

1.1 CONFERENCE COMMITTEE REPORT ON S.F. No. 1384

1.2 A bill for an act

1.3 relating to state government; modifying labor policy provisions; modifying building
1.4 codes, occupational safety and health, and employment law; amending Minnesota
1.5 Statutes 2022, sections 13.43, subdivision 6; 120A.414, subdivision 2; 122A.181,
1.6 subdivision 5; 122A.26, subdivision 2; 122A.40, subdivision 5; 122A.41,
1.7 subdivision 2; 177.27, subdivision 4; 177.42, subdivision 2; 179A.03, subdivisions
1.8 14, 18; 179A.06, subdivision 6; 179A.07, subdivision 6, by adding subdivisions;
1.9 179A.12, subdivisions 6, 11, by adding a subdivision; 181.03, subdivision 6;
1.10 181.06, subdivision 2; 181.172; 181.275, subdivision 1; 181.932, subdivision 1;
1.11 181.939; 181.940, subdivisions 2, 3; 181.941, subdivision 3; 181.9413; 181.942;
1.12 181.9436; 181.945, subdivision 3; 181.9456, subdivision 3; 181.956, subdivision
1.13 5; 181.964; 182.659, subdivisions 1, 8; 182.66, by adding a subdivision; 182.661,
1.14 by adding a subdivision; 182.676; 326B.093, subdivision 4; 326B.106, by adding
1.15 a subdivision; 326B.163, subdivision 5, by adding a subdivision; 326B.164,
1.16 subdivision 13; 326B.31, subdivision 30; 326B.32, subdivision 1; 326B.36,
1.17 subdivision 7, by adding a subdivision; 326B.805, subdivision 6; 326B.921,
1.18 subdivision 8; 326B.925, subdivision 1; 326B.988; 572B.17; proposing coding
1.19 for new law in Minnesota Statutes, chapters 16A; 181; 327; repealing Minnesota
1.20 Statutes 2022, section 179A.12, subdivision 2.

1.21 May 21, 2023

1.22 The Honorable Bobby Joe Champion

1.23 President of the Senate

1.24 The Honorable Melissa Hortman

1.25 Speaker of the House of Representatives

1.26 We, the undersigned conferees for S.F. No. 1384 report that we have agreed upon the
1.27 items in dispute and recommend as follows:

1.28 That the House recede from its amendments and that S.F. No. 1384 be further amended
1.29 as follows:

1.30 Delete everything after the enacting clause and insert:

1.31 "Section 1. TITLE.

1.32 This act shall be known as the Keeping Nurses at the Bedside Act.

2.1 Sec. 2. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

2.2 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
2.3 apply.

2.4 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist
2.5 under section 150A.06, and who is certified as an advanced dental therapist under section
2.6 150A.106.

2.7 (c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and
2.8 drug counselor under chapter 148F.

2.9 (d) "Dental therapist" means an individual who is licensed as a dental therapist under
2.10 section 150A.06.

2.11 (e) "Dentist" means an individual who is licensed to practice dentistry.

2.12 (f) "Designated rural area" means a statutory and home rule charter city or township that
2.13 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,
2.14 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

2.15 (g) "Emergency circumstances" means those conditions that make it impossible for the
2.16 participant to fulfill the service commitment, including death, total and permanent disability,
2.17 or temporary disability lasting more than two years.

2.18 (h) "Hospital nurse" means an individual who is licensed as a registered nurse and who
2.19 is providing direct patient care in a nonprofit hospital setting.

2.20 (i) "Mental health professional" means an individual providing clinical services in the
2.21 treatment of mental illness who is qualified in at least one of the ways specified in section
2.22 245.462, subdivision 18.

2.23 (†) (j) "Medical resident" means an individual participating in a medical residency in
2.24 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

2.25 (†) (k) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse
2.26 anesthetist, advanced clinical nurse specialist, or physician assistant.

2.27 (⊖) (l) "Nurse" means an individual who has completed training and received all licensing
2.28 or certification necessary to perform duties as a licensed practical nurse or registered nurse.

2.29 (†) (m) "Nurse-midwife" means a registered nurse who has graduated from a program
2.30 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

3.1 ~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program
3.2 of study designed to prepare registered nurses for advanced practice as nurse practitioners.

3.3 ~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

3.4 ~~(o)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas
3.5 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

3.6 ~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

3.7 ~~(q)~~ (r) "Public health nurse" means a registered nurse licensed in Minnesota who has
3.8 obtained a registration certificate as a public health nurse from the Board of Nursing in
3.9 accordance with Minnesota Rules, chapter 6316.

3.10 ~~(r)~~ (s) "Qualified educational loan" means a government, commercial, or foundation
3.11 loan for actual costs paid for tuition, reasonable education expenses, and reasonable living
3.12 expenses related to the graduate or undergraduate education of a health care professional.

3.13 ~~(s)~~ (t) "Underserved urban community" means a Minnesota urban area or population
3.14 included in the list of designated primary medical care health professional shortage areas
3.15 (HPSAs), medically underserved areas (MUAs), or medically underserved populations
3.16 (MUPs) maintained and updated by the United States Department of Health and Human
3.17 Services.

3.18 Sec. 3. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

3.19 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness
3.20 program account is established. The commissioner of health shall use money from the
3.21 account to establish a loan forgiveness program:

3.22 (1) for medical residents, mental health professionals, and alcohol and drug counselors
3.23 agreeing to practice in designated rural areas or underserved urban communities or
3.24 specializing in the area of pediatric psychiatry;

3.25 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach
3.26 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program
3.27 at the undergraduate level or the equivalent at the graduate level;

3.28 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
3.29 facility for persons with developmental disability; a hospital if the hospital owns and operates
3.30 a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse
3.31 is in the nursing home; a housing with services establishment as defined in section 144D.01,
3.32 subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or

4.1 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a
4.2 postsecondary program at the undergraduate level or the equivalent at the graduate level;

4.3 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
4.4 hours per year in their designated field in a postsecondary program at the undergraduate
4.5 level or the equivalent at the graduate level. The commissioner, in consultation with the
4.6 Healthcare Education-Industry Partnership, shall determine the health care fields where the
4.7 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory
4.8 technology, radiologic technology, and surgical technology;

4.9 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses
4.10 who agree to practice in designated rural areas; ~~and~~

4.11 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
4.12 encounters to state public program enrollees or patients receiving sliding fee schedule
4.13 discounts through a formal sliding fee schedule meeting the standards established by the
4.14 United States Department of Health and Human Services under Code of Federal Regulations,
4.15 title 42, section 51, chapter 303; and

4.16 (7) for nurses employed as a hospital nurse by a nonprofit hospital and providing direct
4.17 care to patients at the nonprofit hospital.

4.18 (b) Appropriations made to the account do not cancel and are available until expended,
4.19 except that at the end of each biennium, any remaining balance in the account that is not
4.20 committed by contract and not needed to fulfill existing commitments shall cancel to the
4.21 fund.

4.22 Sec. 4. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

4.23 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an
4.24 individual must:

4.25 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or
4.26 education program to become a dentist, dental therapist, advanced dental therapist, mental
4.27 health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel
4.28 practitioner, registered nurse, or a licensed practical nurse. The commissioner may also
4.29 consider applications submitted by graduates in eligible professions who are licensed and
4.30 in practice; and

4.31 (2) submit an application to the commissioner of health. A nurse applying under
4.32 subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is employed
4.33 as a hospital nurse.

5.1 (b) An applicant selected to participate must sign a contract to agree to serve a minimum
5.2 three-year full-time service obligation according to subdivision 2, which shall begin no later
5.3 than March 31 following completion of required training, with the exception of:

5.4 (1) a nurse, who must agree to serve a minimum two-year full-time service obligation
5.5 according to subdivision 2, which shall begin no later than March 31 following completion
5.6 of required training;

5.7 (2) a nurse selected under subdivision 2, paragraph (a), clause (7), who must agree to
5.8 continue as a hospital nurse for a minimum two-year service obligation; and

5.9 (3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3),
5.10 who must sign a contract to agree to teach for a minimum of two years.

5.11 Sec. 5. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

5.12 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each
5.13 year for participation in the loan forgiveness program, within the limits of available funding.
5.14 In considering applications, the commissioner shall give preference to applicants who
5.15 document diverse cultural competencies. The commissioner shall distribute available funds
5.16 for loan forgiveness proportionally among the eligible professions according to the vacancy
5.17 rate for each profession in the required geographic area, facility type, teaching area, patient
5.18 group, or specialty type specified in subdivision 2, except for hospital nurses. The
5.19 commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the
5.20 funds available are used for rural physician loan forgiveness and 25 percent of the funds
5.21 available are used for underserved urban communities and pediatric psychiatry loan
5.22 forgiveness. If the commissioner does not receive enough qualified applicants each year to
5.23 use the entire allocation of funds for any eligible profession, the remaining funds may be
5.24 allocated proportionally among the other eligible professions according to the vacancy rate
5.25 for each profession in the required geographic area, patient group, or facility type specified
5.26 in subdivision 2. Applicants are responsible for securing their own qualified educational
5.27 loans. The commissioner shall select participants based on their suitability for practice
5.28 serving the required geographic area or facility type specified in subdivision 2, as indicated
5.29 by experience or training. The commissioner shall give preference to applicants closest to
5.30 completing their training. Except as specified in paragraph (c), for each year that a participant
5.31 meets the service obligation required under subdivision 3, up to a maximum of four years,
5.32 the commissioner shall make annual disbursements directly to the participant equivalent to
5.33 15 percent of the average educational debt for indebted graduates in their profession in the
5.34 year closest to the applicant's selection for which information is available, not to exceed the

6.1 balance of the participant's qualifying educational loans. Before receiving loan repayment
6.2 disbursements and as requested, the participant must complete and return to the commissioner
6.3 a confirmation of practice form provided by the commissioner verifying that the participant
6.4 is practicing as required under subdivisions 2 and 3. The participant must provide the
6.5 commissioner with verification that the full amount of loan repayment disbursement received
6.6 by the participant has been applied toward the designated loans. After each disbursement,
6.7 verification must be received by the commissioner and approved before the next loan
6.8 repayment disbursement is made. Participants who move their practice remain eligible for
6.9 loan repayment as long as they practice as required under subdivision 2.

6.10 (b) For hospital nurses, the commissioner of health shall select applicants each year for
6.11 participation in the hospital nursing education loan forgiveness program, within limits of
6.12 available funding for hospital nurses. Before receiving the annual loan repayment
6.13 disbursement, the participant must complete and return to the commissioner a confirmation
6.14 of practice form provided by the commissioner, verifying that the participant continues to
6.15 meet the eligibility requirements under subdivision 3. The participant must provide the
6.16 commissioner with verification that the full amount of loan repayment disbursement received
6.17 by the participant has been applied toward the designated loans.

6.18 (c) For each year that a participant who is a nurse and who has agreed to teach according
6.19 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner
6.20 shall make annual disbursements directly to the participant equivalent to 15 percent of the
6.21 average annual educational debt for indebted graduates in the nursing profession in the year
6.22 closest to the participant's selection for which information is available, not to exceed the
6.23 balance of the participant's qualifying educational loans.

6.24 Sec. 6. Minnesota Statutes 2022, section 144.566, is amended to read:

6.25 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

6.26 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have
6.27 the meanings given.

6.28 (b) "Act of violence" means an act by a patient or visitor against a health care worker
6.29 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections
6.30 609.221 to 609.2241.

6.31 (c) "Commissioner" means the commissioner of health.

6.32 (d) "Health care worker" means any person, whether licensed or unlicensed, employed
6.33 by, volunteering in, or under contract with a hospital, who has direct contact with a patient

7.1 of the hospital for purposes of either medical care or emergency response to situations
7.2 potentially involving violence.

7.3 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

7.4 (f) "Incident response" means the actions taken by hospital administration and health
7.5 care workers during and following an act of violence.

7.6 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's
7.7 ability to report acts of violence, including by retaliating or threatening to retaliate against
7.8 a health care worker.

7.9 (h) "Preparedness" means the actions taken by hospital administration and health care
7.10 workers to prevent a single act of violence or acts of violence generally.

7.11 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against,
7.12 or penalize a health care worker regarding the health care worker's compensation, terms,
7.13 conditions, location, or privileges of employment.

7.14 (j) "Workplace violence hazards" means locations and situations where violent incidents
7.15 are more likely to occur, including, as applicable, but not limited to locations isolated from
7.16 other health care workers; health care workers working alone; health care workers working
7.17 in remote locations; health care workers working late night or early morning hours; locations
7.18 where an assailant could prevent entry of responders or other health care workers into a
7.19 work area; locations with poor illumination; locations with poor visibility; lack of effective
7.20 escape routes; obstacles and impediments to accessing alarm systems; locations within the
7.21 facility where alarm systems are not operational; entryways where unauthorized entrance
7.22 may occur, such as doors designated for staff entrance or emergency exits; presence, in the
7.23 areas where patient contact activities are performed, of furnishings or objects that could be
7.24 used as weapons; and locations where high-value items, currency, or pharmaceuticals are
7.25 stored.

7.26 Subd. 2. ~~Hospital duties~~ Action plans and action plan reviews required. (a) All
7.27 hospitals must design and implement preparedness and incident response action plans to
7.28 acts of violence by January 15, 2016, and review and update the plan at least annually
7.29 thereafter. The plan must be in writing; specific to the workplace violence hazards and
7.30 corrective measures for the units, services, or operations of the hospital; and available to
7.31 health care workers at all times.

7.32 Subd. 3. Action plan committees. (b) A hospital shall designate a committee of
7.33 representatives of health care workers employed by the hospital, including nonmanagerial

8.1 health care workers, nonclinical staff, administrators, patient safety experts, and other
8.2 appropriate personnel to develop preparedness and incident response action plans to acts
8.3 of violence. The hospital shall, in consultation with the designated committee, implement
8.4 the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall
8.5 require the establishment of a separate committee solely for the purpose required by this
8.6 subdivision.

8.7 Subd. 4. Required elements of action plans; generally. The preparedness and incident
8.8 response action plans to acts of violence must include:

8.9 (1) effective procedures to obtain the active involvement of health care workers and
8.10 their representatives in developing, implementing, and reviewing the plan, including their
8.11 participation in identifying, evaluating, and correcting workplace violence hazards, designing
8.12 and implementing training, and reporting and investigating incidents of workplace violence;

8.13 (2) names or job titles of the persons responsible for implementing the plan; and

8.14 (3) effective procedures to ensure that supervisory and nonsupervisory health care
8.15 workers comply with the plan.

8.16 Subd. 5. Required elements of action plans; evaluation of risk factors. (a) The
8.17 preparedness and incident response action plans to acts of violence must include assessment
8.18 procedures to identify and evaluate workplace violence hazards for each facility, unit,
8.19 service, or operation, including community-based risk factors and areas surrounding the
8.20 facility, such as employee parking areas and other outdoor areas. Procedures shall specify
8.21 the frequency that environmental assessments take place.

8.22 (b) The preparedness and incident response action plans to acts of violence must include
8.23 assessment tools, environmental checklists, or other effective means to identify workplace
8.24 violence hazards.

8.25 Subd. 6. Required elements of action plans; review of workplace violence
8.26 incidents. The preparedness and incident response action plans to acts of violence must
8.27 include procedures for reviewing all workplace violence incidents that occurred in the
8.28 facility, unit, service, or operation within the previous year, whether or not an injury occurred.

8.29 Subd. 7. Required elements of action plans; reporting workplace violence. The
8.30 preparedness and incident response action plans to acts of violence must include:

8.31 (1) effective procedures for health care workers to document information regarding
8.32 conditions that may increase the potential for workplace violence incidents and communicate
8.33 that information without fear of reprisal to other health care workers, shifts, or units;

9.1 (2) effective procedures for health care workers to report a violent incident, threat, or
9.2 other workplace violence concern without fear of reprisal;

9.3 (3) effective procedures for the hospital to accept and respond to reports of workplace
9.4 violence and to prohibit retaliation against a health care worker who makes such a report;

9.5 (4) a policy statement stating the hospital will not prevent a health care worker from
9.6 reporting workplace violence or take punitive or retaliatory action against a health care
9.7 worker for doing so;

9.8 (5) effective procedures for investigating health care worker concerns regarding workplace
9.9 violence or workplace violence hazards;

9.10 (6) procedures for informing health care workers of the results of the investigation arising
9.11 from a report of workplace violence or from a concern about a workplace violence hazard
9.12 and of any corrective actions taken;

9.13 (7) effective procedures for obtaining assistance from the appropriate law enforcement
9.14 agency or social service agency during all work shifts. The procedure may establish a central
9.15 coordination procedure; and

9.16 (8) a policy statement stating the hospital will not prevent a health care worker from
9.17 seeking assistance and intervention from local emergency services or law enforcement when
9.18 a violent incident occurs or take punitive or retaliatory action against a health care worker
9.19 for doing so.

9.20 Subd. 8. **Required elements of action plans; coordination with other employers.** The
9.21 preparedness and incident response action plans to acts of violence must include methods
9.22 the hospital will use to coordinate implementation of the plan with other employers whose
9.23 employees work in the same health care facility, unit, service, or operation and to ensure
9.24 that those employers and their employees understand their respective roles as provided in
9.25 the plan. These methods must ensure that all employees working in the facility, unit, service,
9.26 or operation are provided the training required by subdivision 10 and that workplace violence
9.27 incidents involving any employee are reported, investigated, and recorded.

9.28 Subd. 9. **Required elements of action plans; training.** (a) The preparedness and incident
9.29 response action plans to acts of violence must include:

9.30 (1) procedures for developing and providing the training required in subdivision 10 that
9.31 permits health care workers and their representatives to participate in developing the training;
9.32 and

10.1 (2) a requirement for cultural competency training and equity, diversity, and inclusion
10.2 training.

10.3 (b) The preparedness and incident response action plans to acts of violence must include
10.4 procedures to communicate with health care workers regarding workplace violence matters,
10.5 including:

10.6 (1) how health care workers will document and communicate to other health care workers
10.7 and between shifts and units information regarding conditions that may increase the potential
10.8 for workplace violence incidents;

10.9 (2) how health care workers can report a violent incident, threat, or other workplace
10.10 violence concern;

10.11 (3) how health care workers can communicate workplace violence concerns without
10.12 fear of reprisal; and

10.13 (4) how health care worker concerns will be investigated, and how health care workers
10.14 will be informed of the results of the investigation and any corrective actions to be taken.

10.15 Subd. 10. **Training required.** (e) A hospital shall ~~must~~ provide training to all health
10.16 care workers employed or contracted with the hospital on safety during acts of violence.
10.17 Each health care worker must receive safety training ~~annually and upon hire~~ during the
10.18 health care worker's orientation and before the health care worker completes a shift
10.19 independently, and annually thereafter. Training must, at a minimum, include:

10.20 (1) safety guidelines for response to and de-escalation of an act of violence;

10.21 (2) ways to identify potentially violent or abusive situations, including aggression and
10.22 violence predicting factors; ~~and~~

10.23 (3) the hospital's ~~incident response reaction plan and violence prevention plan~~
10.24 preparedness and incident response action plans for acts of violence, including how the
10.25 health care worker may report concerns about workplace violence within each hospital's
10.26 reporting structure without fear of reprisal, how the hospital will address workplace violence
10.27 incidents, and how the health care worker can participate in reviewing and revising the plan;
10.28 and

10.29 (4) any resources available to health care workers for coping with incidents of violence,
10.30 including but not limited to critical incident stress debriefing or employee assistance
10.31 programs.

11.1 Subd. 11. **Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual
11.2 review of preparedness and incident response action plans required under paragraph (a)
11.3 subdivision 2, the hospital must review with the designated committee:

11.4 (1) the effectiveness of its preparedness and incident response action plans, including
11.5 the sufficiency of security systems, alarms, emergency responses, and security personnel
11.6 availability;

11.7 (2) security risks associated with specific units, areas of the facility with uncontrolled
11.8 access, late night shifts, early morning shifts, and areas surrounding the facility such as
11.9 employee parking areas and other outdoor areas;

11.10 (3) the most recent gap analysis as provided by the commissioner; and

11.11 ~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous
11.12 year, including injuries sustained, if any, and the unit in which the incident occurred;

11.13 (5) evaluations of staffing, including staffing patterns and patient classification systems
11.14 that contribute to, or are insufficient to address, the risk of violence; and

11.15 (6) any reports of discrimination or abuse that arise from security resources, including
11.16 from the behavior of security personnel.

11.17 (b) As part of the annual update of preparedness and incident response action plans
11.18 required under subdivision 2, the hospital must incorporate corrective actions into the action
11.19 plan to address workplace violence hazards identified during the annual action plan review,
11.20 reports of workplace violence, reports of workplace violence hazards, and reports of
11.21 discrimination or abuse that arise from the security resources.

11.22 Subd. 12. **Action plan updates.** Following the annual review of the action plan, a hospital
11.23 must update the action plans to reflect the corrective actions the hospital will implement to
11.24 mitigate the hazards and vulnerabilities identified during the annual review.

11.25 Subd. 13. **Requests for additional staffing.** A hospital shall create and implement a
11.26 procedure for a health care worker to officially request of hospital supervisors or
11.27 administration that additional staffing be provided. The hospital must document all requests
11.28 for additional staffing made because of a health care worker's concern over a risk of an act
11.29 of violence. If the request for additional staffing to reduce the risk of violence is denied,
11.30 the hospital must provide the health care worker who made the request a written reason for
11.31 the denial and must maintain documentation of that communication with the documentation
11.32 of requests for additional staffing. A hospital must make documentation regarding staffing
11.33 requests available to the commissioner for inspection at the commissioner's request. The

12.1 commissioner may use documentation regarding staffing requests to inform the
12.2 commissioner's determination on whether the hospital is providing adequate staffing and
12.3 security to address acts of violence, and may use documentation regarding staffing requests
12.4 if the commissioner imposes a penalty under subdivision 17.

12.5 Subd. 14. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent

12.6 action plans and the information listed in paragraph ~~(d)~~ most recent action plan reviews

12.7 available to local law enforcement, all direct care staff and, if any of its workers are

12.8 represented by a collective bargaining unit, to the exclusive bargaining representatives of

12.9 those collective bargaining units.

12.10 (b) Beginning January 1, 2025, a hospital must annually submit to the commissioner its

12.11 most recent action plan and the results of the most recent annual review conducted under

12.12 subdivision 11.

12.13 Subd. 15. **Legislative report required.** (a) Beginning January 15, 2026, the commissioner

12.14 must compile the information into a single annual report and submit the report to the chairs

12.15 and ranking minority members of the legislative committees with jurisdiction over health

12.16 care by January 15 of each year.

12.17 (b) This subdivision does not expire.

12.18 Subd. 16. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner,

12.19 association, or any person or group of persons acting directly or indirectly in the interest of

12.20 the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health

12.21 care worker wishes to contact law enforcement or the commissioner regarding an act of

12.22 violence.

12.23 Subd. 17. **Penalties.** ~~(g)~~ Notwithstanding section 144.653, subdivision 6, the

12.24 commissioner may impose ~~an administrative~~ a fine of up to ~~\$250~~ \$10,000 for failure to

12.25 comply with the requirements of this ~~subdivision~~ section. The commissioner must allow

12.26 the hospital at least 30 calendar days to correct a violation of this section before assessing

12.27 a fine.

12.28 Subd. 18. **Applicability.** The amendments in this act to this section do not apply to a

12.29 hospital that meets the criteria in section 144.7052.

13.1 Sec. 7. Minnesota Statutes 2022, section 144.608, subdivision 1, as amended by Laws
13.2 2023, chapter 25, section 47, is amended to read:

13.3 Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council
13.4 is established to advise, consult with, and make recommendations to the commissioner on
13.5 the development, maintenance, and improvement of a statewide trauma system.

13.6 (b) The council shall consist of the following members:

13.7 (1) a trauma surgeon certified by the American Board of Surgery or the American
13.8 Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

13.9 (2) a general surgeon certified by the American Board of Surgery or the American
13.10 Osteopathic Board of Surgery whose practice includes trauma and who practices in a
13.11 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (f)~~;

13.12 (3) a neurosurgeon certified by the American Board of Neurological Surgery who
13.13 practices in a level I or II trauma hospital;

13.14 (4) a trauma program nurse manager or coordinator practicing in a level I or II trauma
13.15 hospital;

13.16 (5) an emergency physician certified by the American Board of Emergency Medicine
13.17 or the American Osteopathic Board of Emergency Medicine whose practice includes
13.18 emergency room care in a level I, II, III, or IV trauma hospital;

13.19 (6) a trauma program manager or coordinator who practices in a level III or IV trauma
13.20 hospital;

13.21 (7) a physician certified by the American Board of Family Medicine or the American
13.22 Osteopathic Board of Family Practice whose practice includes emergency department care
13.23 in a level III or IV trauma hospital located in a designated rural area as defined under section
13.24 144.1501, subdivision 1, ~~paragraph (f)~~;

13.25 (8) a nurse practitioner, as defined under section 144.1501, subdivision 1, ~~paragraph~~
13.26 ~~(m)~~, or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph~~
13.27 ~~(p)~~, whose practice includes emergency room care in a level IV trauma hospital located in
13.28 a designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (f)~~;

13.29 (9) a physician certified in pediatric emergency medicine by the American Board of
13.30 Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency
13.31 Medicine or certified by the American Osteopathic Board of Pediatrics whose practice
13.32 primarily includes emergency department medical care in a level I, II, III, or IV trauma

14.1 hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose
14.2 practice involves the care of pediatric trauma patients in a trauma hospital;

14.3 (10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or
14.4 the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma
14.5 and who practices in a level I, II, or III trauma hospital;

14.6 (11) the state emergency medical services medical director appointed by the Emergency
14.7 Medical Services Regulatory Board;

14.8 (12) a hospital administrator of a level III or IV trauma hospital located in a designated
14.9 rural area as defined under section 144.1501, subdivision 1, ~~paragraph (f)~~;

14.10 (13) a rehabilitation specialist whose practice includes rehabilitation of patients with
14.11 major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under
14.12 section 144.661;

14.13 (14) an attendant or ambulance director who is an EMT, AEMT, or paramedic within
14.14 the meaning of section 144E.001 and who actively practices with a licensed ambulance
14.15 service in a primary service area located in a designated rural area as defined under section
14.16 144.1501, subdivision 1, ~~paragraph (f)~~; and

14.17 (15) the commissioner of public safety or the commissioner's designee.

14.18 Sec. 8. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

14.19 Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state
14.20 commissioner of health finds upon inspection of a facility required to be licensed under the
14.21 provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance
14.22 with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or
14.23 626.557, or the applicable rules promulgated under those sections, a correction order shall
14.24 be issued to the licensee. The correction order shall state the deficiency, cite the specific
14.25 rule violated, and specify the time allowed for correction.

14.26 Sec. 9. **144.7051 DEFINITIONS.**

14.27 Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the
14.28 terms defined in this section have the meanings given.

14.29 Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a
14.30 standard uniform form developed by the commissioner that may be used by any hospital
14.31 employee to report unsafe staffing situations while maintaining the privacy of patients.

15.1 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

15.2 Subd. 4. **Daily staffing schedule.** (a) "Daily staffing schedule" means:

15.3 (1) for hospitals other than critical access hospitals, the projected number of full-time
15.4 equivalent nonmanagerial care staff assigned to an inpatient care unit and providing care
15.5 in that unit during a 24-hour period and the projected number of patients assigned to each
15.6 direct care registered nurse present and providing care in the unit; and

15.7 (2) for hospitals designated as critical access hospitals under section 144.1483, clause
15.8 (9), the projected number of full-time equivalent nonmanagerial care staff, and full-time
15.9 equivalent managerial staff who provide direct patient care at least 60 percent of the time,
15.10 assigned to an inpatient care unit and providing care in that unit during a 24-hour period
15.11 and the projected number of patients assigned to each direct care registered nurse present
15.12 and providing care in the unit.

15.13 (b) A hospital may utilize a grid for daily staffing schedules.

15.14 Subd. 5. **Direct care registered nurse.** "Direct care registered nurse" means a registered
15.15 nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and
15.16 nonmanagerial and who directly provides nursing care to patients more than 60 percent of
15.17 the time.

15.18 Subd. 6. **Emergency.** "Emergency" means a period when replacement staff are not able
15.19 to report for duty for the next shift or a period of increased patient need because of unusual,
15.20 unpredictable, or unforeseen circumstances, including but not limited to an act of terrorism,
15.21 a disease outbreak, adverse weather conditions, a mass casualty incident, or a natural disaster
15.22 that impacts continuity of patient care.

15.23 Subd. 7. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a
15.24 hospital.

15.25 Subd. 8. **Patient population.** "Patient population" means a group of patients with certain
15.26 diseases or disorders or certain characteristics.

15.27 Sec. 10. **[144.7052] APPLICABILITY.**

15.28 Sections 144.7053; 144.7056 to 144.7059; and 144.7067, subdivision 1, paragraph (b),
15.29 clause (2), and the amendments to section 144.7055 enacted in this act do not apply to any
15.30 hospital that is part of a health care system owned, operated, or governed by a nonprofit
15.31 corporation that includes a national referral center located in Olmsted County engaged in

16.1 substantial programs of patient care, medical research, and medical education addressing
16.2 state and national needs.

16.3 Sec. 11. [144.7053] HOSPITAL NURSE STAFFING COMMITTEE.

16.4 Subdivision 1. Hospital nurse staffing committee required. (a) Each hospital must
16.5 establish and maintain a functioning hospital nurse staffing committee. A hospital may
16.6 assign the functions and duties of a hospital nurse staffing committee to an existing committee
16.7 provided that either: (1) the existing committee meets the membership requirements for a
16.8 hospital nurse staffing committee in subdivision 2; or (2) an existing committee agreed to
16.9 by the hospital and the exclusive representative of the hospital's registered nurses as part of
16.10 a collective bargaining agreement is modified through a memorandum of understanding to
16.11 meet the requirements of subdivision 2.

16.12 (b) The commissioner is not required to verify compliance with this section by an on-site
16.13 visit.

16.14 (c) Service on a hospital nurse staffing committee shall be considered performing duties
16.15 of the employee's position with the employer for purposes of indemnification under section
16.16 181.970, 302A.521, 317A.521, 322C.0408, or other state law.

16.17 Subd. 2. Staffing committee membership. (a) Fifty percent of the hospital nurse staffing
16.18 committee's membership must be composed of direct health care workers. Approximately
16.19 35 percent of the hospital nurse staffing committee's membership must be direct care
16.20 registered nurses typically assigned to a specific unit for an entire shift and approximately
16.21 15 percent of the committee's membership must be other direct care workers typically
16.22 assigned to a specific unit for an entire shift. A hospital's nurse staffing committee shall
16.23 include participation from the direct care, nonmanagerial staff for each patient population
16.24 while determining or reviewing those unit staffing plans and concern for safe staffing forms.
16.25 Direct care registered nurses and other direct care workers who are members of a collective
16.26 bargaining unit shall be appointed or elected to the committee according to the guidelines
16.27 of the applicable collective bargaining agreement. If there is no collective bargaining
16.28 agreement, direct care registered nurses shall be elected to the committee by direct care
16.29 registered nurses employed by the hospital and other direct care workers shall be elected
16.30 to the committee by other direct care workers employed by the hospital.

16.31 (b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's
16.32 membership.

17.1 Subd. 3. Staffing committee compensation. A hospital must treat participation in the
17.2 hospital nurse staffing committee meetings by any hospital employee as scheduled work
17.3 time and compensate each committee member at the employee's existing rate of pay. A
17.4 hospital must relieve all direct care registered nurse members of the hospital nurse staffing
17.5 committee of other work duties during the times when the committee meets.

17.6 Subd. 4. Staffing committee meeting frequency. Each hospital nurse staffing committee
17.7 must meet at least quarterly.

17.8 Subd. 5. Staffing committee duties. (a) Each hospital nurse staffing committee shall
17.9 create, implement, continuously evaluate, and update as needed evidence-based written
17.10 core staffing plans to guide the creation of daily staffing schedules for each inpatient care
17.11 unit of the hospital. Each hospital nurse staffing committee must adopt a core staffing plan
17.12 annually by a majority vote of all members.

17.13 (b) Each hospital nurse staffing committee must:

17.14 (1) establish a secure, uniform, and easily accessible method for any hospital employee
17.15 to submit directly to the committee a concern for safe staffing form;

17.16 (2) establish and maintain a process to resolve disputes regarding concern for safe staffing
17.17 forms and to review unresolved concern for safe staffing forms that involves engaging with
17.18 nonmanagerial, direct care registered nurses from the unit involved;

17.19 (3) review the documentation of compliance maintained by the hospital under section
17.20 144.7056, subdivision 7;

17.21 (4) develop a mechanism for tracking and analyzing staffing trends within the hospital
17.22 and track and analyze staffing trends within the hospital, including any patterns or trends
17.23 in the submission and resolution of concern for safe staffing forms;

17.24 (5) submit a nurse staffing report to the commissioner;

17.25 (6) collect data on and review differences between projected staffing and staff available
17.26 to receive patients as it relates to the surgical schedule;

17.27 (7) assist the commissioner in compiling data for the Nursing Workforce Report by
17.28 encouraging participation in the commissioner's independent study on reasons licensed
17.29 registered nurses are leaving the profession; and

17.30 (8) record in the committee minutes for each meeting a summary of the discussions and
17.31 recommendations of the committee. Each committee must maintain the minutes, records,
17.32 and distributed materials for five years.

18.1 **EFFECTIVE DATE.** This section is effective July 1, 2024.

18.2 Sec. 12. Minnesota Statutes 2022, section 144.7055, is amended to read:

18.3 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

18.4 Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to
18.5 144.7058, the following terms have the meanings given.

18.6 (b) "Core staffing plan" means ~~the projected number of full-time equivalent~~
18.7 ~~nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit~~
18.8 a plan described in subdivision 2.

18.9 (c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and
18.10 other health care workers, which may include but is not limited to nursing assistants, nursing
18.11 aides, patient care technicians, and patient care assistants, who perform nonmanagerial
18.12 direct patient care functions for more than 50 percent of their scheduled hours on a given
18.13 patient care unit.

18.14 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients
18.15 and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates
18.16 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not
18.17 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

18.18 (e) "Staffing hours per patient day" means the number of full-time equivalent
18.19 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care
18.20 divided by the expected average number of patients upon which such assignments are based.

18.21 ~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for~~
18.22 ~~nursing care. This includes utilizing a professional registered nursing assessment of patient~~
18.23 ~~condition to assess staffing need.~~

18.24 Subd. 2. **Hospital core staffing report plans.** (a) ~~The chief nursing executive or nursing~~
18.25 ~~designee~~ hospital nurse staffing committee of every ~~reporting~~ hospital ~~in Minnesota under~~
18.26 ~~section 144.50 will~~ must develop a core staffing plan for each ~~patient~~ inpatient care unit.

18.27 (b) The commissioner is not required to verify compliance with this section by an on-site
18.28 visit.

18.29 ~~(b)~~ (c) Core staffing plans ~~shall~~ must specify all of the following:

18.30 (1) the projected number of full-time equivalent ~~for~~ nonmanagerial care staff that will
18.31 be assigned in a 24-hour period to each patient inpatient care unit ~~for each 24-hour period;~~

19.1 (2) the estimated whole number of patients on each inpatient care unit for whom a direct
19.2 care nurse can safely care;

19.3 (3) criteria for determining when circumstances exist on each inpatient care unit such
19.4 that a direct care nurse cannot safely care for the number of patients specified according to
19.5 clause (2) and when assigning a lower number of patients to each nurse on the inpatient
19.6 unit would be appropriate;

19.7 (4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing
19.8 levels when such adjustments are required by patient acuity and nursing intensity in the
19.9 unit;

19.10 (5) a contingency plan for each inpatient unit to safely address circumstances in which
19.11 patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing
19.12 schedule. A contingency plan must include a method to quickly identify, for each daily
19.13 staffing schedule, additional direct care registered nurses who are available to provide direct
19.14 care on the inpatient care unit;

19.15 (6) strategies to enable direct care registered nurses to take breaks they are entitled to
19.16 under law or under an applicable collective bargaining agreement; and

19.17 (7) strategies to eliminate patient boarding in emergency departments that do not rely
19.18 on requiring direct care registered nurses to work additional hours to provide care.

19.19 (e) (d) Core staffing plans must ensure that:

19.20 (1) the person creating a daily staffing schedule has sufficiently detailed information to
19.21 create a daily staffing schedule that meets the requirements of the plan;

19.22 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff
19.23 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive
19.24 24-hour periods requiring 16 or more hours;

19.25 (3) a direct care registered nurse is not required or expected to perform tasks outside of
19.26 the practice of professional nursing as defined in section 148.171, subdivision 15, clause
19.27 (1), when patient care dictates;

19.28 (4) a light duty direct care registered nurse is given appropriate assignments;

19.29 (5) except in circumstances specified by the hospital nurse staffing committee, a charge
19.30 nurse does not have patient assignments; and

19.31 (6) daily staffing schedules do not interfere with applicable collective bargaining
19.32 agreements.

20.1 Subd. 2a. Development of hospital core staffing plans. (a) Prior to submitting
20.2 completing or updating the core staffing plan, as required in subdivision 3, hospitals shall
20.3 a hospital nurse staffing committee must consult with representatives of the hospital medical
20.4 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about
20.5 the core staffing plan and the expected average number of patients upon which the core
20.6 staffing plan is based.

20.7 (b) When developing a core staffing plan, a hospital nurse staffing committee must
20.8 consider all of the following:

20.9 (1) the individual needs and expected census of each inpatient care unit;

20.10 (2) unit-specific patient acuity, including fall risk and behaviors requiring intervention,
20.11 such as physical aggression toward self or others or destruction of property;

20.12 (3) unit-specific demands on direct care registered nurses' time, including: frequency of
20.13 admissions, discharges, and transfers; frequency and complexity of patient evaluations and
20.14 assessments; frequency and complexity of nursing care planning; planning for patient
20.15 discharge; assessing for patient referral; patient education; and implementing infectious
20.16 disease protocols;

20.17 (4) the architecture and geography of the inpatient care unit, including the placement of
20.18 patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

20.19 (5) mechanisms and procedures to provide for one-to-one patient observation for patients
20.20 on psychiatric or other units;

20.21 (6) the impacts on the quality of patient care and nurse retention resulting from significant
20.22 overtime, shifts in excess of 12 hours, or multiple consecutive double shifts;

20.23 (7) the need for specialized equipment and technology on the unit;

20.24 (8) other special characteristics of the unit or community patient population, including
20.25 age, cultural and linguistic diversity and needs, functional ability, communication skills,
20.26 and other relevant social and socioeconomic factors;

20.27 (9) the skill mix of personnel other than direct care registered nurses providing or
20.28 supporting direct patient care on the unit;

20.29 (10) mechanisms and procedures for identifying appropriate additional direct care staff
20.30 who are available for direct patient care when patients' unexpected needs exceed the planned
20.31 workload for direct care staff; and

21.1 (11) demands on direct care registered nurses' time not directly related to providing
21.2 direct care on a unit, such as involvement in quality improvement activities, professional
21.3 development, service to the hospital, including serving on the hospital nurse staffing
21.4 committee, and service to the profession.

21.5 Subd. 2b. **Failure to develop hospital core staffing plans.** (a) If a hospital nurse staffing
21.6 committee cannot approve a hospital core staffing plan by a majority vote, the members of
21.7 the nurse staffing committee must enter into a mediation process with a mutually agreed-upon
21.8 mediator. If the mediator determines that the members of the nurse staffing committee have
21.9 reached an impasse, the mediator may recommend that the members of the committee enter
21.10 an arbitration process with a mutually agreed-upon arbitrator. The members of the committee
21.11 may not enter an arbitration process without the prior recommendation of the mediator.

21.12 (b) For a three-year period beginning October 1, 2025, hospitals must annually report
21.13 to the commissioner, in a form, format, and timeline determined by the commissioner, when
21.14 a mediation process or arbitration process is used to adopt a new or updated core staffing
21.15 plan. In addition, hospitals must include the following information:

21.16 (1) the duration of each mediation process or arbitration process measured in business
21.17 days; and

21.18 (2) whether or not the mediation process or arbitration process resulted in a decision.

21.19 (c) The commissioner must analyze the data submitted under paragraph (b) and, by July
21.20 1, 2029, submit to the chairs and ranking minority members of the legislative committees
21.21 with jurisdiction over the Department of Health a report compiling the submitted information
21.22 and describing summary data and trends.

21.23 Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects
21.24 to a core staffing plan approved by a majority vote of the hospital nurse staffing committee,
21.25 the hospital may elect to attempt to amend the core staffing plan through mediation. If the
21.26 mediator determines that hospital management and the nurse staffing committee have reached
21.27 an impasse, the mediator may recommend that hospital management and the committee
21.28 enter an arbitration process with a mutually agreed-upon arbitrator. Hospital management
21.29 and the committee may not enter an arbitration process without the prior recommendation
21.30 of the mediator.

21.31 (b) During an ongoing dispute resolution process, a hospital must continue to implement
21.32 the existing core staffing plan.

22.1 (c) If the dispute resolution process results in an amendment to the core staffing plan,
22.2 the hospital must implement the amended core staffing plan.

22.3 Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital
22.4 must submit to the commissioner the core staffing plans approved by the hospital's nurse
22.5 staffing committee. A hospital must submit any substantial updates to any previously
22.6 approved plan, including any amendments to the plan resulting from mediation or arbitration,
22.7 within 30 calendar days of approval of the update by the committee or the conclusion of
22.8 mediation or arbitration.

22.9 Subd. 3. **Standard electronic reporting developed.** ~~(a) Hospitals must submit the core~~
22.10 ~~staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota~~
22.11 ~~Hospital Association shall include each reporting hospital's core staffing plan on the~~
22.12 ~~Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,~~
22.13 ~~2014. any substantial changes to the core staffing plan shall be updated within 30 days.~~

22.14 ~~(b) The Minnesota Hospital Association shall include on its website for each reporting~~
22.15 ~~hospital on a quarterly basis the actual direct patient care hours per patient and per unit.~~
22.16 ~~Hospitals must submit the direct patient care report to the Minnesota Hospital Association~~
22.17 ~~by July 1, 2014, and quarterly thereafter.~~

22.18 **EFFECTIVE DATE.** This section is effective July 1, 2025.

22.19 Sec. 13. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

22.20 Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core
22.21 staffing plans approved annually by a majority vote of its hospital nurse staffing committee
22.22 or established through mediation or arbitration. Nothing in sections 144.7051 to 144.7058
22.23 relieves the chief nursing executive of a hospital from fulfilling the chief nursing executive's
22.24 duties under Code of Federal Regulations, title 42, section 482.23, and other standards
22.25 established by accreditation organizations approved by the Centers for Medicare and
22.26 Medicaid Services. If at any time the chief nursing executive believes the types and numbers
22.27 of nursing personnel and staff required under the hospital's core staffing plan are insufficient
22.28 to provide nursing care for a unit in the hospital, the chief nursing executive may increase
22.29 the staffing on that unit beyond the levels required by the plan.

22.30 (b) A core staffing plan does not apply during an emergency and a hospital is not out of
22.31 compliance with its core staffing plan during an emergency. A nurse may be required to
22.32 accept an additional patient assignment in an emergency.

23.1 (c) The commissioner is required to verify compliance with this section by on-site visits
23.2 during routine hospital surveys.

23.3 Subd. 2. **Public posting of core staffing plans.** A hospital must post its core staffing
23.4 plan for each inpatient care unit in a public area on the relevant unit.

23.5 Subd. 3. **Public posting of compliance with plan.** (a) For each publicly posted core
23.6 staffing plan, a hospital must either:

23.7 (1) post a notice at each shift change stating whether the current staffing on the unit
23.8 complies with the hospital's core staffing plan for that unit; or

23.9 (2) post a notice daily stating whether the staffing on the unit complies with the hospital's
23.10 core staffing plan, provided that the notice is updated at a shift change if the unit's compliance
23.11 status changes for that shift.

23.12 (b) The hospital nurse staffing committee must determine the method of public posting
23.13 in paragraph (a) utilized by the hospital. The public notice of compliance must include a
23.14 list of the number of nonmanagerial care staff working on the unit during the current shift
23.15 and the number of patients assigned to each direct care registered nurse working on the unit
23.16 during the current shift. The list must enumerate the nonmanagerial care staff by health care
23.17 worker type. The public notice of compliance must be posted immediately adjacent to the
23.18 publicly posted core staffing plan.

23.19 Subd. 4. **Public posting of emergency department wait times.** A hospital must publicly
23.20 display in its emergency department the approximate wait time for patients who are not in
23.21 critical need of emergency care. The approximate wait time must be updated at least hourly.

23.22 Subd. 5. **Public distribution of core staffing plan and notice of compliance.** (a) A
23.23 hospital must include with the posted materials described in subdivisions 2 and 3 a statement
23.24 that individual copies of the posted materials are available upon request to any patient on
23.25 the unit, visitor of a patient on the unit, or prospective patient. The statement must include
23.26 specific instructions for obtaining copies of the posted materials.

23.27 (b) A hospital must, within 12 hours after the request, provide individual copies of all
23.28 the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any
23.29 visitor of a patient on the unit who requests the materials.

23.30 Subd. 6. **Reporting noncompliance.** (a) Any hospital employee may submit a concern
23.31 for safe staffing form to report an instance of noncompliance with a hospital's core staffing
23.32 plan, to object to the contents of a core staffing plan, or to challenge the process of the
23.33 hospital nurse staffing committee.

24.1 (b) A hospital must not interfere with or retaliate against a hospital employee for
24.2 submitting a concern for safe staffing form.

24.3 (c) The commissioner of labor and industry may investigate any report of interference
24.4 with or retaliation against a hospital employee for submitting a concern for safe staffing
24.5 form. The commissioner of labor and industry may fine a hospital up to \$10,000 if the
24.6 commissioner finds the hospital interfered with or retaliated against a hospital employee
24.7 for submitting a concern for safe staffing form. The commissioner of labor and industry
24.8 may issue a compliance order under section 177.27, subdivision 4, to enforce this section.

24.9 Subd. 7. **Documentation of compliance.** Each hospital must document compliance with
24.10 its core staffing plans and maintain records demonstrating compliance for each inpatient
24.11 care unit for five years. Each hospital must provide to its nurse staffing committee access
24.12 to all documentation required under this subdivision.

24.13 Subd. 8. **Collective bargaining.** Nothing in sections 144.7051 to 144.7059 shall limit
24.14 the parties to a collective bargaining agreement from bargaining and agreeing with respect
24.15 to nurse and patient protections, standards, protocols, and procedures that meet or exceed,
24.16 and do not conflict with, the minimum standards and requirements in sections 144.7051 to
24.17 144.7059.

24.18 **EFFECTIVE DATE.** This section is effective October 1, 2025.

24.19 **Sec. 14. [144.7057] HOSPITAL NURSE STAFFING REPORTS.**

24.20 Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee
24.21 must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted
24.22 within 60 days of the end of the quarter.

24.23 Subd. 2. **Nurse staffing report.** (a) Nurse staffing reports submitted to the commissioner
24.24 by a hospital nurse staffing committee must:

24.25 (1) identify any suspected incidents of the hospital failing during the reporting quarter
24.26 to meet the standards of one of its core staffing plans;

24.27 (2) identify each occurrence of the hospital performing an urgent, emergent, or elective
24.28 surgery at a time when the unit to which the patient is discharged is out of compliance with
24.29 its core staffing plan;

24.30 (3) identify problems of insufficient staffing, including but not limited to:

24.31 (i) inappropriate number of direct care registered nurses scheduled in a unit;

25.1 (ii) inappropriate number of direct care registered nurses present and delivering care in
25.2 a unit;

25.3 (iii) inappropriately experienced direct care registered nurses scheduled for a particular
25.4 unit;

25.5 (iv) insufficient number of nursing staff with appropriate competencies and skill mix
25.6 present and delivering care in a unit;

25.7 (v) inability for nurse supervisors to adjust daily nursing schedules for increased patient
25.8 acuity or nursing intensity in a unit; and

25.9 (vi) chronically unfilled direct care positions within the hospital;

25.10 (4) identify any units that pose a risk to patient safety due to inadequate staffing;

25.11 (5) propose solutions to solve insufficient staffing;

25.12 (6) propose solutions to reduce risks to patient safety in inadequately staffed units; and

25.13 (7) describe staffing trends within the hospital, including numbers of direct care registered
25.14 nurses scheduled in a unit, numbers of direct care registered nurses present and delivering
25.15 care in a unit, and differences between the numbers of direct care registered nurses scheduled
25.16 and direct care registered nurses present and delivering care in a unit, with particular attention
25.17 to these staffing trends and differences in units caring for patients for whom emergent,
25.18 urgent, and elective surgeries have been or will be performed.

25.19 (b) A hospital must submit with its nurse staffing report the turnover rate among direct
25.20 care registered nurses and other direct care health care workers at the hospital and the
25.21 frequency and extent of the hospital's noncompliance with its core staffing plan for the
25.22 purposes of reporting compliance with core staffing plans under section 144.7058.

25.23 Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on
25.24 its website each quarterly nurse staffing report submitted to the commissioner under
25.25 subdivision 1.

25.26 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each
25.27 hospital nurse staffing committee a uniform format or standard form the committee must
25.28 use to comply with the nurse staffing reporting requirements under this section. The format
25.29 or form developed by the commissioner must present the reported information in a manner
25.30 allowing patients and the public to clearly understand and compare staffing patterns and
25.31 actual levels of staffing across reporting hospitals. The commissioner must include, in the
25.32 uniform format or on the standard form, space to allow the reporting hospital to include a

26.1 description of additional resources available to support unit-level patient care and a
26.2 description of the hospital. The commissioner must ensure that the uniform format or standard
26.3 form complies with all applicable federal requirements, and that any information made
26.4 available to the public under this section complies with federal antitrust laws.

26.5 **EFFECTIVE DATE.** This section is effective October 1, 2025.

26.6 **Sec. 15. [144.7058] EVALUATION OF COMPLIANCE WITH CORE STAFFING**
26.7 **PLANS.**

26.8 Subdivision 1. **Evaluating compliance with core staffing plans.** The commissioner of
26.9 health must convene a stakeholder group to recommend a system for evaluating hospital
26.10 nurse staffing. The system recommended by the stakeholder group must use data collected
26.11 from nurse staffing reports, employment turnover rates among direct care registered nurses
26.12 and other direct care health care workers within an individual hospital, the frequency of a
26.13 hospital's noncompliance with a core staffing plan, and the extent of a hospital's
26.14 noncompliance with a core staffing plan. By January 31, 2025, the commissioner must
26.15 submit to the chairs and ranking minority members of the legislative committees with
26.16 jurisdiction over the Department of Health the evaluation system recommended by the
26.17 stakeholder group and any draft legislation the commissioner recommends to ensure the
26.18 commissioner receives from hospitals data the commissioner requires to implement the
26.19 recommended evaluation system. The stakeholder group under this section is exempt from
26.20 the requirements of sections 15.014, 15.0593, and 15.0597. No member of the stakeholder
26.21 group may be a member of the legislature.

26.22 Subd. 2. **Public disclosure of compliance.** Beginning January 1, 2027, the commissioner
26.23 must publish on the Department of Health website a compliance report for each hospital
26.24 based on the system recommended under subdivision 1 with links to the hospital's core
26.25 staffing plan, the hospital's nurse staffing reports, and an accessible and easily understandable
26.26 explanation of what the compliance report means.

26.27 **EFFECTIVE DATE.** This section is effective January 1, 2026.

26.28 **Sec. 16. [144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

26.29 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
26.30 the meanings given.

26.31 (b) "Emergency" means a period when replacement staff are not able to report for duty
26.32 for the next shift, or a period of increased patient need, because of unusual, unpredictable,

27.1 or unforeseen circumstances, including but not limited to an act of terrorism, a disease
27.2 outbreak, adverse weather conditions, a mass casualty incident, or a natural disaster, that
27.3 impacts continuity of patient care.

27.4 (c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses
27.5 employed by the state.

27.6 (d) "Taking action against" means discharging, disciplining, threatening, reporting to
27.7 the Board of Nursing, discriminating against, or penalizing regarding compensation, terms,
27.8 conditions, location, or privileges of employment.

27.9 Subd. 2. **Prohibited actions; process.** (a) Except as provided in subdivision 5, a hospital
27.10 or other entity licensed under sections 144.50 to 144.58, and its agent, or other health care
27.11 facility licensed by the commissioner of health, and the facility's agent, is prohibited from
27.12 taking action against a nurse solely on the ground that the nurse fails to accept an assignment
27.13 of one or more additional patients because the nurse reasonably and in good faith determines
27.14 that in the nurse's professional judgment accepting an additional patient assignment may
27.15 create an unnecessary danger to a patient's life, health, or safety or may otherwise constitute
27.16 a ground for disciplinary action under section 148.261. Nothing in this section modifies a
27.17 nurse's professional obligations under sections 148.171 to 148.285, which include, but are
27.18 not limited to, a nurse's obligation to not engage in unprofessional conduct and to not create
27.19 unnecessary danger to a patient's life, health, or safety. A nurse can violate a professional
27.20 obligation without a patient being actually injured.

27.21 (b) For a nurse to decline to accept an additional patient assignment, the following
27.22 process must be followed:

27.23 (1) a charge nurse must evaluate relevant factors to assess and determine the adequacy
27.24 of resources and invoke the hospital's chain of command policy to meet patient care needs;
27.25 and

27.26 (2) if the issue cannot be resolved and resources cannot be reallocated by the manager
27.27 or administrative supervisor, and the nurse reasonably and in good faith determines in their
27.28 professional judgment that accepting an additional patient assignment may create an
27.29 unnecessary danger to a patient's life, health, or safety, the nurse may decline to accept the
27.30 additional patient assignment.

27.31 A retrospective review of the incident may be initiated by the individuals involved, and
27.32 may be completed at the unit level or at the hospital nurse staffing committee level.

28.1 (c) This subdivision does not apply to a nursing facility, an intermediate care facility
28.2 for persons with developmental disabilities, or a licensed boarding care home.

28.3 Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless
28.4 of the type of facility where the nurse is employed and regardless of the facility's license,
28.5 if the nurse is involved in resident or patient care.

28.6 Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the
28.7 rights of a person under any collective bargaining agreement.

28.8 Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment
28.9 in an emergency.

28.10 Subd. 6. **Enforcement.** The commissioner of labor and industry may enforce this section
28.11 by issuing a compliance order under section 177.27, subdivision 4. The commissioner of
28.12 labor and industry may assess a fine of up to \$5,000 for each violation of this section.

28.13 Sec. 17. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

28.14 Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish
28.15 an adverse health event reporting system designed to facilitate quality improvement in the
28.16 health care system. The reporting system shall not be designed to punish errors by health
28.17 care practitioners or health care facility employees.

28.18 (b) The reporting system shall consist of:

28.19 (1) mandatory reporting by facilities of 27 adverse health care events;

28.20 (2) mandatory reporting by facilities of whether the unit where an adverse event occurred
28.21 was in compliance with the core staffing plan for the unit at the time of the adverse event;

28.22 (3) mandatory completion of a root cause analysis and a corrective action plan by the
28.23 facility and reporting of the findings of the analysis and the plan to the commissioner or
28.24 reporting of reasons for not taking corrective action;

28.25 ~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of
28.26 systemic failure in the health care system and successful methods to correct these failures;

28.27 ~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system
28.28 requirements; and

28.29 ~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and
28.30 the public to maximize the use of the reporting system to improve health care quality.

29.1 (c) The commissioner is not authorized to select from or between competing alternate
29.2 acceptable medical practices.

29.3 **EFFECTIVE DATE.** This section is effective October 1, 2025.

29.4 Sec. 18. Minnesota Statutes 2022, section 147A.08, is amended to read:

29.5 **147A.08 EXEMPTIONS.**

29.6 (a) This chapter does not apply to, control, prevent, or restrict the practice, service, or
29.7 activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13);² persons
29.8 regulated under section 214.01, subdivision 2;² or ~~persons~~ midlevel practitioners, nurses,
29.9 or nurse-midwives as defined in section 144.1501, subdivision 1, paragraphs (i), (k), and
29.10 (l).

29.11 (b) Nothing in this chapter shall be construed to require licensure of:

29.12 (1) a physician assistant student enrolled in a physician assistant educational program
29.13 accredited by the Accreditation Review Commission on Education for the Physician Assistant
29.14 or by its successor agency approved by the board;

29.15 (2) a physician assistant employed in the service of the federal government while
29.16 performing duties incident to that employment; or

29.17 (3) technicians, other assistants, or employees of physicians who perform delegated
29.18 tasks in the office of a physician but who do not identify themselves as a physician assistant.

29.19 Sec. 19. **IMPLEMENTATION STAKEHOLDER GROUPS.**

29.20 (a) The commissioner of health must convene a stakeholder group to advise the
29.21 Department of Health on the development of a toolkit with best practices for implementation
29.22 of hospital staffing committees. The toolkit and best practices may include a recommendation
29.23 on whether hospitals should use a federal mediator to moderate the establishment of
29.24 committees in each hospital. The commissioner must develop the toolkit with the
29.25 recommended best practices and make it available to hospitals by July 1, 2024.

29.26 (b) The commissioner of health may convene a stakeholder group to examine whether
29.27 there are objective metrics to verify that a hospital is adequately staffed or may assign this
29.28 task to the stakeholder group established under Minnesota Statutes, section 144.7058,
29.29 subdivision 1. No member of either stakeholder group may be a member of the legislature.
29.30 By February 15, 2024, the commissioner must submit to the chairs and ranking minority
29.31 members of the legislative committees with jurisdiction over the Department of Health any

30.1 recommendations on the feasibility of establishing an alternative compliance pathway to
30.2 ensure adequate hospital staffing.

30.3 (c) The stakeholder groups in paragraphs (a) and (b) are exempt from the requirements
30.4 of Minnesota Statutes, sections 15.014, 15.0593, and 15.0597. No member of any stakeholder
30.5 group under this section may be a member of the legislature.

30.6 (d) Any contracts the commissioner enters into in connection with this section are exempt
30.7 from Minnesota Statutes, sections 16C.05, subdivision 2; 16C.06, subdivisions 1, 2, and 6;
30.8 and 16C.08, subdivisions 3 and 3a.

30.9 **Sec. 20. DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT OF**
30.10 **ANALYTICAL TOOLS.**

30.11 (a) The commissioner of health, in consultation with the Minnesota Nurses Association
30.12 and other professional nursing organizations, the Minnesota Hospital Association, and
30.13 experts in patient safety, must develop a means of analyzing available adverse event data,
30.14 available staffing data, and available data from concern for safe staffing forms to examine
30.15 potential correlations between adverse events and understaffing.

30.16 (b) The commissioner must develop an initial means of conducting the analysis described
30.17 in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's
30.18 initial findings by January 1, 2026.

30.19 (c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority
30.20 members of the house and senate committees with jurisdiction over the regulation of hospitals
30.21 a report on the available data, potential sources of additional useful data, and any additional
30.22 statutory authority the commissioner requires to collect additional useful information from
30.23 hospitals.

30.24 **EFFECTIVE DATE.** This section is effective August 1, 2023.

30.25 **Sec. 21. DIRECTION TO COMMISSIONER OF HEALTH; KEEPING NURSES**
30.26 **AT THE BEDSIDE ACT IMPACT EVALUATION.**

30.27 By October 1, 2023, the commissioner of health must contract with the commissioner
30.28 of management and budget for the services of the Impact Evaluation Unit to design and
30.29 implement a rigorous causal impact evaluation using time-series data or other evaluation
30.30 methods as determined by the Impact Evaluation Unit to estimate the causal impact of the
30.31 implementation of Minnesota Statutes, sections 144.7051 to 144.7059, on patient care, nurse
30.32 job satisfaction, nurse retention, and other outcomes as determined by the commissioner

31.1 and the Impact Evaluation Unit. The Impact Evaluation Unit may subcontract with other
31.2 research organizations to assist with the design or implementation of the impact evaluation.
31.3 The commissioner of management and budget may obtain any relevant data from any state
31.4 agency necessary to conduct this evaluation under Minnesota Statutes, section 15.08. By
31.5 February 15, 2024, the commissioner of health must submit to the chairs and ranking minority
31.6 members of the legislative committees with jurisdiction over health finance and policy draft
31.7 legislation specifying any additional authorities the commissioner and the Impact Evaluation
31.8 Unit may require to collect the data required to conduct a successful impact evaluation of
31.9 the implementation of Minnesota Statutes, sections 144.7051 to 144.7059. By October 1,
31.10 2024, the Impact Evaluation Unit must begin collecting baseline data. By June 30, 2029,
31.11 the Impact Evaluation Unit must submit to the commissioner of health a public initial report
31.12 on the status of the evaluation project and any preliminary results.

31.13 Sec. 22. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING**
31.14 **WORKFORCE REPORT.**

31.15 (a) The commissioner of health must publish a public report on the current status of the
31.16 state's nursing workforce employed by hospitals. In preparing the report, the commissioner
31.17 shall utilize information collected in collaboration with the Board of Nursing as directed
31.18 under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active
31.19 licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals;
31.20 information collected and shared by the Minnesota Hospital Association on retention by
31.21 hospitals of licensed nurses; information collected through an independent study on reasons
31.22 licensed nurses are choosing not to renew their licenses and leaving the profession; and
31.23 other publicly available data the commissioner deems useful.

31.24 (b) The commissioner must publish the report by January 1, 2026.

31.25 Sec. 23. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES.**

31.26 The commissioner of human services must define as a direct educational expense the
31.27 reasonable child care costs incurred by a nursing facility employee scholarship recipient
31.28 while the recipient is receiving a wage from the scholarship sponsoring facility, provided
31.29 the scholarship recipient is making reasonable progress, as defined by the commissioner,
31.30 toward the educational goal for which the scholarship was granted.

33.1 action plans to acts of violence; modifying eligibility for nursing facility employee
33.2 scholarships; modifying eligibility for the health professional education loan
33.3 forgiveness program; requiring the commissioner of health to study hospital
33.4 staffing; requiring a report; amending Minnesota Statutes 2022, sections 144.1501,
33.5 subdivisions 1, 2, 3, 4; 144.566; 144.608, subdivision 1, as amended; 144.653,
33.6 subdivision 5; 144.7055; 144.7067, subdivision 1; 147A.08; proposing coding for
33.7 new law in Minnesota Statutes, chapter 144."

34.1 We request the adoption of this report and repassage of the bill.

34.2 Senate Conferees:

34.3
34.4 Erin Murphy Jim Abeler

34.5
34.6 Liz Boldon

34.7 House Conferees:

34.8
34.9 Sandra Feist Kaela Berg

34.10
34.11 Greg Davids