



Chair and conferees:

With 22,000 members, the Minnesota Nurses Association (MNA) represents 80 percent of all active bedside hospital nurses in Minnesota and is the largest voice for professional nursing in the state. We are a leader in nursing, labor, health care and social justice communities and a voice for nurses and patients on issues relating to the professional, economic, and general well-being of nurses and in promoting the health and well-being of the public.

Professional Distinction

Personal Dignity

Patient Advocacy

Healthcare in Minnesota used to be about taking care of each other. Our system of nation-leading care was built by passionate providers and community members working together to build up and sustain community hospitals across our state. But in recent years, we've seen the focus drift away from the bedside to the bottom line.

Nurse staffing levels are cut, patients are charged more every year, and community clinics and hospitals that have served patients for generations are closed. We need to return to a healthcare system that puts the needs of patients at the center. The legislation before you today would give nurses and patients a voice to improve conditions in our hospitals and keep care in our communities, and would keep patients and nurses safe at the bedside.

HF 4200: The Healthcare Employee Anti-Retaliation and Labor (HEAL) Act

Fewer nursing staff for patients at the bedside puts care at risk and pushes nurses to do more with less. There are more nurses in Minnesota than before the COVID-19 pandemic began, with more graduating every year. But recent studies show that nurses are not returning to our hospitals, as the crisis of under-staffing and care continues.

There is a moral injury that comes from being forced to provide care that feels unsafe or inadequate. This feeling is exacerbated when to speak up about these concerns means a nurse may not have food on the table next week, or a job next month. Too often, when a nurse raises a concern about the safety of a patient care assignment, they are sent home without pay, or are later denied leave, career opportunities, or schedule requests.

To recruit and retain nurses at the bedside, lawmakers must protect nurses who take action to fight for the care and working conditions we all deserve. The bill also recognizes that nurses are experts in patient care, spending more time at the bedside than anyone else; so nurses must be included in discussions about how to improve patient care when something goes wrong, especially when short staffing is so often to blame.

HF 4210: Improving Safety in Hospitals Act

Lower bedside staff levels increase the risk of violence for patients and workers in our hospitals. Hospitals are now one of the most dangerous places to work in Minnesota. In 2021, 97 percent of surveyed Minnesota nurses had observed violence in the workplace, including verbal and physical intimidation and assaults,

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AFL-CIO

and 79 percent identified safe staffing levels as the solution needed to protect worker and patient safety in Minnesota hospitals.

This bill would improve violence prevention in Minnesota hospitals with crisis response teams on every hospital floor, better record-keeping of incidents of violence, trauma-informed care plans for patients, and de-escalation training for all hospital staff. The bill would also make hospital executives, not nurses, responsible for their staffing and safety decisions when something goes wrong.

HF3700: Hospital Closures Act

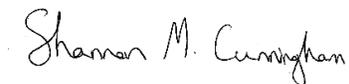
The crisis in our healthcare system can be seen clearly in the shuttered hospitals and units in communities across our state. Between 2011 and 2021, 22 Obstetrics units closed in Greater Minnesota, the highest number of any state in the nation. Mayo Clinic executives have closed at least 22 rural facilities since 2009. M Health Fairview executives bought up and then closed down two hospitals in St. Paul in the midst of a global pandemic, including the state's only dedicated COVID-19 hospital. In the last two years, Allina executives closed baby deliveries in Hastings and desperately needed adolescent mental health beds in the Twin Cities.

When these closures take place, they disrupt care access for thousands of Minnesotans, eliminate good-paying jobs, and take a vital resource out of our communities. When facilities or services are slated for closure, those who would be most affected need to be given a voice. This bill will require significant public notice before a planned service or facility closure takes place and will require that at least one public hearing be held in the community affected by corporate decision-making. The bill would impose serious penalties on healthcare systems that refuse to comply and would ensure local communities have the option to buy back facilities slated for closure by hospital corporations.

Just as patients depend on nurses to care for them at the bedside, Minnesotans need legislators to ensure that patients and nurses are protected in our hospitals – from retaliation, violence, and unsafe staffing.

Thank you for taking up these important bills. We appreciate and are grateful for the work and consideration of this committee and look forward to your support for these critical pieces of legislation.

Thank you,



Shannon M. Cunningham
Director of Governmental and Community Relations Minnesota Nurses Association

Respected members of the legislature,

I need you to know just how real workplace retaliation is within the hospitals in your state. It's happened to so many nurses in Minnesota, where large corporate entities see the bottom line before they ever consider the dying patient. But today I will only tell you about what happened to me, personally.

Last year, after the Keeping Nurses at the Bedside Act was no more, I arrived to work at my Allina facility cardiac unit ready for another incredibly stressful day, only to discover that the floor was not just stressful, but actually very dangerous. That day there were three times as many highly acute (meaning intense amount of care) patients than was planned. My assignment was completely unmanageable. I requested for my assignment to be changed so that my patients would get the care they were hospitalized for, only to find out that every other nurse on the floor was in the same predicament I was. Shuffling our assignments would not work. The charge nurse agreed the situation was extremely unsafe for our patients and for the nurses.

I would like to remind everyone that medical errors are the third leading cause of death in the U.S. That's a statistic I do not intend on contributing to, but very well could have if I would have accepted that assignment.

When the charge nurse asked if there were any extra nurses in house who could be spared for the safety of the unit, management said yes, but we could not have the additional nurse. After the nurses all determined we could not provide safe care, we repeated our request for safety to management. The Chief Nursing Officer's response was to storm into our breakroom, call our nursing judgement inferior, directly call us ridiculous, threaten to terminate us, and to report us to the Board of Nursing. We were told we were abandoning our patients. Then the entire cardiac unit was dismissed for the day without pay.

All I ask for is the normal amount of stress that comes with taking care of my patients. Now added on top of that, I also have the stress of being unable to speak up for safety due to the **very real** fear of intimidation and retaliation. I am one of many nurses that feel like they cannot speak up.

Thank you for your time,

Ryan Hilmoie, RN

February 29th, 2024

Chair Liebling
State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Chair and Committee Members,

My name is Wayne R Garrett, Certified Psychiatric RN working at Fairview Range in Hibbing, MN. I have been working as a RN in private acute care psychiatric units since 2007 as well as 17 years working for MN Department of Corrections.

I have seen many different approaches for how to deal with people in psychiatric crisis. Most hospitals and corrections facilities use a response team that resembles a police response. All available staff are expected to show up. An Incident Commander assigns these people different tasks. In my experience, what often happens with this police style approach, is that the person in crisis sees a **mob form** and becomes more frightened, not calming, but further **escalating the situation**. The people responding have some training on restraining patients but little training on **de-escalation**. What is truly needed is a few highly trained individuals skilled in de-escalation techniques. Fairview uses Behavioral Control Situation (BCS) which offers some limited lectures on de-escalation but includes no actual role-playing practice and teaching. Most of the training is focused on learning hands on restraint of the patient. When I am Charge Nurse and in charge of the incident, I direct the BCS team hang back and go in to talk with the patient with their nurse. If the situation becomes violent, then the response team is needed.

In about 95% of situations, talking to the patient in a soft kind manner with genuine concern and compassion de-escalates the situation. This approach works best when the staff know the patient well and have developed a caring relationship beforehand. It takes a great deal of practice and experience to have the emotional control to be calm, centered, and aware of your own non-verbal communication when dealing with someone who is yelling and screaming in crisis. I have been assaulted and injured many times during my career. Nearly every time I have witnessed a staff or

patient injury, I can point to a lack of training and experience as a key factor. At Fairview and other hospitals, Behavioral Health RN's are the most skilled resource available for a behavioral crisis. I have advocated for almost two decades that Behavioral Health RN's need to be used for behavioral emergencies, just like ICU RN's are used in hospitals to lead Rapid Response Teams for medical emergencies.

My teaching and guidance have been ignored by leadership at both hospitals I have worked at. Most of the violence at hospitals I have seen occurs in the ER. At Fairview and at St. Luke's in Duluth where I have worked, a Behavioral RN responds to the behavioral code in the ER but is not in charge of the code. This is no different than having a behavioral health RN leading a Rapid Response code for a cardiac arrest!

I implore the legislature to pass HF 4140 to enact change that the hospitals are too reluctant or incompetent to implement on their own. Currently, ER's around the state and country have lost the majority of their most experienced nurses. My hospital is currently struggling with two thirds of the ER nurses being new or travel nurses. Having a Violence Interruption Crisis Response Team and adequate staffing will prevent violence in the ER and ensure appropriate care of people in mental health crisis.

Reducing violence will help Keep Nurses at the Bedside!



February 28, 2024

Dear Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Chamber of Commerce, representing 6,300 employers and their more than 500,000 employees across the state, I am writing to share our concerns about the bills under consideration today, HF 4200 (Feist), HF 4210 (Reyer), and HF 3700 (Smith).

Individually and collectively, these bills would place significant new burdens on Minnesota's hospitals and health systems, which have been operating for many years under extremely challenging circumstances. These bills would significantly limit hospitals' ability to respond to patient care needs by undercutting staffing decisions, requiring the creation and staffing of positions that may not align with the needs of a hospital and its patients, and requiring hospitals to make decisions about operations and service offerings well before the financial and staffing data used to support such decisions can be known.

Taken together, these bills would:

- Allow patient care staff to circumvent hospital staffing and care management plans and current whistleblower protections and processes by independently and unilaterally deciding not to accept a patient assignment (HF 4200);
- Require all hospitals to hire dedicated staff to respond to behavioral health crises, regardless of the hospital's size or case mix, putting additional strain on hospitals' efforts to fulfill its workforce needs and further challenging their efforts to direct scarce resources to patient care (HF 4210); and
- Further restrict a hospital's ability to respond in a timely manner to challenges it may face in its finances or its workforce needs by adjusting, altering, or halting service offerings (HF 3700).

Each of these bills represents an effort to address very real challenges. But the solutions proposed in these bills will take away flexibility that hospitals need to fulfill their responsibilities to address these challenges while also meeting the needs of the patients they serve.

Thank you for the opportunity to provide this input.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Bentley Graves', is written over a light blue horizontal line.

Bentley Graves

Director, Health Care & Transportation Policy

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February 28, 2024

Honorable Members of the Minnesota House Health Finance and Policy Committee:

AFSCME Council 5 strongly supports HF 4200, HF 3700, and HF 4210. The consolidation of hospitals under large corporations has focused more attention on profits and the bottom line than on patients and the critical staff at their bedside. These bills work to re-focus the attention on patient care and the staff critical to delivering that care. These bills collectively address several threats posed to the quality of health care Minnesotans expect and deserve.

HF 4200 addresses the need for greater transparency and the need to protect health care workers from retaliation when they raise concerns and speak out or take action to protect safe patient care. Nurses spend more time at the bedside than anyone else and their voices are critically important to ensuring problems affecting patient health care are addressed.

HF 3700 requires more prior notification along with hearings for hospital closures or curtailment of services. Such closures or curtailment of services have a devastating impact on the communities they serve and the ability of citizens to access health care. Citizens need to have the opportunity to respond and be heard before such consequential decisions are made and implemented. The bill also includes a right of first refusal requirement when a hospital or hospital campus are put up for sale to give a chance for communities to retain the health care access they need.

HF 4210 establishes a hospital health crisis team and strengthens provisions preventing violence at health care facilities. Today, health care workers are overworked, and hospitals are understaffed, which increases the risk of violence. This increased workload and risk of violence exacerbates the problem of recruiting and retaining badly needed direct care staff. Health care workers leaving direct care worsens the understaffing problem and intensifies the downward spiral in the quality of care for Minnesota citizens. This bill also requires disclosure of emergency department wait times so the public becomes aware of the negative results from understaffing and the need to stop the downward spiral.

It is time to stop the decline and re-focus our attention on the quality of patient care instead of the size of corporate profits. Minnesota AFSCME Council 5 stands in solidarity with Minnesota Nurses and all workers delivering direct patient care.

In Solidarity,

A handwritten signature in black ink, appearing to read "Bart Andersen", written over a horizontal line.

Bart Andersen, Interim Executive Director

A handwritten signature in black ink, appearing to read "Ethan Vogel", written over a horizontal line.

Ethan Vogel, Legislative Director

Allina failed to alert state when it shuttered mental health unit for kids

Ricky Campbell and Kirsten Swanson KSTP

Updated: December 7, 2023 - 12:15 PM

Published: December 6, 2023 - 6:54 PM

Play Video

Allina failed to alert state when it shuttered mental health unit for kids

Susan's daughter survived sexual assault, but it's the lingering trauma that she says triggers the teen's severe mental illness.

The 14-year-old spent a year and a half seeking help at different emergency rooms and inpatient facilities dedicated to children and teens, like the one at United Hospital, where they had one of their best experiences.

"It's been very, very difficult," Susan said. 5 INVESTIGATES is protecting Susan's identity because her daughter is a victim of sexual assault.

But the mental health bed that proved so helpful for Susan's daughter is no longer available.

Allina Health, which operates United in St. Paul, [shuttered that adolescent mental health unit in September](#) and moved its operations to Abbott Northwestern Hospital in Minneapolis.

Allina's decision to "consolidate" the inpatient service is now prompting new concerns from nurses and mental health advocates who say the system is already stretched to the point that families like Susan's are relying on emergency rooms for care.

"Emergency Room department boarding was already bad before they closed this unit," registered nurse Chad Schulze said. "And now it's even worse."

Letter of concern

In November, the state's nurses' union and the Minnesota chapter of the National Association on Mental Illness sent Allina a letter criticizing the reduction in capacity at such a critical time.

“Closing beds for children and youth during this mental health crisis in the east metro and shifting services to Minneapolis, creates barriers for people in this community,” the letter states.



In the letter, obtained by 5 INVESTIGATES, Allina is also accused of violating a law that requires hospitals to notify the Minnesota Department of Health (MDH) about any closures, relocations, and reductions in services.

Allina officials admitted to the violation in an interview this week.

"It was our error," said Dr. Mary Beth Lardizabal, Allina's Vice President of Mental Health and Addiction Services. "They told us that, you know, we did not interpret that regulation correctly."

MDH has scheduled a virtual public hearing with Allina regarding the changes for Dec. 21 at 6 p.m. Interested participants can also call in at (651) 395-7448 and use the access code 933 516 723#.

State Sen. Erin Murphy (DFL-St. Paul) believes the hospital's failure shows the regulation needs to be tightened.

"The law that we put in place seems not strong enough," Murphy said. "And I think it is time for us to strike a new deal with our hospitals."

Lawmakers added requirements for hospitals in recent years after an outcry over consolidations and closures in Greater Minnesota.

The consolidation of inpatient mental health services for adolescents has been an ongoing concern for the Minnesota Nurses Association, which co-authored the letter with NAMI.

Capacity crunch

Dr. Lardizabal said the children's mental health unit is still below its capacity.

In the last year and a half, Susan said her daughter spent 95 days boarding in various ERs in the Twin Cities **due to a lack of inpatient beds.**

Her last resort: moving her daughter to a residential facility in North Carolina.

"In reality, we're losing beds for children, and more and more children are needing the help, mental health help," she said.

Editor's note: The original version of this story stated Allina did not clarify the number of mental health beds available for children and adolescents. However, in a subsequent email to 5 INVESTIGATES, Allina Health did clarify the number of beds in writing. According to Allina, there are currently 32 mental health beds that are available for youth and adolescent care.

February 27, 2024

Representative Tina Liebling
477 State Office Building
St. Paul, MN 55155

Re: HF3700 (Smith) - Notice and public hearings for hospital closures, curtailment of operations, relocation of services, and cessation in offering services governing requirements modified

Dear Chair Liebling and committee members,

On behalf of Allina Health, I am writing to express our strong opposition to HF3700, which would extend the timeline for hospitals to notify the Minnesota Department of Health of the closure, curtailments, relocation, or cessation of services from 120 to 300 days.

Allina Health is a fully integrated health system with 11 hospital campuses, 65 primary care clinics, and 14 urgent care centers across the Twin Cities, central and southern Minnesota and western Wisconsin. We are also proud to operate more than 100 specialty care sites including retail pharmacy, emergency medical services, same-day surgery centers, virtual care, and expert specialty care for cancer, heart, orthopedics, rehabilitation and more. We are dedicated to serving our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care.

Extending the notification timeline to 300 days for service closures, cessations, curtailments or relocations is unrealistic and impractical given the dynamic nature of health care today. Often, hospitals are forced to make decisions due to extenuating circumstances that accelerate the timeline, including challenges in staffing, a drop in patient acuity or demand for services, or the accumulating effect of chronically low reimbursement rates that threaten the long-term viability of care. Additionally, by moving from 120 to 300 days, this bill eliminates up to 180 days that hospitals currently utilize to find and implement innovative solutions that may prevent service changes. By extending to 300 days, this bill would potentially lead to additional closures to avoid the potentially devastating fines that the bill imposes.

Overall, HF3700 does not address the core issues that force hospitals to close, curtail or relocate services, and instead will force hospitals to make decisions sooner than they would have and potentially lead to service changes that would otherwise be avoidable. It does not address the underlying cause of most closures: changes in patient demographics and demand for services, chronic underfunding, and workforce shortages. For those reasons, we ask you to oppose HF3700.

Thank you for the opportunity to provide comments. We look forward to working with you to address the ongoing challenges facing health care providers in Minnesota.

Sincerely,

A handwritten signature in blue ink that reads "Dominica Tallarico".

Dominica Tallarico
EVP, Chief Operations Officer
Allina Health

February 27, 2024

Representative Tina Liebling
477 State Office Building
St. Paul, MN 55155

Re: HF4200 (Feist) – allowing for refusal of patient assignment

Dear Chair Liebling and committee members,

On behalf of Allina Health, I am writing to express our concerns regarding the potential impacts of HF4200, which allows registered nurses to refuse a patient assignment.

Allina Health is a fully integrated health system with 11 hospital campuses, 65 primary care clinics, and 14 urgent care centers across the Twin Cities, central and southern Minnesota and western Wisconsin. We are also proud to operate more than 100 specialty care sites including retail pharmacy, emergency medical services, same-day surgery centers, virtual care, and expert specialty care for cancer, heart, orthopedics, rehabilitation and more. We are dedicated to serving our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care.

Currently, Allina Health hospitals have a process in place as agreed to as part of our Collective Bargaining Agreements for nurses to elevate staffing assignment concerns. This includes the nurse elevating the concern to the nursing leader who will then determine whether the assignment presents an unsafe staffing assignment and will determine the best way to proceed. HF4200, which is language carried over from last session's problematic "Keeping Nurses at the Bedside Act," would allow an individual nurse on any unit throughout the hospital to refuse a patient assignment. This raises significant concerns regarding the potential for inequitable health care delivery. Currently, all hospitals have a reporting process for nurses that have concerns regarding taking a patient assignment. This bill would supersede our current process, eliminating input from nursing leaders and other care team members. This will make it challenging to plan and flex to meet patient demand. Allowing nurses to refuse patient assignments will inevitably lead to unit closures and delays in care. These unit closures will lead to additional backups in the emergency departments.

Overall, this bill represents a real threat to patient care. The current process for a nurse to elevate staffing assignment concerns works and accounts for the best interest of the entire care team and the patient as well.

Thank you for the opportunity to comment. We look forward to continuing to work with you on behalf of our patients, providers, and communities.

Sincerely,



Dr. D'Andre Carpenter
SVP, Chief Nursing Executive
Allina Health

February 27, 2024

Representative Tina Liebling
477 State Office Building
St. Paul, MN 55155

Re: HF4210 (Reyer) - Hospital behavioral health crisis intervention team requirements established

Dear Chair Liebling and committee members,

On behalf of Allina Health, I am writing to express our concerns regarding the potential impacts of HF4210, which establishes requirements for hospitals to have behavioral health crisis intervention teams.

Allina Health is a fully integrated health system with 11 hospital campuses, 65 primary care clinics, and 14 urgent care centers across the Twin Cities, central and southern Minnesota and western Wisconsin. We are also proud to operate more than 100 specialty care sites including retail pharmacy, emergency medical services, same-day surgery centers, virtual care, and expert specialty care for cancer, heart, orthopedics, rehabilitation and more. We are dedicated to serving our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care.

The safety of our patients and staff is our top priority. Preventing crisis situations and being prepared for the rare instances they do occur. With safety in mind, Allina Health has dedicated considerable time and resources to develop models for crisis intervention that account for the needs of staff and patients while also considering the very limited resources available at many of our hospitals. The bill as drafted combines two distinct response protocols into a single response model that doesn't acknowledge the nuances of patient and staff safety needs. While it may be ideal for crisis intervention teams to not take patient assignments, many hospitals across the state simply do not have the staff available as prescribed in the bill to meet these requirements. Additionally, once the situation elevates to the status of a Code Green, it's imperative that hospitals can deploy the staff best suited to de-escalating the situation and ensuring safety for all parties.

This proposal, as currently drafted, would create a rigid model that is incapable of adapting to the dynamic health care environment. We need more flexibility in responding to patients' needs, not less as is prescribed under this proposal.

Thank you for the opportunity to provide comments and we look forward to working with the bill author and advocates on finding solutions to address workplace violence.

Sincerely,



Dr. D'Andre Carpenter
SVP, Chief Nursing Executive
Allina Health

Baby delivery in Fosston is latest victim of health care executives' greed

It joins examples from other communities and other systems.

By Cassie Heide and Chris Rubesch

FEBRUARY 13, 2024 — 5:30PM



ESSENTIA HEALTH

Essentia Health's hospital in Fosston is permanently ending the scheduling of baby deliveries.

Opinion editor's note: *Star Tribune Opinion publishes a mix of national and local [commentaries](#) online and in print each day. To contribute, [click here](#).*

...

Health care in Minnesota used to be about taking care of one another. Local care providers, grounded in our communities, worked hard to build up Minnesota's reputation for excellent care. But highly paid executives with corporate agendas have taken over our health care system, and the results have been disastrous. What is happening right now in the northwestern city of Fosston is a dire warning for patients, workers and communities across the state about the creeping influence of corporate greed in our hospitals.

When the Fosston Hospital joined Essentia Health in a strategic partnership in 2009, the financially stable hospital had been providing exceptional care in the community for more than 60 years. Community leaders recognized the risk a large corporate entity posed to the 15 rural communities and 20,000 people who depended on the hospital, so Fosston negotiated hard and won an agreement to guarantee that the services rural people relied on would always be there, including birth care.



Worthy battle to keep hospital birth care

[The fight in Fosston, Minn., to maintain labor and delivery at its hospital should spur rural communities facing similar closures to rally.](#)

The agreement held until May 2022, when the city learned that Essentia executives were planning a 120-day pause of scheduled births. Fosston formed a task force of local community stakeholders who worked hard to meet the standards set by Essentia to reopen labor and deliver services. More nurses were hired, despite the challenges of short-staffing and moral distress from the pandemic. A third family medicine obstetrician was hired. Staff were trained, no thanks to Essentia executives, but to local hospital staff.

Despite this success, Essentia executives continued to move the goalposts, and it soon became clear that they had no intention to end the "pause" of birth care. Having labor and delivery services in the community means expectant parents don't have to drive hours in the harsh Minnesota winter when they are desperate to reach the hospital for scheduled or emergency care. It also means attracting and retaining residents in Greater Minnesota, where young couples

expect to find care they can count on. But on some spreadsheet on a desk at Essentia headquarters, some executive saw a bigger bonus in their pocket if they drew a red line through the heart of this community.

The actions of Essentia in Fosston follow a clear course set by the CEO and other executives at the hospital system. After nurses represented by the Minnesota Nurses Association (MNA) won new contract language in 2022 meant to include nurse voices in the process of setting staff levels, Essentia instead slashed staffing when it opened a new hospital in Duluth last summer. Just a month later, Essentia closed urgent care services in a nearby rural community. Essentia executives recently utilized an emergency alert system — meant to warn employees about active shooters and natural disasters — to spread anti-union messages to care staff trying to come together to bargain collectively. And during the pandemic, Essentia executives put 500 staff members on "unpaid leave" while CEO David Herman gave himself a \$1 million raise, to now take home more than \$3 million per year.

As former Fosston Hospital administrator Pat Wangler put it at an emergency meeting about this service closure last fall, this is about one thing: "greed." Labor and delivery services are not a moneymaker for corporate health care systems, and so executives put them on the chopping block. Essentia is not unique in this regard. Mayo Clinic executives recently announced similar plans to end baby delivery services in New Prague. In 2022, Allina Health executives shuttered birth care at Regina Hospital in Hastings. After Fairview purchased the HealthEast system in 2017, executives there closed the doors on two hospitals providing care to underserved communities in St. Paul at the height of the pandemic.

When these large health care corporations come into small, rural communities, they often present themselves as the only hope to keep a struggling health care system afloat. But all too often after being "rescued," we see the same facilities and services closed down anyway; the only difference is the fat bonus in the pocket of corporate executives after they sell off our hospitals for scraps.

Fosston's experience shows clearly that these decisions by hospital executives are about nothing but the bottom line. We need to return to a health care system that serves patient needs, not corporate greed.

Cassie Heide is the Fosston city administrator. Chris Rubesch is an RN at Essentia Duluth and president of the Minnesota Nurses Association. For more on this issue, see the Feb. 4 editorial, ["Worthy battle to keep hospital birth care."](#)

Name

[REDACTED]

Personal Email

[REDACTED]

Facility

[REDACTED]

Date

02/2024

Unit

[REDACTED]

Shift

Evenings

Are you staffed via an electronic staffing program that predicts the staff necessary for your unit?

No

Person(s) Notified

Manager

Name of Person(s) Notified

[REDACTED]

What Response did the supervisor/manager give you?

Nursing supervisor was in support of us getting another nurse, but that has to be approved through the manager on call. Discussed situation w/ manager on call [REDACTED]. She moved it up the chain of command. Received a call back from manager that our request for another nurse was denied. Manager on call's response: We'll just have to make it work within our grid [with our current number of staff]; put down more fall mats and re-instate ROBS cameras (that were just weaned off earlier that day).

Did anyone attempt to discourage you from filling out this form?

No

Were you bullied regarding your concern for short /unsafe staffing?

No

RNs on duty

6

RNs scheduled

5

RNs needed

7

LPNs on duty

0

LPNs scheduled

0

LPNs needed

0

UAPs on duty

4

UAPs scheduled

4

UAPs needed

4

What made your shift unsafe?

- Too many patients/clients
- High acuity
- Charge nurse took patients over and above what staffing grid provides

How was the unsafe staffing situation rectified?

- It was not rectified
- Closed the unit to admissions
- Other (resolution)

Resolution Other

charge nurse took a 4 patient assignment for 12 hours

What impact did this have on patient care?

- Inability to answer call lights

What impact did this have on the nurse/s and other support staff?

- Nurse experienced increased stress
- Nurse experienced increased anxiety
- Nurse experienced fatigue
- Missed meal break

Action Taken

- Move up the chain of command with phone calls
- Refused the assignment
- Refused additional clients/visits

Additional Action Taken

- Notify nurses on the next shift

afl-cio^{MINNESOTA}

The HEAL Act

Healthcare workers are on the frontlines of the fight to improve care and working conditions in our hospitals and other care settings. These workers know that healthcare in Minnesota should be about taking care of each other.

Now, our healthcare system is suffering from a corporate greed crisis. While hospital CEOs take massive paychecks, they slash hospital staffing levels, charge patients more, and close clinics and hospitals in our communities. When workers speak up for patient safety and their own rights, they all too often they face management retaliation.

Lawmakers need to pass the Healthcare Employee Anti-Retaliation and Labor (HEAL) Act (HF4200) this year to guarantee protections against retaliation for healthcare workers and include those care workers in the conversation about how to improve safe patient care in our care settings. The HEAL Act would:

Protect workers from retaliation

When healthcare executives cut staff levels, care conditions worsen for patients. But when care workers raise these concerns, they often face retaliation, including unfair scheduling, being sent home without pay, or being denied time off. Healthcare workers seek protections when they take action to hold hospital executives accountable to safe patient care, while codifying protections against discrimination in care delivery.

Include workers' voices to improve patient outcomes

Care workers are the ones by patients' sides every day in our hospitals; when patients experience adverse events like bedsores or falls, often due to low staffing levels by executives, those bedside care workers need to be included in the process and protected in discussions about what went wrong and why to improve patient care going forward.

Minnesota lawmakers made historic steps forward for working people and families last year; **now lawmakers must guarantee protections for care workers on the frontlines of the fight to improve our healthcare system for workers, patients, and families.**





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February 29, 2024

House Health Finance and Policy Committee
477 State Office Building
St. Paul, MN 55155

Written testimony submitted electronically.

Dear Chair Liebling and members of Minnesota House Health Finance and Policy Committee,

Mayo Clinic appreciates the opportunity to submit written testimony on legislative proposals before your committee, specifically H.F. 4200, H.F. 4210 and H.F. 3700. Our testimony is consistent with Mayo's deeply rooted primary value—the needs of the patient come first. Mayo Clinic is one of the nation's leading healthcare systems, with locations in Minnesota, Florida, Wisconsin, and Arizona, employing more than 80,000 people. Each year, roughly 1.3 million patients come to Mayo Clinic from every state and nearly 130 countries to receive care that they often cannot receive anywhere else. Mayo Clinic is committed to delivering hope and healing to all patients through our integrated clinical practice, education, and research.

Supporting Mayo staff is essential to delivering on the commitment we make to care for patients. The health of our patients, and overall health of our communities, gets better when we have a skilled workforce leveraging their talents to the greatest extent. Mayo invests in a healthy and skilled workforce:

- **Attracting talent:** Mayo has modernized its recruitment approaches, tailoring them based on critical openings and geographic needs. Last year, we welcomed approximately 14,000 new hires to Mayo because of our efforts, and we continue to prioritize recruitment to meet the growing needs of our patients and communities.
- **New educational opportunities:** Mayo is also ensuring our education and training opportunities are aligned with future workforce needs. For example, Mayo Clinic College of Medicine and Science has introduced several new programs that cover new and emerging skill sets like AI development and data science.
- **New career pathways:** Mayo has built relationships with key community partners to introduce people to careers in healthcare, especially people in populations underrepresented in medicine. For example, we are working with middle school students in healthcare simulation labs, showing them what it's like to treat a blocked airway or give an ultrasound exam. Mayo is a committed partner of the Bridges to Healthcare program, which provides support services and education guidance for nontraditional students seeking to pursue a career in healthcare. Project SEARCH, a nine-month employment preparation program, serves young people with disabilities. We're also leveraging more formal career advancement opportunities, like our Career Investment Program, which works directly with different academic partners to offer highly relevant degree and certificate programs that empower our staff to prepare for new, critical roles.
- **New well-being resources:** Mayo has invested significantly in more resources to support the well-being of our staff. From workshops and coaching groups to well-being influencers and recognition resources, we are building connection and belonging among our staff. We have also expanded our more formal well-being supports, like back-up childcare resources, student loan repayment, and financial planning support.



These efforts show how Mayo Clinic is supporting our staff while also protecting healthcare that, consistent with our primary value, puts the needs of patients first. Putting the needs of patients first is a Minnesota value, too. Mayo Clinic cannot support proposed legislation that would cause harm to patients, would put Mayo staff at-risk, would compromise Mayo's standard of care, or would put additional strain on Minnesota hospitals and providers. For these reasons, we oppose H.F. 4200 as introduced.

H.F. 4200 – Anti-retaliation

Mayo Clinic knows that staffing should be a dynamic and collaborative process based on patient needs and staff input and delivered by a team of professionals working in harmony. We use a model that gathers patient acuity information and feedback directly from our bedside nurses and care teams to adjust staffing according to changing circumstances. Our clinical and nurse leaders shape every aspect of our staffing model, from how we implement care on the floor, to the governance structures, to the quality and outcomes for our patients.

H.F. 4200, undermines how patient care is delivered at Mayo Clinic. It is in direct opposition to our primary value to put the needs of patients first. Indeed, H.F. 4200 codifies a policy that fails to support patients. Mayo Clinic knows that nurses accept the calling to help and care for people when they are ill. They did not become nurses to turn patients away. We all have an obligation to support nurses and our hospital staff, so they can care for patients. H.F. 4200 fails to do this.

Beyond H.F. 4200, Mayo has concerns with H.F. 4210 and H.F. 3700 for the reasons below.

H.F. 4210 – Violence in the workplace

Safety for our staff and patients is a paramount concern for Mayo Clinic. While the goal of H.F. 4210 to ensure every hospital has a robust behavioral health response team is commendable, it is likely not possible given the prescriptive makeup of the proposed response teams and limited number of providers. Alternatively, we would encourage the state to think about other opportunities to ensure Minnesota can recruit more practitioners to our state and decompress boarding in hospitals that is resulting in enormous strain on our staff and non-optimal care settings for patients.

H.F. 3700 – Healthcare operations

Hospitals are challenged every day to assess the finite and oftentimes limited resources they have to meet the needs of their patients. A 300-day requirement for the announcement of service changes is not feasible when hospitals are continuously assessing how best they can deliver care locally in a safe manner with the resources they have at present. Mayo Clinic agrees with the concerns raised by the Minnesota Hospital Association (MHA) regarding this and the other bills being heard today.

Thank you again for the opportunity to voice these concerns on behalf of our staff, communities and patients.

Sincerely,

A handwritten signature in cursive script that reads "Ryannon K. Frederick RN".

Ryannon K. Frederick, RN
Chief Nursing Officer, Mayo Clinic



February 29, 2024

Minnesota House of Representatives
Health Finance and Policy Committee
HF 4200

Dear Committee Members,

The Minnesota Business Partnership is a membership organization comprised of the top business leaders from Minnesota's largest employers, employing almost half a million workers across the state. Health care availability, access, and equity are incredibly important to our members, and I want to express our concerns regarding HF 4200.

Ensuring the safety and well-being of patients is the top priority for Minnesota hospitals. Hospitals are already short-staffed and fewer individuals are training to enter the health care workforce. Allowing a nurse to decline a patient care assignment based on professional judgement raises serious concerns on health equity and the treatment of patients with conditions such as a mental illness or substance abuse issues. This could adversely affect patients and is an improper interference with a hospital's role to determine their own patient and staff needs. This also interferes with the chain-of-command reporting process hospitals already have in place where a nurse who feels they need additional help can request it.

Our shared goal is for patients to have access to the highest quality of care possible. We look forward to working together to find solutions that help solve our health care workforce shortage without impacting the quality and availability of patient care.

Sincerely,

Abby Loesch
Health Policy Director
Minnesota Business Partnership



02/28/24

RE: HF 4200 & HF3700

Members of the House Health Finance and Policy Committee,

Medical Alley represents a global network of more than 800 leading health technology and care organizations in all corners of this state. Our mission is to activate and amplify healthcare transformation.

Minnesota, recognized globally as a leader in healthcare innovation, sets a standard for excellence, which not only impacts local communities, but extends its influence worldwide. With access, affordability, and quality as top priorities, Medical Alley and our partners are committed to developing solutions which drive meaningful change and save lives.

It is with these guiding principles that we express concern about House File 4200's impact on access to care. Under the language of this bill, hospital management would lose its authority to engage in an accountability process should a nurse decline a patient care assignment. Allowing an individual nurse to make this type of decision creates an uneven standard for care, resulting in inequitable delivery and possible delays. Patients experiencing episodes of mental illness or those who are victims of substance abuse may not have access to the care they need, exacerbating their illness.

Not only would access to care for patients in need of care be jeopardized under this proposal, but it could allow an individual nurse to establish a staffing framework for the hospital by deciding which patients he or she will see, thereby assigning further patients to other caregivers and increasing their workloads. This decision should be the hands of hospital administration in order to properly balance the needs of the staff with the needs of the patients.

Important safeguards are already in place for hospital staff who believe they do not have the capacity to care for a patient to request further assistance. State law protects whistleblowers who believe they are working in unsafe conditions and prevents employer retaliation.

Medical Alley also is concerned about the impact of House File 3700 requiring hospitals to give 300 days notice of any inpatient service change or closure. Such a requirement may put a hospital in a situation of closing a line of service unnecessarily or prematurely before the hospital has a fully accurate financial and personnel assessment of that service.

We ask committee members to prioritize access to care and oppose House File 4200 and House File 3700.

Sincerely,

A handwritten signature in black ink that reads 'Peter Glessing'. The signature is written in a cursive, flowing style.

Peter Glessing
Senior Director of Policy and Advocacy
Medical Alley



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Phone: (651) 639-1223 ■ www.mfu.org

February 29, 2024

Chair Tina Liebling
House Health Finance and Policy
477 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Chair Liebling and committee members:

On behalf of Minnesota Farmers Union (MFU), I write to share our organization's support for HF3700, which will create more comprehensive disclosure of potential hospital closures and give impacted communities an opportunity to retain control of their local hospitals. We are grateful for Representative Smith's leadership on this important topic.

MFU is a grassroots organization that has represented Minnesota's family farmers, ranchers and rural communities since 1918 and at our most recent annual convention our members voted to make ensuring affordable and accessible care in rural Minnesota a top priority for this year. Within that priority, members specifically called for measures that will strengthen existing or create new tools to prevent further consolidation of healthcare entities and services.

HF3700 builds off the work the legislature did last year in enacting meaningful checks on large hospital mergers by helping to address a key consequence of health system consolidation, which is hospital closures and loss of critical services. Rural Minnesota has been heavily impacted by this consolidation as it has one of the most highly concentrated hospital markets in the entire country.ⁱ

Over the past twenty years the share of Minnesota's hospitals that are affiliated with a larger health system has increased from 33%ⁱⁱ to 72%ⁱⁱⁱ. Today just three health systems (The Mayo Clinic, M Health Fairview, Allina Health System) generate nearly half of all hospital operating revenue in the state.^{iv} While consolidation is increasing, the number of hospitals in Minnesota has declined from 158 in 1990 to 127 in 2020 while the number of licensed hospital beds has remained nearly the same since 2001 despite the state's population aging and growing by over 730,000 people.^v

This is not just a coincidence. Research has found that health system acquisitions often lead to the closure of various services like intensive care, labor and delivery, psychiatric care, and cardiac surgery.^{vi} Recent reporting found that twenty years ago, more than 110 hospitals in Minnesota offered birth services and today that number stands at just 76.^{vii} A study of non-profit hospitals in New York found that increases in consolidation are followed with reductions in the admission of Medicaid patients, limiting choices for low-income patients.^{viii} A national study found joining a health system was significantly associated with a loss of inpatient pediatric services.^{ix}

Minnesota law recognizes that the loss of a hospital or key healthcare services is a significant event for a community and requires that health systems provide advance notification of a proposed closure. However, current law is not comprehensive enough, lacks teeth, and provides little in the way of effective response to a closure. HF3700 addresses this by:

- Requiring more disclosure when a health system is proposing to close a hospital or hospital unit by expanding the range of information that is required to be disclosed, such as the number of beds impacted and information on where patients can receive services after the closure, and expanding the methods of disclosure, such as issuing letters to patients, letters to nurses, and other impacted stakeholders.
- Creates a \$20,000 penalty that MDH would be required to impose if a hospital fails to adhere to those disclosure requirements, creating a real deterrent to ignoring the law.
- Gives communities a first right of refusal by requiring that a health system offer to sell the hospital to a local unit of government before closing the facility.

The closure of a hospital or loss of vital healthcare services is a significant loss for a community, particularly in rural Minnesota. This legislation will give communities a chance to better respond to proposed closures and maintain critical healthcare infrastructure. The bill is another opportunity for the legislature to help address the harms of our highly consolidated hospital market and create a healthcare system in Minnesota that works for everyone.

We thank Rep. Smith for his leadership on this issue and urge the committee to support this legislation. If you have any questions, please contact our Government Relations Director, Stu Lourey, at stu@mfu.org or (320) 232-2047 (C). Thank you for considering the needs and perspectives of Minnesota's farm families.

Sincerely,



Gary Wertish
President, Minnesota Farmers Union

ⁱ <https://sourceonhealthcare.org/market-consolidation/>

ⁱⁱ <https://mnnurses.org/issues-advocacy/issues/minnesotas-most-and-least-expensive-hospitals/>

ⁱⁱⁱ <https://www.health.state.mn.us/data/economics/chartbook/docs/section8a.pdf>

^{iv} <https://www.health.state.mn.us/data/economics/hccis/data/stndrdrpts.html#bottom>

^v <https://www.lrl.mn.gov/docs/2003/other/030318.pdf>

^{vi} <https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/>

^{vii} <https://minnesotareformer.com/2024/01/25/giving-birth-in-rural-minnesota-be-prepared-for-a-long-drive/>

^{viii} https://nihcm.org/assets/articles/Final_RI-PDF-Sunita-Desai_2023-09-15-133001.pdf

^{ix} <https://www.fiercehealthcare.com/providers/hospital-consolidation-followed-inpatient-pediatric-service-closures-study-finds>



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To: Representative Tina Liebling, Chair
Members, MN House Health Finance and Policy Committee

From: Jennifer Mohlenhoff, Executive Director

RE: House File 4210

Date: February 28, 2024

Thank you for considering this written testimony.

[House file 4210](#) includes the following provision (Lines 4.31-4.32): **Subd. 6.** "Licensed mental health professional" means a psychologist or clinical social worker licensed by the profession's licensing board.

"Mental health professional" has a defined meaning in Minnesota law. The [Minnesota Mental Health Uniform Service Standards Act](#) was intended to create a system of mental health care for Minnesotans that provided access to quality mental health services. The provider qualification and scope of practice provision of that Act ([Minn. Stat. 245I.04, subd. 2](#)) defines a "mental health professional":

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services to a client as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization; or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

If seeking to ensure Minnesotans access to qualified, licensed behavioral health care, the defined standard in Minnesota law is to reference "mental health professional." To then limit who can provide those services, as HF 4210 does to psychologists and clinical social worker, unnecessarily restricts

Minnesotans access to qualified care. All “mental health professionals” as defined by Minnesota law, may only provide specified treatment and care when the professional has the requisite education, training, and skill to provide such care competently. Please consider a change to HF 4210 which utilizes “mental health professional” without restriction and allows the six named professionals to provide the qualified behavioral health care services envisioned by the bill.

BMJ Open Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: an observational study

Karen B Lasater ^{1,2}, Linda H Aiken ^{1,2}, Douglas Sloane,¹ Rachel French,^{1,2} Brendan Martin,³ Maryann Alexander,³ Matthew D McHugh ^{1,2}

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ABSTRACT

Objective To evaluate variation in Illinois hospital nurse staffing ratios and to determine whether higher nurse workloads are associated with mortality and length of stay for patients, and cost outcomes for hospitals.

Design Cross-sectional analysis of multiple data sources including a 2020 survey of nurses linked to patient outcomes data.

Setting: 87 acute care hospitals in Illinois.

Participants 210 493 Medicare patients, 65 years and older, who were hospitalised in a study hospital. 1391 registered nurses employed in direct patient care on a medical–surgical unit in a study hospital.

Main outcome measures Primary outcomes were 30-day mortality and length of stay. Deaths avoided and cost savings to hospitals were predicted based on results from regression estimates if hospitals were to have staffed at a 4:1 ratio during the study period. Cost savings were computed from reductions in lengths of stay using cost-to-charge ratios.

Results Patient-to-nurse staffing ratios on medical-surgical units ranged from 4.2 to 7.6 (mean=5.4; SD=0.7). After adjusting for hospital and patient characteristics, the odds of 30-day mortality for each patient increased by 16% for each additional patient in the average nurse's workload (95% CI 1.04 to 1.28; p=0.006). The odds of staying in the hospital a day longer at all intervals increased by 5% for each additional patient in the nurse's workload (95% CI 1.00 to 1.09, p=0.041). If study hospitals staffed at a 4:1 ratio during the 1-year study period, more than 1595 deaths would have been avoided and hospitals would have collectively saved over \$117 million.

Conclusions Patient-to-nurse staffing ratios vary considerably across Illinois hospitals. If nurses in Illinois hospital medical–surgical units cared for no more than four patients each, thousands of deaths could be avoided, and patients would experience shorter lengths of stay, resulting in cost-savings for hospitals.

INTRODUCTION

Despite substantial evidence that high registered nurse (RN) workloads are related to patient mortality—among other adverse patient outcomes^{1–4}—no US states, except for California,⁵ have implemented minimum

Strengths and limitations of this study

- Study design, staffing and outcome measures are similar to previously published studies evaluating the link between nurse staffing and patient outcomes.
- Staffing measures collected as prepolicy implementation baseline data to quantify the scope of the variation in staffing within Illinois state, and the impact of staffing variation on the public's health.
- Patient-to-nurse staffing measures are derived directly from staff nurses on medical and surgical units.
- Patient outcomes are risk-adjusted 30-day mortality and hospital length of stay.
- The cross-sectional study design precludes causal statements about the relationship of nurse staffing and patient outcomes.

hospital nurse staffing requirements. While many US states have pursued legislation to regulate hospital nurse staffing levels, support for such regulation is dampened for three primary reasons: (1) lack of prepolicy data documenting significant variation of hospital nurse staffing ratios across the state debating staffing regulation, (2) lack of local, timely evidence demonstrating variation in nurse staffing adversely affects patient outcomes and (3) an underdeveloped business case to justify the fiscal investments required to staff greater numbers of nurses at the bedside.

In this study, we address each of these three concerns using 2020 data from a large sample of 87 hospitals in Illinois where legislation to mandate patient-to-nurse staffing ratios is actively being debated (HB 2604 *Safe Patient Limits Act*).⁶ We project the number of deaths and hospital days that could be avoided, if Illinois hospitals staffed medical–surgical nurses at the 4:1 patient per nurse ratio proposed in the legislation. Because reductions in patient length of stays have economic implications



for hospitals, we estimate the potential cost savings to hospitals through reduced lengths of stay if hospitals moved to the 4:1 staffing ratio.

This is the first study to report local and timely evidence about staffing variation in a large sample of hospitals across Illinois, and the consequences of staffing variation for patient outcomes and costs of care to directly inform public policy efforts actively under consideration. The main objectives of this study are to evaluate variation in Illinois hospital nurse staffing ratios and to determine whether higher nurse workloads are associated with mortality and length of stay for patients, and cost outcomes for hospitals.

Background

Nurses are the around-the-clock surveillance system of hospitals; closely monitoring changes in patients' clinical condition and administering treatments and care as appropriate. When nurses care for fewer patients at time, they are able to spend more time at each patient's bedside, and as a result, patients are less likely to experience an adverse outcome such as a hospital-acquired infection,⁷ poor glycaemic control,⁸ readmission⁹ and even death.^{10–14} The clinical benefits of nurse staffing have primarily been studied in adult medical and surgical populations, but have also been observed in special populations including babies in neonatal intensive care units¹⁵ and children;¹⁶ and may also be key to reducing racial disparities in outcomes.^{9,17–19} The benefits of better nurse staff extend to nurses as well; with nurses in better-staffed hospitals reporting less burnout, less job dissatisfaction and being less likely to intend to leave their employer.^{10,20}

An emerging body of research evidence articulates the human and economic consequences of adverse patient outcomes that result from hospital nurse understaffing. For example, an analysis of hospital nurse staffing among New York hospitals found that if hospitals staffed medical–surgical units with four patients per nurse, as opposed to the average hospital ratio of 6.3 patients per nurse, then thousands of deaths could have been avoided and many hundreds of millions of dollars saved through shorter lengths of stay and avoided readmissions.²¹ The same study²² showed that improving nurse staffing in New York hospitals would have reduced deaths among sepsis patients more than a policy passed earlier that mandated adherence to a standardised set of services for sepsis patients. A study of adult medical patients showed that patients in hospitals with better nurse resources had better outcomes including less mortality, fewer readmissions and shorter lengths of stay—at no difference in cost, when compared with similar patients in hospitals with poorer resources.²³ These study findings have been corroborated in surgical patients;^{24,25} and find that improving nurse staffing would avoid adverse outcomes with sizeable cost savings to hospitals.²⁶

Despite the social and economic case for improving hospital nurse staffing, California remains the only US state to have implemented required staffing standards.

Passed in 1999 and implemented in 2004, the California legislation resulted in improved staffing, with the greatest improvements observed among safety-net hospitals.²⁷ Compared with other states which did not implement safe staffing requirements, patients in California hospitals experienced lower mortality and failure-to-rescue rates.^{5,28} The California experience serves as an example of a successfully implemented and sustained state-wide policy mandate for safe hospital staffing and patient care.

DATA AND METHODS

Design

This observational study of hospitals and patients uses multiple linked data sources including Medicare patient claims data, American Hospital Association (AHA) data of hospital characteristics and a survey of RNs to provide data on hospital nurse staffing ratios on medical and surgical units.

Patient sample

The patient sample includes persons insured by Medicare who were 65 years and older (the qualifying age for Medicare—the US federal government health insurance programme) and who were admitted to an acute care hospital in Illinois in 2018. Data on Medicare patients were obtained from the Centers for Medicare and Medicaid Services (CMS) MEDPAR files. Patients admitted for psychiatric reasons and drug/alcohol use were excluded, as were patients with lengths of stay greater than 60 days. Each unique patient was assigned an index hospitalisation, created by selecting the first admission during the study period. The analytic sample included only these index hospitalisations, which accounted for roughly half of all the Medicare hospitalisations in Illinois during the study period.

Hospital sample

Short-term acute care and critical access hospitals that had medical and surgical direct care nurses who responded to the survey of nurses were included. The survey of nurses was sent via email to all actively licensed RNs in the state of Illinois (n=168001). Data collection ran from 16 December 2019 to 24 February 2020. Nurse responses were anonymous, but nurses were asked to report the name of their employer, thus allowing responses from nurses working in the same hospitals to be aggregated together to create hospital-level measures of patient-to-nurse staffing ratios. Our data collection method relies on nurses as key informants of their hospital.²⁹ Thus, while we directly survey nurses, our interest is in hospital-level organisational measures, in this case, patient-to-nurse staffing ratios.

The nurse response rate was 18% of the 168001 RNs surveyed, which is anticipated considering endemic difficulties with survey response rates³⁰ and the fact that our sampling frame consisted of 100% of licensed nurses in the state, only a fraction of whom are employed in

hospitals, which was the focus of our study. A similar survey conducted in other states yielded comparable response rates. In the broader multistate study, the survey implemented a double-sampling approach to evaluate for potential non-response bias. The results demonstrated that nurse reports of patient-to-nurse staffing ratios were no different among nurses who responded to the main survey and those that responded to the non-respondent survey.²⁹ Thus despite an 18% response rate, evidence suggests that even if non-response bias were present, it likely does not affect the validity of the resultant staffing estimates.

Because this is a study of hospitals and the patients in them, the nurse survey response rate is of somewhat lesser importance than the degree to which the survey achieved adequate representation of hospitals (via a high hospital response rate) and the patients in them. We excluded hospitals that were long-term rehabilitation hospitals, psychiatric facilities or free-standing children's hospitals. Based on the remaining acute care hospitals, our analytic sample of 87 hospitals represented 86.5% of Medicare index admissions in the state and roughly two-third of the short-term acute care hospitals in Illinois. We have less representation of critical access hospitals since we were not able to obtain data from enough nurses in those small facilities to reliably estimate staffing ratios.

Patient-to-nurse staffing

Surveyed nurses were asked to report whether they were working in direct patient care or indirect care positions (eg, management); which type of unit they worked on and how many patients they were assigned to care for on their most recent shift. Only data from direct care RNs who reported working their most recent shift on a medical or surgical unit were used to create our measure of staffing. Responses were then aggregated to create a hospital-level measure of medical–surgical patient-to-nurse staffing. The survey also asked nurses to report how many patients they could safely care for in their job setting.

Patient outcomes

Patient outcome measures included 30-day mortality and hospital length of stay. 30-day mortality was defined as a death occurring 30-days from date of admission and included deaths that occurred outside of the hospital. Hospital length of stay was defined as total number of days in the hospital during the index admission.

Cost outcomes

Cost savings were estimated using Medicare-specific cost-to-charge ratios using patient-level charge data from the MEDPAR files. Cost savings from reductions in length of stay were computed by first estimating the predicted reduction in patient days if hospitals staffed at the 4:1 ratio, then applying the reduction to total charges and then converting to costs using the hospital-level Medicare-specific cost-to-charge ratios from CMS Impact Files.

Risk-adjustment

Hospital risk-adjustment variables included hospital size, defined by number of beds, from the AHA Annual Survey. Patient covariates included patient age, sex, Elixhauser comorbidities,³¹ dummy variables for diagnostic-related groups—and in models estimating effects of staffing on length of stay, patient discharge disposition status.

Statistical analysis

Descriptive statistics were used to show medical–surgical nurse staffing ratios, and the numbers of patients and nurse survey respondents in the 87 study hospitals. Patient characteristics (eg, age, sex, transfer status, comorbidities) as well as percentage of patients who died within 30-days of admission and average (and SD) length of stay are reported. We also show percentages of nurses who reported that the number of patients they cared for during their last shift exceeded the number of patients they felt they could safely care for. Prior to accounting for confounding factors, we show variation in patient mortality rates and lengths of stay among hospitals with different staffing levels (ie, <5, 5≤6, ≥6 patients per nurse).

Multilevel random-effects logistic regression models and zero-truncated negative binomial regression models were used to estimate the association between nurse staffing with 30-day mortality and length of stay, respectively. These associations were estimated before and after accounting for potentially confounding hospital and patient characteristics. Using adjusted estimates from our regression models, we estimated how many deaths could have been avoided and how much money could have been saved (from shorter lengths of stay) were hospitals to staff medical–surgical nurses at the levels proposed in the legislation (4:1 patients per nurse). STATA was used to perform the analyses. This study received IRB approval from the University of Pennsylvania (Protocol #834307).

Patient and public involvement

No patient involved.

RESULTS

Our analytic sample included 210 493 Medicare beneficiaries in 87 Illinois hospitals (table 1). Staffing estimates were derived from an average of 16 direct care medical–surgical nurse respondents per hospital, with as many as 68 nurse respondents in larger hospitals. Medical–surgical staffing ratios ranged from 4.2 to 7.6 patients per nurse, with the lower bound just above the four patients per nurse proposed in the legislation. The average staffing ratio in Illinois hospitals was 5.4 and somewhat higher (5.6) among smaller hospitals than larger hospitals (5.3).

Among the study patients, 5.8% died within 30-days of admission and the average length of stay was 4.1 days, with a SD of 3.7 days (online supplemental table 1). Forty percent of the patients were 80 years of age or older, and 56% were female. The most common comorbidities included hypertension, fluid and electrolyte

Table 1 Hospital size, numbers of patients and nurse respondents and patient-to-nurse staffing ratios among 87 Illinois study hospitals

Hospital characteristics	Number of hospitals	Percent of hospitals	Medical-surgical staffing (patients per nurse)			Range in staffing		
			Mean	SD	Median	Minimum	Maximum	
Hospital size								
≤100 beds	9	10.3	5.6	0.8	5.2	4.2	6.5	
101–250 beds	32	36.8	5.5	0.8	5.3	4.4	7.6	
>250 beds	46	52.9	5.3	0.6	5.2	4.2	6.7	
Total	87	100.0	5.4	0.7	5.3	4.2	7.6	
Patients discharged from 87 study hospitals								
Patients	Number		Mean	SD	Median	Minimum	Maximum	
	210493		2420	1821	1933	100	11470	
Nurses completing surveys in 87 study hospitals								
Medical-surgical nurses	Number		Mean	SD	Median	Minimum	Maximum	
	1391		16	12.9	12	5	68	

Table 2 Percent of nurses reporting that the number of patients assigned to them during the last shift exceeded the number they could safely care for

Number of patients assigned on last shift	Whether number assigned exceeds number RN reports could safely care for		
	Does not exceed % (no.)	Exceeds % (no.)	Total % (no.)
Four or fewer	82.7 (253)	17.3 (53)	100 (306)
Five	41.6 (211)	58.4 (296)	100 (507)
Six or more	33.0 (142)	67.0 (288)	100 (430)
Total	48.8 (606)	51.2 (637)	100 (1243)

Note. 148 of the 1391 nurses did not provide a response about how many nurses they could safely care for. Thus, the analytic sample in table 2 is 1243 nurses for whom the relevant data were available. RN, registered nurse.

disorders, chronic pulmonary disease and renal failure. Nurses reported safety concerns related to the number of patients they cared for during their last shift (table 2). Half of nurses (51.2%) reported that their patient assignment during their last shift exceeded the number they assessed they could safely care for. Two-thirds of nurses (67.0%) who were assigned 6 or more patients assessed that workload was unsafe. Most nurses (82.7%) who were assigned four or fewer patients assessed that patient assignment constituted a safe workload.

Prior to adjusting for confounding variables of the hospitals and patients, we found that patient mortality and lengths of stay in hospitals varied with different nurse staffing ratios (table 3). The average 30-day mortality rate among hospitals with an average staffing ratio of <5 patients per nurse was lower (5.6%) compared with mortality among hospitals where nurses cared for between 5≤6 patients (6.1%) and ≥6 patients (6.1%). Lengths of stay were shorter in hospitals where nurses cared for fewer patients at a time (4.0 days in hospitals with <5 patients per nurse, vs 4.1 days in hospitals with 5≤6 patients per nurse, vs 4.5 days in hospitals with ≥6 patients per nurse).

Table 4 presents the effect of nurse staffing on mortality and length of stay. After adjusting for hospital and patient characteristics, the odds of 30-day mortality for each patient increased by a factor of 1.16 (or 16%) for each additional patient added to the average nurse's workload (OR 1.16, 95% CI 1.04 to 1.28; p 0.006). The odds

Table 3 Average mortality and lengths of stay for patients in hospitals with different patient-to-nurse staffing ratios

Patient-to-nurse ratio	N	30-day mortality Mean (SD)	Length of stay Mean (SD)
<5	24	5.6% (1.4%)	4.0 (0.55)
5≤6	44	6.1% (1.2%)	4.1 (0.52)
≥6	19	6.1% (2.0%)	4.5 (1.27)
Total	87	6.0% (1.5%)	4.2 (0.77)

Table 4 Effect of medical–surgical patient-to-nurse staffing on patient outcomes

Patient outcome	Coefficient	Unadjusted models	Fully adjusted models
30-day mortality	OR (95% CI)	1.15 (1.06 to 1.26)	1.16 (1.04 to 1.28)
	P> z	0.001	0.006
Length of stay	Incident rate ratio (95% CI)	1.00 (0.95 to 1.06)	1.05 (1.00 to 1.09)
	P> z	0.909	0.041

Note. 30-day mortality outcomes are estimated from 196270 patients and excludes DRGs with <5 cases and admissions by transfer. Hospital controls included number of beds. Patient controls included age, sex, comorbidities and dummy variables for DRG. Length of stay outcomes are estimated from 210493 and excludes DRGs with zero deaths and patients transferring in or out. Hospital controls included number of beds. Patient controls included age, sex, comorbidities, dummy variables for DRG and discharge disposition of death or transfer. DRG, diagnostic-related groups.

of staying in the hospital a day longer at all intervals increased by a factor of 1.05 (or 5%) for each additional patient in the nurse’s workload (IRR 1.05, 95% CI 1.00 to 1.09, p 0.041).

Using these results from the adjusted regression models, we estimated the number of deaths that would have been avoided if hospitals staffed at the four patients per nurse recommendation in the proposed policy (as opposed to the observed ratio which was greater than four patients per nurse in all hospitals and nearly eight patients per nurse in some of them). Roughly 1595 deaths could have been avoided among Medicare beneficiaries in the study hospitals during the 1-year study period. Improving staffing ratios to the 4:1 ratio was projected to reduce patient lengths of stay by over 40 000 days. These reductions in lengths of stay would collectively save Illinois hospitals over \$117 million per year (table 5).

Table 5 Deaths avoided and cost savings from shorter lengths of stay with 4:1 staffing ratios

Variables used to estimate deaths avoided and cost savings	Mortality	Length of stay
Number of patients at risk of experiencing outcomes	196270	210493
Observed number of patients who died	11370	
Number of patients expected to die with 4:1 patient/nurse ratio	9775	
Difference between observed and expected deaths	1595	
Observed number of patient days		867694
Expected number of patient days with 4:1 patient/nurse ratio		826784
Difference between observed and expected patient days		40910
Observed total charges		\$11 798 193 318
Projected reduction in total charges		\$486 714 034
Projected cost savings		\$117 557 590

Note. Data from 84 short-term acute care hospitals were used in the projection of cost savings from reduced lengths of stay. Three critical access hospitals were excluded from the cost-saving analyses reported in table 5 because critical access hospitals do not report cost-to-charge ratios needed to compute cost savings.

DISCUSSION

Studying a large sample of 87 acute care hospitals in Illinois, we found considerable variation in medical–surgical nurse staffing ratios, ranging from 4.2 to 7.6 patients per nurse. The average hospital staffing across the state (outside intensive care settings) was 5.4 patients per nurse, which is nearly 1.5 patients above the recommended staffing levels proposed in the HB 2604 *Safe Patient Limits Act*.⁶ Half (51.2%) of nurses reported their patient assignment during their last shift was unsafe; and among nurses assigned four or fewer patients, only 17.3% found that staffing ratio to be unsafe.

Staffing conditions were associated with adverse health outcomes for Medicare patients, including mortality and longer lengths of stay. Each additional patient in a nurse’s workload increased the odds of patient death by 16%. If the study hospitals had been staffing medical–surgical nurses at the proposed ratio during the 1-year study period, we projected that 1595 deaths would have been avoided just among Medicare patients. Had our study considered patients of all ages who would benefit from improved nurse staffing, we anticipate considerably more deaths would have been avoided.

The odds of Medicare patients staying in the hospital a day longer increased by 5% for each additional patient in the nurse’s workload. Hospitals would have collectively saved over \$117 million annually from length of stay reductions just among Medicare patients—cost savings which could be reinvested into financing safer nurse staffing ratios. These findings are consistent with other research conducted in New York hospitals³² and internationally^{33 34} which show that patients in hospitals with better nurse staffing have shorter lengths of stay as well as fewer readmissions, both of which translate to avoided costs. Studies conducted in Queensland Australia and Chile demonstrate that the magnitude of the cost savings associated with better nurse staffing were in excess of the costs of hiring more nurses;^{33 34} a



illustration of the value proposition for increasing nurse staffing.

In the current study, estimates of avoidable deaths and cost savings are conservative. Our analysis used roughly half of the annual Medicare hospitalisations in Illinois state since we restricted the sample to index hospitalisations. Other studies show that patients of all ages benefit from improved hospital nurse staffing.^{16 35} Thus, if the staffing policy were to be enacted, the human and economic benefits would likely be much greater. Additionally, our cost savings analysis is conservative because it does not account for the savings that may be realised from reductions in nurse burnout and turnover that result from chronic understaffing. In a previously published paper on nurse staffing in Illinois hospitals, we showed that hospital understaffing is associated with poor nurse outcomes including burnout, job dissatisfaction and intent to leave.^{20 36} Nurse burnout has been linked with worse patient outcomes including mortality and longer lengths of stay³⁷ and intent to leave is associated with turnover.^{38–40} Turnover of nurses is cost consequential for hospitals, with estimates of replacing a single bedside nurse ranging from \$20 561⁴¹ to \$88 000.⁴² Although evidence demonstrates that cost savings can be achieved—via shorter lengths of stay and reduced readmissions—from staffing more nurses at the bedside, future research could expand the scope of the economic consequences of improving nurse staffing in terms of other patient and nurse outcomes with their associated cost savings.

Strengths and limitations

This study uses hospital medical–surgical nurse staffing data collected in 2020 to inform current staffing policy debates in Illinois. Rarely is timely, rigorous and objective evidence, analysed by an independent team of researchers, available to inform policy in this way. Reporting lags in claims data meant that the most recent available data on patients were from 2018. Although the hospital staffing and patient data do not coincide, hospital nurse staffing has changed little in the last decade.⁴³ Thus, the staffing estimates obtained in 2020 likely resemble those in 2018. While our study included most large and medium size hospitals in Illinois, which account for most hospitalised patients in the state, smaller hospitals including critical access hospitals are underrepresented in the study. The cross-sectional study design precludes causal statements about the relationship between nursing staffing and patient outcomes.

Implications for policy decision-making

A recent US Harris Poll⁴⁴ suggests that 90% of the US public favour requiring hospitals to meet minimum safe nurse staffing standards. Our study finds uneven nurse staffing among Illinois hospitals which poses unfavourable consequences for patients and hospitals. If Illinois enacted the *Safe Patient Limits Act*, our analysis suggests thousands of deaths per year could be avoided.

Additionally, hospitals could save substantially through reductions in patients' lengths of stay associated with improving nurse staffing. These savings could be reinvested into the costs of employing additional nurses.

Enacting the *Safe Patient Limits Act* would likely create opportunities for more nurses to enter the workforce, raising questions about where these nurses would be drawn from. There is currently no widespread shortage of actively licensed RNs. Nurse graduations are at an all-time high, with enough nurses entering the workforce annually to more than replace retirements.⁴⁵ California, the only state to enact nurse staffing ratio mandates similar to what is being proposed in Illinois, has successfully implemented the ratios despite have a lower nurse-to-population ratio compared with Illinois (11.3 RNs per 1000 population in California; 16.7 RNs per 1000 population in Illinois).⁴⁶ Finally, the Nurse Licensure Compact, which is state legislation to permit nurses to hold a multistate US license is currently under consideration in Illinois.⁴⁷ Passing such legislation would enable nurses licensed in any of the 34 states currently in the Compact to practice in any other Compact state, without the burden of having to obtain an additional license. Such legislation permits greater mobility of nurses to practice across state lines. Thus, trends in the nursing workforce and the opportunity for Illinois to join the Nurse Licensure Compact suggest it is unlikely that passing mandated safe nurse staffing legislation would result in nursing shortages that would negatively affect access to care or care quality.

CONCLUSIONS

Nurse staffing on medical and surgical units in Illinois hospitals averaged 5.4 patients per nurse and ranged from as few as 4.2 patients per nurse to as many as to 7.6. These estimates suggest that few Illinois hospitals are currently meeting the minimum staffing levels which would be required by the *Safe Patient Limits Act* currently under consideration. We found that each additional patient in a nurses' workload was associated with 16% higher odds of death and longer lengths of stay. If Illinois hospitals staffed medical and surgical units at the ratio proposed in the legislation, we project thousands of deaths could be avoided each year and patients would experience shorter lengths of stay resulting in hundreds of millions of dollars in cost-savings for hospitals.

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