

SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 1561

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DATE	D-PG	OFFICIAL STATUS
02/13/2023	797	Introduction and first reading Referred to Health and Human Services
02/16/2023	874	Author added Wiklund
02/21/2023	992	Author added Marty
03/09/2023	1457a	Comm report: To pass as amended and re-refer to Labor
03/15/2023	1764a	Comm report: To pass as amended and re-refer to Judiciary and Public Safety

1.1 A bill for an act

1.2 relating to health; establishing requirements for hospital nurse staffing committees

1.3 and hospital nurse workload committees; modifying requirements of hospital core

1.4 staffing plans; requiring the commissioner of health to grade and publicly disclose

1.5 hospital compliance with core staffing plans; modifying requirements related to

1.6 hospital preparedness and incident response action plans to acts of violence;

1.7 modifying eligibility for nursing facility employee scholarships; establishing a

1.8 hospital nursing education loan forgiveness program; modifying eligibility for the

1.9 health professional education loan forgiveness program; requiring the commissioner

1.10 of health to study hospital staffing; establishing a grant program to improve the

1.11 mental health of health care workers; requiring a report; appropriating money;

1.12 amending Minnesota Statutes 2022, sections 144.1501, subdivisions 1, 2, 3, 4, 5;

1.13 144.566; 144.608, subdivision 1; 144.653, subdivision 5; 144.7055; 144.7067,

1.14 subdivision 1; 147A.08; proposing coding for new law in Minnesota Statutes,

1.15 chapter 144.

1.16 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.17 **ARTICLE 1**

1.18 **KEEPING NURSES AT THE BEDSIDE ACT**

1.19 Section 1. **TITLE.**

1.20 This act shall be known as "The Keeping Nurses at the Bedside Act of 2023."

1.21 **ARTICLE 2**

1.22 **HOSPITAL STAFFING**

1.23 Section 1. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

1.24 Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state

1.25 commissioner of health finds upon inspection of a facility required to be licensed under the

1.26 provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance

2.1 with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or
2.2 626.557, or the applicable rules promulgated under those sections, a correction order shall
2.3 be issued to the licensee. The correction order shall state the deficiency, cite the specific
2.4 rule violated, and specify the time allowed for correction.

2.5 Sec. 2. **[144.7051] DEFINITIONS.**

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

2.8 Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a
2.9 standard uniform form developed by the commissioner that may be used by any individual
2.10 to report unsafe staffing situations while maintaining the privacy of patients.

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

2.12 Subd. 4. **Daily staffing schedule.** "Daily staffing schedule" means the actual number
2.13 of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and
2.14 providing care in that unit during a 24-hour period and the actual number of patients assigned
2.15 to each direct care registered nurse present and providing care in the unit.

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

2.20 Subd. 6. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a
2.21 hospital.

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

2.23 Sec. 3. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

2.24 Subdivision 1. **Hospital nurse staffing committee required.** (a) Each hospital must
2.25 establish and maintain a functioning hospital nurse staffing committee. A hospital may
2.26 assign the functions and duties of a hospital nurse staffing committee to an existing committee
2.27 provided the existing committee meets the membership requirements applicable to a hospital
2.28 nurse staffing committee.

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

3.1 Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse
3.2 staffing committee's membership must be direct care registered nurses typically assigned
3.3 to a specific unit for an entire shift and at least 15 percent of the committee's membership
3.4 must be other direct care workers typically assigned to a specific unit for an entire shift.
3.5 Direct care registered nurses and other direct care workers who are members of a collective
3.6 bargaining unit shall be appointed or elected to the committee according to the guidelines
3.7 of the applicable collective bargaining agreement. If there is no collective bargaining
3.8 agreement, direct care registered nurses shall be elected to the committee by direct care
3.9 registered nurses employed by the hospital and other direct care workers shall be elected
3.10 to the committee by other direct care workers employed by the hospital.

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

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

3.18 Subd. 4. **Staffing committee meeting frequency.** Each hospital nurse staffing committee
3.19 must meet at least quarterly.

3.20 Subd. 5. **Staffing committee duties.** (a) Each hospital nurse staffing committee shall
3.21 create, implement, continuously evaluate, and update as needed evidence-based written
3.22 core staffing plans to guide the creation of daily staffing schedules for each inpatient care
3.23 unit of the hospital.

3.24 (b) Each hospital nurse staffing committee must:

3.25 (1) establish a secure, uniform, and easily accessible method for any hospital employee,
3.26 patient, or patient family member to submit directly to the committee a concern for safe
3.27 staffing form;

3.28 (2) review each concern for safe staffing form;

3.29 (3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse
3.30 workload committee;

3.31 (4) review the documentation of compliance maintained by the hospital under section
3.32 144.7056, subdivision 10;

4.1 (5) conduct a trend analysis of the data related to all reported concerns regarding safe
4.2 staffing;

4.3 (6) develop a mechanism for tracking and analyzing staffing trends within the hospital;

4.4 (7) submit a nurse staffing report to the commissioner;

4.5 (8) assist the commissioner in compiling data for the Nursing Workforce Report by
4.6 encouraging participation in the commissioner's independent study on reasons licensed
4.7 registered nurses are leaving the profession; and

4.8 (9) record in the committee minutes for each meeting a summary of the discussions and
4.9 recommendations of the committee. Each committee must maintain the minutes, records,
4.10 and distributed materials for five years.

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

4.12 Sec. 4. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

4.13 Subdivision 1. **Hospital nurse workload committee required.** (a) Each hospital must
4.14 establish and maintain functioning hospital nurse workload committees for each unit.

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

4.17 Subd. 2. **Workload committee membership.** (a) At least 35 percent of each workload
4.18 committee's membership must be direct care registered nurses typically assigned to the unit
4.19 for an entire shift and at least 15 percent of the committee's membership must be other direct
4.20 care workers typically assigned to the unit for an entire shift. Direct care registered nurses
4.21 and other direct care workers who are members of a collective bargaining unit shall be
4.22 appointed or elected to the committee according to the guidelines of the applicable collective
4.23 bargaining agreement. If there is no collective bargaining agreement, direct care registered
4.24 nurses shall be elected to the committee by direct care registered nurses typically assigned
4.25 to the unit for an entire shift and other direct care workers shall be elected to the committee
4.26 by other direct care workers typically assigned to the unit for an entire shift.

4.27 (b) The hospital shall appoint 50 percent of each unit's nurse workload committee's
4.28 membership.

4.29 (c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing
4.30 committee through collective bargaining, the composition of that committee prevails.

4.31 Subd. 3. **Workload committee compensation.** A hospital must treat participation in a
4.32 hospital nurse workload committee meeting by any hospital employee as scheduled work

5.1 time and compensate each committee member at the employee's existing rate of pay. A
 5.2 hospital must relieve all direct care registered nurse members of a hospital nurse workload
 5.3 committee of other work duties during the times when the committee meets.

5.4 Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload
 5.5 committee must meet at least monthly whenever the committee is in receipt of an unresolved
 5.6 concern for safe staffing form.

5.7 Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee
 5.8 must create, implement, and maintain dispute resolution procedures to guide the committee's
 5.9 development and implementation of solutions to the staffing concerns raised in concern for
 5.10 safe staffing forms that have been forwarded to the committee. The dispute resolution
 5.11 procedures must include an expedited arbitration process with an arbitrator who has expertise
 5.12 in patient care. The committee must use the expedited arbitration process for any complaint
 5.13 that remains unresolved 30 days after the submission of the concern for safe staffing form
 5.14 that gave rise to the complaint.

5.15 (b) Each hospital nurse workload committee must attempt to expeditiously resolve
 5.16 staffing issues the committee determines arise from a violation of the hospital's core staffing
 5.17 plan.

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

5.19 Sec. 5. Minnesota Statutes 2022, section 144.7055, is amended to read:

5.20 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

5.21 Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to
 5.22 144.7058, the following terms have the meanings given.

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

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

5.31 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients
 5.32 and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates

6.1 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not
6.2 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

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

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

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

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

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

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

6.17 (2) the maximum number of patients on each inpatient care unit for whom a direct care
6.18 nurse can typically safely care;

6.19 (3) criteria for determining when circumstances exist on each inpatient care unit such
6.20 that a direct care nurse cannot safely care for the typical number of patients and when
6.21 assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

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

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

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

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

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

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

7.6 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff
 7.7 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive
 7.8 24-hour periods requiring 16 or more hours;

7.9 (3) a direct care registered nurse is not required or expected to perform functions outside
 7.10 the nurse's professional license;

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

7.12 (5) a charge nurse does not have patient assignments; and

7.13 (6) daily staffing schedules do not interfere with applicable collective bargaining
 7.14 agreements.

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

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

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

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

7.26 (3) unit-specific demands on direct care registered nurses' time, including: frequency of
 7.27 admissions, discharges, and transfers; frequency and complexity of patient evaluations and
 7.28 assessments; frequency and complexity of nursing care planning; planning for patient
 7.29 discharge; assessing for patient referral; patient education; and implementing infectious
 7.30 disease protocols;

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

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

8.3 (6) the stress that direct-care nurses experience when required to work extreme amounts
 8.4 of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

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

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

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

8.11 (10) mechanisms and procedures for identifying additional registered nurses who are
 8.12 available for direct patient care when patients' unexpected needs exceed the planned workload
 8.13 for direct care staff; and

8.14 (11) demands on direct care registered nurses' time not directly related to providing
 8.15 direct care on a unit, such as involvement in quality improvement activities, professional
 8.16 development, service to the hospital, including serving on the hospital nurse staffing
 8.17 committee or the hospital nurse workload committee, and service to the profession.

8.18 Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing
 8.19 committee cannot approve a hospital core staffing plan by a majority vote, the members of
 8.20 the nurse staffing committee must enter an expedited arbitration process with an arbitrator
 8.21 who understands patient care needs.

8.22 Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects
 8.23 to a core staffing plan approved by a majority vote of the hospital nurse staffing committee,
 8.24 the hospital may elect to attempt to amend the core staffing plan through arbitration.

8.25 (b) During an ongoing dispute resolution process, a hospital must continue to implement
 8.26 the core staffing plan as written and approved by the hospital nurse staffing committee.

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

8.29 Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital
 8.30 must submit to the commissioner the core staffing plans approved by the hospital's nurse
 8.31 staffing committee. A hospital must submit any substantial updates to any previously

9.1 approved plan, including any amendments to the plan resulting from arbitration, within 30
 9.2 calendar days of approval of the update by the committee or the conclusion of arbitration.

9.3 ~~Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core~~
 9.4 ~~staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota~~
 9.5 ~~Hospital Association shall include each reporting hospital's core staffing plan on the~~
 9.6 ~~Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,~~
 9.7 ~~2014. any substantial changes to the core staffing plan shall be updated within 30 days.~~

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

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

9.13 Sec. 6. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

9.14 Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core
 9.15 staffing plans approved by a majority vote of its hospital nurse staffing committee.

9.16 (b) The commissioner is required to verify compliance with this section by on-site visits
 9.17 during routine hospital surveys.

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

9.20 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing
 9.21 plan, a hospital must post a notice stating whether the current staffing on the unit complies
 9.22 with the hospital's core staffing plan for that unit. The public notice of compliance must
 9.23 include a list of the number of nonmanagerial care staff working on the unit during the
 9.24 current shift and the number of patients assigned to each direct care registered nurse working
 9.25 on the unit during the current shift. The list must enumerate the nonmanagerial care staff
 9.26 by health care worker type. The public notice of compliance must be posted immediately
 9.27 adjacent to the publicly posted core staffing plan.

9.28 Subd. 4. **Posting of compliance in patient rooms.** A hospital must post on a whiteboard
 9.29 in a patient's room or make available through a television in a patient's room both the number
 9.30 of patients a nurse on the patient's unit should be assigned under the relevant core staffing
 9.31 plan and the number of patients actually assigned to a nurse during the current shift.

10.1 Subd. 5. **Deviations from core staffing plans.** (a) Before hospital management lowers
10.2 the staffing level of any unit, management must consult with and receive agreement from
10.3 at least 50 percent of the direct care registered nurses staffing the unit.

10.4 (b) Deviation from a core staffing plan with the agreement of at least 50 percent of the
10.5 direct care registered nurses staffing the unit does not constitute compliance with the core
10.6 staffing plan.

10.7 Subd. 6. **Public posting of emergency department wait times.** A hospital must maintain
10.8 on its website and publicly display in its emergency department the approximate wait time
10.9 for patients who are not in critical need of emergency care. The approximate wait time must
10.10 be updated at least hourly.

10.11 Subd. 7. **Disclosure of staffing plan upon admission.** A hospital must provide an
10.12 explanation of its core staffing plan to each patient upon admission.

10.13 Subd. 8. **Public distribution of core staffing plan and notice of compliance.** (a) A
10.14 hospital must include with the posted materials described in subdivisions 2 and 3 a statement
10.15 that individual copies of the posted materials are available upon request to any patient on
10.16 the unit or to any visitor of a patient on the unit. The statement must include specific
10.17 instructions for obtaining copies of the posted materials.

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

10.21 Subd. 9. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient
10.22 family member may submit a concern for safe staffing form to report an instance of
10.23 noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing
10.24 plan, or to challenge the process of the hospital nurse staffing committee.

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

10.27 (c) The commissioner of labor and industry may investigate any report of interference
10.28 with or retaliation against a hospital employee for submitting a concern for safe staffing
10.29 form. The commissioner of labor and industry may fine a hospital up to \$250,000 if the
10.30 commissioner finds the hospital interfered with or retaliated against a hospital employee
10.31 for submitting a concern for safe staffing form.

10.32 Subd. 10. **Documentation of compliance.** Each hospital must document compliance
10.33 with its core nursing plans and maintain records demonstrating compliance for each inpatient

11.1 care unit for five years. Each hospital must provide to its nurse staffing committee access
11.2 to all documentation required under this subdivision.

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

11.4 Sec. 7. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

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

11.8 Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner
11.9 by a hospital nurse staffing committee must:

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

11.12 (2) identify each occurrence of the hospital accepting an elective surgery at a time when
11.13 the unit performing the surgery is out of compliance with its core staffing plan;

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

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

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

11.18 (iii) inappropriately experienced direct care registered nurses scheduled for a particular
11.19 unit;

11.20 (iv) inappropriately experienced direct care registered nurses present and delivering care
11.21 in a unit;

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

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

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

11.26 (5) propose solutions to solve insufficient staffing;

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

11.28 (7) describe staffing trends within the hospital.

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

12.1 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each
12.2 hospital nurse staffing committee a uniform format or standard form the committee must
12.3 use to comply with the nurse staffing reporting requirements under this section. The format
12.4 or form developed by the commissioner must present the reported information in a manner
12.5 allowing patients and the public to clearly understand and compare staffing patterns and
12.6 actual levels of staffing across reporting hospitals. The commissioner must include, in the
12.7 uniform format or on the standardized form, space to allow the reporting hospital to include
12.8 a description of additional resources available to support unit-level patient care and a
12.9 description of the hospital.

12.10 Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the
12.11 commissioner may impose an immediate fine of up to \$5,000 for each instance of a failure
12.12 to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility
12.13 may request a hearing on the immediate fine under section 144.653, subdivision 8.

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

12.15 Sec. 8. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

12.16 Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the
12.17 commissioner must develop a uniform annual grading system that evaluates each hospital's
12.18 compliance with its own core staffing plan. The commissioner must assign each hospital a
12.19 compliance grade based on a review of the hospital's nurse staffing report submitted under
12.20 section 144.7057. The commissioner must assign a failing compliance grade to any hospital
12.21 that has not been in compliance with its staffing plan for six or more months during the
12.22 reporting year.

12.23 Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing
12.24 plan, the commissioner must consider at least the following factors:

12.25 (1) the number of assaults and injuries occurring in the hospital involving patients;

12.26 (2) the prevalence of infections, pressure ulcers, and falls among patients;

12.27 (3) emergency department wait times;

12.28 (4) readmissions;

12.29 (5) use of restraints and other behavior interventions;

12.30 (6) employment turnover rates among direct care registered nurses and other direct care
12.31 health care workers;

13.1 (7) prevalence of overtime among direct care registered nurses and other direct care
 13.2 health care workers;

13.3 (8) prevalence of missed shift breaks among direct care registered nurses and other direct
 13.4 care health care workers;

13.5 (9) frequency of incidents of being out of compliance with a core staffing plan; and

13.6 (10) the extent of noncompliance with a core staffing plan.

13.7 Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the
 13.8 commissioner must publish a compliance grade for each hospital on the department website
 13.9 with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an
 13.10 accessible and easily understandable explanation of what the compliance grade means.

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

13.12 Sec. 9. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

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

13.15 (b) "Emergency" means a period when replacement staff are not able to report for duty
 13.16 for the next shift, or a period of increased patient need, because of unusual, unpredictable,
 13.17 or unforeseen circumstances, including but not limited to an act of terrorism, a disease
 13.18 outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient
 13.19 care.

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

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

13.25 Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other
 13.26 entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility
 13.27 licensed by the commissioner of health, and the facility's agent, is prohibited from taking
 13.28 action against a nurse solely on the ground that the nurse fails to accept an assignment of
 13.29 one or more additional patients because the nurse determines that accepting an additional
 13.30 patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's
 13.31 life, health, or safety or may otherwise constitute a ground for disciplinary action under

14.1 section 148.261. This subdivision does not apply to a nursing facility, an intermediate care
14.2 facility for persons with developmental disabilities, or a licensed boarding care home.

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

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

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

14.10 Subd. 6. **Enforcement.** The commissioner of labor and industry shall enforce this section.
14.11 The commissioner of labor and industry may assess a fine of up to \$5,000 for each violation
14.12 of this section.

14.13 Sec. 10. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**
14.14 **BEDSIDE ACT.**

14.15 (a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing
14.16 committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse
14.17 workload committee as described under Minnesota Statutes, section 144.7054.

14.18 (b) By October 1, 2025, each hospital must implement core staffing plans developed by
14.19 its hospital nurse staffing committee and satisfy the plan posting requirements under
14.20 Minnesota Statutes, section 144.7056.

14.21 (c) By October 1, 2025, each hospital must submit to the commissioner of health core
14.22 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

14.23 (d) By October 1, 2025, the commissioner of health must develop a standard concern
14.24 for safe staffing form and provide an electronic means of submitting the form to the relevant
14.25 hospital nurse staffing committee. The commissioner must base the form on the existing
14.26 concern for safe staffing form maintained by the Minnesota Nurses' Association.

14.27 (e) By January 1, 2026, the commissioner of health must provide electronic access to
14.28 the uniform format or standard form for nurse staffing reporting described under Minnesota
14.29 Statutes, section 144.7057, subdivision 4.

15.1 Sec. 11. **APPROPRIATION; HOSPITAL STAFFING.**

15.2 (a) \$..... in fiscal year 2024 and \$..... in fiscal year 2025 are appropriated from the
15.3 general fund to the commissioner of health for the administration of Minnesota Statutes,
15.4 section 144.7057.

15.5 (b) \$..... in fiscal year 2024 and \$..... in fiscal year 2025 are appropriated from the
15.6 general fund to the commissioner of health for the grading duties described in Minnesota
15.7 Statutes, section 144.7058.

15.8 Sec. 12. **REVISOR INSTRUCTION.**

15.9 In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b) to
15.10 (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.
15.11 The revisor shall make any necessary changes to sentence structure for this renumbering
15.12 while preserving the meaning of the text. The revisor shall also make necessary
15.13 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the
15.14 renumbering.

15.15 **ARTICLE 3**

15.16 **WORKPLACE VIOLENCE PREVENTION**

15.17 Section 1. Minnesota Statutes 2022, section 144.566, is amended to read:

15.18 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

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

15.21 (b) "Act of violence" means an act by a patient or visitor against a health care worker
15.22 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections
15.23 609.221 to 609.2241.

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

15.25 (d) "Health care worker" means any person, whether licensed or unlicensed, employed
15.26 by, volunteering in, or under contract with a hospital, who has direct contact with a patient
15.27 of the hospital for purposes of either medical care or emergency response to situations
15.28 potentially involving violence.

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

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

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

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

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

16.9 (j) "Workplace violence hazards" means locations and situations where violent incidents
 16.10 are more likely to occur, including, as applicable, but not limited to locations isolated from
 16.11 other health care workers; health care workers working alone; health care workers working
 16.12 in remote locations; health care workers working late night or early morning hours; locations
 16.13 where an assailant could prevent entry of responders or other health care workers into a
 16.14 work area; locations with poor illumination; locations with poor visibility; lack of physical
 16.15 barriers between health care workers and persons at risk of committing workplace violence;
 16.16 lack of effective escape routes; obstacles and impediments to accessing alarm systems;
 16.17 locations within the facility where alarm systems are not operational; entryways where
 16.18 unauthorized entrance may occur, such as doors designated for staff entrance or emergency
 16.19 exits; presence, in the areas where patient contact activities are performed, of furnishings
 16.20 or objects that could be used as weapons; and locations where high-value items, currency,
 16.21 or pharmaceuticals are stored.

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

16.28 Subd. 3. **Action plan committees.** ~~(b)~~ A hospital shall designate a committee of
 16.29 representatives of health care workers employed by the hospital, including nonmanagerial
 16.30 health care workers, nonclinical staff, administrators, patient safety experts, and other
 16.31 appropriate personnel to develop preparedness and incident response action plans to acts
 16.32 of violence. The hospital shall, in consultation with the designated committee, implement
 16.33 the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall

17.1 require the establishment of a separate committee solely for the purpose required by this
17.2 subdivision.

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

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

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

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

17.12 Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The
17.13 preparedness and incident response action plans to acts of violence must include assessment
17.14 procedures to identify and evaluate workplace violence hazards for each facility, unit,
17.15 service, or operation, including community-based risk factors and areas surrounding the
17.16 facility, such as employee parking areas and other outdoor areas. Procedures shall specify
17.17 the frequency with which such environmental assessments will take place.

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

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

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

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

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

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

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

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

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

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

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

18.18 Subd. 8. **Required elements of action plans; coordination with other employers.** The
18.19 preparedness and incident response action plans to acts of violence must include methods
18.20 the hospital will use to coordinate implementation of the plan with other employers whose
18.21 employees work in the same health care facility, unit, service, or operation and to ensure
18.22 that those employers and their employees understand their respective roles as provided in
18.23 the plan. These methods must ensure that all employees working in the facility, unit, service,
18.24 or operation are provided the training required by subdivision 11 and that workplace violence
18.25 incidents involving any employee are reported, investigated, and recorded.

18.26 Subd. 9. **Required elements of action plans; white supremacist affiliation and support**
18.27 **prohibited.** (a) The preparedness and incident response action plans to acts of violence
18.28 must include a policy statement stating that security personnel employed by the hospital or
18.29 assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or
18.30 advocating for white supremacist groups, causes, or ideologies or participating in, or actively
18.31 promoting, an international or domestic extremist group that the Federal Bureau of
18.32 Investigation has determined supports or encourages illegal, violent conduct.

19.1 (b) For purposes of this subdivision, white supremacist groups, causes, or ideologies
 19.2 include organizations and associations and ideologies that promote white supremacy and
 19.3 the idea that white people are superior to Black, Indigenous, and people of color (BIPOC);
 19.4 promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between
 19.5 BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation,
 19.6 and violence against BIPOC as means of promoting white supremacy.

19.7 Subd. 10. **Required elements of action plans; training.** (a) The preparedness and
 19.8 incident response action plans to acts of violence must include:

19.9 (1) procedures for developing and providing the training required in subdivision 11 that
 19.10 permits health care workers and their representatives to participate in developing the training;
 19.11 and

19.12 (2) a requirement for cultural competency training and equity, diversity, and inclusion
 19.13 training.

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

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

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

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

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

19.26 Subd. 11. **Training required.** (e) A hospital ~~shall~~ must provide training to all health
 19.27 care workers employed or contracted with the hospital on safety during acts of violence.
 19.28 Each health care worker must receive safety training ~~annually and upon hire~~ during the
 19.29 health care worker's orientation and before the health care worker completes a shift
 19.30 independently, and annually thereafter. Training must, at a minimum, include:

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

20.1 (2) ways to identify potentially violent or abusive situations, including aggression and
 20.2 violence predicting factors; and

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

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

20.12 **Subd. 12. Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual
 20.13 review of preparedness and incident response action plans required under ~~paragraph (a)~~
 20.14 subdivision 2, the hospital must review with the designated committee:

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

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

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

20.22 ~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous
 20.23 year, including injuries sustained, if any, and the unit in which the incident occurred;

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

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

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

21.1 Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital
 21.2 must update the action plans to reflect the corrective actions the hospital will implement to
 21.3 mitigate the hazards and vulnerabilities identified during the annual review.

21.4 Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a
 21.5 procedure for a health care worker to officially request of hospital supervisors or
 21.6 administration that additional staffing be provided. The hospital must document all requests
 21.7 for additional staffing made because of a health care worker's concern over a risk of an act
 21.8 of violence. If the request for additional staffing to reduce the risk of violence is denied,
 21.9 the hospital must provide the health care worker who made the request a written reason for
 21.10 the denial and must maintain documentation of that communication with the documentation
 21.11 of requests for additional staffing. A hospital must make documentation regarding staffing
 21.12 requests available to the commissioner for inspection at the commissioner's request. The
 21.13 commissioner may use documentation regarding staffing requests to inform the
 21.14 commissioner's determination on whether the hospital is providing adequate staffing and
 21.15 security to address acts of violence, and may use documentation regarding staffing requests
 21.16 if the commissioner imposes a penalty under subdivision 18.

21.17 Subd. 15. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent

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

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

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

21.21 those collective bargaining units.

21.22 (b) A hospital must also annually submit to the commissioner its most recent action plan

21.23 and the results of the most recent annual review conducted under subdivision 12.

21.24 Subd. 16. **Legislative report required.** (a) The commissioner must compile the

21.25 information into a single annual report and submit the report to the chairs and ranking

21.26 minority members of the legislative committees with jurisdiction over health care by January

21.27 15 of each year.

21.28 (b) This subdivision does not expire.

21.29 Subd. 17. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner,

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

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

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

21.33 violence.

22.1 Subd. 18. Penalties. (g) Notwithstanding section 144.653, subdivision 6, the
 22.2 commissioner may impose an administrative fine of up to \$250 \$10,000 for failure to
 22.3 comply with the requirements of this subdivision section. The commissioner must allow
 22.4 the hospital at least 30 calendar days to correct a violation of this section before assessing
 22.5 a fine.

22.6 Sec. 2. **APPROPRIATION; PREVENTION OF VIOLENCE IN HEALTH CARE.**

22.7 \$50,000 in fiscal year 2024 and \$50,000 in fiscal year 2025 are appropriated to the
 22.8 commissioner of health to continue the prevention of violence in health care programs and
 22.9 to create violence prevention resources for hospitals and other health care providers to use
 22.10 to train their staff on violence prevention.

22.11 **ARTICLE 4**

22.12 **PIPELINE TO REGISTERED NURSE DEGREES**

22.13 Section 1. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES.**

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

22.19 **ARTICLE 5**

22.20 **NURSE LOAN FORGIVENESS**

22.21 Section 1. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

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

22.24 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist
 22.25 under section 150A.06, and who is certified as an advanced dental therapist under section
 22.26 150A.106.

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

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

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

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

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

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

23.10 (i) "Mental health professional" means an individual providing clinical services in the
23.11 treatment of mental illness who is qualified in at least one of the ways specified in section
23.12 245.462, subdivision 18.

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

23.15 ~~(k)~~ (k) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse
23.16 anesthetist, advanced clinical nurse specialist, or physician assistant.

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

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

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

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

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

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

23.27 (r) "PSLF program" means the federal Public Service Loan Forgiveness program
23.28 established under Code of Federal Regulations, title 34, section 685.219.

23.29 ~~(s)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has
23.30 obtained a registration certificate as a public health nurse from the Board of Nursing in
23.31 accordance with Minnesota Rules, chapter 6316.

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

24.4 ~~(s)~~ (u) "Underserved urban community" means a Minnesota urban area or population
 24.5 included in the list of designated primary medical care health professional shortage areas
 24.6 (HPSAs), medically underserved areas (MUAs), or medically underserved populations
 24.7 (MUPs) maintained and updated by the United States Department of Health and Human
 24.8 Services.

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

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

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

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

24.19 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
 24.20 facility for persons with developmental disability; a hospital if the hospital owns and operates
 24.21 a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse
 24.22 is in the nursing home; a housing with services establishment as defined in section 144D.01,
 24.23 subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or
 24.24 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a
 24.25 postsecondary program at the undergraduate level or the equivalent at the graduate level;

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

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

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

25.6 (7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by
25.7 a nonprofit hospital that is an eligible employer under the PSLF program, and providing
25.8 direct care to patients at the nonprofit hospital.

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

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

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

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

25.22 (2) submit an application to the commissioner of health. Nurses applying under
25.23 subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled
25.24 in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

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

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

25.31 (2) a nurse selected under subdivision 2, paragraph (a), clause (7), must agree to continue
25.32 as a hospital nurse for the repayment period of the participant's eligible loan under the PSLF
25.33 program; and

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

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

26.4 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each
26.5 year for participation in the loan forgiveness program, within the limits of available funding.
26.6 In considering applications, the commissioner shall give preference to applicants who
26.7 document diverse cultural competencies. The commissioner shall distribute available funds
26.8 for loan forgiveness proportionally among the eligible professions according to the vacancy
26.9 rate for each profession in the required geographic area, facility type, teaching area, patient
26.10 group, or specialty type specified in subdivision 2, except for hospital nurses. The
26.11 commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the
26.12 funds available are used for rural physician loan forgiveness and 25 percent of the funds
26.13 available are used for underserved urban communities and pediatric psychiatry loan
26.14 forgiveness. If the commissioner does not receive enough qualified applicants each year to
26.15 use the entire allocation of funds for any eligible profession, the remaining funds may be
26.16 allocated proportionally among the other eligible professions according to the vacancy rate
26.17 for each profession in the required geographic area, patient group, or facility type specified
26.18 in subdivision 2. Applicants are responsible for securing their own qualified educational
26.19 loans. The commissioner shall select participants based on their suitability for practice
26.20 serving the required geographic area or facility type specified in subdivision 2, as indicated
26.21 by experience or training. The commissioner shall give preference to applicants closest to
26.22 completing their training. Except as specified in paragraphs (b) and (c), for each year that
26.23 a participant meets the service obligation required under subdivision 3, up to a maximum
26.24 of four years, the commissioner shall make annual disbursements directly to the participant
26.25 equivalent to 15 percent of the average educational debt for indebted graduates in their
26.26 profession in the year closest to the applicant's selection for which information is available,
26.27 not to exceed the balance of the participant's qualifying educational loans. Before receiving
26.28 loan repayment disbursements and as requested, the participant must complete and return
26.29 to the commissioner a confirmation of practice form provided by the commissioner verifying
26.30 that the participant is practicing as required under subdivisions 2 and 3. The participant
26.31 must provide the commissioner with verification that the full amount of loan repayment
26.32 disbursement received by the participant has been applied toward the designated loans.
26.33 After each disbursement, verification must be received by the commissioner and approved
26.34 before the next loan repayment disbursement is made. Participants who move their practice

27.1 remain eligible for loan repayment as long as they practice as required under subdivision
27.2 2.

27.3 (b) For hospital nurses, the commissioner of health shall select applicants each year for
27.4 participation in the hospital nursing education loan forgiveness program, within limits of
27.5 available funding for hospital nurses. Applicants are responsible for applying for and
27.6 maintaining eligibility for the PSLF program. For each year that a participant meets the
27.7 eligibility requirements described in subdivision 3, the commissioner shall make an annual
27.8 disbursement directly to the participant in an amount equal to the minimum loan payments
27.9 required to be paid by the participant under the participant's repayment plan established for
27.10 the participant under the PSLF program for the previous loan year. Before receiving the
27.11 annual loan repayment disbursement, the participant must complete and return to the
27.12 commissioner a confirmation of practice form provided by the commissioner, verifying that
27.13 the participant continues to meet the eligibility requirements under subdivision 3. The
27.14 participant must provide the commissioner with verification that the full amount of loan
27.15 repayment disbursement received by the participant has been applied toward the loan for
27.16 which forgiveness is sought under the PSLF program.

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

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

27.24 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required
27.25 minimum commitment of service according to subdivision 3; or, for hospital nurses, the
27.26 secretary of education determines that the participant does not meet eligibility requirements
27.27 for the PSLF, the commissioner of health shall collect from the participant the total amount
27.28 paid to the participant under the loan forgiveness program plus interest at a rate established
27.29 according to section 270C.40. The commissioner shall deposit the money collected in the
27.30 health care access fund to be credited to the health professional education loan forgiveness
27.31 program account established in subdivision 2. The commissioner shall allow waivers of all
27.32 or part of the money owed the commissioner as a result of a nonfulfillment penalty if
27.33 emergency circumstances prevented fulfillment of the minimum service commitment or,

28.1 for hospital nurses, if the PSLF program is discontinued before the participant's service
28.2 commitment is fulfilled.

28.3 Sec. 6. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

28.22 (7) a physician certified by the American Board of Family Medicine or the American
28.23 Osteopathic Board of Family Practice whose practice includes emergency department care
28.24 in a level III or IV trauma hospital located in a designated rural area as defined under section
28.25 144.1501, subdivision 1, ~~paragraph (e)~~;

28.26 (8) a nurse practitioner, as defined under section 144.1501, subdivision 1, ~~paragraph (l)~~,
28.27 or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph (o)~~,
28.28 whose practice includes emergency room care in a level IV trauma hospital located in a
28.29 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

28.30 (9) a physician certified in pediatric emergency medicine by the American Board of
28.31 Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency
28.32 Medicine or certified by the American Osteopathic Board of Pediatrics whose practice

29.1 primarily includes emergency department medical care in a level I, II, III, or IV trauma
 29.2 hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose
 29.3 practice involves the care of pediatric trauma patients in a trauma hospital;

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

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

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

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

29.14 (14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the
 29.15 meaning of section 144E.001 and who actively practices with a licensed ambulance service
 29.16 in a primary service area located in a designated rural area as defined under section 144.1501,
 29.17 subdivision 1, ~~paragraph (e)~~; and

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

29.19 Sec. 7. Minnesota Statutes 2022, section 147A.08, is amended to read:

29.20 **147A.08 EXEMPTIONS.**

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

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

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

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

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

30.3 Sec. 8. **APPROPRIATION; HOSPITAL NURSING LOAN FORGIVENESS.**

30.4 Notwithstanding the priorities and distribution requirements under Minnesota Statutes,
30.5 section 144.1501, \$5,000,000 in fiscal year 2024 and \$5,000,000 in fiscal year 2025 are
30.6 appropriated from the general fund to the commissioner of health for the health professional
30.7 education loan forgiveness program under Minnesota Statutes, section 144.1501, to be
30.8 distributed to eligible nurses who have agreed to be hospital nurses in accordance with
30.9 Minnesota Statutes, section 144.1501, subdivision 2, clause (7).

30.10 Sec. 9. **APPROPRIATION; LOAN FORGIVENESS FOR NURSING**
30.11 **INSTRUCTORS.**

30.12 Notwithstanding the priorities and distribution requirements under Minnesota Statutes,
30.13 section 144.1501, \$..... in fiscal year 2024 and \$..... in fiscal year 2025 are appropriated
30.14 from the general fund to the commissioner of health for the health professional education
30.15 loan forgiveness program under Minnesota Statutes, section 144.1501, to be distributed in
30.16 accordance with the program to eligible nurses who have agreed to teach in accordance
30.17 with Minnesota Statutes, section 144.1501, subdivision 2, clause (3).

30.18 **ARTICLE 6**

30.19 **REPORT ON HOSPITAL STAFFING**

30.20 Section 1. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

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

30.25 (b) The reporting system shall consist of:

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

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

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

31.1 ~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of
 31.2 systemic failure in the health care system and successful methods to correct these failures;

31.3 ~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system
 31.4 requirements; and

31.5 ~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and
 31.6 the public to maximize the use of the reporting system to improve health care quality.

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

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

31.10 Sec. 2. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT OF**
 31.11 **ANALYTICAL TOOLS.**

31.12 (a) The commissioner of health, in consultation with the Minnesota Nurses Association
 31.13 and other professional nursing organizations, must develop a means of analyzing available
 31.14 adverse event data, available staffing data, and available data from concern for safe staffing
 31.15 forms to examine potential causal links between adverse events and understaffing.

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

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

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

31.25 Sec. 3. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING**
 31.26 **WORKFORCE REPORT.**

31.27 (a) The commissioner of health must publish a public report on the current status of the
 31.28 state's nursing workforce employed by hospitals. In preparing the report, the commissioner
 31.29 shall utilize information collected in collaboration with the Board of Nursing as directed
 31.30 under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active
 31.31 licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals;

32.1 information collected and shared by the Minnesota Hospital Association on retention by
 32.2 hospitals of licensed nurses; information collected through an independent study on reasons
 32.3 licensed nurses are choosing not to renew their licenses and leaving the profession; and
 32.4 other publicly available data the commissioner deems useful.

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

32.6 Sec. 4. **APPROPRIATION; HOSPITAL STAFFING STUDY.**

32.7 \$..... in fiscal year 2024 and \$..... in fiscal year 2025 are appropriated to the
 32.8 commissioner of health for the hospital staffing study authorized under Minnesota Statutes,
 32.9 section 144.7067, subdivision 4.

32.10 **ARTICLE 7**

32.11 **MENTAL HEALTH SERVICES FOR NURSES**

32.12 Section 1. **APPROPRIATION; IMPROVING MENTAL HEALTH OF HEALTH**
 32.13 **CARE WORKERS.**

32.14 \$10,000,000 in fiscal year 2024 and \$10,000,000 in fiscal year 2025 are appropriated
 32.15 from the general fund to the commissioner of health for competitive grants to hospitals,
 32.16 community health centers, rural health clinics, and medical professional associations to
 32.17 establish or enhance evidence-based or evidence-informed programs dedicated to improving
 32.18 the mental health of health care professionals.