DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB−3062/P1dn
DAK:lmk:rs

August 8, 2005

To Representative Hines:

I have drafted this bill in preliminary form, because I have numerous questions about the language and want you to have an opportunity to review it before it is in introducible form. Issues that arose in the course of drafting are as follows:

1. Please review s. 250.03 (1) (k); note that I split the "full faith and credit" provision concerning court orders from the other provisions. Usually, the term "full faith and credit" refers to the financial support behind an undertaking; is "validity" possibly meant, instead? What is the problem that is being addressed here, i.e., are tribal orders not being sufficiently recognized, or is there some other issue?

2. Please also review s. 250.03 (1) (L); I am somewhat puzzled by this provision (the second bullet point of the instructions); is it intended that DHFS *directly* perform these services, or was it, rather, thought that local health departments would do this work under DHFS' supervision? As to s. 250.03 (1) (L) 3., how is one "empowered" about health issues? In addition, I am concerned that s. 250.03 (1) (L) 7. might be able to be interpreted as creating an entitlement to health care; is that the intent?

3. In s. 250.04 (12m), I did not use the term "incorporate public and private sector partners into the public health planning process," because it is vague. Please review the drafted language for this subsection.

4. With regard to the sixth bullet point of the instructions:

a. Currently, s. 252.05 (1), stats., require a health care provider to report known or suspected instances of communicable disease for persons treated or visited by the health care provider. The instructions indicate that tribes and tribal health agencies should be included in this requirement. I have included only tribal health agencies because I'm unsure how a tribe, or the governing body of a tribe, would be able to diagnose a communicable disease adequately for this requirement and because s. 252.05 (3), stats., should cover reporting by a person who is a tribal member. Also, do most tribes have tribal agencies as part of their governing bodies? If, instead, these "tribal health agencies" are part of the Indian Health Services Division of the U. S. Public Health Service, the legislature may have no jurisdiction over them.

b. Currently, s. 95.22 (4), stats., requires DATCP to provide any report of an animal's communicable disease, as submitted by a veterinarian, to DHFS. I have created s.

95.22 (1m), which requires the veterinarian to submit this information to the local health officer and, if so directed, to DHFS. Do you want me to repeal s. 95.22 (4), stats.?

5. With regard to the seventh bullet point of the instructions, currently, s. 440.142 (2), stats., prohibits a pharmacist or pharmacy from reporting to DHFS personally identifying information concerning an individual who is dispensed a prescription or purchases a nonprescription drug product, unless DHFS specifically requests this information; even if DHFS requests the information, the pharmacist or pharmacy may not provide the individual's social security number. The instructions, by contrast, require that the pharmacist or pharmacy report "include as much information as is available on the disease or condition and afflicted individual." Therefore, I have repealed s. 440.142 (2) (a) in the draft and have amended s. 450.145 (2) (renumbered from s. 440.142 (2) (b)) to require reporting of personally identifying information, including a social security number. Is this what you want?

Please let me know if I may provide further assistance with regard to this draft. I will be happy to meet with you or your staff if it would be helpful to you.

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