Senator .... moves to amend S.F. No. 1384 as follows:

Delete everything after the enacting clause and insert:

"Section 1. **TITLE.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse. The commissioner may also

consider applications submitted by graduates in eligible professions who are licensed and in practice; and

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

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

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

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

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

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

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

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

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

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

144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) the hospital's ~~incident response reaction plan and violence prevention plan~~ preparedness and incident response action plans for acts of violence, including how the health care worker may report concerns about workplace violence within each hospital's

reporting structure without fear of reprisal, how the hospital will address workplace violence incidents, and how the health care worker can participate in reviewing and revising the plan; and

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

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

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

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

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

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

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

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

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

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

Subd. 13. **Requests for additional staffing.** A hospital shall create and implement a procedure for a health care worker to officially request of hospital supervisors or administration that additional staffing be provided. The hospital must document all requests for additional staffing made because of a health care worker's concern over a risk of an act of violence. If the request for additional staffing to reduce the risk of violence is denied, the hospital must provide the health care worker who made the request a written reason for the denial and must maintain documentation of that communication with the documentation of requests for additional staffing. A hospital must make documentation regarding staffing requests available to the commissioner for inspection at the commissioner's request. The commissioner may use documentation regarding staffing requests to inform the commissioner's determination on whether the hospital is providing adequate staffing and security to address acts of violence, and may use documentation regarding staffing requests if the commissioner imposes a penalty under subdivision 17.

Subd. 14. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent action plans and ~~the information listed in paragraph (d)~~ most recent action plan reviews available to local law enforcement, all direct care staff and, if any of its workers are represented by a collective bargaining unit, to the exclusive bargaining representatives of those collective bargaining units.

(b) Beginning January 1, 2025, a hospital must annually submit to the commissioner its most recent action plan and the results of the most recent annual review conducted under subdivision 11.

Subd. 15. **Legislative report required.** (a) Beginning January 15, 2026, the commissioner must compile the information into a single annual report and submit the report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care by January 15 of each year.

(b) This subdivision does not expire.

Subd. 16. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner, association, or any person or group of persons acting directly or indirectly in the interest of the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health care worker wishes to contact law enforcement or the commissioner regarding an act of violence.

Subd. 17. **Penalties.** ~~(g)~~ Notwithstanding section 144.653, subdivision 6, the commissioner may impose ~~an administrative~~ a fine of up to ~~$250~~ $10,000 for failure to comply with the requirements of this ~~subdivision~~ section. The commissioner must allow the hospital at least 30 calendar days to correct a violation of this section before assessing a fine.

Subd. 18. **Applicability.** The amendments in this act to this section do not apply to a hospital that meets the criteria in section 144.7052, clause (1) or (2).

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

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

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

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

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

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

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

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

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

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

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

(9) a physician certified in pediatric emergency medicine by the American Board of Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency

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

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

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

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

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

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

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

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

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

Sec. 9. **[144.7051] DEFINITIONS.**

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

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

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

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

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

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

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

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

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

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

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

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

Sections 144.7053 to 144.7054; the amendments in this act to section 144.7055; 144.7056 to 144.7059; and 144.7067, subdivision 1, paragraph (b), clause (2), do not apply to:

(1) a hospital that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs; that receives more than 40 percent of its patients from outside the state of Minnesota; and that is located outside the seven-county metropolitan area; or

(2) a hospital that is owned, operated, or governed by a hospital that meets the criteria in clause (1), or that is owned, operated, or governed by an entity that also owns, operates, or governs a hospital that meets the criteria in clause (1).

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

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

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

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

Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse staffing committee's membership must be direct care registered nurses typically assigned to a specific unit for an entire shift and at least 15 percent of the committee's membership must be other direct care workers typically assigned to a specific unit for an entire shift. A hospital's nurse staffing committee shall include participation from the direct care, nonmanagerial staff for each patient population while determining or reviewing those unit staffing plans and concern for safe staffing forms. Direct care registered nurses and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses employed by the hospital and other direct care workers shall be elected to the committee by other direct care workers employed by the hospital.

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

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

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

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

(b) Each hospital nurse staffing committee must:

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

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

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

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

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

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

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

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

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

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

144.7055 HOSPITAL CORE STAFFING PLAN ~~REPORTS~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c)~~ (d) Core staffing plans must ensure that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing committee cannot approve a hospital core staffing plan by a majority vote, the members of the nurse staffing committee must enter into an expedited mediation process with a mutually agreed-upon mediator. If the nurse staffing committee cannot approve a core staffing plan through mediation, the members of the nurse staffing committee must enter into an expedited arbitration process with a mutually agreed-upon arbitrator.

Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects to a core staffing plan approved by a majority vote of the hospital nurse staffing committee, the hospital may elect to attempt to amend the core staffing plan through mediation. For any objections that cannot be resolved through mediation, the hospital may elect to attempt to amend the core staffing plan through arbitration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The commissioner of labor and industry may investigate any report of interference with or retaliation against a hospital employee for submitting a concern for safe staffing form. The commissioner of labor and industry may fine a hospital up to $250,000 if the commissioner finds the hospital interfered with or retaliated against a hospital employee for submitting a concern for safe staffing form. The commissioner of labor and industry may issue a compliance order under section 177.27, subdivision 4, to enforce this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) propose solutions to solve insufficient staffing;

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

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

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

Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each hospital nurse staffing committee a uniform format or standard form the committee must use to comply with the nurse staffing reporting requirements under this section. The format or form developed by the commissioner must present the reported information in a manner allowing patients and the public to clearly understand and compare staffing patterns and actual levels of staffing across reporting hospitals. The commissioner must include, in the uniform format or on the standard form, space to allow the reporting hospital to include a description of additional resources available to support unit-level patient care and a description of the hospital. The commissioner must ensure that the uniform format or standard form complies with all applicable federal requirements, and that any information made available to the public under this section complies with federal antitrust laws.

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

Sec. 15. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

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

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

(1) the number of assaults and injuries occurring in the hospital involving patients, use of restraints and other behavior interventions, and number of inpatient psychiatric units;

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

(3) emergency department wait times;

(4) employment turnover rates among direct care registered nurses and other direct care health care workers;

(5) except in instances when nurses volunteer for overtime, prevalence of overtime among direct care registered nurses and other direct care health care workers;

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

(7) whether the population served by the hospital includes a high proportion of persons from underserved communities;

(8) the perceived experience of the hospital's workforce, as indicated by employee engagement surveys or other means; and

(9) frequency of incidents of being out of compliance with a core staffing plan and the extent of noncompliance with the core staffing plan.

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

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

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

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

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

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

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

Subd. 2. **Prohibited actions; process.** (a) Except as provided in subdivision 5, a hospital or other entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility licensed by the commissioner of health, and the facility's agent, is prohibited from taking action against a nurse solely on the ground that the nurse fails to accept an assignment of one or more additional patients because the nurse reasonably determines that accepting an additional patient assignment may create an unnecessary danger to a patient's life, health, or safety or may otherwise constitute a ground for disciplinary action under section 148.261.

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

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

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

A retrospective review of the incident may be initiated by the individuals involved, and may be completed at the unit level or at the hospital nurse staffing committee level. Nothing in this section modifies a nurse's professional obligations under sections 148.171 to 148.285.

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

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

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

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

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

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

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

(b) The reporting system shall consist of:

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

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

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

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

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

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

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

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

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

147A.08 EXEMPTIONS.

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

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

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

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

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

Sec. 19. **BEST PRACTICES TOOLKIT DEVELOPMENT.**

The commissioner of health must convene a stakeholder group to develop a toolkit with best practices for implementation of hospital nurse staffing committees and protocols for mediation and arbitration, including choosing a mutually agreed-upon mediator or arbitrator. The toolkit and best practices must include a recommendation that each hospital utilize a federal mediator or the Office of Collaboration and Dispute Resolution to moderate the establishment of committees in each hospital. The commissioner must make the toolkit with the recommended best practices available to hospitals by July 1, 2024. The stakeholder group must also examine whether there are objective metrics by which the commissioner could verify that a hospital is adequately staffed and must provide recommendations to the legislature by December 15, 2023, on the feasibility of establishing an alternative compliance pathway to ensure adequate hospital staffing.

EFFECTIVE DATE. This section is effective the day following final enactment.

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

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

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

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

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

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

By October 1, 2023, the commissioner of health must contract with the commissioner of management and budget for the services of the Impact Evaluation Unit to design and implement a rigorous causal impact evaluation using time-series data or other evaluation methods as determined by the Impact Evaluation Unit to estimate the causal impact of the implementation of Minnesota Statutes, sections 144.7051 to 144.7059, on patient care, nurse job satisfaction, nurse retention, and other outcomes as determined by the commissioner and the Impact Evaluation Unit. The Impact Evaluation Unit may subcontract with other research organizations to assist with the design or implementation of the impact evaluation. The commissioner of management and budget may obtain any relevant data from any state agency necessary to conduct this evaluation under Minnesota Statutes, section 15.08. By February 15, 2024, the commissioner of health must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy draft legislation specifying any additional authorities the commissioner and the Impact Evaluation Unit may require to collect the data required to conduct a successful impact evaluation of the implementation of Minnesota Statutes, sections 144.7051 to 144.7059. By October 1, 2024, the Impact Evaluation Unit must begin collecting baseline data. By June 30, 2029, the Impact Evaluation Unit must submit to the commissioner of health a public initial report on the status of the evaluation project and any preliminary results.

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

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

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

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

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

Sec. 24. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE BEDSIDE ACT.**

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

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

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

(d) By October 1, 2025, the commissioner of health must develop a standard concern for safe staffing form and provide an electronic means of submitting the form to the relevant hospital nurse staffing committee. The commissioner must base the form on the existing concern for safe staffing form maintained by the Minnesota Nurses' Association. The commissioner must include the following information on the form or accompanying the form: the specific purpose of the form as compared to other forms hospitals may use for concerns regarding personnel and other matters, and a statement that concern for safe staffing forms do not address or replace other established hospital forms and procedures relating to personnel issues and other hospital processes relating to matters other than staffing concerns.

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

Sec. 25. **REVISOR INSTRUCTION.**

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

Amend the title accordingly