

1.1 Senator moves to amend S.F. No. 4691 as follows:

1.2 Page 1, delete section 2 and insert:

1.3 "Sec. 2. Minnesota Statutes 2024, section 13.384, subdivision 3, is amended to read:

1.4 Subd. 3. **Classification of medical data.** Unless the data is summary data or a statute
1.5 specifically provides a different classification, medical data are private but are available
1.6 only to the subject of the data as provided in sections 144.291 to 144.298, and shall not be
1.7 disclosed to others except:

1.8 (a) pursuant to ~~section~~ sections 13.05 and 13.46;

1.9 (b) pursuant to section 253B.0921;

1.10 (c) pursuant to a valid court order;

1.11 (d) to administer federal funds or programs;

1.12 (e) to the surviving spouse, parents, children, siblings, and health care agent of a deceased
1.13 patient or client or, if there are no surviving spouse, parents, children, siblings, or health
1.14 care agent to the surviving heirs of the nearest degree of kindred;

1.15 (f) to communicate a patient's or client's condition to a family member, health care agent,
1.16 or other appropriate person in accordance with acceptable medical practice, unless the
1.17 patient or client directs otherwise; or

1.18 (g) as otherwise required by law."

1.19 Page 8, line 12, delete everything after "data" and insert "as provided in subdivision 14."

1.20 Page 8, delete lines 13 to 30 and insert:

1.21 "Sec. 5. Minnesota Statutes 2024, section 13.46, is amended by adding a subdivision to
1.22 read:

1.23 Subd. 14. **Direct Care and Treatment.** (a) Notwithstanding sections 144.291 to 144.298,
1.24 Direct Care and Treatment may disclose data pursuant to subdivision 2 and as otherwise
1.25 permitted by law.

1.26 (b) Direct Care and Treatment is not required to share with federal law enforcement data
1.27 on individuals collected, maintained, used, or disseminated by Direct Care and Treatment
1.28 that relate to the reporting of suspected crime unless specifically required to do so by a
1.29 Minnesota or federal law.

2.1 (c) Direct Care and Treatment may disclose welfare system data held by the agency to
2.2 facilitate coordination of guardianship services for Direct Care and Treatment clients,
2.3 including but not limited to making disclosures in guardianship proceedings, identifying
2.4 potential guardians, communicating with guardianship legal representation, and reporting
2.5 complaints to the Minnesota Judicial Branch or the Office of Ombudsman for Mental Health
2.6 and Developmental Disabilities. Direct Care and Treatment must obtain the client's consent
2.7 for a disclosure made pursuant to this paragraph except when the client:

2.8 (1) lacks capacity to provide the consent; or

2.9 (2) has a current legal guardian who is unavailable, is nonresponsive, or refuses to
2.10 authorize the disclosure in relation to complaints to the Minnesota Judicial Branch or Office
2.11 of Ombudsman for Mental Health and Developmental Disabilities.

2.12 Sec. 6. Minnesota Statutes 2024, section 182.6545, is amended to read:

2.13 **182.6545 RIGHTS OF NEXT OF KIN UPON DEATH.**

2.14 In the case of a death of an employee, the department shall make reasonable efforts to
2.15 locate the employee's next of kin and shall mail to them copies of the following:

2.16 (1) citations and notification of penalty;

2.17 (2) notices of hearings;

2.18 (3) complaints and answers;

2.19 (4) settlement agreements;

2.20 (5) orders and decisions; and

2.21 (6) notices of appeals.

2.22 In addition, the next of kin shall have the right to request a consultation with the
2.23 department regarding citations and notification of penalties issued as a result of the
2.24 investigation of the employee's death. For the purposes of this section, "next of kin" refers
2.25 to the nearest proper relative as that term is defined by section 253B.03, subdivision 6,
2.26 paragraph ~~(b)~~ (a), clause (3).

2.27 Sec. 7. Minnesota Statutes 2024, section 253B.03, subdivision 6, is amended to read:

2.28 Subd. 6. **Consent for medical procedure.** (a) For purposes of this subdivision, the
2.29 following terms have the meaning given:

3.1 (1) notwithstanding section 253B.02, subdivision 10, "interested person" has the meaning
3.2 given under section 524.5-102, subdivision 7;

3.3 (2) notwithstanding section 253B.02, subdivision 15, "patient" includes a person
3.4 committed under chapter 253D who is in a state-operated treatment program; and

3.5 (3) "proper relative" means, in the following order, the patient's spouse, parent, adult
3.6 child, or adult sibling.

3.7 (b) A patient has the right to give prior consent to any medical or surgical treatment,
3.8 including but not limited to surgery, other than treatment for chemical dependency or
3.9 nonintrusive treatment for mental illness.

3.10 ~~(b)~~ (c) The following procedures shall be used to obtain consent for any treatment
3.11 necessary to preserve the life or health of any committed patient:

3.12 (1) the written, informed consent of a competent adult patient for the treatment is
3.13 sufficient;

3.14 (2) if the patient is subject to guardianship which includes the provision of medical care,
3.15 the written, informed consent of the guardian for the treatment is sufficient;

3.16 (3) if the head of the treatment facility ~~or state-operated treatment program~~ determines
3.17 that the patient is not competent to consent to the treatment and the patient has not been
3.18 adjudicated incompetent, written, informed consent for the ~~surgery or~~ medical treatment
3.19 shall be obtained from the person appointed the health care power of attorney, the patient's
3.20 agent under the health care directive, or the nearest proper relative. ~~For this purpose, the~~
3.21 ~~following persons are proper relatives, in the order listed: the patient's spouse, parent, adult~~
3.22 ~~child, or adult sibling.~~ If the nearest proper ~~relatives~~ relative cannot be located, ~~refuse~~ refuses
3.23 to consent to the procedure, or ~~are~~ is unable to consent, the head of the treatment facility ~~or~~
3.24 ~~state-operated treatment program~~ or an interested person may petition the committing court
3.25 for approval for the treatment or may petition a court of competent jurisdiction for the
3.26 appointment of a guardian. The determination that the patient is not competent, and the
3.27 reasons for the determination, shall be documented in the patient's clinical record;

3.28 (4) for patients in a state-operated treatment program, if (i) the patient does not have a
3.29 health care power of attorney or an agent under a health care directive or the patient's health
3.30 care agent is not reasonably available to make the necessary health care decision for the
3.31 patient, and (ii) the patient's treating physician determines that the patient lacks
3.32 decision-making capacity to consent to the medical treatment, the state-operated treatment

4.1 program must make a good faith attempt to locate the patient's nearest proper relative to
4.2 obtain written informed consent for the medical treatment;

4.3 (5) if the state-operated treatment program is unable to reasonably locate a proper relative,
4.4 the executive medical director has decision-making authority for the health care decision
4.5 for the patient subject to the provisions under subdivision 6e;

4.6 (6) if the state-operated treatment program consults with the patient's nearest proper
4.7 relative under clause (4) and the patient's nearest proper relative and the patient's treating
4.8 physician are not in agreement with respect to a medical treatment decision, the state-operated
4.9 treatment program or an interested person may petition the committing court for approval
4.10 of the treatment. The state-operated program may also petition a court of competent
4.11 jurisdiction for the appointment of a guardian at any time. If a court determines that a patient
4.12 is not competent, the determination and the reasons for the determination must be documented
4.13 in the patient's clinical record;

4.14 ~~(4)~~ (7) consent to treatment of any minor patient shall be secured in accordance with
4.15 sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization,
4.16 routine diagnostic evaluation, and emergency or short-term acute care; and

4.17 ~~(5)~~ (8) in the case of an emergency when the persons ordinarily qualified to give consent
4.18 cannot be located in sufficient time to address the emergency need, the head of the treatment
4.19 facility or state-operated treatment program may give consent.

4.20 ~~(e)~~ (d) No person who consents to treatment pursuant to the provisions of this subdivision
4.21 shall be civilly or criminally liable for the performance or the manner of performing the
4.22 treatment. No person shall be liable for performing treatment without consent if written,
4.23 informed consent was given pursuant to this subdivision. This provision shall not affect any
4.24 other liability which may result from the manner in which the treatment is performed.

4.25 Sec. 8. Minnesota Statutes 2024, section 253B.03, is amended by adding a subdivision to
4.26 read:

4.27 Subd. 6e. **Health care decisions made by executive medical director.** (a) For purposes
4.28 of this subdivision, the following terms have the meanings given:

4.29 (1) notwithstanding section 253B.02, subdivision 10, "interested person" has the meaning
4.30 given under section 524.5-102, subdivision 7; and

4.31 (2) notwithstanding section 253B.02, subdivision 15, "patient" includes a person
4.32 committed under chapter 253D who is in a state-operated treatment program.

5.1 (b) Any health care decision made by the executive medical director under subdivision
5.2 6, paragraph (c), clause (5), must be consistent with any documented patient health care
5.3 directive and with reasonable medical practice and applicable law.

5.4 (c) Before proceeding with treatment under subdivision 6, paragraph (c), clause (5), a
5.5 state-operated treatment program must inform the patient of the determination by the patient's
5.6 treating physician that the patient lacks decision-making capacity to consent to the medical
5.7 treatment, the proposed treatment, and the right to request review. Upon the request of the
5.8 patient or an interested person a second physician not directly involved in the patient's
5.9 current treatment must review the incapacity determination. The executive medical director
5.10 must review the proposed treatment decision and the second physician's review of the
5.11 incapacity determination and make an updated determination. A state-operated treatment
5.12 program may proceed with treatment of the patient while a review under this paragraph is
5.13 pending.

5.14 (d) When a determination is made under paragraph (c), the state-operated treatment
5.15 program must document the following information in the patient's clinical record:

5.16 (1) the determination of incapacity and the clinical basis for the determination;

5.17 (2) the specific treatment authorized;

5.18 (3) the person who provided consent or who made the determination allowing the
5.19 treatment;

5.20 (4) the efforts made to locate and consult with a health care agent or nearest proper
5.21 relative; and

5.22 (5) the patient's expressed preferences regarding the treatment, if known, and how the
5.23 preferences were considered.

5.24 (e) The executive medical director must review a determination that a patient lacks
5.25 capacity periodically as medically appropriate, but not less than every six months. The
5.26 outcome of a review under this paragraph must be documented in the patient's clinical
5.27 record.

5.28 (f) If a patient or interested person is dissatisfied with the outcome of the review under
5.29 paragraph (c), the patient or interested person may petition the committing court under
5.30 section 253B.17 for review of the incapacity determination made under paragraph (c). Filing
5.31 a petition under section 253B.17 does not stay treatment under this subdivision unless
5.32 otherwise ordered by the court. In reviewing the executive medical director's decision under
5.33 paragraph (c) and issuing a determination, the court must determine if the patient lacks

6.1 capacity. If the patient lacks capacity, the court must determine if the patient clearly stated
6.2 what the patient would choose to do in the situation when the patient had the capacity to
6.3 make a reasoned decision. Evidence of the patient's wishes may include written instruments,
6.4 including a durable power of attorney for health care under chapter 145C or a declaration
6.5 under section 253B.03, subdivision 6d. If the court finds that the patient clearly stated what
6.6 the patient would choose to do in the situation, the patient's wishes must be followed. If the
6.7 court determines that the evidence of the patient's wishes regarding the situation are
6.8 conflicting or lacking, the court must make a decision based on what a reasonable person
6.9 would do, taking into consideration:

6.10 (1) the patient's family, community, moral, religious, and social values;

6.11 (2) the medical risks, benefits, and alternatives to the proposed treatment;

6.12 (3) past efficacy and any extenuating circumstances of past experience with the particular
6.13 medical treatment; and

6.14 (4) any other relevant factors.

6.15 Sec. 9. Minnesota Statutes 2025 Supplement, section 253B.18, subdivision 6, is amended
6.16 to read:

6.17 Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is
6.18 dangerous to the public shall not be transferred out of a secure treatment facility unless it
6.19 appears to the satisfaction of the executive board, after a hearing and favorable
6.20 recommendation by a majority of the special review board, that the transfer is appropriate.
6.21 Transfer may be to another state-operated treatment program. In those instances where a
6.22 commitment also exists to the Department of Corrections, transfer may be to a facility
6.23 designated by the commissioner of corrections.

6.24 (b) The following factors must be considered in determining whether a transfer is
6.25 appropriate:

6.26 (1) the person's clinical progress and present treatment needs;

6.27 (2) the need for security to accomplish continuing treatment;

6.28 (3) the need for continued institutionalization;

6.29 (4) which facility can best meet the person's needs; and

6.30 (5) whether transfer can be accomplished with a reasonable degree of safety for the
6.31 public.

7.1 (c) If a committed person has been transferred out of a secure treatment facility pursuant
7.2 to this subdivision, that committed person may voluntarily return to a secure treatment
7.3 facility ~~for a period of up to 60 days~~ with the consent of the head of the treatment facility;
7.4 for a period of up to:

7.5 (1) 90 days if due to a psychiatric medical condition; or

7.6 (2) six months if due to a nonpsychiatric medical condition.

7.7 (d) If the committed person is not returned to the original, nonsecure transfer facility
7.8 within ~~60~~ 90 days of being readmitted to a secure treatment facility if due to a psychiatric
7.9 medical condition or within six months of being readmitted to a secure treatment facility if
7.10 due to a nonpsychiatric medical condition, the transfer is revoked and the committed person
7.11 must remain in a secure treatment facility. The committed person must immediately be
7.12 notified in writing of the revocation.

7.13 (e) Within 15 days of receiving notice of the revocation, the committed person may
7.14 petition the special review board for a review of the revocation. The special review board
7.15 shall review the circumstances of the revocation and shall recommend to the executive
7.16 board whether or not the revocation should be upheld. The special review board may also
7.17 recommend a new transfer at the time of the revocation hearing.

7.18 (f) No action by the special review board is required if the transfer has not been revoked
7.19 and the committed person is returned to the original, nonsecure transfer facility with no
7.20 substantive change to the conditions of the transfer ordered under this subdivision.

7.21 (g) The head of the treatment facility may revoke a transfer made under this subdivision
7.22 and require a committed person to return to a secure treatment facility if:

7.23 (1) remaining in a nonsecure setting does not provide a reasonable degree of safety to
7.24 the committed person or others; or

7.25 (2) the committed person has regressed clinically and the facility to which the committed
7.26 person was transferred does not meet the committed person's needs.

7.27 (h) Upon the revocation of the transfer, the committed person must be immediately
7.28 returned to a secure treatment facility. A report documenting the reasons for revocation
7.29 must be issued by the head of the treatment facility within seven days after the committed
7.30 person is returned to the secure treatment facility. Advance notice to the committed person
7.31 of the revocation is not required.

7.32 (i) The committed person must be provided a copy of the revocation report and informed,
7.33 orally and in writing, of the rights of a committed person under this section. The revocation

8.1 report must be served upon the committed person, the committed person's counsel, and the
 8.2 designated agency. The report must outline the specific reasons for the revocation, including
 8.3 but not limited to the specific facts upon which the revocation is based.

8.4 (j) If a committed person's transfer is revoked, the committed person may re-petition for
 8.5 transfer according to subdivision 5.

8.6 (k) A committed person aggrieved by a transfer revocation decision may petition the
 8.7 special review board within seven business days after receipt of the revocation report for a
 8.8 review of the revocation. The matter must be scheduled within 30 days. The special review
 8.9 board shall review the circumstances leading to the revocation and, after considering the
 8.10 factors in paragraph (b), shall recommend to the executive board whether or not the
 8.11 revocation shall be upheld. The special review board may also recommend a new transfer
 8.12 out of a secure treatment facility at the time of the revocation hearing.

8.13 **EFFECTIVE DATE.** This section is effective July 1, 2026.

8.14 Sec. 10. Minnesota Statutes 2024, section 253B.18, subdivision 14, is amended to read:

8.15 Subd. 14. **Voluntary readmission.** (a) With the consent of the head of the treatment
 8.16 facility or state-operated treatment program, a patient may voluntarily return from provisional
 8.17 discharge with the consent of the designated agency for a period of up to:

8.18 (1) 30 days; ~~or;~~

8.19 ~~(2) up to 60 90 days with the consent of the designated agency.~~ if due to a psychiatric
 8.20 medical condition; or

8.21 (3) six months if due to a nonpsychiatric medical condition.

8.22 (b) If the patient is not returned to provisional discharge status within 60 90 days of
 8.23 being readmitted if due to a psychiatric medical condition or within six months of being
 8.24 readmitted if due to a nonpsychiatric medical condition, the provisional discharge is revoked.
 8.25 Within 15 days of receiving notice of the change in status, the patient may request a review
 8.26 of the matter before the special review board. The special review board may recommend a
 8.27 return to a provisional discharge status.

8.28 ~~(b)~~ (c) The treatment facility or state-operated treatment program is not required to
 8.29 petition for a further review by the special review board unless the patient's return to the
 8.30 community results in substantive change to the existing provisional discharge plan. All the
 8.31 terms and conditions of the provisional discharge order shall remain unchanged if the patient
 8.32 is released again.

9.1 **EFFECTIVE DATE.** This section is effective July 1, 2026."

9.2 Amend the title accordingly