall notify the applicant in writing of the reasons therefore, at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the applicant contests the proposed staff recommendation to deny approval, it shall request in writing a hearing, within 30 days of the receipt of the proposed staff recommendation or otherwise, it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

E. Annual Reapproval

1. An approved program shall be reviewed annually by the MDH staff to determine if approval status shall continue. Reapproval shall be based on the program's continued compliance with the standards specified in Rule 7 MCAR § 1.175 A., B., C.

2. The Commissioner of Health shall notify the program within 30 days after receipt of the staff recommendation of reapproval.

3. In the event that MDH staff intends to recommend to the Commissioner of Health a denial of reapproval, the staff shall notify the program in writing of the conditions necessary to gain reapproval. Technical assistance and consultation shall be offered by MDH to the program. If following the offer of consultation and with reconsideration, MDH staff intends to recommend to the Commissioner of Health, denial of reapproval, the staff shall notify the program at least 33 days prior to the submission of the recommendation to the Commissioner of Health. If the program contests the proposed staff recommendation to deny reapproval it shall request in writing a hearing within 30 days of receipt of the proposed staff recommendation or otherwise it shall be deemed to concur with the staff recommendation. This hearing shall be conducted in accordance with the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

7 MCAR § 1.177 MDH responsibilities in relation to applicants and approved programs.

A. The MDH shall provide technical assistance and consultation for the planning, implementing and administering of EPS programs and those programs seeking approval.

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B. The MDH shall survey and evaluate approved programs on a periodic basis to assure compliance with the standards contained in these rules.

C. The MDH shall provide in-service EPS training seminars for local staff based upon the needs as determined jointly by approved programs and MDH staff. This training shall address at least the following areas:

1. Administration of EPS

2. Pediatric nursing skills in relation to the specific screening assessments and tests of children.

7 MCAR § 1.178 Approved program responsibilities.

A. Approved programs shall provide EPS service in accordance with or exceeding the standards contained in these rules.

B. The criteria for referral resulting from the screening tests and assessments are outlined in the 1977 EPS Procedures Manual.[3] Approved programs shall refer children to an appropriate resource for evaluation, diagnosis and treatment.

C. Approved programs shall assure that EPS personnel obtain continuing education in order to maintain or improve clinical skills. This training may be provided by MDH or the University of Minnesota, School of Public Health. The content shall relate to child ambulatory health care, screening principles and clinical skills.

D. Approved programs shall coordinate the EPS program with schools or other community child health programs and health care providers.

E. Approved programs shall participate in evaluation of their programs and submit evaluation data as requested by MDH. This data includes at least a screening and referral form and forms for tracking diagnosis and treatment results. Data provided to MDH by approved programs may be summarized and the child's identity shall remain anonymous.

F. Approved Program Option

Approved programs may include the Physician Integration Plan, provided such a plan meets or exceeds the standards contained in these rules. If this plan is included, the health history, physical examination and the laboratory tests shall be performed on the child, under a physician's supervision. This examination shall be performed within the previous 6 months if the child is under the age of 2, within 12 months if the child is 2 years or older, or 60 days after the provision of the other EPS screening tests (vision, hearing, and developmental). There shall be a mutual exchange of information to assure that each provider has the complete health and developmental profile of the child.

[3] The EPS Procedures Manual is available to the public and may be obtained from the Minnesota Department of Health.

Minnesota Tax Court

Proposed Rules and Amendments to Rules of the Minnesota Tax Court

Notice of Hearing

Notice is hereby given that a public hearing in the above-entitled matter will be held in the Tax Court's Hearing Room, 5th floor, Space Center, 444 Lafayette Road, St. Paul, Minnesota, 55101, on February 6, 1978, at 9:30 a.m. and continuing until all persons have had an opportunity to be heard.

Copies of the proposed rules are now available and one free copy may be obtained by writing to the Minnesota Tax Court. Additional copies will be available at the door on the date of the hearing.

Please be advised that pursuant to Minn. Stat. § 10A.01, Subd. 11 (1974) any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual.

Rules as Proposed

13 MCAR § 2.001 Rules of civil procedure [**and uniform rules of evidence**] adopted by reference. The rules of civil procedure of the Minnesota District Courts **and the Uniform Rules of Evidence for Minnesota State Courts** are hereby adopted as the rules of this Court except as hereinafter modified or amended.

13 MCAR § 2.002 Appearance and practice before the court. Any person may appear and act for himself or for a partnership of which he is a member or for a corporation of which he is an officer.

Others who may practice before the Court as hereinafter provided shall be:

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

AFFIDAVIT OF RECEIPT OF THE SECRETARY OF STATE'S LIST

Sheila Swaiman, being duly sworn upon oath, deposes and says:

1. That she is an employee of the Minnesota Department of Health.

2. That on the 19th day of December, 1977, she called the Minnesota Secretary of State's office and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules or amendments thereto pursuant to Minn. Stat. § 15.0412 subd. 4 (Supp. 1977).

3. That on the 19th day of December, 1977, in response to the above request, the Secretary of State provided her with such a list.

Further affiant sayeth not.

Sheila Swaiman

Subscribed and sworn to before me

this 6 day of January, 1978.

ROSALYN KNUTSON
Notary Public, Ramsey Co., Mn.
My Commission Expires
Oct. 1, 1982

STATE OF MINNESOTA

COUNTY OF HENNEPIN

In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs.

AFFIDAVIT OF MAILING

John A. Sweet, being first duly sworn, deposes and says:

That on the 28 day of December, 1977, at the City of Minneapolis, County of Hennepin, State of Minnesota, he served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, as well as to all members of the Minnesota Legislature as of the date of mailing.

John A. Sweet

Subscribed and sworn to before me this 10 day of January, 1978.

Rosalyn Knutson

ROSALYN KNUTSON
Notary Public, Ramsey Co., Minn.
My Commission Expires
Oct 1, 1982

Exhibit A

STATE OF MINNESOTA
COUNTY OF RAMSEY

CERTIFICATE

In the matter of the Proposed Adoption
of Rules of _____ Division
Governing _____

I hereby certify that the attached 486 labels 5 sheets constitute the complete list of persons, associations, and other interested groups who as of 4:00 o'clock P .M, this 19th day of December, 19 77, have requested pursuant to M.S. 19 76, 15.0413 _____, that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

Secretary of State

Joan Anderson Growe

By Cheri L. Mattson

Exhibit B

TEST PATTERN TEST PATTERN
ADDRESS TEST ADDRESS
CITY TESTCITY MN
55555

TEST PATTERN TEST PATTERN
ADDRESS TEST ADDRESS
CITY TESTCITY MN
55555

TEST PATTERN TEST PATTERN
ADDRESS TEST ADDRESS
CITY TESTCITY MN
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TEST PATTERN TEST PATTERN
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TEST PATTERN TEST PATTERN
ADDRESS TEST ADDRESS
CITY TESTCITY MN
55555

TEST PATTERN TEST PATTERN
ADDRESS TEST ADDRESS
CITY TESTCITY MN
55555

ALBERT,AA CALDER CORP
366 JACKSON ST
ST PAUL MN
55101

ALLIN M KARLS
2333 UNIV AVE SE
MPLS MN
55414

ALLENDORF MARSHALL
220 GRAIN EX 400 S 4TH
MPLS MN
55415

ALLERS JOHN
1501 W 80TH ST SUITE210
BLOOMINGTON MN
55431

AMER CAMPING ASSN
3639-21/2 ST N.E.
MPLS MN
55418

AM INST PROF GEOLOGISTS
2201 PRINCETON AVE
ST PAUL MN
55105

ANCHOR BLOCK COMPANY
PO BOX 3360
ST PAUL MN
55165

ANDERSON HERBERT
418 8TH ST. SO.
VIRGINIA MN
55792

ANDERSON HAROLD
BOX 3047
MANKATO MN
56001

ANDERSON JAMES
7703 NORMANDALE RD
MPLS MN
55435

ANDERSON MARY
4425 RUTLEDGE AVE
EDINA MN
55436

ANDERSON STANFORD P
14600 MINNETONKA BLVD
MINNETONKA MN
55343

ANTHONY DICK WDSM RADIO
230 E SUPR ST
DULUTH MN
55102

ANTI-TRUST DIV.ATTY GEN.
160 STATE OFF BLDG
ST PAUL MN
55155

ARNOLD ROBERT MESPA
41 SHERBURNE
ST PAUL MN
55103

ARROWHEAD ECONOMIC OP AGENCY
CO S BRUSTUN BOX 1066
VIRGINIA MN
55792

ARROWHEAD REG. DEV COMM.
211 W 2ND ST
DULUTH MN
55802

ARROWHEAD REGIONAL DEV C
200 ARROWHEAD PLACE
DULUTH MN
55802

ASMUSSEN,DENNIS,MPIRG
3036 UNIV AVE SE
MPLS MN
55414

ASSOCIATED GEN CONTROF MN
48 E 8TH STREET
ST PAUL MN
55101

ASSN OF MINN COUNTIES
55 SHERBURNE AVE #203
ST PAUL MN
55103

ASSN RESIDENCES FOR RETARDED
459 RICE SUITE 301
ST PAUL MN
55103

BABCOCK LOCHER NELSON ET AL
118 E MAIN ST
ANOKA MN
55303

BADALICH JOHN P
2025 THOMPSON AVE
SO ST PAUL MN
55075

BARATTO DIVINE M
1192 BUSH ST
ST PAUL MN
55106

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BARTHOLOW HAROLD E FIRE CHF
2600 109 AVE N W
COON RAPIDS MN
55433

BECK PAT
953 HYACINTH AVE
ST PAUL MN
55106

BEGALKA D REV
212 N ELK ST
BELLE PLAINE MN
56011

BEMIDJI STATE COLLEGE
PLACEMENT BUR.J.C.BRADY
BEMIDJI MN
56601

BERGERUD ALF
300 ROANOKE BLDG
MPLS MN
55402

BERGSETH THOMAS
1011 NICOLLET MALL
MPLS MN
55403

BEST FLANAGAN ET AL
4040 IDS CENTER
MPLS MN
55402

BEUTEL ROBERT
2200 SILVER LAKE RD
NEW BRIGHTON MN
55112

BLADIN PAPER CO W J LICKE
115 1ST ST SW
GRAND RAPIDS MN
55744

BLOMQUIST BARRY L

NORTH BRANCH MN
55056

BLOOMINGTON CITY CLERK
2215 W CLD SHAKOPEE RD
BLOOMINGTON MN
55431

BOLTON MALCOLM
422 ALDRICH AVE NO
MPLS MN
55405

BOWMAN & BRUNS ATTN P MA
1616 PIONEER BLDG
ST PAUL MN
55101

BRAHL JAMES N

BRIGGS [illegible]

ASMUSSEN,DENNIS,MPIRG
3036 UNIV AVE SE
MPLS MN
55414

ASSOCIATED GEN CONTROF MN
48 E 8TH STREET
ST PAUL MN
55101

ASSN OF MINN COUNTIES
55 SHERBURNE AVE #203
ST PAUL MN
55103

ASSN RESIDENCES FOR RETARDED
459 RICE SUITE 301
ST PAUL MN
55103

BABCOCK LOCHER NELSON ET AL
118 E MAIN ST
ANOKA MN
55303

BADALICH JOHN P
2025 THOMPSON AVE
SO ST PAUL MN
55075

BARATTO DIVINE M
1192 BUSH ST
ST PAUL MN
55106

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BARTHOLOW HAROLD E FIRE CHF
2600 109 AVE N W
COON RAPIDS MN
55433

BECK PAT
953 HYACINTH AVE
ST PAUL MN
55106

BEGALKA D REV
212 N ELK ST
BELLE PLAINE MN
56011

BEMIDJI STATE COLLEGE
PLACEMENT BUR.J.C.BRADY
BEMIDJI MN
56601

BERGERUD ALF
300 ROANOKE BLDG
MPLS MN
55402

BERGSETH THOMAS
1011 NICOLLET MALL
MPLS MN
55403

BEST FLANAGAN ET AL
4040 IDS CENTER
MPLS MN
55402

BEUTEL ROBERT
2200 SILVER LAKE RD
NEW BRIGHTON MN
55112

BLADIN PAPER CO W J LICKE
115 1ST ST SW
GRAND RAPIDS MN
55744

BLOMQUIST BARRY L

NORTH BRANCH MN
55056

BLOOMINGTON CITY CLERK
2215 W CLD SHAKOPEE RD
BLOOMINGTON MN
55431

BOLTON MALCOLM
422 ALDRICH AVE NO
MPLS MN
55405

BOWMAN & BRUNS ATTN P
1616 PIONEER BLDG
ST PAUL MN
55101

BREHL JAMES W
332 HAMM BLDG
ST PAUL MN
55102

BRICK PHILIP D
807 SELLWOOD BLDG
DULUTH MN
55802

BRIGGS & MORGAN - B F FRIEL
2200 W 1ST NATL BK BLDG
ST PAUL MN
55101

BROEKER JOHN
2850METRO DR. SUITE 50
BLOOMINGTON MN
55420

BROOKS WILLIAM F JR
854 MIDLAND BK BLDG
MPLS MN
55401

BROWN D M GOODRIDGE PUB SCH
IND DIST #561
GOODRIDGE MN
56725

BROWN H D
4961 KINGSBERRY LANE
MINNETONKA MN
55343

BRUBACHER RICHARD COMM
208 ADM BLDG
ST PAUL MN
55101

BRUNING C.R.DEPT.CLINIC.EXP.
BURTON HALL
MPLS. MN
55455

BUSCH NOEL
SUITE 705 510 MARQUETTE
MPLS MN
55402

BUCHHOLTZ CHARLES
5044 BRENT AVE E
INV GRV HTS MN
55075

BURGER ALBERT
600 DEGREE OF HONOR BL
ST PAUL MN
55101

BUR.ENGR.IND.DIV. MR.KIBIGER
219 N. 2ND ST.
MPLS. MN

BUR NATL AFFAIRS INC
1231 25TH ST NW
WASHINGTON DC
20037

CABLE COMM SYST-H SARR
BOX 777
HECTOR MN
55342

CAIN RUTH
730 E 38TH ST
MPLS MN
55407

CAIRNS JOHN A
47TH FLR IDS CENTER
MPLS MN
55402

CARLSON CARL L
7516 80TH ST S
COTTAGE GROVE MN
55016

CARLSON VERNE E
BOX 755 CITY HALL
WILLMAR MN
56201

CARRISON DALE K
MANKATO STATE COLLEGE
MANKATO MN
56001

CHAMBER OF COMMERCE
30 SO 1ST AVE EAST
ELY MN
55731

CHAVARRIA ADAM
1325 W 251/2 ST APT 206
MPLS MN
55405

CHERCHES CHRIS CITY MG
5005 MTKA BLVD
ST LOUIS PARK MN
55416

CHILDS J L
4012 LYNN AVE S
MPLS MN
55416

CHRISTIAN SCI COMM ON PUB
1821 UNIV AVE SUITE 271
ST PAUL MN
55104

CHRISTIANSEN FREDRIK
RM 505 CAPITOL SQ BLDG
ST PAUL MN
55155

CHRYSALIS CENTER FOR WO
2104 STEVENS AVE S
MPLS MN
55404

CITY CLERK
386 CITY HALL
ST PAUL MN
55102

CITIZENS LEAGUE
530 SYNDICATE BLDG
MPLS MN
55402

CITY OF ROBBINSDALE
C LARSON 4221 LAKE RD
ROBBINSDALE MN
55422

CLARKSON J.B.
2350 I.D.S. CENTER
MINNEAPOLIS MN
55402

CLAUSEN PHILLIP
2307 STANDISH ST
ST PAUL MN
55108

CLAWSON CONNIE
HELP CT 317-17TH AV SE
MPLS MN

COLEMAN NICHOLAS
208 STATE CAPITOL
ST PAUL MN
55155

COLLIN LAURENCE
RT 2
ISANTI MN
55040

COMMUNITY DESIGN CENTER
118 E 26TH ST
MPLS MN
55404

CONCORDIA COLLEGE
DEAN
MOORHEAD MN
56560

CONSUMER SERVICES DEPT COMM
5TH FLR METRO SQ BLDG
ST PAUL MN
55101

COUNTY ATTYS COUNCIL
95 SHERBURNE AVE S20
ST PAUL MN
55103

CRAVEN NORMAN
10637 THOMAS AVE S
BLOOMINGTON MN
55431

CROW WING CO PLANNING & ADV
COURT HOUSE
BRAINERD MN
56401

CUSHMAN J S DAYTON HUDSON
700 NICOLLET MALL
MPLS MN
55402

DAHLKE LOIS M
118 S EAGLE ST
BELLE PLAINE MN
56011

DAILEY THOMAS ECONOMICS LAB
370 WABASHA ST
ST PAUL MN
55102

DANKERS, KENNETH
1200 WEST FOURTH STREET
RED WING MN
55066

DANIELSON RODNEY L
418 AUDITORIUM
ST PAUL MN
55102

DAYTON CHAS SIERRA CLUB
800 MIDLAND BANK BLDG
MPLS MN
55401

DEVELOP DISABILITIES PROGRAM
STATE PLAN 101 CAP SQ
ST PAUL MN
55155

DICKINSON MRS JOANNE
BOX 1065
MARSHALL MN
56258

DIEHL JOHN
26 KENWOOD PKWY
ST PAUL MN
55105

DISPATCH PIONEER PRESS
PRESS RM STATE CAPITOL
ST PAUL MN
55101

DORSEY MARQUART
2400 1ST NATL BANK BLDG
MPLS MN
55402

DOUGLAS BELL ET AL
2212 AM.NATL BK BLDG
ST PAUL MN
55102

DOW CHEMICAL
47 BLDG
MIDLAND MI
48640

DUNN OLIVER PLUMBERS LOC 15
708 SO 10TH ST
MPLS MN
55404

DUPONT MIKE
5720 EXCELSIOR BLVD
MPLS MN
55416

DZUGAN KEN ST PAUL PLANNING
421 WABASHA ST
ST PAUL MN
55102

E CENTRAL REG. DEV. COMM
COURTHOUSE 18 N VINE ST
MORA MN
55051

EBELING EDWARD H.
161 W. MAIN
PERHAM MN
56573

EICHTEN DANIEL
3794 HAZEL
WHITE BEAR LK MN
55110

ELDER DR JAMES B
11140 WASHBURN AVE SO
BLOOMINGTON MN
55431

ELDRED R W ARMOUR & CO
UNION STOCK YARDS
SO ST PAUL MN
55075

ELMER EDWIN W
2901 PLEASANT AVE
MPLS MN
55408

EMERICK RICHARD A
1908 IDS CENTER
MPLS MN
55402

ENNIS A F BOISE CASCADE
PO BOX 713
INTL FALLS MN
56649

ENV SERV-GEN RESOURCE CORP
6340 INDUSTRIAL DR
HOPKINS MN
55343

ERDMAN ROGER TENNANT CO
701 N LILAC DR
MPLS MN
55441

ERNEST K LEHMANN & ASSOC.
1409 WILLOW ST.
MPLS MN
55403

ESSE KENNETH
4801 W 50TH ST
EDINA MN
55424

ETHICS COMM
RM 410 STATE OFF BLDG
ST PAUL MN
55155

EVANS CHAS.L. PRENTICE-HALL
ENGELWOOD CLIFFS
NEW JERSEY

EWING MRS WM
42 ASTAR RD
BABBITT MN
55706

FAEGRE & BENSON ATTN LIBR
1300 NW BANK BLDG
MPLS MN
55402

FARMERS ELEVATOR ASSN
852 GRAIN EXCH BLDG
MPLS MN
55415

FARRELL FRANK BUR NOR
RM 1180 176 E 5TH ST
ST PAUL MN
55101

FELHABER R S
W 1ST NATL BANK BLDG
ST PAUL MN
55101

FILTER LOREN
BOX 36
BRITT MN
55701

FINLEY JAMES F
920 MINN BLDG
ST PAUL MN
55101

FINNEGAN J.R.
55 E. 4TH
ST.PAUL MN
55101

FITZGERALD DR BOB
3007 LYNDALE AVE SO
MPLS MN
55408

FITZPATRICK LEO
8138 HENSLOWE AVE S
COTTAGE GROVE MN
55016

FLEMING FREDERICK A
1860 HIGHLAND PARKWAY
ST PAUL MN
55116

FLADLAND CLINT MN L&P BUR
795 RAYMOND AVE
ST PAUL MN
55114

FORBES GORDON MINN RRS
203 HANOVER 480 CEDAR
ST PAUL MN
55101

FORSBERG AGR SERV
518 SUMMIT AVE
NEW ULM MN
56073

FOX W.E. LINDQUIST & VENNUM
4200 IDSCTR 80 S.8TH ST
MINNEAPOLIS MN
55402

FRANKLIN ROBERT B MPLS TRIB
426 PORTLAND
MPLS MN
55415

FREDIN CONRAD M
811 FIRST NATL BK BLDG
DULUTH MN
55802

FREDLUND MRS PHYLLIS
RR 4 BOX 37
CANBY MN
56220

FREDRIKSON BYRON ET AL
47TH FLR IDS CENTER M
PLS MN
55402

FRIESEN MILLER A
RAHR BD 624 13TH ST S
VIRIGINIA MN
55792

FRISON FRANK NECA
RM 305 200 SO ROBERT
ST PAUL MN
55107

GALVIN M J JR
W2162 1ST NATL BK BLDG
ST PAUL MN
55101

GARDNER HDW - R A JOHNSON
515 WASHINGTON AVE N
MPLS MN
55401

GEBERT K L
220 GRAIN EXCH
MPLS MN
55415

GEO A HORMEL & CO LAW DEPT
PO BOX 800
AUSTIN MN
55912

GIEL DAVID
RM B-28 STATE CAPITOL
ST PAUL MN
55155

GLEESON MICHAEL
909 SOC SC BLDG U OF M
MPLS MN
55455

GLEN. HILLS HOSP.R.VAN
3901 GOLDEN VALLEY RD.
MPLS. MN
55422

GODIN RALPH J
3824 47TH AVE SO
MPLS MN
55406

GOLDBERG PROF MELVIN
WM MITCHELL COL OF LAW
ST PAUL MN
55105

GOODMAN DF TEL CABLE TV
302 E SUPERIOR
DULUTH MN
55802

GRAHAM THOS H
854 MIDLAND BK BLDG
MPLS MN
55401

GRANATH MARVIN -HONEYWELL
2701 4TH AVE SO
MPLS MN
55408

GREATER MET AREA HOSPITALITY
5152 CEDAR AVE S
MPLS MN
55417

GREEN DEL CITY MGR
BLOOMINGTON CITY HALL
BLOOMINGTON MN
55431

GREEN GARY J
41 SHERBURNE AVE
ST PAUL MN
55102

GREEN JANET
9773 N SHORE DR
DULUTH MN
55804

GRUMMERT REV DONALD
1435 ADAMS ST
MPLS MN
55413

GUSTAFSON DAN-LABOR TEMPLE
312 CENTRAL
MPLS MN
55414

GUSTAFSON WALLACE
BOX 567
WILLMAR MN
56201

H B FULLER CO
2400 KASOTA AVE
ST PAUL MN
55108

HAFNER DR A J
BOX393 MAYO U OF M
MPLS MN
55455

HALLBERG LEE & MCCABE
4927 34TH AVE S
MPLS MN
55417

HANFT PHILIP M
1200 ALWORTH BLDG
DULUTH MN
55802

HANSON ETHEL
2813 85TH AVE N
MPLS MN
55444

HAROLD J WESTIN CONSTRUCTORS
45 E 8TH ST
ST PAUL MN
55101

HARRY RICK
RT 1 BOX 138
KETTLE RIVER MN
55757

HAUN DR J W GEN MILLS
PO BOX 1113
MPLS MN
55440

HAYES,THOMAS W
700 SELLWOOD BLG
DULUTH MN
55812

HART PATRICK V
112 E LIBERTY BOX 3271
MANKATO MN
56001

HARTFELDT WILL
434 HAMM BLDG
ST PAUL MN
55102

HAVEN ROBT TWIN TN TREATMENT
1706 UNIV AVE
ST PAUL MN
55104

HEAD & TRUHN
1007 SOO LINE BLDG
MPLS MN
55402

HEADWATERS REG DEV. COMM
BOX 584 MENTAL HEALTH
BEMIDJI MN
56601

HEALTH MANPOWER C LARSON
717 DELAWARE ST SE
MPLS MN
55440

HEANEY BILL
30 W SUPERIOR ST
DULUTH MN
55802

HEARING EX.OFF. M GREENBERG
1745 UNIV AVE
ST PAUL MN
55104

HEIM PAUL M
3944 IDS CENTER 80 S 8
MPLS MN
55402

HEISENFELT WM
BOX 516
BEMIDJI MN
56601

HELTZER JAMES DAYTON HUDSON
777 NICOLLET MALL
MPLS MN
55402

HENDRICKSON A WM
100 FREEMAN DRIVE
ST PETER MN
56082

HENDRICKSON MRS VIRGINIA
3324 COUNTRY WOOD DR
BURNSVILLE MN
55337

HINRICHSEN PATRICK
MANKATO FREE PRESS
MANKATO MN
56001

HOLEY GEORGE
1509 SW SIXTH STREET
FARIBAULT MN
55021

HOLMES EUSTIS ET AL
4610 IDS CENTER
MPLS MN
55402

HOPKINS WM.B. DIR.MISCCA
3915 GOLDEN VALLEY ROAD
GOLDEN VALLEY MN
55422

HORNER WALDORF - KAZIUKE
PO BOX 3260
ST PAUL MN
55165

HOLT JOHN
517 4TH ST NW
FARIBUALT MN
55021

HOULE MELVIN
881 W HWY 96
SHOREVIEW MN
55112

HOUSE APPROPRIATIONS COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HULSTRAND ANDERSON & LA
PO BOX 130
WILLMAR MN
56201

HUMAN RIGHTS
200 CAPITOL SQ BLDG
ST PAUL MN
55101

HUMAN SERVICES
414 LAFFAYETTE RD 5THFL
ST PAUL MN
55101

HUSEBYE, CRAIG J.
5036 FRANCE S.
EDINA MN
55410

HUTCHISON R.M. ANOKA CO.
COURT HOUSE
ANOKA MN
55303

HYLAND DEAN
1501 W 50TH ST
MPLS MN
55419

IMAGE
BOX 3215
ST PAUL MN
55165

INGEBRIGTSEN DR K H
23 SE 4TH ST
MPLS MN
55414

INGVALSON VERN MN.FARM BU
1976 WOODDALE BOX 43370
ST PAUL MN
55164

INS FED OF MINN
902 SOO LINE BLDG
MPLS MN
55402

INTERSTATE POWER-RW STEELE
1000 MAIN ST
DUBUQUE IA
52001

IUOE LOC 49 CHAS SWENSO
2580 UNIV AVE
ST PAUL MN
55101

IVERSON DR JOS DEPT ED
ST OLAF COLLEGE
NORTHFIELD MN
55057

IZAAK WALTON MN DIV
111 E FRANKLIN RM-210
MPLS MN
55404

JAIN NIRMAL ENIV PROCE
1220 GLENWOOD AVE
MPLS MN
55405

JENOS INC
525 LAKE AVE SO
DULUTH MN
55802

JENSEN ARTHUR,CITY CLK
2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
55431

JENSEN CARL A
127 E MAIN ST
SLEEPY EYE MN
56085

JENSEN MRS GAYNOLD
111 WEST 107TH ST
MPLS MN
55420

JOHANSEN BUS SERV INC
19 DAYTON RD
CHAMPLIN MN
55316

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

JOHNSON CLARENCE IBEW LU 292
3615 37TH AVE S
MPLS MN
55406

JOHNSON G ROBERT
4344 IDS CENTER
MPLS MN
55402

JOHNSON LEROY
9939 BLUEBIRD ST NW
COON RAPIDS MN
55433

JOHNSON M.D. FRUNDT & FRUNDT

BLUE EARTH MN
56013

JOHNSON LANCE J
265 S LAFAYETTE RD
ST PAUL MN
55107

JONES C NORTHSIDE RES R
1800 OLSON MEMORIAL HWY
MPLS MN
55411

KABLE RICHARD W

BETHEL MN
55006

KAVANEY RICHARD
1220 NORTHERN FED BLDG
ST PAUL MN
55102

KEABLE MIKE
909 6TH AVE N
ST CLOUD MN
56301

KEENAN RICHARD J
4444 IDS BLDG
MPLS MN
55402

KJERVIK DIANE
4302 POWEL HALL U OF M
MPLS MN

KLOSTER MARION PEAVEY CO
730 2ND AVE S
MPLS MN
55402

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNOPP TIMOTHY
COLLEGE FORESTRY U OF M
ST PAUL MN
55108

KNUTSON DR KEITH,BIOLOGY DPT
ST CLOUD STATE
ST CLOUD MN
56301

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KOLLER MR & MRS ERWIN A
1568 DULUTH ST
ST PAUL MN
55108

KOPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

KRAMER ERNEST W
717 DELAWARE ST SE
MPLS MN
55440

KROEGER CHARLES
122 NW 7TH STREET
FARIBAULT MN
55021

KRONLOKKEN J E
10048 NORD RD
BLOOMINGTON MN
55437

KROON H CLIFTON
210 E WALNUT
MANKATO MN
56001

KUHL CARL
4421 4TH ST NE
COL HEIGHTS MN
55421

KVB ENGINEERING INC
600 S CO RD 18
MPLS MN
55426

LABELLE JUANITA MRS
5816 AQUILA AVE NO
NEW HOPE MN
55428

LAKE SUPERIOR INDUSTRIAL BUR
828 FIRST AM. BK. BLDG.
DULUTH MN
55802

LANAHAN E F - SIBLEY CO
184 E 6TH ST
ST PAUL MN
55101

LANGVIN DAVID
7500 80TH ST S
COTTAGE GROVE MN
55016

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LARSON C L
3800 MINNEHAHA AVE SO
MPLS MN
55406

LARSON HANS P DIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LEAGUE MN MUNIC
300 HANOVER 480 CEDAR
ST PAUL MN
55101

LEAGUE WOMEN VOTERS OF MINN
555 WABASHA
ST PAUL MN
55102

LEG.REF.LIB-Z. DEWITT
RM 111 STATE CAPITOL
ST PAUL MN
55155

LEVEY JESS MET STATE UNIV
METRO SQ RM 121
ST PAUL MN
55101

LEAVEY THOS
829 22ND AVE SE
MPLS MN
55414

LEWIS DR.G.M JR.
ABBOTT 110 E 16TH ST
MPLS MN
55403

LIBBEY LEONARD
BOX 17011 NOKOMIS STA
MPLS MN
55417

LINDALL & JONATHAN DEVELOP.
VILLAGE ONE CENTER
CHASKA MN
55318

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

LOWE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

LUTH SOC SERVICE OF MN
2414 PARK AVE
MPLS MN
55404

LYNCH DONALD SIBLEY CO
184 E 6TH ST
ST PAUL MN
55102

MADSON HUGH
AETNA 212 S 6TH ST
MPLS MN
55402

MAHCF RICK CARTER
2850 METRO DR SUITE 431
BLOOMINGTON MN
55420

MALECKI JAMES
1 SO STATE ST
NEW ULM MN
56073

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANKATO STAT STUDENT SENATE
CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO STATE STUDENT ASSN
BOX 58 MANKATO COLLEGE
MANKATO MN
56001

MANTHEY T J PICKANDS MA
1100 SUPERIOR AVE
CLEVELAND OH
44114

MARRINAN MARGARET M
1117 COMMERCE BLDG
ST PAUL MN
55101

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MAYO FOUNDATION G ORWO
200 FIRST AVE NW
ROCHESTER MN
55901

MCCLURG EUNICE
1061 109TH AVE NE
BLAINE MN
55434

MCDONALD PHILIP M
2077 SELBY AVE
ST PAUL MN
55104

MCFADDEN G H DISPATCH-PRESS
55 E 4TH ST
ST PAUL MN
55101

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MCLELLAN LARKIN
215 ADM BLDG ST CAPITOL
ST PAUL MN
55101

MCNEILLY GREG MNDSVIEW ED AS
41 SHERBURNE AVE
ST PAUL MN
55103

MET. WASTE CONTOL COMM.
350 METRO SQ BLG
ST PAUL MN
55101

MEIEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

MET TFR MEN ASSN A ROSENTHAL
1821 UNIV AVE
ST PAUL MN
55104

METROPOLITAN COUNCIL LIBRARY
300 METRO SQUARE
ST PAUL MN
55155

MEYER HERBERT
10824 ZENITH AVE S
BLOOMINGTON MN
55431

MIDLAND GLASS-HD SPURLI
PO BOX 69
SHAKOPEE MN
55379

MILLER M ADMIN AGENCIES DIV
G19K STATE ADM BLDG
ST PAUL MN
55155

MILLER PAUL J PHARMACY SERV
ST MARYS HOSP
ROCHESTER MN
55901

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MINN ASPHALT PAVEMENT ASSN
555 WABASHA RM 209
ST PAUL MN
55102

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERAT
4901 W 77TH ST
MPLS MN
55435

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN ASSN VOL SOC SERVICE
1821 UNIV SUITE 389
ST PAUL MN
55114

MINN ASSN WATERSHED DIST'S

ADA MN
56510

MINN CHAP ASSOC BLDRS-C
7204 W 27TH ST
MPLS MN
55426

MINN COMM FOR HANDICAPPED
METRO SQ 492 7TH & ROBT
ST PAUL MN
55101

MINN COMMUNITY DEVELOP SERV
512 ROSSMOR BLDG
ST PAUL MN
55101

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINNESOTA FARMERS UNION
1717 UNIVERSITY AVE
ST PAUL MN
55104

MINN FOOD RETAILERS ASSN
555 WABASHA
ST PAUL MN
55101

MINN GOV ENG COUNCIL
2400 SHERWOOD HILL RD
MINNETONKA MN
55343

MINN HEREFORD-LJ SCHAFER

BUFFALO LAKE MN
55314

MINN. HOTEL & MTR. ASSN
2001 UNIVERSITY AVE
ST PAUL MN

MINN HOUSING INST N T CARTER
1573 SELBY AVE APT 101
ST PAUL MN
55104

MINN HWYS MANAGEMENT SERVICE
407 HWY BLDG
ST PAUL MN
55101

MINN LAND USE COMMITTEE
4344 IDS CENTER
MPLS MN
55402

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINNE MINE CREDIT UNION
3000 HUDSON PK S 100
ST PAUL MN
55119

MINN POULTRY & HATCHERY ASSN
BOX 158
MADELIA MN
56062

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN STATE EMP UNION COUNC 6
236 E PLATO BLVD
ST PAUL MN
55107

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN-WISC BOUNDARY AREA COMM
600 2ND ST
HUDSON WI
54016

MN.BD OF NURSING
717 DELAWARE ST SE
MPLS MN
55414

MN ST PHARMACEUTICAL ASSN
2469 UNIVERSITY AVE
ST PAUL MN
55114

MOOD R BLOOMINGTON HLTH DEPT
10200 PENN SO
BLOOMINGTON MN
55431

MPIRG
BOX 45 ST MARYS COLLEGE
WINONA MN
55987

MPLS TRIBUNE CITY DESK
425 PORTLAND AVE
MPLS MN
55415

MINN.MTR.TRANSP. J.N.DENN
1621 UNIV.
ST.PAUL MN
55104

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN SOCIETY ARCHITECTS AIA
NW NATL BK BLDG
ST PAUL MN
55101

MINN STATE MEDICAL ASSOC
STE 900 AM NATL BK BLDG
STPAUL MN
55101

MINN.TURKEY GROWERS ASSN
2383 UNIV AVE
ST PAUL MN
55114

MN AUTOMOBILE DEALERS ASSN
277 UNIV AVE
ST PAUL MN
55103

MN ELECTRICAL ASSN
3100 HUMBOLT SO
MPLS MN
55408

MN STATE SER BLIND-K NATARDY
1745 UNIVERSITY AVE
ST PAUL MN
55104

MORTON BUILDINGS INC
R #1
FOLEY MN
56329

MPLS ASSN RETARDED CITIZENS
3100 W LAKE ST
MPLS MN
55416

MT OLIVET ROLLING ACRES
R 1 BOX 576
EXCELSIOR MN
55331

NASS GEO V HENN CO GEN HOSP
5TH AND PORTLAND AVE
MPLS MN
55415

MINN PETROLEUM COUNCIL
1020 NORTHERN FED BLDG
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN
55104

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MINN VETERANS MED ASSN
2175 W HWY 36
ROSEVILLE MN
55113

MN. ASN.C&IND H.D.PETERSON
480 CEDAR ST.
ST.PAUL MN
55101

MN PUB INT RESEARCH GROUP
3036 UNIV AVE SE
MPLS MN
55414

MIXA FRANK LK MNTKA CONS DIS
402 E LAKE ST
WAYZATA MN
55391

MOSS DR JEROME
125 PEIK 159 PILLSBURY
MPLS MN
55455

MPLS CITY ATTORNEY
325M CITY HALL
MPLS MN
55415

MURPHY DIANA E
4200 IDS-LINDQUIST VENN
MPLS MN
55402

NATL CAR RENTAL ATT D MITZEL
5501 GREEN VALLEY DR
MPLS MN
55437

MINN POLLUTION CONTROL
1935 W CO RD B2
ROSEVILLE MN
55113

MINN RETAIL FED INS
131 METRO SP
ST PAUL MN
55101

MINN STATE BD PHARMACY
717 DELAWARE ST SE #351
MPLS MN
55414

MINN TEAMSTERS CREDIT U
2021 HENN AVE E
MPLS MN
55413

MINN WATER RESOURCES BD
RM 206 555 WABASHA ST
ST PAUL MN
55102

MN AFL-CIO L.O. LASHOMB
175 AURORA
ST PAUL MN
55103

MN SOC SERV ASS J HOOD
614 PORTLAND
ST PAUL MN
55102

MOFFITT R C
RM 301 M MPLS CITYHALL
MPLS MN
55415

MOTOR VEHICLE MFRS ASSN
411 MAIN ST (215)
ST PAUL MN
55102

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MURPHY PATRICK DUFFY
1440 SUMMITT AVE
ST PAUL MN
55105

NATL COUNCIL JEWISH WOM
4330 CEDAR LK RD
MPLS MN
55416

NATL FAMILY INS CO
2147 UNIV AVE
ST PAUL MN
55114

NEUMAN RALPH W
RT 2 BOX 125
EMBARRASS MN
55732

NURSING HOME ADMRS BD EXAMRS
RM 340 717 DELAWARE SE
MPLS MN
55414

NW COUNTRY ELEVATOR ASSN
802 GRAIN EXCH BLDG
MPLS MN
55415

O'BRIEN J.DENNIS
1100 1ST NATL.BANK BLDG
MINNEAPOLIS MN
55402

OLSON KATHLEEN
192 SEYMOUR AVE SE
MPLS MN
55414

PAYNE CCL ALVIN

DEGRAFF MN
56233

PHAR MFGRS ASSN WM D PATTON
1155 15TH ST NW
WASHINGTON DC DC
20005

PORTER DAVID
3002 27 AVE S
MPLS MN
55406

POYZER ROBT
BOX 675
FERGUS FALLS MN
56357

RAMSEY CO MEDICAL SOC
908 AM NATL BK BLDG
ST PAUL MN
55101

NCEC INC C/O DR DAHLBERG
CONCORDIA COLLEGE
MOORHEAD MN
56560

NURSING HOME RES ADV CO.
111 E FRANKLIN S210
MPLS MN
55404

NW REG. DEV. COMM
425 WOODLAND AVE
CROOKSTON MN
56716

O'CONNELL RAY
MN GAS CO 733 MARQ AVE
MPLS MN
55402

OTTER TAIL POWER CO.
215 S. CASCADE ST.
FERGUS FALLS MN
56537

PAYNE WM B
2400 FIRST NATL BK BLDG
MPLS MN
55402

PHILLIPS LEGISLATIVE SERVICE
459 RICE ST
ST PAUL MN
55103

PORTER LYLE O

TRACY MN
56175

PRAUSE JOS.C.
2220 105TH AVE.N.W.
COON RAPIDS MN
55433

RAUENHORST CORP-C ANDERSON
7900 XERXES S. S-2200
MPLS MN
55431

NELSON JOHN
4809 180TH ST N
HUGO MN
55038

NO SUB MONTESSORI-S SADDLER
2487 HELEN COURT
NO ST PAUL MN
55109

NUTTER JULIA
743 W MONTANA
ST PAUL MN
55117

NYQUIST DEAN A
3707 53RD PL N
BROOKLYN CTR MN
55429

OFFICE OF THE GOVERNOR
130 STATE CAPITOL
ST PAUL MN
55101

PETERSON GARY
854 MIDLAND BK BLDG
MPLS MN
55401

PINNETTI NICK M HALEY & ASS.
40 CENTRAL PARK S
NEW YORK NY
10019

PORT AUTH CITY OF ST PAUL
330 MINNESOTA BLDG
ST PAUL MN
55101

PROCTOR&GAMBLE L THEOHAROUS
IVORYDALE TECH CENTER
CINCINNATI OH
45217

RADMAN RICHARD-LABOR TEMPLE
418 AUDITORIUM
ST PAUL MN
55102

REAGAN MICHAEL
% MINN LEARNING CTR
BRAINERD MN
56401

NEREN MADONNA
376 NEAL AVE S
AFTON MN
55001

NORTH CENTRAL ELEC ASSN
PO BOX 202
BATTLE LAKE MN
56515

NW BELL TEL CO LEGAL DEP
224 S 5TH ST RM 2000
MPLS MN
55402

OLOFSON ARTHUR MBD & MA
927 SOO LINE BLDG
MPLS MN
55402

PATTISON ORVIS
BOX 645
WILLMAR MN
56201

PFEIFER AND SHULTZ, INC
1433 UTICA AVE S
MPLS MN
55416

POPOVICH PETER S
314 MINN BLDG
ST PAUL MN
55101

POSS DONALD G
6301 SHINGLE CREEK PKWY
BROOKLYN CTR MN
55430

PULSCHER RBT SPRINGSTED
813 OSBORN BLDG
ST PAUL MN
55102

RALPH BURKE ASSOCIATES
7710 COMPUTER #S101
MPLS MN
55435

REARDON MRS HELEN
1125 S E 6TH ST
WILLMAR MN
56201

REID DAVID H
6469 N GRAHAM RD
INDIANAPOLIS IN
46220

REINO O LAINE 3M COMPANY
3M CENTER
ST PAUL MN
55101

RICHARDS MONTGOMERY ET AL
1430 RAND TOWER
MPLS MN
55402

ROBERTS DR ALAN
BOX 297 MAYO U OF M
MPLS MN
55455

ROWLEY STEPHEN
4305 15TH AVE S
MPLS MN
55407

SANFORD S M
7000 PORTLAND AVE
RICHFIELD MN
55423

ST PAUL BUR HLTH DR P COX
555 CEDAR ST
ST PAUL MN
55101

SCHAEN ETHEL
1745 UNIVERSITY AVE
ST PAUL MN
55104

SCHMIDT LARRY WCCO-TV NEWS
50 S 9TH ST
MPLS MN
55402

SCHWARTAU NEAL METH HOSP
201 W CENTER ST
ROCHESTER MN
55901

SCHROEDER ALFRED H
2172 CARROLL AVE
ST PAUL MN
55104

SENATE GOV OP COMM
RM 303 STATE CAPITOL
ST PAUL MN
55155

RED OWL STORES INC
215 E EXCELSIOR AVE
HOPKINS MN
55343

RENNER R.H. ST PAUL AREA CC
300 OSBORN BLDG.
ST PAUL MN
55102

RIEKE DAVID
PO BOX 9311
MPLS MN
55440

ROBERTS DAVID E
1260 NW NATL BK BLDG
ST PAUL MN
55101

SAX DOVE & STENSON
310 ENDICOTT BLDG
ST PAUL MN
55101

ST PAUL FOOD RETAILERS ASSN
1220 ARCADE
ST PAUL MN
55106

SCHLICHT REV ROBT
611 W MAIN ST
BELLE PLAINE MN
56011

SCHMIDT WARREN WELLCOME MHS
GARDEN CITY
MN
56034

SCHWERMAN EARL JR
1535 8TH AVE SE
ROCHESTER MN
55901

SELECTVISION INC FR VALENTIN
1 DAG HAMMARSKJOLD PL
NEW YORK NY
10017

SHABATURA EUGENE H
2833 LAKE AVE SO
DULUTH MN
55811

REGION FIVE REG. DEV. COMM.
102 6TH ST N
STAPLES MN
56479

RENQUIST ARTHUR NSP CO
414 NICOLLET MALL
MPLS MN
55401

ROE DAVID
175 AURORA
ST PAUL MN
55103

ROSS ALFRED
6356 WARE RD
LINO LAKES MN
55014

SE MN REG DEV COMM
301 MARQ BK BLDG
ROCHESTER MN
55901

SW REGIONAL DEV COMM
2811 BDWY
SLAYTON MN
56172

SCHMIDT D R MN ASSN REALTORS
6101 WAYZATA BLVD
MPLS MN
55416

SCHNEIDER MAHLON
GREEN GIANT
LESUEUR MN
56058

SCHWINN ROBT.P.
1400 SOO LINE BLDG.
MPLS. MN
55402

SENATE COUNSEL OFFICE
ROOM 480 STATE OFF BLDG
ST PAUL MN
55055

SHAW ROBERT M
616 MOBIL OIL BLDG
MPLS MN
55402

REGION NINE DEV. COMM.
709 N FRONT ST
MANKATO MN
56001

RICHARDSON THOS
7851 METRO PKWY S 103
MPLS MN
55420

ROBBIE JOSEPH
904 CARGILL BLDG NO CT
MPLS MN
55402

ROSS ROY J
CLK TREAS
LITCHFIELD MN
55355

SAN SIMEON DEVELOP CORP
OLD 1ST STATE BK BLDG
PAYNESVILLE MN

SPRAGUE CHARLOTTE B
AREA HOSPITAL BOX 339
WINDOM MN
56101

SCARBOROUGH WILLIAM
DIV.ED. U.M.
MORRIS MN
56267

SCHMIDT H W TCHRS RETIR
302 CAPITOL SQ BLDG
ST PAUL MN
55101

SCHUTZ LINDA
RM 328 CAPITOL BLDG
ST PAUL MN
55155

SCHNEIDER & NEESER
706 1ST ST SO PO BX 876
WILLMAR MN
56201

SENATE FINANCE COMMITTE
ROOM 121 STATE CAPITOL
ST PAUL MN
55155

SILVERMAN JUDITH
8545 W 28TH ST
ST LOUIS PARK MN
55426

SITE ENGINEER INC
12 OLD DEERFIELD RD
WELCH MN
55089

SIX EAST REG. DEV. COMM.
311 W 6TH ST
WILLMAR MN
56201

SIX W REG. DEV. COMM
128 W SORENSON
APPLETON MN
56208

SMERIKA WM.
BOISE CASCADE PAPERS
INTL FALLS MN
56649

SMITH MICHAEL
128 PLEASANT STREET SE
MPLS MN
55455

SNELL LYN
BOX 314
EDEN VALLEY MN
55329

SNYDER, R.W. U OF M
RM 248C CLASS OFF BLDG.
ST PAUL MN
55108

SODERBERG HAROLD J
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

SODERMAN ANTHONY
1414 FOSHAY TOWER
MPLS MN
55402

STANSFIELD ARLENE LAND OLKS
PO BOX 116
MPLS MN
55440

STATE BD VETERINARY EXAMINER
C/O DR A C SPANNAUS DVM
WACONIA MN

STD AM LIFE & ANNUITY CO
3801 W 50TH ST
MPLS MN
55410

STEELWORKERS CREDIT UNION
BOX 250
BABBITT MN
55706

STOLPESTAD BROWN & SMITH
1550 NW BK BLDG
ST PAUL MN
55101

STUPKA & MOREM
MIDTOWN BLDG
AUSTIN MN
55912

SULLIVAN J KIRK
PO BOX 200
BOISE ID
83701

SULLIVAN JEANETTE
CDIC SW STATE UNIV
MARSHALL MN
56258

SUMMIT NATL BANK D L MORRILL
205 AURORA AVE
ST PAUL MN
55103

SUSSEL CO.ATTN:TED SCHWENKER
1850 COMO AVE.
ST PAUL MN
55108

SWANSON BURT E
W-2162 1ST NATL BK BLDG
ST PAUL MN
55101

SWANSON DALE
P O BOX 339
FOREST LAKE MN
55025

SWANSON MORTIMER C
5824 FRANCE AVE S
EDINA MN
55410

TATE VERN 3M CO
3M CENTER 220/6W
ST PAUL MN
55101

TENNESSEN SEN ROBERT J
RM 309 STATE CAPITOL
ST PAUL MN
55165

THOMPSON CONRAD
1107 23RD ST NW
ROCHESTER MN
55901

THOMPSON HESSIAN ET AL
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

TIMESAVERS INC ATT R S
5270 HANSON COURT
MPLS MN
55422

TOUCHE ROSS & CO K H STOCKE
780 NORTHSTAR CNTR
MPLS MN
55402

TWIN CITIES PIPING IND ASSN
2829 UNIV SE SUITE 304
MPLS MN
55414

UNION STOCK YARDS
ATTN PRES
SO ST PAUL MN
55075

UTLEY JOHN
4610 IDS CENTER
MPLS MN
55402

VANDERVOORT T J MET WASTE
350 METRO SQUARE BLDG
ST PAUL MN
55101

VAN DRAKE STEPHEN R
BOX 353
PELICAN RAPID MN
56572

VAN EVERA MUNCT ET AL
700 TORREY BLDG
DULUTH MN
55802

VERRILL JOHN E
DEPT SECONDARY ED UOF M
DULUTH MN
55812

VIITALA, W.C. HONEYWELL
HONEYWELL PLAZA
MPLS MN
55408

VILLAGE OF WOODBURY
2100 RADIO DRIVE
WOODBURY MN
55042

VOSS REV GORDON O
11120 NE 7TH ST
BLAINE MN
55434

VOS LEROY
2137 BURNS AVE
ST PAUL MN
55119

WALTERS THOS H
4510 W 77TH ST STE 235
MPLS MN
55435

WAMPLER LINUS CIR USW OF AM
609 PROVIDENCE BLDG
DULUTH MN

WANQUIST ALLEN
RM 252 FEDERAL BLDG
ST PAUL MN
55101

WATERS, DONNA M.
110506 WINDMILL COURT
CHASKA MN
55318

WELK G V NORTHERN STAT
414 NICOLLET MALL
MPLS MN
55401

WELLINGTON R R SKELLY OIL
PO BOX 1650
TULSA OK
75102

WHITLOCK MARSHALL
RM 3 CAPITOL BLDG
ST PAUL MN
55155

WILEY ENTERPRISES
101 5TH AVE SE
OSSEO MN
55369

WOZNIAK C D
401 FIRST FED BLDG
ST PAUL MN
55101

WEST CENTRAL REG. DEV.
ADM BLDG.COMMUNITY COLL
FERGUS FALLS MN
56537

WHITING RALPH
7316 BAILEY ROAD
NEWPORT MN
55055

WILSON R GARY PPG INDUSTR
1 GATEWAY CENTER
PITTSBURGH PA
15222

WYANT CLINTON W ATTY

ATKIN MN
56431

ZIMMERMAN & OFFERMAN
CAMBRIDGE STATE HOSP
CAMBRIDGE MN
55008

WESTIN CHAS W
220 MEDICAL ARTS BLDG
DULUTH MN
55802

WILCOX J PATRICK
1220 NORTHERN FED BLDG
ST PAUL MN
55102

WIS FEEDER PIG MARKET CO-OP

FRANCIS CREEK WI

WHITLOCK A G
ECON LAB OSBORN BLDG
ST PAUL MN
55102

WM.MITCHEL COLLEGE LAW L
2100 SUMMIT AVE.
ST.PAUL MN
55105

WOLKERSTORTER THEODORE
676 17TH AVE NW
NEW BRIGHTON MN
55112

Please Note:

If you intend to supplement this list with other lists when mailing a hearing notice, please compare lists and eliminate duplicate notices.

Thank you.

ALSO
NOTIFY ALL INTERESTED STATE DEPARTMENTS, BOARDS AND COMMISSIONS
AND
PLEASE SORT OUT INTEROFFICE MAIL FROM LABELS

The following Names on the General Mailing List can be sent through Interoffice Mail

Anti-Trust Div., Attorney General, 160 State Office Bldg.

Brubacher, Richard, Comm. Adm., 208 Adm. Bldg.

Christiansen, Fredrik, Rm 505, Capitol Square Bldg.

Coleman, Nicholas, 208 State Capitol

Consumer Services Dept. Comm., 5th Floor, Metro Square Bldg.

Develop Disabilities Programs, State Plan, 101 Capitol Square Bldg.

Dispatch Pioneer Press, Press Rm, State Capitol

Ethics Comm., Rm 410, State Office Bldg.

✓Farseth, Paul, Welfare Dept., 690 N Robert Street, St. Paul

Giel, David, Rm B-28, State Capitol

House Appropriations Comm., Rm 109 State Capitol

Human Rights, 200 Capitol Square Bldg.

Human Services 414 Lafayette Rd., 5th Floor

Leg. Ref. Lib-Z. Dewitt, Rm 111, State Capitol

Levey, Jess, Met. State Univ., Metro Square Bldg., Rm 121

McLellan, Larkin, 215 Adm. Bldg. St. Capitol

Malone, E.I., Comm. Labor & Industry, 444 Lafayette Rd., 5th Floor

Met. Waste Control Comm., 350 Metro Square Bldg.

Metropolitan Council Library, 300 Metro Square

Miller, Michael, Admin. Agencies Div., G19K State Admin. Bldg

Minn Comm for Handicapped, Metro Square

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Minn State Retirement System, 529 Jackson St

Minn Water Resources Bd, Rm 206, 555 Wabasha St.

Mpls Star Press Room, State Capitol

Office of the Governor, 130 State Capitol

St. Paul Bur Hlth Dr P Cox, 555 Cedar St.

Schmidt, H.W. Teachers Retirement, 302 Capitol Square Bldg.

Schutz, Linda, Rm 328 Capitol Bldg.

Senate Coun. Office, Room 480, State Office Bldg.

Senate Finance Comm., 121 State Capitol

Senate Gov. Op. Comm. Rm 303, State Capitol

Senator Robert J. Tennessen, 309 State Capitol

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HOTELS, RESORTS, RESTAURANTS

U.S. Soil Conservation Service, 517 Red Courts Bldg., St Paul (Trailer Parks, et

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5. Information on the potential hazard resulting from interference of transmission line structures and conductors with agricultural operations; and on tower placement, conductor height, and other applicable standards and agricultural practices that minimize this hazard.

6. Data on the impact of fault conditions such as conductor breakage, including the magnitude of fault currents, strength of the transient electromagnetic field and time for fault isolation; and information on applicable performance standards.

7. Effects of electrostatic and electromagnetic fields, steady-state and transient, on critical life support devices such as cardiac pacemakers.

8. Information on the inspection and test programs required by the NESC, including descriptions of appropriate instrumentation, procedures and schedules.

D. **Biological effects.** Information is sought on all data, studies and analyses that have been conducted on animal or human subjects concerning the health effects of chronic exposure to steady-state static and 60 Hz electrostatic, electromagnetic and ion current fields; and on current and planned research programs that can be reasonably expected to produce data adequate to guide formulation of any necessary performance and/or exposure-limitation standards.

SUBMISSION OF INFORMATION

Interested parties are requested to submit written materials (preferably in triplicate) no later than February 28, 1977, addressed to:

Minnesota Department of Health
Division of Environmental Health
717 Delaware Street S.E.
Minneapolis, Minnesota 55440
ATTN: HVTL Study

Materials as received will be cataloged and available for public inspection. Further information can be obtained by calling (612) 296-5347.

Warren R. Lawson, M.D.
Commissioner of Health

Department of Administration Office of the State Register

Transfer of MSAR to the Office of the State Register

Effective January 1, 1977, the Manual of State Agency Rules (MSAR) will be transferred from the Documents Sections to the Office of the State Register. Personnel of the Office of the State Register are presently preparing to codify the MSAR and to devise suitable finding aids.

Opinion and comment from the public regarding this project is hereby solicited.

George T. Morrow, II
Director

Minnesota State Agricultural Society

Notice of Meeting

The 118th annual meeting of the Minnesota State Agricultural Society, governing body of the Minnesota State Fair, will be held Jan. 23, 24 and 25 at the Leamington Hotel, Minneapolis.

A complete time schedule is available during regular business hours at the Administration Building on the Fairgrounds, Falcon Heights, or at the hotel during the meeting.

Department of Health State Board of Health

Notice of Intent to Solicit Outside Opinion on Health Screenings of Children, Crippled Children Services, and Cystic Fibrosis Program

Notice is hereby given, pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6 (Supp. 1975) that the Minnesota State Board of Health will propose the adoption of new rules and the amendment and revision of existing rules.

All interested parties desiring to submit data or views relating to the proposed adoption, amendment or revision of the rules noted below should address their comments (either written or oral) to the Minnesota Department of Health, Division of Personal Health Services, 717 Delaware Street S.E., Minneapolis, Minnesota 55440, by writing or calling the persons designated. Evidence submitted for consideration should be pertinent to the matter at hand. Any materials received by the Department will become part of the hearing record.

1. Rules relating to standards for early and periodic screening for children 0-21 years.

Contact: Sheila Swaiman
Phone: (612) 296-5286

2. Rule relating to application procedures and eligibility for crippled children services including but not limited to the new cystic fibrosis program for persons over 21.

Contact: Dr. Mildred Norval
Phone: (612) 296-5389

Any materials submitted shall be reviewed and considered by the Department of Health during the preparation of the proposed rules. Notice of the public hearing on the proposed rules shall be published in the State Register and given to all interested parties who have registered with the Secretary of State's Office in accordance with the provisions of the Administrative Procedure Act.

Under the provisions of Minn. Stat. § 10A.01, subd. 11 (1974), any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at Room 401, State Office Building, Saint Paul, Minnesota 55155.

Warren R. Lawson, M.D.
Secretary and Executive Officer

Board of Teaching
Code of Ethics for Educators

Notice of Intent to Solicit Outside Opinion

Notice is hereby given that the Board of Teaching is seeking information or opinions from sources outside the Board in preparing to propose the amendment and/or adoption of rules governing A Code of Ethics for Minnesota Educators. Any interested persons may submit data or views on this subject in writing or orally to:

Kenneth L. Peatross, Executive Secretary
MINNESOTA BOARD OF TEACHING
607 Capitol Square Building
550 Cedar Street
St. Paul, Minnesota 55101
(612) 296-2415

Any written material received by the Board shall become a part of the hearing record in the event rules governing this subject are promulgated.

Kenneth L. Peatross, Executive Secretary

ERRATA

1. 1 S.R. 864: change "Camping Products Association" to "Canvas Products Association" at FireMar 61 and 62.

2. 1 S.R. 865: change "CPA" to "CPAI" at paragraph 3.1.

minnesota department of health
717 s.e. delaware st. minneapolis 55440

RECEIVED
FEB 17 1978
OFFICE OF HEARING EXAMINERS

M E M O R A N D U M

TO: Mr. Peter Erickson
Hearing Examiner

February 17, 1978

FROM: Sheila Swaiman, Supervisor
Comprehensive Child Health Screening

SUBJECT: Department of Health Response to EPS Hearing Testimony and Letters Sent to the Hearing Examiner Regarding 7 MCAR 1.175 - 1.178

1.174 B (8) W. A. Wettergren, Minnesota School Boards Association refers to the definition of the EPS Procedures Manual. It should be clarified that this manual is incorporated by reference only as it pertains to Minnesota Department of Health EPS approved programs. It is not incorporated into Department of Education regarding school screening rules.

1.175 (2) There is not statutory authority for Minnesota Department of Health (MDH) to bring the EPS Procedures Manual to hearing on behalf of the Department of Education (DPE) Preschool Screening Rule. The suggestion of Education incorporating the EPS Procedures Manual by reference has been made by individuals at the Preschool Rule Hearing and this is a decision for the Office of the Hearing Examiner.

1.175 A (1) The testimony submitted by Elaine Saline, Ramsey County Child Health Consortium, states that outreach should be coordinated with local welfare agencies and schools, and this is clearly required and stated in 1.175 A (1) (b).

1.175 (2) (b) The MDH offered testimony at the EPS Rule Hearing for amendment to 1.175 (2) (b). The amendment and justification proposed by Ronald G. Campbell, M.D., Chief of Maternal and Child Health (MCH), is as follows:

> "There is one amendment to the proposed Rule 1.175 A (2) (b) which I would like to propose. This component now reads ' An immunization which shall include a review of immunization status of child in relation to the following immunizations: Diptheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella.' Footnote 1 reads: 'It is recommended that approved

programs provide immunization on site.' I propose adding the following after the above referenced sentence ending with 'Rubella': 'The child who is thus found to have deficiencies in his immunization status shall be offered appropriate immunization services as part of the EPS service rather than through referral, if there is legal consent from the parent(s)/guardian or from the emancipated minor and there are no medical or religious contradictions to administration of vaccine.' The footnote referenced above would be deleted. This is necessary because the federal requirements of Title XIX, SSA relative to the Early and Periodic, Diagnosis and Treatment Program (EPSDT) will be changed in the near future to require the availability of vaccination services at the time of the screening service rather than at another site and time through referral. It is our intent to maintain the compatability of EPS and the EPSDT federal requirements to obtain Title XIX reimbursements for EPS programs. Therefore, it is necessary to revise the minimal requirements related to the immunization component of the EPS Rule.

This amendment requiring that on-site immunizations be provided at approved EPS programs was supported by Ms. Nancy Feldman, EPSDT Coordinator, Department of Public Welfare, and Mr. Fred Aden, Co-chairperson, Interagency Committee on Child Health Screening and Ms. Elaine Saline, Ramsey County Child Health Consortium.

Ms. Diane Peterson, Supervisor of the Immunization Program, Minnesota Department of Health offered the following impartial testimony supporting provision of on-site immunizations:

"In fiscal year 1977, of the 5,184 children who were referred for treatment through the EPS Program, these children were found to be in need of more than 10,800 different immunizations. A random sample of referrals made during this same report period showed that referral for immunization was the number one reason identified during the screening process -- far outleading the other areas of concern. A full three months after the referrals had been made, one third of the needed immunizations had not as yet been provided. These children had not (and probably would not) receive this rather simple, but highly proven, preventive health measure. This situation would not have existed if the services had been made available on-site as part of the screening package in EPS clinics."

1.175 A (2) (e) Ms. Elaine Saline, Ramsey County Child Health Consortium, comments that there are omissions of screening of teenagers (specifically for cancer pap smears) and venereal disease. The approved EPS screening programs do not directly provide teenagers either pap smears or venereal disease testing as the nurses in the programs are not trained to perform these tests. In discussions in this matter, most have stated they do not desire to perform such tests in the context of this program. Most EPS clinics are conducted in community sites such as churches and schools which do not provide sufficient privacy to perform these tests and assure the confidentiality required. However, for selected teenagers, a referral is made for these tests through other resources such as physicians or family planning clinics, V.D. clinics. The referral criteria related to teenagers in EPS Procedures Manual under referral (17) (18) (19), page 204.

In further discussion at the EPS Hearing, it was noted by Ms. Saline that referral criteria for venereal disease testing of males is not included in the EPS Procedures Manual. The Minnesota Department of Health concurs that this is an omission and suggests the following referral criteria be added to the EPS Manual, page 209:

(20) Refer all sexually active males for V.D. screening.

(21) Refer males for V.D. who have any signs or symptoms such as:

(a) discharge from urethra;
(b) burning upon urination;
(c) sores or rashes on genital areas of body.

1.175 A (2) (g) Mr. Dominic Sposeto, Minnesota Dental Association requested that referral criteria be included in the dental screening section of the rule. Recommended referral criteria are incorporated by reference in the EPS Manual on page 194. Incorporation of referral criteria by reference in EPS Manual is consistent with all the other tests and assessments in EPS Program. Therefore, it would be inconsistent to include referral criteria for dental assessment in body of rule.

1.175 A (2) (g) (2) (b) Mr. Tom Lombard, Consultant for Preschool Developmental Screening offered the following amendment:

> "In order to secure approval of an alternative test, such a test must be standardized and able to provide at a minimum . . . "

The Minnesota Department of Health concurs with the recommended amendment which adds the word "standardized" when describing

a possible alternative test. The rationale offered by Mr. Lombard is supported by MDH, and we encourage this amendment be adopted in the final EPS Rule.

1.175 A (4) Ms. Elaine Saline, Ramsey County Child Health Consortium, suggests that one copy of Summary and Referral Form be given to the parents. The Department concurs with this suggestion and notes that this procedure is indicated in the EPS Procedures Manual.

1.175 A (6) (a) (1) Mr. Thomas Olson, State Developmental Achievement Centers Advisory Task Force, suggests that "Developmental Achievement Centers" be inserted after Head Start. The MDH concurs with this amendment and the rationale offered. We would request this be included in the final EPS Rule.

1.175 B (1) Representative James Swanson states his concern regarding utilization of volunteers in the EPS Program. This concern was also expressed by Representative Peggy Byrne at the EPS Hearing. MDH concurs with their concerns and suggests that the following amendment be added to 1.175 B (1):

> "The use of volunteers is encouraged in the screening program and volunteer vision and hearing technicians, clinic assistants and clerical personnel are suggested as appropriate use of volunteers, providing they meet the qualifications as defined 1.175 B (d) (e) and (f)."

The use of volunteers is also encouraged in the EPS Manual. It is reasonable to include volunteers because they are a valuable source of clinic staff and a direct link to the community for providing local support and positive feedback to the community regarding the screening program. They can relate to other parents, their sponsoring organization and can often serve on a local speakers bureau. Utilizing volunteers is cost efficient and can help reduce or minimize the unit cost.

1.175 B (1) (f) Mr. W. A. Wettergren, School Boards Association, comments on inclusion of human relations skills in the qualifications of clerical personnel. This is considered important because the clerical personnel often do the initial intake at a clinic. Therefore, it is appropriate for that person to have skills which make the family comfortable and put them at ease. The rule requires that other personnel with clinical responsibility must have the ability to work effectively with children.

1.175 B Ms. Elaine Saline states qualifications of personnel do not have to be stated in the rule. It is MDH's understanding that the rule informs the general public as well as

the agency. Therefore, it is in the interest of the public that it be aware of qualifications of the personnel implementing the program. The same rationale applies to Ms. Saline's comments on 1.175 C (2) and (3).

1.175 C (1) Ms. Elaine Saline states that the space requirements are going to place a hardship on present clinic facilities. The rule is based on minimal requirements, recognizing the diversity of facilities where screening programs can be located. The rule refers to "separate areas" not rooms, for screening procedures waiting and play. Space can be divided into "areas" in inexpensive and simple ways.

Existing EPS programs have had no difficulty meeting this requirement, many of which are in available community space as described by Ms. Saline.

Mr. W. A. Wettergren, Minnesota School Boards Association, comments on the following sections of rule:

1.176 C "District" refers to MDH districts, to the title of the MDH District Nursing Consultant in whose district the local program is located.

1.176 D Mr. Wettergren is concerned about the EPS Program approval process as it relates to Preschool Screening. The MDH approval process, as described in Rule 1.175 - 1.178, does not relate to schools engaged only in preschool screening programs. The funding for such programs is governed by Department of Education Rules, currently in the rule-making process.

1.178 C There will be no costs to the school districts as a result of continuing education mandates under this rule. MDH assumes the costs of MDH Continuing Education. Of those programs offered, MDH shall provide continuing education free of charge.

Other concerns for comment:

EPS Rule and relationship to Community Health Services Act; and MDH authority to promulgate rule:

Comments relating to EPS Rule and Community Health Services Act, 1976 (Health Laws, Chapter 9) are contained in letters and testimony.

The EPS Rules are not in conflict with the Community Health Services Act, 1976, which establishes a mechanism and state subsidy funds to develop and maintain an integrated system of community health services under local administration. The rules governing the CHS Act relate to the planning process

and the method for submitting plans for the subsidy funds. All public health programs provided under CHS Act are voluntarily chosen by the CHS agency in keeping with a community participation process. CHS agencies may choose or not choose to develop an EPS program for that county or group of counties.

The definitions of community health services mentioned in the CHS Act serve as a means of identifying areas of public health program which are possible considerations for inclusion in a plan; health screening is listed as possible personal health service which a community nursing program might include.

The CHS Act does not provide any program standards or guidelines for any of the numerous public health programs; thus, these rules do not conflict.

A local CHS agency is free to choose or not choose to offer EPS services; however, if a local CHS chooses to provide EPS and wants to obtain reimbursement from Title XIX or the Preschool Screening Act, it must be approved as defined in these rules.

The following is from the EPS Rule:

> "The purpose and scope of these rules is to establish minimum standards and procedures for MDH approved nurse-administered local provision of comprehensive health screening of children.
>
> These rules apply to those organizations seeking MDH approval in order to qualify for reimbursement by third parties for which such reimbursement requires MDH approval; and constitutes standards for the nurse-supervised EPSDT programs as prescribed in Department of Public Welfare (DPW) Rule and Preschool Screening Program as prescribed in Department of Education (DPE) Rule."

MDH has a memorandum of understanding with the Department of Public Welfare regarding MDH approval of nurse-supervised programs in which MDH shall establish program standards to assure that these programs maintain standards that are equal to or exceed Title XIX standards for screening. DPW refers to such standards in their proposed Rule 61.

The Preschool Screening Law (123.702 - 703, Section 2, supp. 1977) clearly states that all screening components shall be consistent with the standards of MDH for Early and Periodic Screening. These proposed rules attempt to establish these standards.

During the legislative process of the Preschool Screening legislation, Senator John Milton inquired as to MDH need

for rule making authority related to EPS standards. He was assured by the MDH that an EPS rule had not yet been promulgated but the process was under way, based upon the EPS Guidelines which were operative. It was with the understanding that EPS rules were being developed, and that such rules were not specifically mandated in Preschool Screening legislation.

Thus, with the necessity to formally establish screening standards for both the DPW and DPE and in keeping with the intent of the Administrative Procedures Act, it is evident that rules establishing screening standards and procedures are required in order to provide both notice and input from the public. Rules provide a mechanism for assurring the potential consumers that minimum program standards are established and that such standards are perceived as reasonable and acceptable as a public health service. A personal health service such as EPS, which makes judgments about the health and developmental status of individual children should have established, well defined and consistent standards. To do less would be to jeopardize the public and the well-being of the children of Minnesota.

The EPS Rule establishes program approval process and a mechanism of redress for the local program which may dispute a decision made by MDH in the approval process.

The authority to promulgate rule under 144.10; 144.11 (1976) is questioned in the letter from Le Sueur Waseca Board of Health because there is not expenditure of Maternal and Child Health funds at the local level. MCH federal funds are provided to augment CHS appropriations. At the local level and during the years 1975 and 1976, MCH Title V dollars were available to local programs through a cost-sharing plan.

In addition, Title V, Maternal and Child Health monies are utilized to provide training, evaluation and technical assistance to local programs and this is specifically addressed as a requirement in 144.10. The guidelines for the EPS Program have been included as part of the approved Maternal and Child Health State Plan and as MCH agencies with approved EPS programs and who meet merit system requirements are eligible for inclusion as mandatory, state matching funds and maintenance level of effort for Title V.

144.11 (1976) and 144.12 (1977) states that Board of Health as amended in 1977 the Commissioner, may make rules in order to carry out the provisions of 144.10.

EPS Procedures Manual

There were comments that questioned the incorporation of EPS Procedures Manual by reference into EPS Rule, because there has not been an opportunity to review the manual prior to rule hearing.

The 1977 edition of EPS Procedures Manual is simply an edited, reorganized edition of the previous manual which has been distributed and in use for the past one and one-half years by approved EPS agencies. There are not any substantive changes in the EPS Procedures Manual (1977 edition). There was an extended input by nurses and other health professionals on the drafting of the previous edition of the manual. We regret that there were not more copies available at the EPS Hearing but the Department has had unpredicted problems with the printer. Copies were available for inspection and copying on the day of the hearing. Subsequent to the hearing we have xeroxed many copies and sent to them to those who have requested the manual, as well as to several of the approved EPS programs. By February 21, we expect to have EPS manuals available for all approved programs and others who may request copies.

There was a statement made that inclusion of the EPS Procedures Manual is counter-productive as the state of the art is such that there will be changes in the manual and any subsequent changes will require a rule hearing to amend the rule.

In response, the MDH offers the following comments. The EPS Procedures Manual, in general, serves as an extensive "how to" manual which is divided into two sections:

I. Community Planning
II. Screening Procedures

Section II, as part of describing "how to" do the screening procedures contains the specific EPS referral criteria for each of the tests and assessments. The referral criteria are an essential part of the tests and assessments, as these criteria are the basis for determining whether a child's findings fall in the normal range or needs referral for further evaluation, diagnosis and treatment.

Given the essential nature of the criteria and the importance to keep them as part of the descriptive procedures for each test and assessment, it seemed more appropriate to incorporate by reference the EPS Procedures Manual, 1977 edition, as well as the DDST Manual (1977 edition) and VASC Manual (1977 edition) rather than incorporate all of the detailed referral criteria in the body of the rule. The rule then would become very lengthy and unwieldy. On this basis, MDH sought permission of the Hearing Examiner to include the above mentioned documents by reference.

The referral criteria contained in this manual are incorporated by reference whereas other parts of the manual are procedural, non-mandatory and don't effect approval or disapproval.

It is, therefore, reasonable that if changes in selected forms, e.g., health histories and other sections of the manual that do not relate to referral criteria are required, these may be changed without having to proceed with the rule-making process.

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RECEIVED
FEB 22 1978
OFFICE OF HEARING
EXAMINERS

February 22, 1978

Mr. Peter Erickson
Hearing Examiner
Office of Hearing Examiners
Room 300 - 1745 University
St. Paul, Minnesota 55104

Re: Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

Dear Mr. Erickson:

On behalf of the Minnesota Department of Health, I respectfully submit several comments for your consideration prior to the close of the record in the above-referenced matter. I will be addressing those areas about which some citizens voiced concern with these rules. Nonetheless, I would ask that you recognize the many comments which were received in support of the rules in general and in particular. Indeed, much of the testimony received at the public hearing on February 2, 1978, as well as subsequent correspondence endorse the rules in concept and in application. Unfortunately, many people who are not opposed to a proposed set of rules or support a proposed set of rules do not offer either oral or written public testimony inasmuch as they feel such offering is unnecessary. I think the number of persons and agencies which stepped forward to speak in favor of these rules in relation to the relatively few and specific remarks critical of the rules is significant.

The Statement of Need filed in support of these rules addresses the legal authority of the Commissioner of Health to propose and adopt these rules. It is not my intention to repeat the substance of that document in asserting the authority for these rules. Nonetheless, some comments were received prior and subsequent to the public hearing which merit response.

Some citizens indicated that proposed rules are not needed since the unpromulgated guidelines and standards used by the health department for the previous two years in approving early and periodic screening programs are sufficient. For example, in a letter dated February 16, 1978, from Mary J. Ripphe to the hearing examiner, it is stated that:

It is the responsibility of MHD to approve nurse-supervised EPS and EPSDT clinics. In order to do this, the Department of Health can set forth standards by which the clinics must abide, but to write rules as such is out of the realm of MHD responsibility.

Clinics and screening programs wishing to receive reimbursement for screening must secure approval from the Department of Health. It is precisely because the Department is required to approve or disapprove EPS programs that criteria and procedures in granting approval or disapproving clinics must be specified in rule form. As a matter of convenience for the agency, the easiest method to approve or disapprove agencies seeking approval is to rely upon unpromulgated "guides" which may be established and changed at will without notice to or input from the public according to the desires of the bureaucrats making the decisions. Inasmuch as Minn. Stat. § 15.0412 subd. 3 (Supp. 1977) requires that the Department adopt rules setting forth the nature and requirements of all formal and informal procedures related to its official duties, the Department is proposing these rules to comply with the administrative procedure act. Furthermore, the Department firmly believes that citizens are entitled to adequate notice of and input about those criteria which will apply to programs seeking approval. In the absence of rules which would bind the Department of Health in reviewing applications for approval, the discretion left within the Department to approve or disapprove a early and periodic screening program is both vast and vague and leaves a potential for abuse and unequal treatment. Frankly stated, these rules are necessary to protect the public from bureaucratic whim in selecting which agencies will be favored with approval and which will not. Agencies seeking approval are notified of standards and procedures in advance. Citizens using the services of the agencies can rest secure in the knowledge that an approved program complied with a set of predetermined criteria which survived the scrutiny of the rule making process.

One person, in questioning whether or not federal funds are involved in the administration of EPS programs, challenged the authority of the Commissioner under Minn. Stat. § 144.11 (1976) to promulgate rules enforcing Minn. Stat. § 144.10 (1976) relating to federally funded child welfare and public health services. Pursuant to 42 USCA § 701-703, 705-713 (1974) and regulations promulgated thereunder, 42 CFR §§ 51a.101-51a.143, Minnesota has received federal monies for maternal and child welfare services. The Minnesota Department of Health is the state agency designated by the U.S. to administer and supervise the administration of the state plan which provides for preventive health services to children and for training of personnel dealing with children.

An Assistant Polk County Attorney alleges in a letter to you on January 5, 1978, that Minn. Stat. § 144.12 (Supp. 1977) enumerates the exclusive subjects of the health Commissioner's regulatory authority. I would respectfully disagree with this opinion. Minn. Stat. § 144.12 (Supp. 1977) does not purport to be exclusive with regard to other statutes granting his authority to promulgate rules, nor according to the terms of the statute itself. This statute states in relevant part as follows:

> The Board may adopt, alter, and enforce reasonable regulations of permanent application throughout the whole or any portion of this state or for specified periods in parts thereof, for the preservation of the public health. . . . The Board may control, by adoption of regulations, by requiring the taking out of licenses or permits, or by other appropriate means, any of the following matters: [followed by 16 enumerated items]

A clear reading of the statute indicates that the 16 enumerated items refer to those matters which the Commissioner can require the taking out of a license or permit. No one claims that the Department will "license" early and periodic screening programs who wish to screen children. The Department never has claimed nor asserted such broad authority. The enumerated items in the statute refer only to those areas such as migrant labor camps which the Board could regulate by requiring the taking out of a license. On the other hand, the first part of the statute is broad and generic. Unquestionably, these proposed rules would preserve the public health as indicated in the Statement of Need and the Statement of Justification. Furthermore, a reading of chapter 144 indicates that the Commissioner of Health has authority under other statutes to promulgate rules. A reading of Minn. Stat. §§ 144.10, 144.11, 144.06, 144.07 and 144.09 are but a few examples of other statutes wherein the Commissioner of Health is given authority to promulgate rules.

Several comments were received concerning the incorporation of the early and periodic screening manual into the proposed rules. The remarks received from the public generally stated that either that there should be no incorporation inasmuch as it would be too difficult to amend the manual in the future or that there was an inadequate opportunity to review the manual. Interestingly enough, it does not appear that the substance of the criteria themselves raised serious objections. If the Department does not incorporate any of the manual into rule, those criteria which are essential to an effective screening program would not be enforceable, and agencies seeking approval need not comply with the criteria.

However, the incorporation by reference of the EPS manual into rule does not tie either the Department or the agencies into such a manual forever. As technology increases and the art, knowledge and skill necessary for screening improves, the rules can be amended. Admittedly, rule making is not an easy process. However, in the absence of incorporating the manual into the rule by reference, the public could be precluded from participating in any changes which might take place in the manual. By incorporating the manual into the rule, any proposed changes will require notice to the public and input from the public with regard to the changes. It is hoped that the incorporation of the manual into rule provides the necessary flexibility to keep pace with developments in the art and science of medical and nursing assessments, as well as a sufficient legal base to require the Department to comply with and apply its own rule.

Several comments were received by members of the public who claimed that the availability of the manual prior to, during and subsequent to the hearing has been insufficient. As a matter of substance, a 1977 EPS procedure manual is essentially the same manual which has been used by approved EPS agencies throughout the state since 1976. The original manual, written in 1974, was reorganized and edited in the fall of 1977. However, it is my understanding that no substantive changes were made in the 1977 edition. Indeed, no one has claimed any substantive difference exists among different editions of the manual.

Minn. Stat. § 15.0412 subd. 4 (Supp. 1977) states in relevant part that the chief hearing examiner may incorporate by reference materials which he determines are ". . . conveniently available for viewing, copying and acquisition by interested person." With regard to the procedure, it should be pointed out that representatives from the Department of Health met with the Chief Hearing Examiner on November 28, 1977 and presented to him the "Early and Periodic Screening Procedures Manual, 1977." Chief Hearing Examiner Harves authorized the incorporation by reference of this document on December 6, 1977, almost two months prior to the rules hearing. The notice of hearing which included the rules making specific reference to the procedures manual was sent out and published well before 30 days prior to the hearing. The manual was available for viewing, copying and acquisition prior to, during and subsequent to the hearing. At the hearing, many copies of the manual were distributed. A public announcement was made that the manual was readily available and could be inspected and copied. Furthermore, a list was distributed on which persons could ask to have a copy of the manual distributed to them free of charge following receipt of the state printer's edition. Subsequent to the hearing, those who signed up to receive copies

of either the entire manual or selected portions of the manual have been sent such copies, although the state printer has still not returned the number of copies ordered by the Department of Health. Some xeroxed copies of the manual were sent to approved EPS programs although they did not so request. It is the Department's belief that it has complied with the administrative procedure act in the incorporation by reference of this manual, and has made the manual available for inspection, copying and has done all it can do to insure distribution of the manual to any who have requested it. Ideally, the state printer would have completed printing all the number of copies ordered by the Department of Health. However, this is a matter over which the Department has little control. The Department served anybody who asked to see and copy the manual and has copied and supplied the manual to anyone who requested it free of charge.

Finally, as the hearing examiner is aware, an amendment to proposed 7 MCAR § 1.175(2)(b) was made. Other minor amendments have been made during the course of the hearing process upon public recommendations. It is the Department's position that these amendments are offered primarily to clarify rules which may have been ambiguous and to specify rules which may have been vague or confusing. The Department submits that none of these amendments, if adopted, would constitute a proposed final rule which is substantially different from that which was proposed. None of the amendments affects a class of persons not represented at the hearing on February 2. None of the amendments go to a new subject matter of significant substantive effect. For example, the proposed amendment with regard to immunizations in 7 MCAR § 1.175(2)(b) relates to immunizations and requirements of EPS screening programs with regard to those immunizations. The amendment goes merely to the site. The amendments do not make a major substantive change that was not raised by the original notice of hearing in such as way as to invite reaction at the hearing or result in a rule fundamentally different from that contained in the notice of hearing. Indeed, every amendment which is offered in a proposed final rule was raised by either members of the public or by the Department at the hearing with substantial public support.

Thank you.

Very truly yours,

TERRY P. O'BRIEN
Special Assistant
Attorney General

TPO:ss
cc: Grace Gumnit
Ron Campbell, M.D.
Sheila Swaiman

ADMIN 1009 (REV. 4/77)

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT HEALTH-PHS/MCH

RECEIVED
FEB 22 1978
OFFICE OF HEARING EXAMINERS

DATE: February 22, 1978

TO : Mr. Peter Erickson
Hearing Examiner
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

FROM : Dr. Ronald Campbell, Chief RJC
Section of Maternal and Child Health

PHONE: 296/5265

SUBJECT: Supplement to February 17, 1978 Response of Minnesota Department of Health Relative to Hearing Testimony and Letters Sent to the Hearing Examiner Regarding 7 MCAR 1.174 - 1.178

7 MCAR § 1.174 B.3. "Approved Program"

In her memorandum of February 19, 1978, Ms. JoAnne Fasching states that "private practitioners, clinics, and hospital out-patient departments should be able to become qualified vendors of EPS for the purpose of providing screening to non-title XIX persons on a sliding fee scale basis"

The definition of "approved program" does not exclude the types of providers suggested by Ms. Fasching. Specifically under 7 MCAR § 1.174 B.3. the Rule states that "approved program" means a screening program which offers regularly scheduled comprehensive health screening for children from birth through 20 years of age, in accordance with the standards contained in Rule 7 MCAR § 1.175 and which has been approved by MDH".

7 MCAR § 1.175 A.1. "An outreach component which shall include a demonstrated ability to stimulate or encourage participation in the screening program."

In her memorandum of February 19, 1978, Ms. Fasching states that "Outreach need not be developed by each applicant -- as this should be the responsibility of the county health and welfare agencies." . . .

The Department agrees that county welfare agencies are responsible for outreach to Title XIX eligible children. However, the EPS Program also serves other children and there is no county health agency that we are aware of that has or plans a program of outreach to these children for other vendors. Hence, it is appropriate that outreach be provided by the approved program in cooperation with the county welfare agency.

7 MCAR § 1.175 A.2. ". . . Referrals resulting from the assessment and testing shall be based on referral criteria as stated in 1977 EPS Procedures Manual."

Several letters questioned the incorporation by reference of the 1977 EPS Procedures Manual into the EPS Rule. These letters were concerned with the procedure of incorporation, and an appropriate response related to procedure was prepared by Ms. Swaiman in her letter of February 17, 1978. It is important to note that none of the letters questioned the substance of the referral criteria contained in the 1977 EPS Procedures Manual; yet it was this substance which was incorporated into the Rule by reference.

These criteria have been operative for the past 18 months in previous drafts and there has been no substantial change in the final 1977 edition from these drafts.

7 MCAR § 1.175 A.2.j 2) "Muscle balance screening procedures include at least observation, cover test, Hirschberg test and the Worth 4-Dot Test."

Dr. Letson in his letter of February 21 suggests that this be amended to read "Muscle balance screening procedures include at least observation, cover test, and the Hirschberg test. The Worth 4-Dot test may be used for children age five or over who are cooperative." Dr. Anderson in his letter of February 15 suggests that following the words "Worth 4-Dot Test" be added the following "for a child age 6 years or older". He further states "we made this suggestion after reviewing the determination of the Board of Directors of PreSchool Medical Survey of Vision and Hearing and the Academy of Ophthalmology and Otolaryngology that the Worth 4-Dot is not a valid screening tool for a child under the age of 6 years."

The experience of the Department's Vision and Hearing Conservation staff supports use of the Worth 4-Dot for children younger than 5-6 years. However, we recognize that significant expertise recommends that the test not be initiated until age 5-6 years. Accordingly, we accept Dr. Letson's proposed language. Because this language directs that the test be administered to children age 5 and over "who are cooperative" we believe Dr. Letson's proposed language will also reflect Dr. Anderson's concerns.

Page 149 of the EPS Procedures Manual would also be amended to reflect this proposed change in the Rules.

7 MCAR § 1.175 A.2.j3) "Test for visual acuity. A test, as appropriate for the child's age, such as the Screening Test for Young Children and Retardates (STYCAR), the Snellen E Cube, the Snellen Alphabet Chart, and plus lenses shall be used".

In his letter of February 21, Dr. Letson proposes that this language be amended as follows:

1. delete "as appropriate for the child's age"
2. delete "and plus lenses shall be used"
3. add "Snellen E Chart or "before "the Snellen Alphabet Chart"

The Department maintains that the phrase "as appropriate for the child's age" must be maintained as not all tests described in the EPS Procedures Manual are appropriate for all ages. Specific recommended age ranges are contained within the Manual.

From our conversation with Dr. Letson we do not believe that he intended to delete the plus lense test but rather to assure that it not be provided to pre-schoolers. Because the EPS Procedures Manual does not recommend administration of the test until age 6 years and because we have found the test to be appropriate from our experience for children 6-21 years, we maintain that the Rule should not be changed in this regard.

We concur with Dr. Letson's addition of the "Snellen E Chart". We had intended to include it in the Rule; its omission was inadvertent.

7 MCAR § 1.175 A.3. "The assessment and tests listed above shall be available on the following periodic schedule".

In her memorandum of February 19, 1978, Ms. Fasching states "Urine-Hematocrit-And Tuberculin tests should all be checked at each 3 year visit - from 3-21 years. Before age 3 they should be done yearly if possible" . . . "These tests are inexpensive and easy to administer, and so cannot be ruled out on that basis. On the other hand, the benefit of early discovery of any problem out weighs any inconvenience in offering them at each visit."

The Department disagrees with Ms. Fasching and is supported in this regard by the American Academy of Pediatric recommendations for EPSDT and the Department's pediatric advisors. Neither of these resources recommend screening with the frequency suggested by Ms. Fasching. In selecting the age intervals for various tests, considerations of cost and ease of testing must not be considered apart from other variables such as the probability that new abnormalities will be discovered at certain age intervals. When these other kinds of variables are considered there is much less justification for regular screening.

In his letter of February 15, 1978, Dr. Anderson states that "In that Chart (EPS Periodicity Chart) urine and tuberculin testing is required one time. However, whether one testing is enough can vary. For a high risk, high exposure situation, it would not be enough. We, therefore, recommend adding the work "minimum" following the words "urine (Bililabstix) " and "Tuberculin" in the chart.

The Department agrees that the frequency for testing should be increased for high risk, high exposure situations not only for these tests but for others on the chart as well. However, the intent of the chart is to demonstrate minimal requirements applicable to most of the population. Testing with a frequency beyond that identified in the chart is best determined on an individual child basis drawing upon the professional judgment of the screener. This intent is reflected in both the EPS Procedures Manual and the EPS Training Seminar. Hence, we do not believe that the suggested change in the chart is appropriate.

In his letter of February 15, 1978, Dr. Anderson states "there is considerable question of the value of the bacteriuria test and we also recommend that this procedure be struck from the chart."

The Department is aware that many physicians question this test and accordingly page 218 of the EPS Procedures Manual states"the recommendation of this test assumes that referred children will receive further evaluation and treatment. However, in some communities physicians may consider that treatment is not indicated for asymptomatic bacteriuria and, hence, that this condition is not appropriate for screening. Accordingly, the local agency may wish to consult with the local medical

society regarding use of this procedure. Thus, this test is included in EPS as a local option. We have maintained bacteriuria screening in the EPS Program for the following reasons:

1. The American Academy of Pediatrics standards for EPSDT include it,

2. Frankenburg recommends it in his book "Pediatric Screening Tests",

3. Pediatric advisors to the Department recommend it,

4. A special study documenting the efficiacy of the Culturia Assay method was prepared for the Department by Dr. Amos Deinard, Department of Pediatrics, University of Minnesota.

7 MCAR § 1.175 A. 5. "A referral component which shall include an organized system of arranging for children with problems identified through screening to be seen by an appropriate resource for evaluation, diagnosis, or treatment. Arrangements shall be made to establish all children who have been screened with ongoing health care services."

In his letter of February 15, 1978, Dr. Anderson suggests deletion of the last sentence of Part 5. and the addition of a new section before Part 5. to read "A continuous care component which shall arrange ongoing health care services through a personal physician for all children who have been screened." He defines personal physician as "a physician who assumes responsibility for the comprehensive medical care of an individual on a continuing basis."

The Department concurs with Dr. Anderson's intent that "Our sincere concern is not only that a child enter into the health care system, but that the child receive ongoing, continuous care" and it was with this in mind that the Rule was drafted. We believe that the existing language is appropriate in this regard as it recognizes the variety of methods by which ongoing services can be provided to children.

We feel that Dr. Anderson's proposed amendment is deficient in that it accommodates only one kind of ongoing health care service, that provided by the personal physician. This amendment fails to recognize other kinds of providers of ongoing health care services such as the pre-paid Health Maintenance Organization and the Children and Youth Project. It also does not provide for the ongoing dental health care services which we consider important. Accordingly, we cannot accept the proposed amendment.

Dr. Anderson also recommends that this section be amended by adding the following after the word "treatment": "Whenever the child has a personal physician, that physician shall be notified of the referral."

The Department strongly concurs with Dr. Anderson and accordingly proposes the Anderson language, slightly amended for clarity as follows: "Whenever the child identifies a personal physician, that physician shall be notified of the referral."

7 MCAR § 1.175 A. 6. a. 1) "Written and formal arrangements with other agencies such as the county welfare departments."

In the February 17, 1978 letter from Wright County Community Nursing Service, it was stated this "could be a disadvantage when excellent informal arrangements with other agencies are in existence."

The Department disagrees that written agreements could be a disadvantage to all the involved parties, but acknowledges there could be instances in which no significant advantage would be obtained through written agreements. However, in the development of new programs or in changing existing programs that affect more than one agency, it has been our experience that a written understanding offers significant advantages. Hence, we believe that written interagency agreements are appropriate for the EPS Program.

7 MCAR § 1.175 B "Personnel for EPS Screening of Children."

In the February 17, 1978 letter from the Wright County Community Nursing Service, it was stated that "no qualifications for EPS clinic coordinator are included but

very specific qualifications for other personnel are included. We would question the clinic coordinator's authority to determine the effectiveness of the nurse in working with children."

The Department agrees that for some personnel, specific minimal qualifications are listed whereas for others only responsibilities are listed. This was done so that the approved program could have maximum flexibility in personnel selection without loss of quality. The responsibilities described for clinic coordinator do not, in our opinion, address evaluation of the nurses' capabilities.

7 MCAR § 1.176 C. 1. "A Statement of Need for EPS - ... "The application shall include at least the following information ..."

In his letter of February 15, 1978, Dr. Anderson suggests that a sub-subdivision (f) be added as follows: "The identification of existing and ongoing health care services including personal physicians, in the community to prevent duplication of services and care and how this proposed program will coordinate and utilize this existing network."

The Department concurs that it is not the intent of EPS to screen children who have already received appropriate screening services. Because physicians are providers of these services, we agree that this proposed addition to the Rules is appropriate for clarification.

7 MCAR § 1.176 D. 2. a. "Upon completion of application, training, the initial screening session, and a satisfactory EPS Consultant report, the Commissioner of Health may grant provisional approval to the applicant prior to any other screening of children by the application ..."

In her memorandum of February 19, 1978 Ms. Fasching states that "Upon receipt of plan, MDH should review and decide upon provisional approval and notify applicants within three weeks from date plan is received."

The Department agrees that provisional approval, if appropriate, should be communicated in a timely fashion and believes that this is usually the case. Often, however, there is the need for clarification and possibly technical consultation before this action can be taken. Hence, it would be undesirable to have an inflexible time frame which may not allow complete review of an application.

7 MCAR § 1.178 C. "Approved programs shall assure that EPS Personnel obtain continuing education in order to maintain or improve clinical skills. This training may be provided by MDH or the University of Minnesota, School of Public Health." ...

In her memorandum of February 19, 1978, Ms. Fasching states that "other programs and resources for further education should be allowed other than just MDH and the University of Minnesota."

The Department agrees and believes that the language in Part C. above permits this flexibility.

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March 21, 1978

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Room 300 - 1745 University
St. Paul, Minnesota 55104

Re: In the Matter of the Proposed Rules of the Minnesota Department of Health Relating to the Approval of Early and Periodic Health and Developmental Screening Programs

Dear Mr. Erickson:

As you are aware, comments were received by the public with regard to the incorporation by reference of sections of the early and periodic screening manual proposed in 7 MCAR §§ 1.175A.2 and 1.178B and its accompanying footnote. In view of the response from some members of the public, I am authorized to state that it is the intent of the Commissioner of Health to withdraw from the final rules proposed 7 MCAR §§ 1.174B.8 in its entirety, and the last sentence lead-in of 1.175A.2 which refers to the manual as well as the first sentence of 1.178B and its accompanying footnote.

It is our opinion that the Department of Health complied with statute and rule in proposing to incorporate portions of the EPS Procedures Manual into its rule. Nonetheless, as I indicated to you during our phone conversation of March 16, 1978, it is the Department's position that while fairness is required in the promulgation of rules, the appearance of fairness is necessary to the effective functioning of government. As indicated in my letter to you dated February 2, 1978, the Department complied with Minn. Stat. § 15.0412 subd. 4 (Supp. 1977); it made specific reference to the procedures manual in the notice of hearing; it made the manual available for viewing and copying throughout these proceedings. Nonetheless, there has been a misunderstanding as to which parts of the manual were to be incorporated by reference into the rule, as well as a delay on the part of the state printer in completing the manual for actual distribution in sufficient quantities to everyone prior to the hearing.

It has always been the Commissioner's intent to allow as wide a public input as possible with regard to all matters in these proposed rules so that he may make his final decision based upon the best evidence available. Accordingly, he has decided to withdraw the sections of the proposed rules as indicated hereinabove, and submit these sections for further hearing at a future time. Nonetheless,

because of the importance of the program, he will not be withdrawing other sections of the rules. Hopefully, EPS rules will be instituted without reference to the EPS manual so as to permit the Department to approve programs in order that they might secure the funds to operate the programs.

Thank you for your attention.

Very truly yours,

TERRY P. O'BRIEN
Special Assistant
Attorney General

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