

**SENATE  
STATE OF MINNESOTA  
NINETY-THIRD SESSION**

**S.F. No. 1561**

(SENATE AUTHORS: MURPHY, Port, Abeler, Wiklund and Marty)

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02/13/2023	797	Introduction and first reading Referred to Health and Human Services
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1.1 A bill for an act

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

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

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

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

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

1.7 modifying eligibility for nursing facility employee scholarships; establishing a

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

1.9 health professional education loan forgiveness program; requiring the commissioner

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

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

1.12 amending Minnesota Statutes 2022, sections 144.1501, subdivisions 3, 4; 144.566;

1.13 144.7055; 144.7067, by adding a subdivision; proposing coding for new law in

1.14 Minnesota Statutes, chapter 144.

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

1.16 **ARTICLE 1**

1.17 **KEEPING NURSES AT THE BEDSIDE ACT**

1.18 Section 1. TITLE.

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

1.20 **ARTICLE 2**

1.21 **HOSPITAL STAFFING**

1.22 Section 1. [144.7051] DEFINITIONS.

1.23 Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the

1.24 terms defined in this section have the meanings given.

2.1 Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a  
2.2 form that may be used by any individual to report unsafe staffing situations while maintaining  
2.3 the privacy of patients.

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

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

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

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

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

2.16 **Sec. 2. [144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

2.17 Subdivision 1. **Hospital nurse staffing committee required.** Each hospital must establish  
2.18 and maintain a functioning hospital nurse staffing committee. A hospital may assign the  
2.19 functions and duties of a hospital nurse staffing committee to an existing committee provided  
2.20 the existing committee meets the membership requirements applicable to a hospital nurse  
2.21 staffing committee.

2.22 Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse  
2.23 staffing committee's membership must be direct care registered nurses typically assigned  
2.24 to a specific unit for an entire shift and at least 15 percent of the committee's membership  
2.25 must be other direct care workers typically assigned to a specific unit for an entire shift.  
2.26 Direct care registered nurses and other direct care workers who are members of a collective  
2.27 bargaining unit shall be appointed or elected to the committee according to the guidelines  
2.28 of the applicable collective bargaining agreement. If there is no collective bargaining  
2.29 agreement, direct care registered nurses shall be elected to the committee by direct care  
2.30 registered nurses employed by the hospital and other direct care workers shall be elected  
2.31 to the committee by other direct care workers employed by the hospital.

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

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

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

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

3.12 (b) Each hospital nurse staffing committee must:

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

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

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

3.19 (4) review the documentation of compliance maintained by the hospital under section  
3.20 144.7056, subdivision 10;

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

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

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

3.25 (8) assist the commissioner in conducting surveys of nonmanagerial care staff by  
3.26 facilitating and encouraging participation in the surveys of a representative sample of direct  
3.27 care registered nurses employed by the hospital; and

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

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

4.1 Sec. 3. [144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.

4.2 Subdivision 1. Hospital nurse workload committee required. Each hospital must  
4.3 establish and maintain a functioning hospital nurse workload committee.

4.4 Subd. 2. Workload committee membership. (a) At least 35 percent of the hospital  
4.5 nurse staffing committee's membership must be direct care registered nurses typically  
4.6 assigned to a specific unit for an entire shift and at least 15 percent of the committee's  
4.7 membership must be other direct care workers typically assigned to a specific unit for an  
4.8 entire shift. Direct care registered nurses and other direct care workers who are members  
4.9 of a collective bargaining unit shall be appointed or elected to the committee according to  
4.10 the guidelines of the applicable collective bargaining agreement. If there is no collective  
4.11 bargaining agreement, direct care registered nurses shall be elected to the committee by  
4.12 direct care registered nurses employed by the hospital and other direct care workers shall  
4.13 be elected to the committee by other direct care workers employed by the hospital.

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

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

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

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

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

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

5.2 Sec. 4. Minnesota Statutes 2022, section 144.7055, is amended to read:

5.3 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

5.4 Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to  
5.5 144.7058, the following terms have the meanings given.

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

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

5.14 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients  
5.15 and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates  
5.16 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not  
5.17 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

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

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

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

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

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

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

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

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

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

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

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

6.16 (c) Core staffing plans must ensure that:

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

6.19 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff  
6.20 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive  
6.21 24-hour periods requiring 16 or more hours;

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

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

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

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

6.28 **Subd. 2a. Development of hospital core staffing plans.** (a) Prior to submitting  
6.29 completing or updating the core staffing plan, as required in subdivision 3, hospitals shall  
6.30 a hospital nurse staffing committee must consult with representatives of the hospital medical  
6.31 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about

7.1 the core staffing plan and the expected average number of patients upon which the core  
7.2 staffing plan is based.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.17 Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core  
8.18 staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota  
8.19 Hospital Association shall include each reporting hospital's core staffing plan on the  
8.20 Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,  
8.21 2014. any substantial changes to the core staffing plan shall be updated within 30 days.

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

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

8.27 Sec. 5. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

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

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



9.1 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing  
9.2 plan, a hospital must post a notice stating whether the current staffing on the unit complies  
9.3 with the hospital's core staffing plan for that unit. The public notice of compliance must  
9.4 include a list of the number of nonmanagerial care staff working on the unit during the  
9.5 current shift and the number of patients assigned to each direct care registered nurse working  
9.6 on the unit during the current shift. The list must enumerate the nonmanagerial care staff  
9.7 by health care worker type. The public notice of compliance must be posted immediately  
9.8 adjacent to the publicly posted core staffing plan.

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

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

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

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

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

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

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

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

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

10.7 (c) The commissioner of labor must investigate any report of retaliation against a hospital  
10.8 employee for submitting a concern for safe staffing form. The commissioner of labor must  
10.9 fine a hospital \$250,000 for each instance of substantiated retaliation against a hospital  
10.10 employee for submitting a concern for safe staffing form.

10.11 Subd. 10. Documentation of compliance. Each hospital must document compliance  
10.12 with its core nursing plans and maintain records demonstrating compliance for each inpatient  
10.13 care unit for five years. Each hospital must provide to its nurse staffing committee access  
10.14 to all documentation required under this subdivision.

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

10.16 Sec. 6. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

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

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

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

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

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

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

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

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

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

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

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

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

11.7 (5) propose solutions to solve insufficient staffing;

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

11.9 (7) describe staffing trends within the hospital.

11.10 Subd. 3. **Public posting of nurse staffing reports.** The Office of Health Facility  
11.11 Complaints must include on its website each quarterly nurse staffing report submitted to  
11.12 the office under subdivision 1.

11.13 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each  
11.14 hospital nurse staffing committee a uniform format or standard form the committee must  
11.15 use to comply with the nurse staffing reporting requirements under this section. The format  
11.16 or form developed by the commissioner must present the reported information in a manner  
11.17 allowing patients and the public to clearly understand and compare staffing patterns and  
11.18 actual levels of staffing across reporting hospitals. The commissioner must include, in the  
11.19 uniform format or on the standardized form, space to allow the reporting hospital to include  
11.20 a description of additional resources available to support unit-level patient care and a  
11.21 description of the hospital.

11.22 Subd. 5. **Penalties.** The commissioner may impose an administrative fine of up to \$5,000  
11.23 for each instance of a failure to report an elective surgery requiring reporting under  
11.24 subdivision 2, clause (2).

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

11.26 Sec. 7. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

11.27 Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the  
11.28 commissioner must develop a uniform annual grading system that evaluates each hospital's  
11.29 compliance with its own core staffing plan. The commissioner must assign each hospital a  
11.30 compliance grade based on a review of the hospital's nurse staffing report submitted under  
11.31 section 144.7057. The commissioner must assign a failing compliance grade to any hospital

12.1 that has not been in compliance with its staffing plan for six or more months during the  
 12.2 reporting year.

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

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

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

12.7 (3) emergency department wait times;

12.8 (4) readmissions;

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

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

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

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

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

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

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

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

12.23 Sec. 8. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

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

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

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

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

13.6 Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other  
13.7 entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility  
13.8 licensed by the commissioner of health, and the facility's agent, is prohibited from taking  
13.9 action against a nurse solely on the ground that the nurse fails to accept an assignment of  
13.10 one or more additional patients because the nurse determines that accepting an additional  
13.11 patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's  
13.12 life, health, or safety or may otherwise constitute a ground for disciplinary action under  
13.13 section 148.261. This subdivision does not apply to a nursing facility, an intermediate care  
13.14 facility for persons with developmental disabilities, or a licensed boarding care home.

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

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

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

13.22 Subd. 6. **Penalty.** The commissioner may impose upon a health care facility an  
13.23 administrative fine of up to \$5,000 for each violation of this section.

13.24 Sec. 9. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**  
13.25 **BEDSIDE ACT.**

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

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

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

14.3 (d) By October 1, 2025, the commissioner of health must provide electronic access to  
 14.4 a standard concern for safe staffing form. The commissioner must base the form on the  
 14.5 existing concern for safe staffing form maintained by the Minnesota Nurses' Association.

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

14.9 **Sec. 10. APPROPRIATION; HOSPITAL STAFFING.**

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

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

14.16 **Sec. 11. REVISOR INSTRUCTION.**

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

14.23 **ARTICLE 3**

14.24 **WORKPLACE VIOLENCE PREVENTION**

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

14.26 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

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

14.29 (b) "Act of violence" means an act by a patient or visitor against a health care worker  
 14.30 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections  
 14.31 609.221 to 609.2241.

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

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

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

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

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

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

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

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

15.30 Subd. 2. ~~Hospital duties~~ **Action plans and action plan reviews required.** (a) All  
15.31 hospitals must design and implement preparedness and incident response action plans to  
15.32 acts of violence by January 15, 2016, and review and update the plan at least annually  
15.33 thereafter. The plan must be in writing; specific to the workplace violence hazards and

16.1 corrective measures for the units, services, or operations of the hospital; and available to  
16.2 health care workers at all times.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.9 (3) the hospital's ~~incident response reaction plan and violence prevention plan~~  
 19.10 preparedness and incident response action plans for acts of violence, including how the  
 19.11 health care worker may report concerns about workplace violence within each hospital's  
 19.12 reporting database without fear of reprisal, how the hospital will address workplace violence  
 19.13 incidents, and how the health care worker can participate in reviewing and revising the plan;  
 19.14 and

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

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

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

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

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

19.28 ~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous  
 19.29 year, including injuries sustained, if any, and the unit in which the incident occurred;

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

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

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

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

20.11 Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a  
20.12 procedure for a health care worker to officially request of hospital supervisors or  
20.13 administration that additional staffing be provided. The hospital must document all requests  
20.14 for additional staffing made because of a health care worker's concern over a risk of an act  
20.15 of violence. If the request for additional staffing is denied, the hospital must provide the  
20.16 health care worker who made the request a written reason for the denial and must maintain  
20.17 documentation of that communication with the documentation of requests for additional  
20.18 staffing. A hospital must make documentation regarding staffing requests available to the  
20.19 commissioner for inspection at the commissioner's request. The commissioner may use  
20.20 documentation regarding staffing requests to inform the commissioner's determination on  
20.21 whether the hospital is providing adequate staffing and security to address acts of violence,  
20.22 and may use documentation regarding staffing requests if the commissioner imposes a  
20.23 penalty under subdivision 18.

20.24 Subd. 15. **Public disclosure of action plans.** ~~(e)~~ (a) A hospital shall must make its most  
20.25 recent action plans and the information listed in paragraph ~~(d)~~ most recent action plan  
20.26 reviews publicly available to local law enforcement and, if any of its workers are represented  
20.27 by a collective bargaining unit, to the exclusive bargaining representatives of those collective  
20.28 bargaining units by posting them on the hospital website.

20.29 (b) A hospital must also annually submit to the commissioner its most recent action plan  
20.30 and the results of the most recent annual review conducted under subdivision 12.

20.31 Subd. 16. **Legislative report required.** The commissioner must compile the information  
20.32 into a single report and submit the report to the chairs and ranking minority members of the  
20.33 legislative committees with jurisdiction over health care.

21.1 Subd. 17. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner,  
 21.2 association, or any person or group of persons acting directly or indirectly in the interest of  
 21.3 the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health  
 21.4 care worker wishes to contact law enforcement or the commissioner regarding an act of  
 21.5 violence.

21.6 Subd. 18. **Penalties.** ~~(g)~~ The commissioner may impose an administrative fine of up to  
 21.7 ~~\$250~~ \$10,000 for failure to comply with the requirements of this ~~subdivision~~ section.

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

21.9 \$50,000 in fiscal year 2024 and \$50,000 in fiscal year 2025 are appropriated to the  
 21.10 commissioner of health to continue the prevention of violence in health care programs and  
 21.11 to create violence prevention resources for hospitals and other health care providers to use  
 21.12 to train their staff on violence prevention.

#### 21.13 **ARTICLE 4**

#### 21.14 **PIPELINE TO REGISTERED NURSE DEGREES**

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

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

#### 21.21 **ARTICLE 5**

#### 21.22 **HOSPITAL NURSING EDUCATION LOAN FORGIVENESS PROGRAM**

21.23 Section 1. **[144.1507] HOSPITAL NURSING EDUCATION LOAN FORGIVENESS**  
 21.24 **PROGRAM.**

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

21.27 (b) "Nurse" means an individual who is licensed as a registered nurse and who is  
 21.28 providing direct patient care in a nonprofit hospital setting.

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

22.1 Subd. 2. **Eligibility.** (a) To be eligible to participate in the hospital nursing education  
22.2 loan forgiveness program, a nurse must be:

22.3 (1) enrolled in the PSLF program;

22.4 (2) employed full time as a registered nurse by a nonprofit hospital that is an eligible  
22.5 employer under the PSLF program; and

22.6 (3) providing direct care to patients at the nonprofit hospital.

22.7 (b) An applicant must submit to the commissioner of health:

22.8 (1) a completed application on forms provided by the commissioner;

22.9 (2) proof that the applicant is enrolled in the PSLF program; and

22.10 (3) confirmation that the applicant is employed full time as a registered nurse by a  
22.11 nonprofit hospital and is providing direct patient care.

22.12 (c) The applicant selected to participate must sign a contract to agree to continue to  
22.13 provide direct patient care as a registered nurse at a nonprofit hospital for the repayment  
22.14 period of the participant's eligible loan under the PSLF program.

22.15 Subd. 3. **Loan forgiveness.** (a) The commissioner of health shall select applicants each  
22.16 year for participation in the hospital nursing education loan forgiveness program, within  
22.17 limits of available funding. Applicants are responsible for applying for and maintaining  
22.18 eligibility for the PSLF program.

22.19 (b) For each year that a participant meets the eligibility requirements described in  
22.20 subdivision 2, the commissioner shall make an annual disbursement directly to the participant  
22.21 in an amount equal to the minimum loan payments required to be paid by the participant  
22.22 under the participant's repayment plan established for the participant under the PSLF program  
22.23 for the previous loan year. Before receiving the annual loan repayment disbursement, the  
22.24 participant must complete and return to the commissioner a confirmation of practice form  
22.25 provided by the commissioner, verifying that the participant continues to meet the eligibility  
22.26 requirements under subdivision 2.

22.27 (c) The participant must provide the commissioner with verification that the full amount  
22.28 of loan repayment disbursement received by the participant has been applied toward the  
22.29 loan for which forgiveness is sought under the PSLF program.

22.30 Subd. 4. **Penalty for nonfulfillment.** If a participant does not fulfill the required  
22.31 minimum commitment of service as required under subdivision 2, or the secretary of  
22.32 education determines that the participant does not meet eligibility requirements for the PSLF

23.1 program, the commissioner shall collect from the participant the total amount paid to the  
 23.2 participant under the hospital nursing education loan forgiveness program plus interest at  
 23.3 a rate established according to section 270C.40. The commissioner shall deposit the money  
 23.4 collected in the health care access fund to be credited to the health professional education  
 23.5 loan forgiveness program account established in section 144.1501, subdivision 2. The  
 23.6 commissioner shall allow waivers of all or part of the money owed to the commissioner as  
 23.7 a result of a nonfulfillment penalty if emergency circumstances prevent fulfillment of the  
 23.8 service commitment or if the PSLF program is discontinued before the participant's service  
 23.9 commitment is fulfilled.

23.10 Sec. 2. **APPROPRIATION; HOSPITAL NURSING LOAN FORGIVENESS.**

23.11 \$5,000,000 in fiscal year 2024 and \$5,000,000 in fiscal year 2025 are appropriated from  
 23.12 the general fund to the commissioner of health for the hospital nursing education loan  
 23.13 forgiveness program under Minnesota Statutes, section 144.1507.

## 23.14 **ARTICLE 6**

### 23.15 **LOAN FORGIVENESS FOR NURSING INSTRUCTORS**

23.16 Section 1. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

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

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

23.25 (2) submit an application to the commissioner of health.

23.26 (b) Except as specified in paragraph (c), an applicant selected to participate must sign  
 23.27 a contract to agree to serve a minimum three-year full-time service obligation according to  
 23.28 subdivision 2, which shall begin no later than March 31 following completion of required  
 23.29 training, with the exception of a nurse, who must agree to serve a minimum two-year  
 23.30 full-time service obligation according to subdivision 2, which shall begin no later than  
 23.31 March 31 following completion of required training.

24.1 (c) An applicant selected to participate who is a nurse and who agrees to teach according  
24.2 to subdivision 2, paragraph (a), clause (3), must sign a contract to agree to teach for a  
24.3 minimum of two years.

24.4 Sec. 2. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

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



25.1 is made. Participants who move their practice remain eligible for loan repayment as long  
 25.2 as they practice as required under subdivision 2.

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

25.9 **Sec. 3. APPROPRIATION; LOAN FORGIVENESS FOR NURSING**  
 25.10 **INSTRUCTORS.**

25.11 Notwithstanding the priorities and distribution requirements under Minnesota Statutes,  
 25.12 section 144.1501, \$50,000 in fiscal year 2024 and \$50,000 in fiscal year 2025 are  
 25.13 appropriated from the general fund to the commissioner of health for the health professional  
 25.14 education loan forgiveness program under Minnesota Statutes, section 144.1501, to be  
 25.15 distributed in accordance with the program to eligible nurses who have agreed to teach in  
 25.16 accordance with Minnesota Statutes, section 144.1501, subdivision 2.

25.17 **ARTICLE 7**  
 25.18 **REPORT ON HOSPITAL STAFFING**

25.19 Section 1. Minnesota Statutes 2022, section 144.7067, is amended by adding a subdivision  
 25.20 to read:

25.21 **Subd. 4. Duty to analyze hospital staffing.** The commissioner shall:

25.22 (1) compare adverse event reports submitted to the Office of Health and nurse staffing  
 25.23 reports submitted to the commissioner under section 144.7057 to determine correlations  
 25.24 between demonstrable understaffing and adverse events and to identify patterns of systemic  
 25.25 understaffing in hospitals;

25.26 (2) communicate to individual hospitals the commissioner's conclusions, if any, regarding  
 25.27 a correlation between adverse events reported in the hospital and understaffing demonstrated  
 25.28 by submitted nurse staffing reports;

25.29 (3) communicate to relevant hospitals any recommendations for corrective action resulting  
 25.30 from the commissioner's analysis conducted under clause (1); and

25.31 (4) publish an annual report;

26.1 (i) describing, by hospital, correlations between adverse events and demonstrable  
 26.2 understaffing;

26.3 (ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses  
 26.4 regarding understaffing in hospitals; and

26.5 (iii) making recommendations for modifications of the regulation of care provided in  
 26.6 hospitals.

26.7 **EFFECTIVE DATE.** This section is effective January 1, 2027.

26.8 **Sec. 2. DIRECTION TO COMMISSIONER OF HEALTH; EXPANSION OF THE**  
 26.9 **NURSING WORKFORCE REPORT.**

26.10 The commissioner of health shall expand the commissioner's existing license renewal  
 26.11 questionnaires authorized under Minnesota Statutes, sections 144.051 and 144.052, to  
 26.12 include the collection, analysis, and reporting of data on the following topics:

26.13 (1) Minnesota's supply of active licensed registered nurses;

26.14 (2) trends in Minnesota regarding retention by hospitals of licensed registered nurses;

26.15 (3) reasons licensed registered nurses are leaving direct care positions at hospitals; and

26.16 (4) reasons licensed registered nurses are choosing not to renew their licenses and leaving  
 26.17 the profession.

26.18 **Sec. 3. APPROPRIATION; HOSPITAL STAFFING STUDY.**

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

## 26.22 **ARTICLE 8**

### 26.23 **MENTAL HEALTH SERVICES FOR NURSES**

26.24 **Section 1. APPROPRIATION; IMPROVING MENTAL HEALTH OF HEALTH**  
 26.25 **CARE WORKERS.**

26.26 \$10,000,000 in fiscal year 2024 and \$10,000,000 in fiscal year 2025 are appropriated  
 26.27 from the general fund to the commissioner of health for competitive grants to hospitals,  
 26.28 community health centers, rural health clinics, and medical professional associations to  
 26.29 establish or enhance evidence-based or evidence-informed programs dedicated to improving  
 26.30 the mental health of health care professionals.