alzheimer's association®

THE BRAINS BEHIND SAVING YOURS.

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March 30, 2023

Dear Members of the Health and Human Services Committee:

The Alzheimer's Association is a nonprofit organization dedicated to supporting people living with Alzheimer's Disease and other forms of dementia. We are writing today to share our comments on SF 2995, the Senate Health and Human Services Omnibus Bill.

Alzheimer's Disease is a public health crisis. In 2020, 99,000 Minnesotans were living with Alzheimer's Disease or another form of dementia. That number is expected to increase by 21.2% by 2025. Alzheimer's and dementia impacts everyone but these impacts are not felt equally. Black people are twice as likely to have dementia, Latinos are 1.5 times as likely, and there are elevated rates in the Indigenous community. People of Color are also more likely to have misunderstandings about dementia and the nature of aging. Facing these racial disparities, the need for culturally relevant messaging on aging is more important than ever.

That's why we strongly support:

Alzheimer's Public Awareness Campaign: When engaging people of color on dementia and healthy aging, particularly in non-English speaking communities, it won't work to rehash or quickly translate existing public health materials. That's why we support funding in this bill for the Department of Health to go out and engage leaders in underserved communities and collaboratively develop culturally relevant information on Alzheimer's Disease.

Community Health Worker Dementia Training: Community Health Workers are trusted messengers with a proven ability to connect underserved communities with accurate information and necessary resources. We support the additional funding for the Community Health Worker Alliance and legislation to develop a dementia training for community health workers to better support elders.

Thank you for the care and attention you all have brought to building this omnibus budget bill. We strongly support this bill and the bipartisan legislation we have mentioned today.

Sincerely,

Sam Smith
State Affairs Manager
Alzheimer's Association

Minnesota Nurses Association
An Affiliate of National Nurses United

March 31st, 2023

Chair Wiklund
Members of the Health and Human Services Committee
Minnesota Senate Building
95 University Ave W
Saint Paul, MN 55155

Professional Distinction

Personal Dignity

Patient Advocacy

Chair Wiklund and members of the Health and Human Services Committee:

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

The following are some provisions included in the SF 2995 DE1 amendment, the Health Finance and Policy omnibus bill, which we support:

Provisions from SF 1561 Keeping Nurses at the Bedside Act
Our hospitals are in crisis with patients waiting for hours and even days in our emergency departments; being boarded and not receiving appropriate care; or receiving that care in unsuitable and undignified spaces such as hallways and the waiting room of emergency departments. This inappropriate type of care is perpetuating thousands more registered nurses leaving the bedside due to incredible stress, physical assaults, and the moral injury they sustain when they do not have the resources and time to provide the care their patients deserve. These provisions included in the omnibus bill provide nurses and other healthcare workers a voice in staffing in their hospitals through a comprehensive, local, and flexible approach to ensure patients are receiving the best care from their nurses. The omnibus bill also includes multiple other recruitment and retention solutions such as workplace violence prevention and loan forgiveness programs. We applaud Chair Wiklund and the committee's inclusion of these important steps to bring nurses back to the bedside and help solve the crisis in our hospitals.

Hospital Merger Regulation and HMO Conversion Moratorium
MNA is proud to support the provisions from House File 402 included in the omnibus bill because it provides the Attorney General and Department of Health with the authorities and tools desperately needed to protect patients, communities, healthcare workers, and our state healthcare delivery system

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GCC/IBT

AFL-CIO

from the harms caused by consolidation and corporatization. We know that nationally, regionally, and right here in Minnesota, corporatization leads to vital services being stripped from rural and lower-income communities and shuttled to larger facilities further and further away. Consolidation raises prices, lowers accessibility, and has negative longstanding impacts on patients and communities. This provision establishes new safeguards at the state level for preventing harmful mergers and transactions and outlines a comprehensive and data-informed approach for ensuring that only transactions that would provide for the public good can move forward, while also preventing charitable assets from being transferred to a for-profit entity. The bill also extends the moratorium on health maintenance organization (HMO) conversions and authorizes a study on regulating nonprofit and for-profit HMO transactions to ensure Minnesotans have quality products available for their health insurance that best match the needs of our state.

Opting Out of Managed Care Plans

We are excited to see meaningful reform to our public health options to ensure that enrollees have choices in the care they receive through being able to opt out of managed care plans. MNA's strong support of public programs is, in part, rooted in deep concerns about the impact of privatization which forces individuals to enroll into HMO plans that are not demonstrated to improve the quality-of-care people receive. Instead, data shows that HMO plans profit by reducing access to providers, increasing denials for medically necessary services, and removing individuals' ability to make their own healthcare decisions. This system further removes transparency from the process and requires publicly funded programs to pay private insurance companies to manage these important benefits without ensuring they are improving the quality of patient care and healthcare access.

Telehealth

The pandemic revealed more clearly both the inequities in the health care system and the possibility of new technology to help more people access care. As MNA works through this language more closely, we want to ensure that telehealth does not replace individualized care at the bedside and that lack of local broadband infrastructure and economic barriers to accessing necessary equipment and internet service do not exacerbate health care issues that already exist in Minnesota.

Just as patients depend on nurses to care for them at the bedside, Minnesotans across the state are counting on legislators to ensure they have access to quality, affordable care. The overall focus on ensuring better access to healthcare is incredible and we strongly support this work to ensure our healthcare system functions better for all Minnesotans.

We appreciate and are grateful for the work and passion put into this omnibus bill and look forward to working with you all over the next weeks to continue building on this critical piece of legislation.

Thank you,

Shannon M. Cunningham

Shannon M. Cunningham
Direction of Community and Government Relations
Minnesota Nurses Association

FAST FACTS

The Keeping Nurses at the Bedside Act

Isn't there a shortage of nurses in Minnesota?

There is no shortage of nurses in Minnesota. More than 4,000 new nurses graduated last year alone, bringing the total RNs in the state to more than 122,000, the highest ever in state history. Studies from the federal government and the Minnesota Hospital Association project a surplus of nurses in Minnesota for the foreseeable future.

Why are more Minnesota nurses working part-time or reducing their hours?

The same factors driving nurses out of the profession are driving nurses to reduce their hours: unsafe staffing, inflexible scheduling, and unsupportive management. Corporate healthcare policies incentivize nurses to schedule fewer regular hours and pick up more last-minute shifts where they are paid better. When hospital CEOs create burnout conditions in our hospitals, nurses are left with no other option than to reduce their hours or leave the bedside entirely.

How is this bill different from mandated ratios?

In the past, when statewide staffing ratios have been proposed, the Minnesota Hospital Association and legislators acknowledged the challenges of staffing but indicated that they wanted "a conversation, not a mandate." The Keeping Nurses at the Bedside Act is a unique, Minnesota approach to ensuring safe staffing levels in our hospitals.

Rather than ratios set by the state, the bill would establish local committees of management and healthcare workers at each hospital to set staffing plans together. This local, flexible approach allows each hospital to set safe staffing levels appropriate to their needs and the patients they serve, and allows for more flexibility when changes need to be made to these staffing plans. In other states, staffing committees have been supported by hospital associations as a compromise measure to work with nurses on staffing.

The Keeping Nurses at the Bedside Act has also been updated since last legislative session, including additional protections against workplace violence, and removing threats to a hospital's license. The revised bill instead includes an arbitration process to resolve disputes and increased transparency around staffing for both patients and nurses.

Isn't there a shortage of nurses in California where these laws exist?

Despite claims of severe nursing shortages, only 7 of 336 California hospitals reported a critical staffing shortage in March of 2023. As a percentage of full-time equivalent RNs, vacancies in California have been lower than the nation as a whole in every year since their safe staffing law was passed. California's RN vacancy rate was significantly lower than Minnesota's in 2021, when the study cited by the Minnesota Hospital Association was conducted.

How will hospitals find enough staff to meet these new plans?

There is a surplus of Registered Nurses in Minnesota, with thousands of nurses ready to return to hospital jobs if staffing levels and working conditions improve. In the interim, hospital executives have demonstrated that they can recruit and staff travel nurses to fill positions when necessary, as they have during recent work stoppages by MNA nurses.

If nurses return to hospital jobs, will that leave other positions unfilled?

There is a surplus of Registered Nurses in Minnesota, meaning there are more than enough nurses here to fill necessary hospital nursing jobs and still have many remaining to work in clinical settings, telehealth, and other occupations. In other settings facing staff shortages, such as long-term care, those positions are overwhelmingly for Licensed Practical Nurses (LPNs), not RNs.

What about the other members of the care team?

The staffing committees created by the Keeping Nurses at the Bedside Act would include fifty percent management and fifty percent frontline care staff, including nurses as well as all other members of the care team who provide direct patient care at the bedside.

Could patient care be harmed if this law were passed?

The Keeping Nurses at the Bedside Act is designed to retain skilled nursing staff to protect patient care. Right now, quality is at risk, safety is compromised, and care is being rationed as a result of under staffing. Studies repeatedly show that higher nurse staffing levels, which correlate to more time spent with each patient, result in better patient outcomes. The time spent in the new staffing committees would not take away time from patient care. Each committee would include just a handful of nurses, together with other healthcare workers and management, with meetings typically taking place quarterly.

Won't this just make the problem in emergency departments worse?

The Keeping Nurses at the Bedside Act aims to ensure there are enough nurses in Emergency Departments, and throughout our hospitals, to give the care patients expect and deserve in their most desperate moments. Right now, when patients show up to an understaffed hospital, they are at risk of receiving substandard care, missing a dose of medication or a change in condition, or worse.

Will this bill allow nurses to refuse to care for patients in need?

Right now, patients are being refused care when executives fail to adequately staff our hospitals. When beds sit empty, patients sit for 24 hours in the emergency department waiting room, and when they lay in bed waiting with their call light on, they are being denied care and are put at risk of adverse events from bedsores to terminal events, meaning death. This bill aims to ensure every patient gets the care they expect and deserve when they walk through the door of any hospital, anywhere in Minnesota. The law would allow nurses to vote only when the long-term staffing plan is changed, not on day-to-day decisions of admitting patients.

Doesn't this put hospitals at financial risk?

With billions in revenues and millions paid our to CEOs and other top executives every year, there is no question that the money exists in our healthcare system to solve the staffing and patient care crisis – it is a question of priorities, and executives have made theirs clear.

Will hospitals or units have to close as a result of this law?

Understanding that every hospital is different, especially between Greater Minnesota and the Twin Cities, this bill allows hospitals to set local staffing plans that make sense for their patients and their units. Patients are already losing access to care when they wait hours to be admitted, or are discharged early due to under staffing. This bill will ensure access to quality care for all patients, everywhere in Minnesota.

Is this bill compatible with federal law?

Multiple states have had either staffing committees or ratios in law for decades, and none have lost federal funding as a result. In fact, staffing committees have been supported by hospital associations in other states as a compromise measure in place of statewide staffing levels.

Are hospital managers aware of nurses' concerns for safe staffing?

The Concern for Safe Staffing forms are not the first or only notification about nurses' concerns about understaffing, as nurses also report their concerns directly to management following the hospital chain of command. In these forms in 2022, nurses reported no response or inadequate response by management in nearly 90 percent of cases.

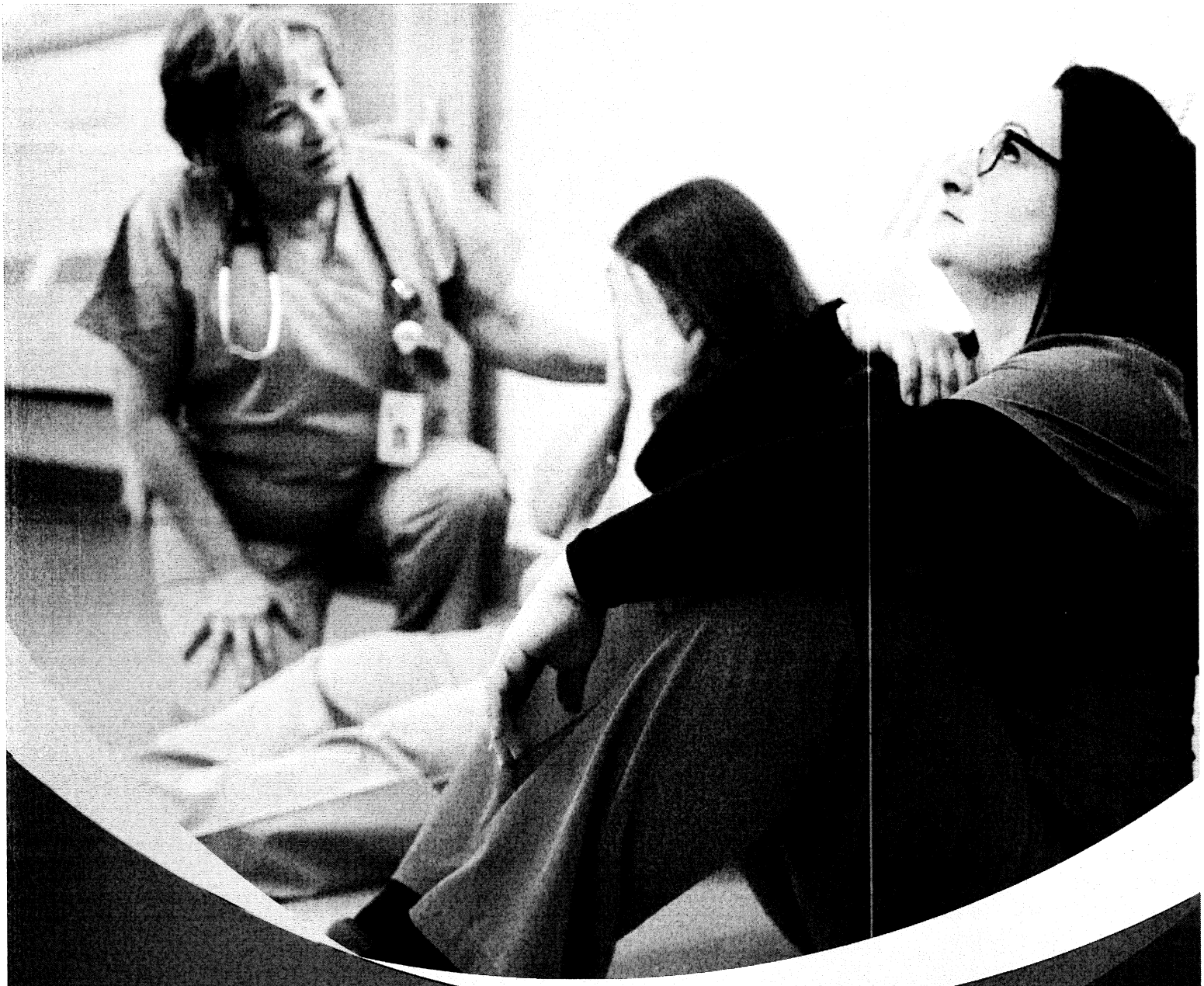
Do some hospitals already have staffing committees that do this work?

Some hospitals do have staffing committees where nurses can give feedback once per year. However, these existing committees are not empowering bedside care workers to help create staffing plans, and there are no enforcement mechanisms to ensure agreed upon staffing levels are put in practice.

How many nurses does the Minnesota Nurses Association represent?

The Minnesota Nurses Association represents 22,000 nurses, 80 percent of all active bedside hospital nurses in Minnesota. Our nurses see patients at their most vulnerable every day, and see firsthand the effects of understaffing on patient care and our nursing workforce.

MNA
Minnesota Nurses Association
An Affiliate of National Nurses United



Why We Left

2023 Nursing Workforce Report

MNA
Minnesota Nurses Association

EXECUTIVE SUMMARY

There is a staffing and retention crisis in Minnesota hospitals which leaves nurses stretched thin trying to do more with less. Executives have created unsafe and unsustainable conditions for nurses and patients in our hospitals. By focusing on the bottom line, hospital executives are driving nurses away from the bedside, putting patient care at risk.

Studies conducted by the Minnesota Nurses Association of its current members, former members, and of the general public make this point clear:

- Minnesotans understand the nature of the staffing and retention crisis, as **85 percent believe it will not be solved without direct action,** and **two-thirds understand that hospital executives created the problem before the pandemic.**
- There is **no shortage of registered nurses in Minnesota**, with **more than 122,000 nurses** here, the **highest ever** in state history
- Over **50 percent** of nurses nationally are **considering leaving the bedside**, citing **under staffing by hospital executives** as their top concern
- In **nearly 90 percent of cases** where MNA nurses filed a concern over the impact of short staffing on patient care, the nurses reported **no response** or **inadequate action** from **hospital management**.
- In this new survey of 2,403 MNA nurses who left their bedside nursing positions, the **top-cited reasons for their departure** by respondents were **stress and "burnout" (75 percent), chronic under-staffing (71 percent), working conditions (63 percent) and management issues (49 percent).**
- **Improved staffing** was the number one condition needed **for nurses to return to the bedside**, cited by **63 percent** of nurse respondents.
- **Nearly 40 percent of nurses who left** the bedside in 2022 had only been in their **nursing careers for less than five years.**
- **Over 75 percent of MNA members have indicated their desire to stay at the bedside** for the near future.

These findings are supported and reinforced by independent studies and research. One recent survey, conducted in November 2022 by OnePoll and connectRN, found that:

- **50 percent of nurses** are considering **leaving the profession** altogether.
- **61 percent cited insufficient staffing** as the biggest contributing factor
- **58 percent** of nurses feel hospital executives are **not doing enough** to solve the staffing crisis

Additionally, recent scholarly research from the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing found that:

- High levels of nurse burnout, job dissatisfaction, and intent to leave their employer predated the pandemic
- Prior to the pandemic, 57 percent of hospital staff nurses said there were too few nurses to care for patients
- Over 69 percent of hospital staff nurses in the pre-pandemic period reported a lack of confidence in hospital management to resolve clinical care problems reported by nurses

BACKGROUND

Minnesota nurses are overworked and overwhelmed, hospitals are understaffed, and patients are overcharged by hospital executives trying to boost their bottom lines. Years of short-staffing and cost-cutting by hospital CEOs leave nurses trying to do more with less.

These conditions that hospital CEOs created are driving nurses away from the profession and putting patient care at risk. There is no shortage of nurses who want to care for patients, there is a shortage of nurses willing to work under these unsafe and unsustainable conditions.

- In 2014, the **Minnesota Hospital Association** (MHA) issued a study which found "**the state-level supply of RNs will more than meet the demand**" through 2024, assuming that RN graduate numbers continue to climb; this conclusion is echoed by the U.S. Department of Health and Human Services which projects a **surplus of registered nurses in Minnesota** through 2030

- A 2022 report from the MN Board of Nursing shows that **new RN graduates continue to climb** in Minnesota **every year**

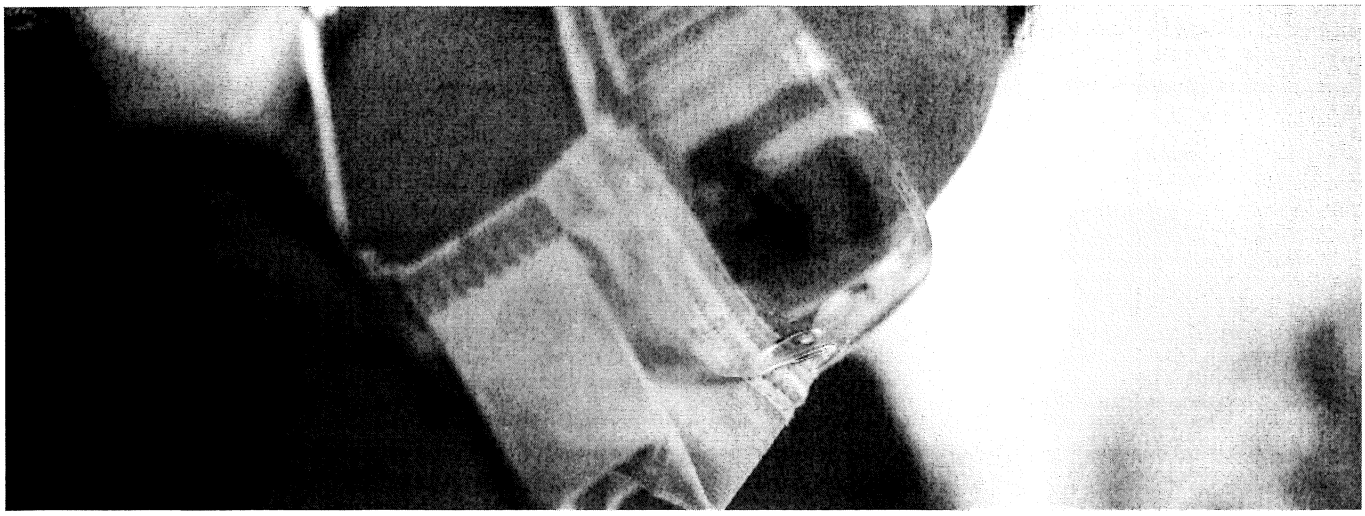
- The **number of registered nurses in Minnesota has increased by over 12,000 in the past four years** to a total of **122,247** last year, the **highest ever** recorded in the state

IN THE LAST FOUR YEARS

Over 122,000 total RNs in MN
highest-ever total nurses

Now, Minnesota nurses are advocating for changes that will retain nurses and prioritize quality patient care by ensuring adequate nurse staffing levels and fair compensation and benefits, putting nurses and patients at the bedside ahead of hospital CEOs and corporate profits in the boardroom.

Our healthcare workforce is in critical condition. The future of our healthcare system in Minnesota depends on the choices we make now.



EXISTING SURVEYS

In the last three years, the Minnesota Nurses Association conducted extensive studies of both its membership and of the Minnesota public to better understand the scope and severity of the staffing and retention crisis in our hospitals.

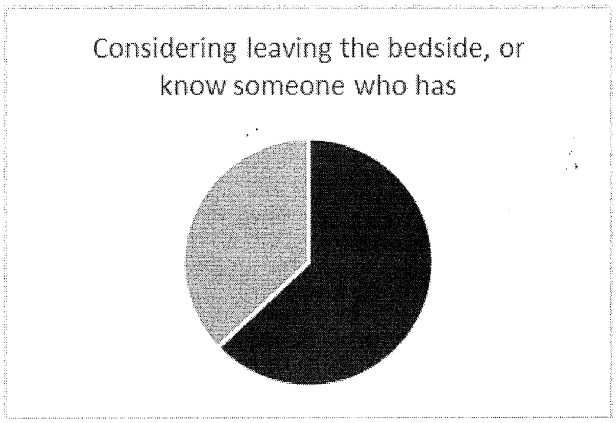
Before exploring the details of the Workforce Report below, several highlights from these previous MNA surveys are worth revisiting.

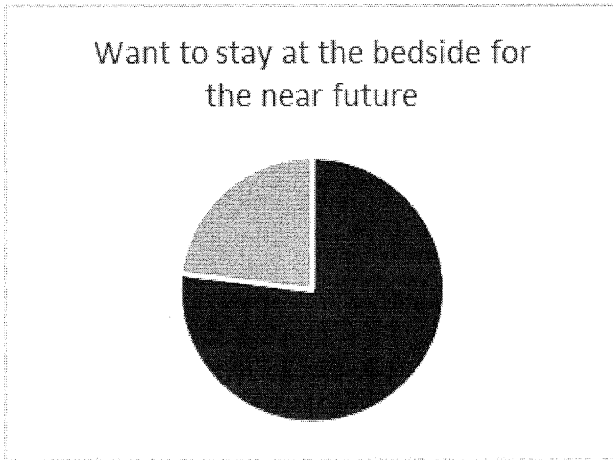
2021 MNA Member Survey

In 2021, MNA conducted a survey of members, asking a variety of questions about their experiences in the nursing profession.

Among the highlights of this survey:

- **55 percent** of nurses reported that they had experienced a situation where they were **not able to provide the care the patient required due to short staffing**
- **44 percent** reported **patient safety had gotten worse** in their hospital over the **last five years, while only 6 percent felt it had improved**
- **63 percent** reported that they had **considered leaving their job** or the profession altogether, or that they **knew someone who had,** due to being **overworked and understaffed**
- Over **75 percent** of nurses reported that they **wanted to stay on the job and in the profession** for at least four more years





Concern for Safe Staffing Forms

In Minnesota, nurses voluntarily file Concern for Safe Staffing (CFSS) Forms when they encounter situations where short staffing is negatively impacting patient care.

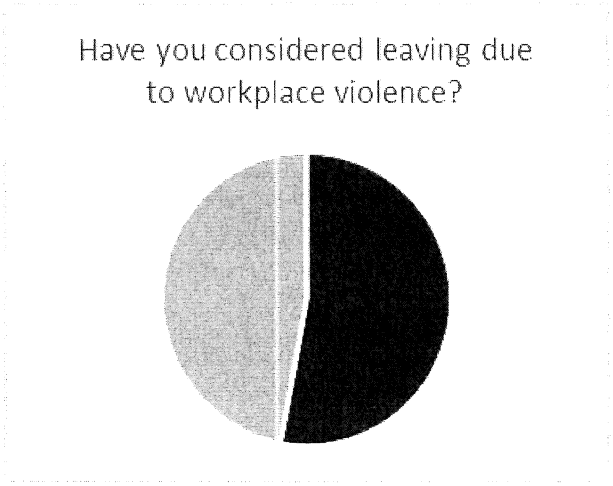
A survey of CFSS forms from 2022 reveals:

- Minnesota nurses filed **8,437 CFSS forms** in 2022, more than a 7 percent increase from 2021.
- In **over 89 percent of those cases**, nurses reported **no response or inadequate action** from **hospital management** when they brought up concerns for patient safety, which is an increase of almost 8% since last year.
- Nearly 80 **percent of cases reported delays in patient care**, a 9.2 percent increase compared to 2021.

2022 MNA Workplace Violence Survey

In 2022, MNA conducted a survey of 950 nurse members about the challenges of violence against nurses and patients in Minnesota hospitals. Nurses in the survey reported that:

- **97 percent** of nurses **observed workplace violence** in the last two years, including verbal abuse, intimidation, harassment, and physical violence.
- **Only 47 percent reported** these incidents to their employer, citing a **lack of time, inadequate staffing, and lack of management action** as the top barriers to reporting.
- **75 percent of nurses cited chronic under-staffing** as a top risk factor for an unsafe work environment, second only to the risks that specific patients might present.
- **62 percent of nurses** believe **patient safety is at risk** due to violence in Minnesota hospitals.

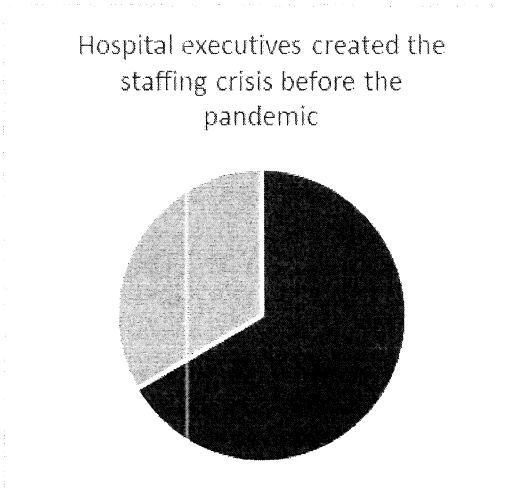


- **65 percent of nurses** believe **hospital executives** have **not adequately prepared** them to prevent or respond to violence.
- **Over half** of all nurse respondents – 53 percent – **have considered leaving** their job or nursing entirely due to violence

2022 MNA Public Polling

In 2022, MNA conducted public polling of registered voters in Minnesota. In this poll, Minnesotans shared the following:

- As patients and family members who see the effects of under staffing, long wait times, and other corporate healthcare policies firsthand, Minnesotans understand the nature of the staffing and retention crisis, and **85 percent understand it will not be solved without corrective action.**
- **Two-thirds of Minnesotans understand that hospital executives** created the problem and that it **pre-dates the pandemic.**
- Minnesotans believe **hospital CEOs can afford to make the changes necessary** to fix the problems they created.
- Minnesotans are especially concerned with the **high salaries and compensation of hospital executives** in Minnesota, who take home **multi-million-dollar salaries while nurses are understaffed and patients are overcharged.**



"'Nominally nonprofit community-spirited institutions have actually come to operate as profit-maximizing monopolies,' with the excess going to executive compensation instead of dividends"

Phil Longman, Policy Director, Open Markets Institute
The Intercept, December 20, 2020

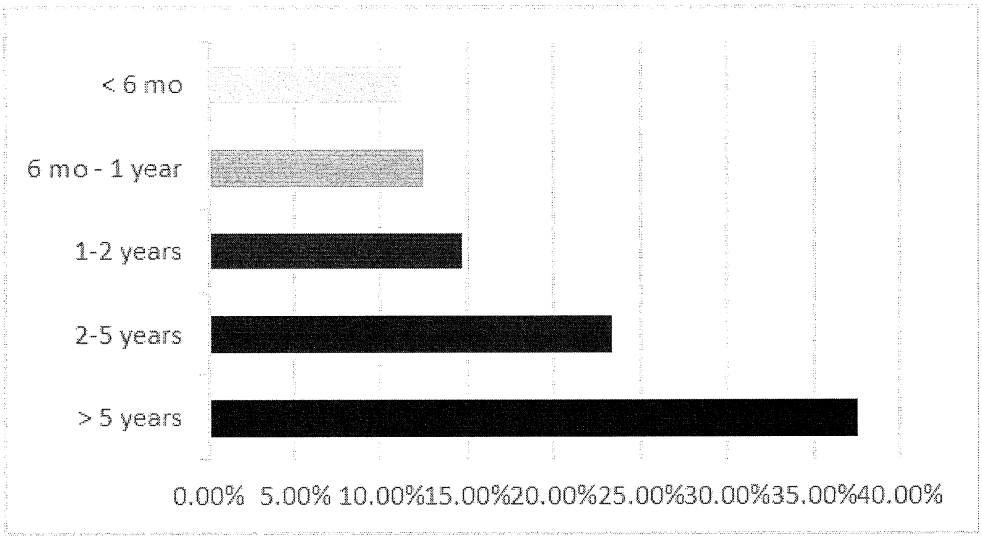
WHY WE LEFT: 2023 MNA WORKFORCE REPORT

Between December 20, 2022 and February 8, 2023, MNA surveyed 2,403 nurse members who left a bedside nursing position within the past year and did not take a new position in an MNA-represented hospital. MNA received responses from 499 nurses who fit this criteria.

The survey focused on determining why nurses left these bedside positions, and asked questions including:

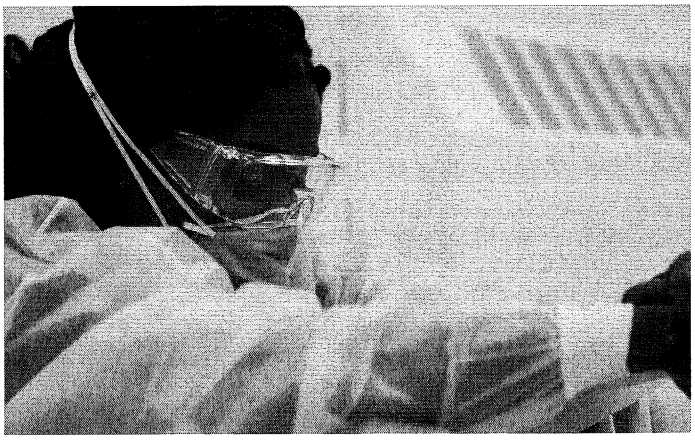
- How long the nurse had been at the bedside
- When the nurse left the bedside
- Whether they had another job when they left
- If they are currently working elsewhere as an RN
- Why they left bedside nursing
- What they would need to return to the bedside

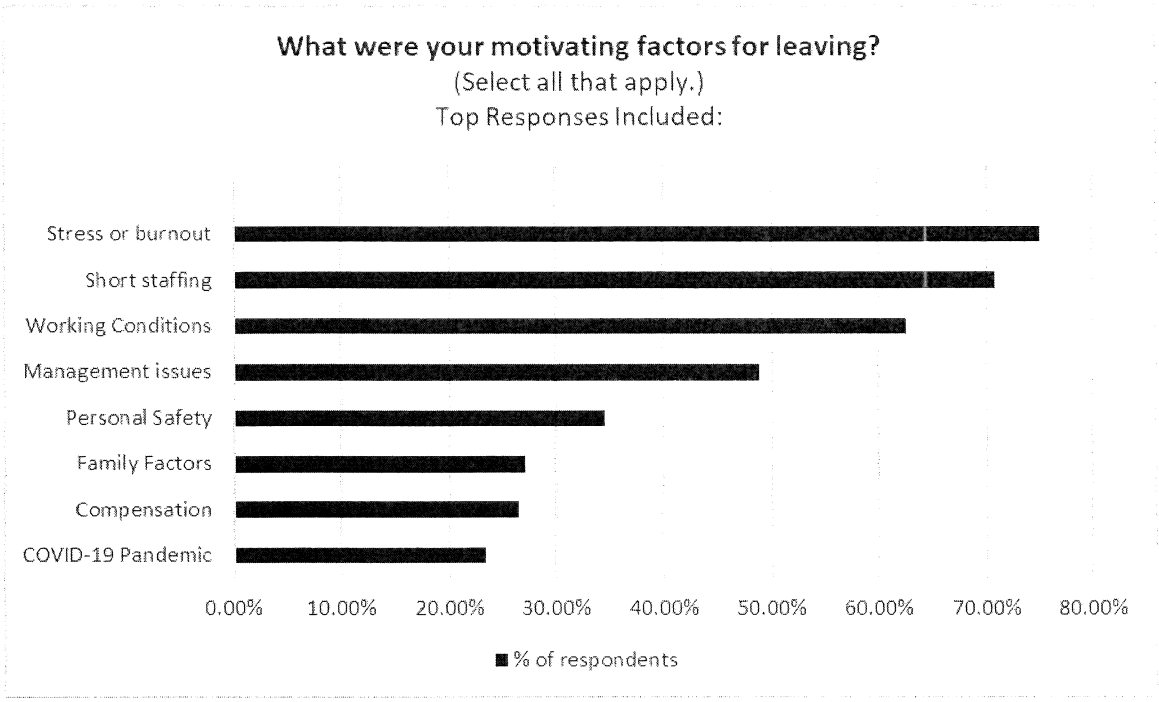
How long had you been in this position before you left?

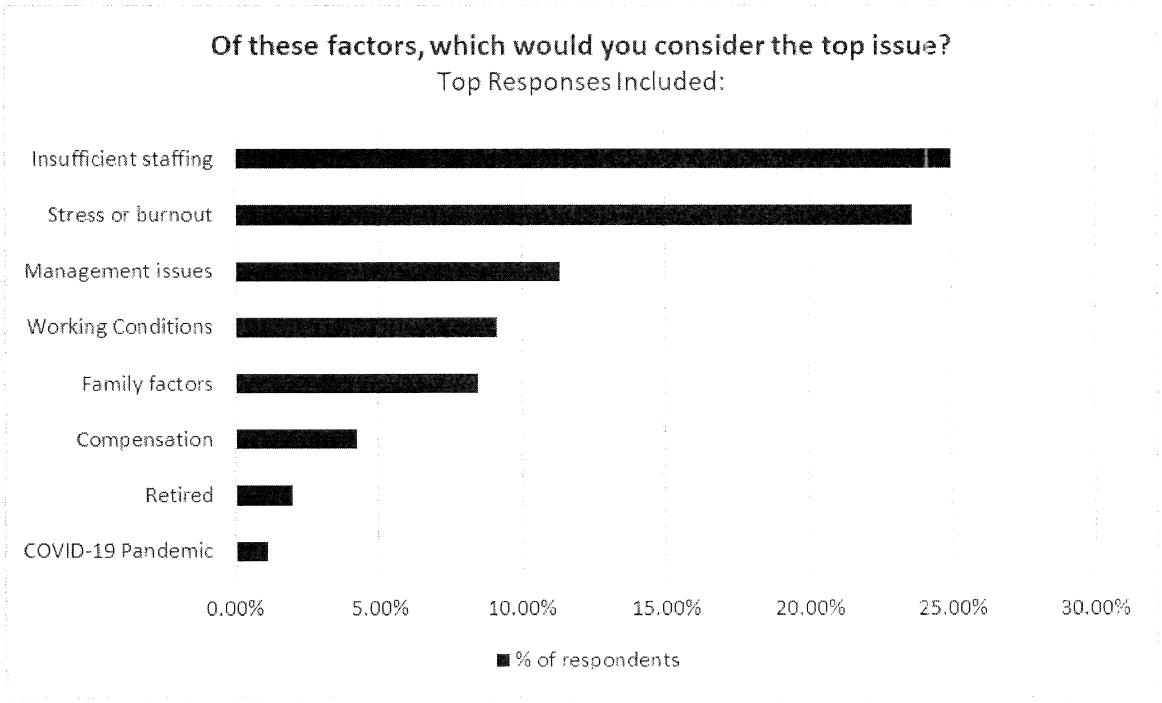


"Everybody wants the nurse with 10 years of ICU experience when they come in the door... successful organizations develop their own work forces and invest in young people and help them to become experts over time and then create policies to retain them."

Linda Aiken, PhD, RN
Founding Director, Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing
MedPage Today, December 30, 2022




What were your motivating factors for leaving?
(Select all that apply.)
Top Responses Included:
Stress or burnout
Short staffing
Working Conditions
Management issues
Personal Safety
Family Factors
Compensation
COVID-19 Pandemic
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
% of respondents


Of these factors, which would you consider the top issue?
Top Responses Included:
Insufficient staffing
Stress or burnout
Management issues
Working Conditions
Family factors
Compensation
Retired
COVID-19 Pandemic
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%
% of respondents

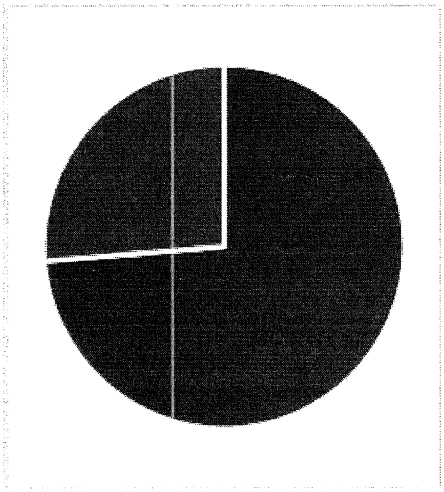
Highlights of this data show:

- **Stress and "burnout" (75 percent), chronic under-staffing (71 percent), working conditions (63 percent) and management issues (49 percent) were the top drivers of nurse departures.**
- In particular, **insufficient staffing was the singular top issue cited** by nurses as the reason they left their bedside care position.
- Of those who identified **stress or so-called "burnout"** as a driving factor in their departure, nearly **82 percent also cited short staffing** concerns, **71 percent cited working conditions,** and **52 percent cited management concerns.**
- **Compensation and the COVID-19 pandemic** were among the lowest-cited reasons to leave the bedside; of those who cited the pandemic, over **90 percent also cited stress or "burnout"** and over **84 percent cited short staffing** as contributing to their decision to leave bedside nursing.
- Of the **31 nurses who reported retiring, 100 percent cited stress or "burnout," 77 percent cited short staffing,** and **64 percent cited working conditions** as contributing factors.

"Burnout" and Moral Injury

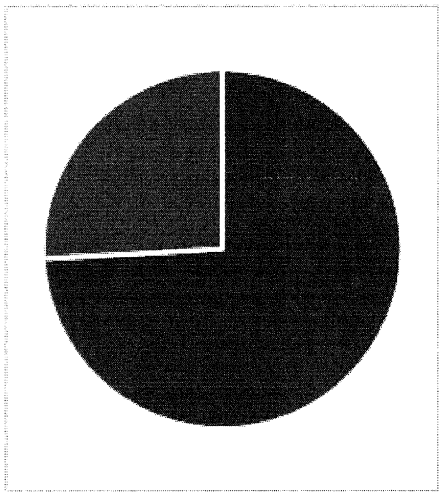
As described in the 2020 "Deadly Shame" report from National Nurses United, the term "burnout" refers to the issues of moral distress and moral injury which nurses experience from working under the conditions CEOs have created in our hospitals including insufficient nurse staffing, rationing and crisis standards of care, and limited resources including support staff, beds, medications, or supplies.

Did you secure new employment before leaving?



Yes 74% | No 26%

Are you currently working as an RN?



Yes 75% | No 25%

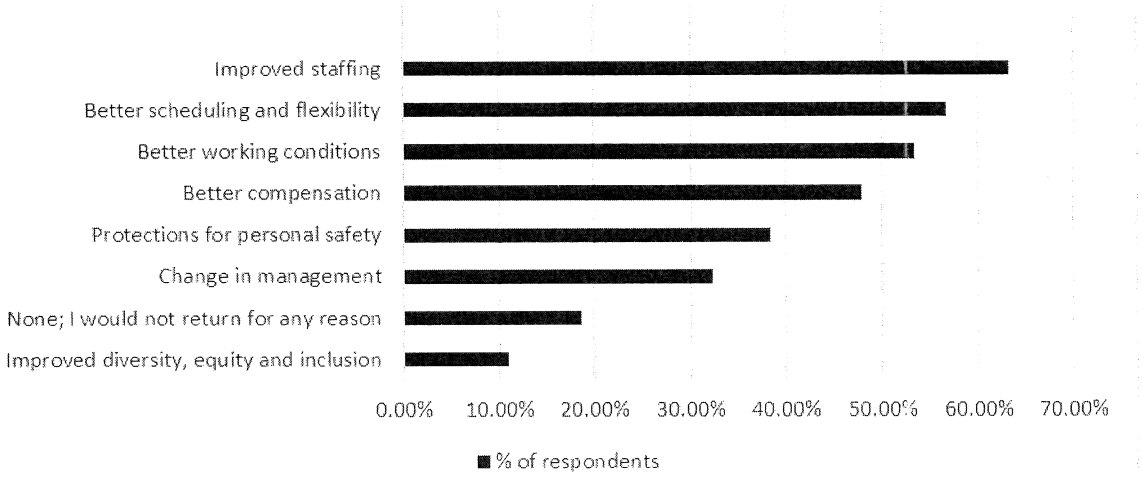
"All this business of people throwing up their arms and saying 'There are not nurses to hire because they've all left' [is] not really true... leaving your employer is not the same as leaving the field of patient care or even leaving hospitals."

Linda Aiken, PhD, RN
Founding Director, Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing
MedPage Today, December 30, 2022

What changes would you need to see to get you to return to hospital bedside nursing?

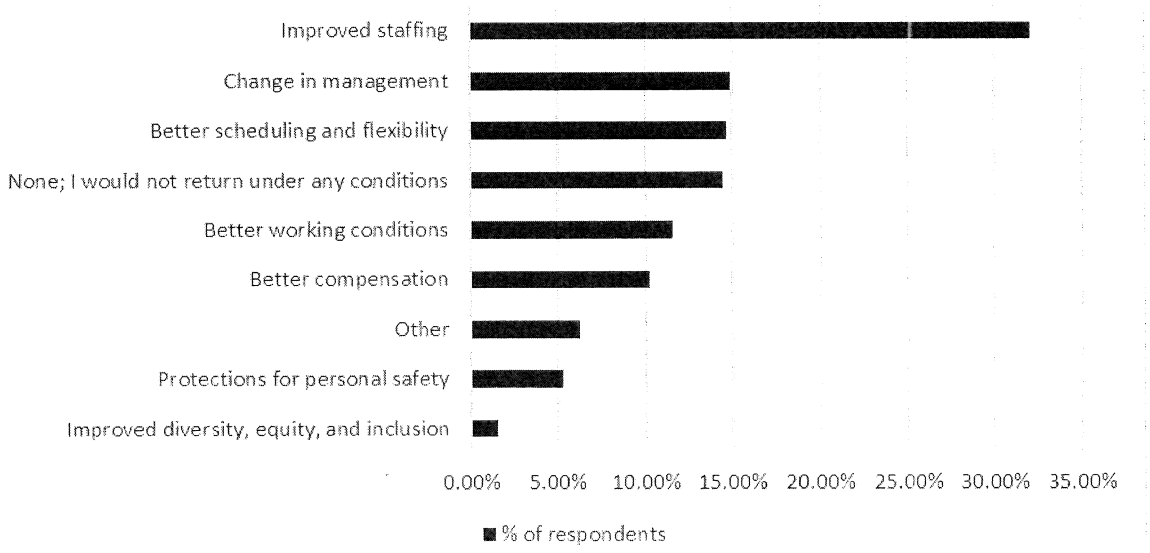
(Select all that apply.)

Top Responses Included:



Of these factors, which would you consider the most important?

Top Responses Included:



SAMPLE RESPONSES

Below is a sampling of responses from the survey to the question: Please elaborate on why you left your previous position. These responses are being presented anonymously, and with minimal editing for content and clarity, to protect the confidentiality of survey respondents.

"Burn out, unmanageable nurse to patient ratios. Constant understaffing, not enough CNA's resulting in impossible conditions for RNs."

"There's not enough time and resources to care for patients the way they deserve to be cared for. Not enough time for walks, safe med administration, even toileting. A patient asked me, 'If you don't come to help me to the bathroom when I push my call button, should I just pee in the bed?' That's the kind of care we're forced to give. This causes severe moral injury. I'm not burnt out, I'm morally injured. I loved caring for patients. I would come back to the bedside if the conditions and compensation were safe for all."

"No support. Greedy management kept adding patients when they knew there was not enough staff to safely take care of patients."

"My previous hospital that I loved was closed due to corporate greed... I tried out [another hospital] - this was the most miserable nursing position I've ever held. Always short staffed, managers tried to make us feel guilty like we weren't team players when we wouldn't pick up double shifts to fix the lack of staff problem. There was a severe & poor low staffing ratios as far as support staff... I never felt so unsupported and short staffed... while taking care of struggling COVID patients on bipap. I just couldn't do it anymore. It wasn't safe. I witnessed turnover like I've never seen in my whole career as a nurse. In one year's time I was at the halfway point on the seniority list. I gave [the hospital] one year, a year I will never get back."

"Multiple events of taking care of patients who needed ICU management on a med-surg floor with 5-6 other patients. Multiple violent experiences with patients resulting in 'paid leave' without support from physicians or management."

"Staffing was horrible and getting worse. It was not realistic in a level 4 NICU and I was afraid that I would miss something big on a patient and they would come to harm because I had to focus on more patients than was safe. I saw this happen to other nurses and patients and it was 100% because of staffing. Management was not supportive of nurses from the top down."

"I left bedside nursing because I was sick and tired of being understaffed all the time and management/CEOs did not care. We are keeping sick people alive a lot longer now and the acuity is much higher than ever before. We constantly were out of supplies or equipment did not work. I was constantly told to do more with less resources. I don't mind hard work, actually love it but when you don't have the support and are forced to do more than you can handle it wears on you. We continuously had to take patients unsafely but because our 'grid' said we can, we couldn't say no. I was also sick of working on Holidays, weekends and night shift. No matter what management/CEOs say, they don't really care about the actual person in that bed. They care about the money. And what they won't earn if the numbers don't align with their narrative."

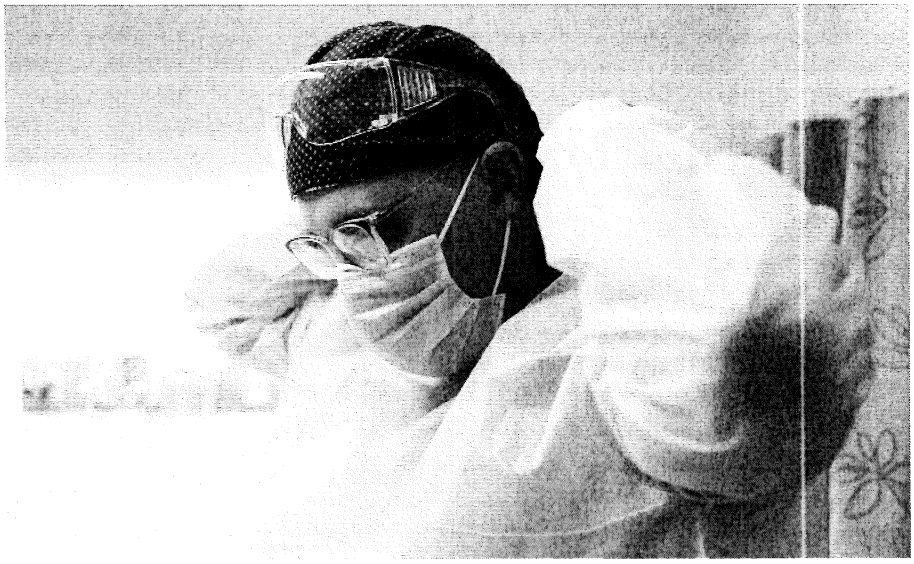
CONCLUSION

Minnesota nurses want to be at the bedside doing what they love, providing exceptional care to their patients. But the corporate healthcare policies of hospital CEOs are driving nurses away from the bedside.

There are more than enough nurses in Minnesota to meet the needs in our hospitals. These nurses want to stay at the bedside for the near future, despite the often unsafe and unsupportive work environments they have faced.

However, without changes that will solve the crisis of under-staffing and retention which hospital CEOs created, nurses will continue to be pushed away from the bedside and from the careers and patients they love.

Minnesota nurses are ready to fight and win legislation and contract language to put patients before profits, retain nurses at the bedside, and prioritize quality patient care throughout Minnesota.



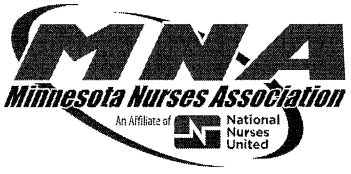
APPENDIX: Methodology

MNA Public Poll

On behalf of the Minnesota Nurses Association, Change Research surveyed 1,025 registered voters in Minnesota between January 8-10, 2022. Respondents were recruited into an online survey instrument via Dynamic Online Sampling which continuously rebalances online advertisements to obtain a representative sample. Post-stratification was done on gender, region, age, ethnicity, education, and 2020 vote.

MNA Workforce Survey

Between December 20, 2022 and February 8, 2023, MNA surveyed 2,403 nurse members who left a bedside nursing position within the past year and did not take a new position in an MNA-represented hospital. MNA received responses from 499 nurses who fit these criteria.


MNA
Minnesota Nurses Association
An Affiliate of
National
Nurses
United

March 31, 2023

Minnesota Senate Health and Human Services Committee

Dear Chair Wiklund and members of the Committee:

The American Cancer Society Cancer Action Network (ACS CAN) is committed to making sure all Minnesotans have a fair and just opportunity to prevent, find, treat, and survive cancer. It is with these goals in mind that we share our support of the following provisions in the Senate Health and Human Services omnibus bill.

1. **ACS CAN supports removing barriers to biomarker testing (Article 1, Sec. 21 and Article 2, Sec. 18).**
   SF1948 (Seeberger) improves coverage of comprehensive biomarker testing. Biomarker testing is an important step to accessing precision medicine that can lead to improved survivorship and better quality of life for cancer patients, but insurance coverage is failing to keep pace with innovation.

   This legislation establishes clear guardrails to align coverage of biomarker testing with robust and reputable sources of evidence. Tests will not meet the criteria spelled out without having clear benefit, and physicians will not order tests that won't provide useful information. Insurers are already covering much of this testing – this is about making sure state-regulated plans play by the same rules and keep up with science so that patients get the testing they need to get the right treatment at the right time.

2. **ACS CAN supports dedicating any funds from the JUUL Lawsuit to tobacco prevention and treatment (Article 4, Sec. 3, 33).**
   SF2520 (Morrison) dedicates any revenue collected from the JUUL Lawsuit to proven, evidence-based programs to prevent youth tobacco use, help those addicted quit, and address tobacco-related health disparities.

3. **ACS CAN supports the Minnesota Palliative Care Advisory Council (Article 4, Sec. 73).**
   SF2145 (Hoffman) which would restore funding for the Minnesota Palliative Care Advisory Council (PCAC), remove the PCAC sunset date, and fund a DHS study on the fiscal, medical, and social impacts of creating a palliative care benefit for Medical Assistance and MinnesotaCare enrollees. The PCAC works to identify barriers to coordinated, supportive care during the treatment of serious illnesses such as cancer.

Thank you for including these provisions in the health omnibus bill and your continued leadership on issues important in the fight against cancer. We look forward to supporting your efforts in the weeks ahead to ensure this language is included in any final health omnibus bill.

Sincerely,

Emily Myatt

Emily Myatt
Regional Government Relations Director
American Cancer Society Cancer Action Network

3/31/2023

To the Members of the Health and Human Services Committee,

I am a parent of four children in the state of Minnesota. I am invested in the education of children in this state as a school board member, teacher, volunteer with children and a degree in youth studies which has given me the opportunity to work with youth of all ages.

I am addressing the bill HF 2930/ SF 2995 and I oppose the School based health center portion of this bill and the Family planning grants.

My first opposition to this bill is found in lines 178.3-180.4. As a parent, I strongly oppose school based health centers. This is a very dangerous addition to the bill that oversteps a government's authority and infringes on parental rights. This bill would allow for a huge variety of health services without limitations or restrictions to take place on the premises of a school or a specific location in the school district without parental consent or knowledge. Services including but not limited to vaccinations on children without parental consent or knowledge, abortion services, gender affirming care including and not limited to extremely harmful, irreversible drugs or surgeries, experimental mental health services, contraception, prescriptions administered without parental knowledge or consent. This is just to name a few very concerning health care options available through this bill.

A "sponsoring organization" opens the door to all kinds of organizations and gives them access to our children. Parents absolutely do not want organizations to have access to our children such as planned parenthood. The language of this bill in regards to a sponsoring organization also opens the door for these "sponsoring organizations" to be able to collect health data on our children without parental consent and knowledge. As in many grants a "authorized representative" for any organization has access to all student data without parental knowledge or permission hidden in the language of school grants. This is unacceptable.

School is a place to learn math and science and how to read and write. It is NOT a medical facility nor is it a counseling center or a professional therapist office. Our children in Minnesota are failing at reading, math and science. It is time to remember and get back to the foundation and core principle of why schools exist, that is to teach our children. Nothing else! According to the State of Minnesota's report card from 2022 out of all students in the state only 44.8% are meeting the State's standards in Math, 51.1% in

reading and 41.3% in science. Yet, legislators continue to legislate against educating children in these areas.

In the original version of this bill there was a section on family planning grants. In the case that the new amended version of this bill still includes the family planning grant, I will include my opposition based on the original version of this bill.

I also oppose all of the changes made in lines 105.26-109.26. I oppose all the changes in these lines in regards to the family planning grants. This bill in the current format is clearly not about helping adults plan for their future families. That was stricken from the bill in lines 106.9- 106.17. This bill is about targeting young children starting in elementary school and teaching them about sexual and reproductive health. This is appalling!

I oppose grant money being used on abortion. It is proven by the science of embryology that from the earliest stages of development, you were a distinct, living and whole human being. It is wrong to intentionally kill an innocent human being. Abortion kills an innocent human being. Therefore, abortion is the intentional killing of a human being. It is of crucial importance that lines 106.18-106.22 be added back into this bill and grant money not to be used to kill innocent human beings through abortion.

I am asking that you add back into this bill lines 106.33-107. As a parent I oppose the use of any grant money to be used to come into schools and educate children on the kind of family planning outlined in this section of the bill, including teaching children that it is ok to kill innocent human beings through the means of abortion. Going back to my point earlier, schools are a place to learn how to read and write, and to learn math and science. School is not the place to override parental authority and teach sex education of this kind to children that goes against family values and morals.

Lines 107.32-108.3 also need to be added back into the bill. It is unthinkable that the legislators in the state of Minnesota continue time and time again to attempt to strip away parental rights. My children can not go on a school field trip without my permission, they can not get their ears pierced without my permission, they can not learn how to drive a car without my permission, they can't leave my house or skip school without my permission, they can not play a sport or activity without my permission. Yet, the legislators in the State of Minnesota want to strip my parental rights away when it comes

to my child's health care and the kind of education they receive. Now, is the time that this stops.

In addition, I oppose all social emotional learning grants. Social emotional learning is an untested, criminal, psychological experimentation on children while collecting and data mining children.

I strongly urge you to oppose these sections of the bill to the fullest extent possible.

Thank you,
Natalie Kasper
Dakota County, Minnesota

Headway
Emotional Health

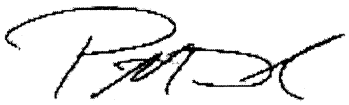
Senator Melissa Wiklund
95 University Ave W
Minnesota Senate Building Room
2107 St Paul, MN 55155

Dear Chair Wiklund,

I would like to express my gratitude to you, your staff and the Health and Human Services Committee for including SF 1620 in your omnibus budget bill. This support for transportation, nutrition, and student learning bolsters our work to the middle and high school students who are addressing critical emotional health issues.

On behalf of our students and their families, thank you again for your support. Let me know if you would like more information or have questions related to SF 1620.

Sincerely,



Patrick Dale
CEO
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NORTHLAND FOUNDATION

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March 30, 2023

Members of the Senate Health & Human Services Committee In Reference to SF2995, Comprehensive and Collaborative Resource and Referral System for Children (Help Me Connect) - Article 4 Section 55

I am pleased to write this letter to express our strong support for funding to support Help Me Connect, Minnesota's Comprehensive and Collaborative Referral System for Children (Help Me Connect under Article 4. Section 55 titled Comprehensive and Collaborative Resource and Referral System for Children).

Since December 2021, the Northland Foundation has been administering the Minnesota Department of Human Services Community Resource Hub grant. This funding has made it possible to establish seven Hubs in Northeastern Minnesota aimed at helping pregnant and parenting families furthest from social and economic opportunity connect with local resources that can help them thrive. Help Me Connect is an effective and efficient web-based resource tool that is helping the Hub Family Navigators help the families they serve. Our Family Navigators across the region share on a regular basis on how helpful Help Me Connect is as they work with families with young children in need of connecting with resources and services like child care and early education programs, health insurance, food, basic needs items, housing, mental health services, and transportation.

The State of Minnesota faces significant challenges in implementing a coordinated, equitable, and efficient system of care for children and their families. The array of early childhood programs is complex and fragmented due to differences in who offers programs, how they are funded, and variation in their eligibility requirements. Tribal nations and community-based organizations offer culturally relevant services, but these are often unknown as potential referral resources by external providers. Statewide, providers consistently indicate that services are unavailable, unknown, or hard to access. Currently funded by the federal Preschool Development Grant which ends in December 2023, Help Me Connect has supported over 170,000 unique users since its launch in May 2021. The site provides connections to 12,500 programs across the state and collects analytics about families' unmet needs that may be used to bridge gaps and build supportive services.

Funding to keep Help Me Connect going is desperately needed to help ensure families with young children can access community resources wherever they are living in Minnesota. Thank you for your consideration of this request.

Sincerely

Zane Bail
Chief Operating Officer

Indigenous Visioning

Indigenous Parent Leadership Initiative
P.O. Box 148
Bagley MN 56621
www.IndigenousVisioning.com

March 30, 2023

Dear Chair Wiklund and Members of the Committee,

On behalf of Indigenous Visioning and All Nations Rise, we thank you for the opportunity to share our strong support for **Article 13, Section 18 of the Senate Health and Human Services omnibus budget bill, Community Solutions for Healthy Child Development Grant Program.** This historic program focuses on improving measures of well-being for children of color and American Indian children in Minnesota prenatal to grade 3 through a community and equity-centered approach across the state.

It is historical because the grant program is guided by a Community Solutions Advisory (CSA) Council comprised of 12 community members who bring professional expertise and lived experience in racial equity, early childhood development and advocacy. The council has been involved from the beginning of the grant program from RFP creation, reading and scoring applications, and ongoing support and advocacy for more streamlined implementation and processes.

As a grantee, we want you to know about the positive impact that Community Solutions funding has brought to the White Earth Ojibwe Nation tribal community through the creation of the Indigenous Parent Leadership Initiative (IPLI). IPLI is a 21 week journey that integrates child development, leadership, democracy skills and Anishinaabe culture into a parent curriculum to empower the parent voice. Through interactive adult learning practices, twenty-two Parents, Grandparents, Foster Parents and Caregivers in the White Earth tribal community learned the importance of the developing child and how local, state and tribal policies and systems affect children & families through a nationally accredited evidence-based civics curriculum. Parents create individual community projects to practice their civic and cultural teachings and help strengthen their leadership skills. IPLI is the first of its kind in Minnesota and White Earth is the second tribal nation in the United States to implement the Parent Leadership Training Institute curriculum. The initiative inspires parents to become empowered to use their voice as change agents and be role models for their children while bringing about positive change within their own lives, their children's lives and the health of their tribal communities.

"*This 21 weeks of the Indigenous Parent Leadership Initiative has been challenging but there comes growth with that. I feel confidence now after learning how to use my voice and build community. It was a blessing getting to know everyone and learning how to network. Everyone is so resourceful! I am grateful!*"
~Autumn O. 2022 Graduate

"The Indigenous Parent Leadership Initiative has really changed my life for the better and given me more opportunities to learn and lead as a parent in my tribal community. I look forward to the future and seeing more parents in my tribal community experience this process and become parent leaders."
~Mykee Brown, 2023 Graduate

We thank you for your commitment to making Minnesota a better place for children and families. We need to continue to leverage more community led solutions beyond the pilot group of grantees as an upstream way to support children and families.

Miigwech (Thank you) for supporting children, families, and communities.

Barb Fabre, CEO
Indigenous Visioning
All Nations Rise

Beth Ann Dodds
Project Director/IPLI
Indigenous Visioning

LA RED LATINA
DE EDUCACION TEMPRANA

Senator Melissa Wiklund
Chair, Health and Human Services Committee
1100 Minnesota Senate Building
St. Paul, MN 55155

March 31, 2023

Madame Chair and Members of the Committee,

We are La Red Latina de Educacion Temprana (La Red), the Latino Early Child Care Providers Network in Spanish, and are writing about the inclusion of the Community Solutions Fund grant program, Article 13 Section 18 in SF 2995. We testified in support of SF 402, which sustainably funds the Community Solutions Fund grant program out of the Minnesota Department of Health, which you have already discussed in your committee. We received the Community Solutions Fund grant in 2020.

La Red is a group of Latina leader founded in 2013 that are making healthy changes that benefit children and members of the Latino community living in Richfield, Bloomington and across Minnesota. We develop community-driven solutions to support healthy child development and early learning opportunities for children whose families choose or need child care from a family member, friend, or neighbor. We do this by providing cultural early childhood trainings, capacity and leadership development for Latina childcare providers to deliver the highest quality child care possible and support school readiness.

Our work has also changed the lives of the FFN providers by changing their understanding of their role from "just babysitting" to knowing that the work they do is important to the children's future and our entire community. We have worked to support other family, friend, and neighbor networks across the state to help build their capacity, and are leaders at the National level supporting FFN networks. The Community Solutions grant program has supported us to provide monthly trainings for family, friend, and neighbor providers, develop our curriculum, provide free summer soccer activities for young children, supporting our families throughout Covid.

This grant's program is different from other state grants we have received. We feel like the state is acting as a partner with us and learning from us. The advisory committee that oversees the work is really interested in hearing what we have to say, and in supporting what the community needs. Other funding from the state should learn from Community Solutions Fund to better support our communities. However, this grant program is time limited and hasn't been able to fully fund all of the work that's needed across our communities. We need ongoing funding to support communities to lead on the work they know will impact the health and wellbeing of their children. Please include the Community Solutions Fund grant program in your Health and Human Services omnibus bill.

Sincerely,

Ruth Evangelista – Co-Founder La Red
Faviola Martinez de Estrada – Co-Founder La Red

LA RED LATINA
DE EDUCACIÓN TEMPRANA

MINNESOTA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

1400 Van Buren St NE
Suite 215
Minneapolis, MN 55413-4605

952-542-0130
office@mafp.org
www.mafp.org

March 31, 2023

Dear Senate Health and Human Services Committee,

On behalf of our more than 3,100 family physician and medical student members, the Minnesota Academy of Family Physicians (MAFP) urges your support of SF 2995. The MAFP is the largest physician specialty society in Minnesota, and our members take care of patients, families and communities across the state. We are leaders in primary care and see it as our job to work with our teams to keep our patients healthy, address health disparities and manage our patients' chronic conditions. Investment in primary care is essential to ensure our health care system works for all Minnesotans and MAFP is pleased to see the many important aspects of this bill that support patients and primary care.

Thank you for the inclusion of the additional collection of non-claims data by the All-Payer Claims Database (APCD) on **page 86.21**. The APCD will be a stronger tool with this additional data. Policymakers will benefit from the studies outlined on **page 94.1,** which will assist in the understanding of current utilization of value-based payment arrangements and begin to provide a baseline for Minnesota's investment in primary care.

Thank you for your inclusion of this important provision on **page 83.17** to protect patients who are on an established treatment from being forced to change drugs by their insurer or PBM, during the middle of their contract year. Allowing payers and PBMs to adjust their formularies without impacting those patients that are already on an effective medication strikes the right balance.

The MAFP was pleased to see the inclusion of coverage for post-partum long-acting reversable contraceptives (LARCs) on **page 9.7**. LARCs are highly effective and have a high level of patient satisfaction. If LARC is the right option, many patients desire to have it placed while they are still in the hospital post-partum. This coverage will make an important difference for these patients.

As the pandemic began, family physicians and other health care clinicians across the state quickly transitioned to telehealth, allowing them to continue to provide patient care safely. Telehealth has become an effective tool to assist many patients that do not need to be seen in the clinic. Audio-only telehealth is effective and its continued coverage until 2025 on **page 65.10** is critical to ensure equitable access to health care across the state.

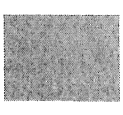
The MAFP was disappointed that support for family medicine rural training residency programs and loan forgiveness programs to recruit physicians to underserved areas were not included in SF 2995. Additional investment to support the future primary care workforce is critical. Training family physicians where they are needed most through rural training residency programs is an important step in ensuring Minnesota has a physician workforce to meet our needs. Loan forgiveness programs have been an

effective tool for incentivizing primary care clinicians where we need them most. We hope to see these important provisions, that were in the Governor's recommendations, in future proposals.

Family physicians and primary care are critical to health care in Minnesota. Supporting primary care workforce development, identifying ways to remove barriers to care and treatments and ensuring we have a system that adequately values and invests in primary care are essential considerations as this committee looks to the future. Your investment in primary care is much needed and the MAFP is ready to partner on these important initiatives.

Sincerely,

Maria Huntley, CAE, MAM
Chief Executive Officer, MAFP



MINNESOTA
BUSINESS
PARTNERSHIP

March 31, 2023
Minnesota Senate
Health and Human Services Committee
SF2995-A2 Amendment

Members of the Committee,

The Minnesota Business Partnership is a membership organization consisting of business leaders from Minnesota's largest employers, employing almost half a million workers across the state. Minnesota ranks near the top in the nation for health care coverage, and we are grateful to our many world-class health care providers. Health care access is vitally important to our members, and I write to express some of our concerns regarding the A2 Amendment.

Nurse Staffing Ratio (SF1561)
Prohibiting staffing flexibility that hospitals have relied on throughout the pandemic will leave little option but to reduce services or turn away patients. Instead, we should be supporting team-based care staffing models that allow staffing decisions to be made at local hospitals based on patient needs and the judgment of experienced nursing staff, especially as hospitals face critical staffing shortages. Beyond the importance our hospitals place on care and wellbeing for their patients, Minnesota currently has a transparent process for public reporting of hospital staffing. Minnesota consistently ranks as one of the top states in the nation for patient care, and this bill does little to improve upon that while creating additional layers of hospital staff management.

All Payer Claims Database (SF302)
The language requiring that third-party administrators (TPA) report data to the Commissioner of Health is concerning, this requirement would require that TPA's report who does and who does not elect to submit data to the All Payer Claims Database. It is also not clear who would have access to this list and what the Commissioner plans to do with this data. In a Supreme Court ruling in 2016, the Court held that requiring self-insured plans covered by ERISA are not required to report payments relating to health care claims to a state agency for compilation to a state's All Payer Claims Database.

Health Entity Transactions (SF1681)
It is vital for healthcare entities in our state to be able to operate with the flexibility they need to ensure quality access and care is provided without the disruption of the increased oversight guidelines. The current oversight and review process we have in place in Minnesota ensures that health entities can make the organizational transactions needed to operate and increase access to the thoughtful care that they provide to patients. Minnesota is experiencing health care workforce shortages, and allowing providers and health care entities to have the balance and flexibility they need to make decisions to best serve their patients and communities should be our goal. There are circumstances where over-regulation of health care oversight can impact patient care, and we must realize that the sustainability of our health care workforce and our health providers will be affected by this additional oversight.

Minnesota Business Partnership members share the goal of patients having access to the highest quality of care possible. We appreciate Senator Wiklund's effort to improve health care access and equity, but each of the provisions outlined above will move us further from that goal.

Thank you for your time and consideration,

Abby Loesch

Health Policy Director

MINNESOTA MEDICAL ASSOCIATION

The voice of medicine in Minnesota since 1853

612-378-1875 | 800-342-5662 | **mnmed.org**

March 31, 2023

Dear Members of the Health and Human Services Committee,

On behalf of over 10,000 members of the Minnesota Medical Association (MMA), thank you for the opportunity to comment on SF 2995. The MMA's mission is to make Minnesota the healthiest state in the nation and the best place to practice medicine. With that in mind, the MMA supports many items in this bill, and appreciates efforts to improve items with which the MMA has concerns.

Art. 1, Sec. 6 (pg. 9): The MMA supports coverage and reimbursement of postpartum use of long-acting reversible contraception (LARC). LARCs are safe and highly effective for decreasing unintended pregnancy. The use of LARC in the immediate postpartum setting has the potential to provide cost savings and decrease the incidence of adverse maternal and child health outcomes.

Art. 1, Sec. 24 (pg. 31): Medical assistance (MA) coverage of recuperative care services is a top legislative priority for the MMA. Patients experiencing homelessness face severe health risks when they do not have access to recuperative care services and will oftentimes not recover and require readmission. An individual's health is heavily influenced by the conditions in which they live. These social drivers of health, such as homelessness, not only drive health outcomes, but also contribute to the significant health inequities experienced by many Minnesotans. The MMA strongly supports expanding MA coverage to include recuperative care services to address homelessness as a social driver of health.

Art. 1, Sec. 38 (pg. 58): The MMA supports increased reimbursement rates for family planning services. Family planning services are critical for families and allow Minnesotans to make informed decisions about their reproductive health and future.

Art. 2, Sec. 7 (pg. 65): Telehealth is a valuable tool for Minnesota's providers. Audio-only telehealth is particularly important for many patients who may not have access to reliable internet or broadband connectivity, low-income patients who may not have access to video-only technology, or patients who are less comfortable using video-only services. The MMA supports continuing the study into telehealth and coverage of audio-only services and extending the sunset date for these items to July 1, 2025.

Art. 2, Sec. 21 (pg. 82): The MMA greatly appreciates the inclusion of this section to limit mid-year formulary changes to prevent patients from being forced to change prescription drugs due to actions by their insurers or pharmacy benefit managers (PBMs). Currently, nothing prohibits insurers or PBMs from changing the formulary of drugs covered during the contract year. This only applies to therapies already begun by a patient.

Art. 2, Sec. 27 (pg. 88): The MMA supports updating the All-Payer Claims Database to ensure it remains a useful tool to evaluate how Minnesotans are paying for healthcare. Currently only gathers claims data, that does not reflect the entire picture of healthcare payments.

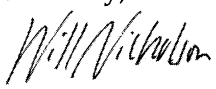
Art. 4, Sec. 35 (pg. 154): The MMA continues to work with the authors to address unintended consequences with the broad authority for the Attorney General oversight regarding private facility transactions. While we agree that over-consolidation results in higher costs and lower patient outcomes, the current language goes beyond that. We appreciate the changes made by the author and we are committed to continue discussions with her.

Art. 4, Sec. 74 (pg. 199): The MMA supports the creation of a statewide database for Provider Order for Lift-Sustaining Treatment (POLST) forms included in the bill. POLST forms are a valuable tool for providers offering end-of-life care. However, POLST forms are currently only available in a physical paper copy that can get lost, damaged, or become otherwise inaccessible for these forms.

Art. 4, Sec. 80 (pg. 205): the MMA supports grant funding to healthcare entities to improve worker safety. Violence against healthcare workers has increased in recent years. This leads to worsened healthcare worker satisfaction and has a negative impact on patient care.

Thank you for the opportunity to provide input on SF 2995.

Sincerely,



William Nicholson, MD
President, Minnesota Medical Association

MINNESOTA DENTAL ASSOCIATION

March 31, 2023

Dear Chair Wiklund and Committee Members,

On behalf of the Minnesota Dental Association (MDA), I write to you in support of the Senate Health and Human Services Omnibus - SF2995. The MDA supports the inclusion of various dental related provisions, most notably the restoration of comprehensive adult dental Medicaid benefits and dental rate rebasing. The MDA is grateful for your support and attention to these matters.

Comprehensive Adult Dental Medicaid Benefits – Article 1, Section 9

Article 1, Section 9, would provide the same Medicaid dental benefit set for all eligible Minnesotans. This provision contains language from SF782, heard in your committee and laid over on March 17, 2023.

Minnesota currently has two different dental benefit sets for enrollees in Minnesota's Medicaid program (Medical Assistance); (1) a benefit set for pregnant adults and children, and (2) a benefit set for non-pregnant adults. In 2009, benefits for non-pregnant adults were significantly limited due to budget cuts. While pregnant adults and children experience extensive dental benefits, many of our vulnerable adult residents enrolled in Medicaid lack coverage of basic dental services. This provision takes the benefit set currently available for pregnant adults and children and makes it available to every medical assistance recipient regardless of age.

As noted during the hearing on March 17, 2023, this provision could save long term costs on emergency dental care. Recent data obtained from the Minnesota Hospital Association indicates that in 2021, approximately $22 million was spent on dental care in the emergency room. $8.1 million was spent providing emergency dental care to recipients on the adult dental benefit set. Spread over a biennium, approximately $16.2 million could be saved if comprehensive adult dental Medicaid benefits are restored.

The MDA appreciates the inclusion of restoring adult dental Medicaid benefits in SF2995.

Dental Reimbursement Rate Rebasing for MHCP – Article 1, Section 35

Prior to the 2021 legislative session, Minnesota nationally ranked toward the bottom in dental Medicaid reimbursement rates. A 2021 study by the American Dental Association ranked Minnesota at 47th out of 50 states for adult dental reimbursement, and 49th for pediatric dental reimbursement. The 2021 Health and Human Services Finance omnibus bill appropriated approximately $61 million to increase reimbursement rates, resulting in an approximate increase of 98% for many dental providers. Despite this increase, rates are still based on average costs from 1989.

MINNESOTA DENTAL ASSOCIATION

In February 2022, the Minnesota Department of Human Services produced a Legislative Report recommending rebasing rates with an inflationary factor. In April 2022, the Department published a report that concluded low provider reimbursement rates was the top issue driving provider hesitancy to participate in Medicaid and MinnesotaCare. It is evident that rebasing should motivate further provider participation in these programs.

The MDA appreciates the inclusion of ongoing dental rate rebasing in SF2995. This provision ensures that Minnesota does not fall behind again and maintains its place as a nationwide leader in dental care.

Dental Claims Added to All Payers Claims Database – Article 2, Sections 22-27

The MDA supports adding dental claims to Minnesota's All Payer Claims Database (APCD). The MDA believes that adding dental claims can positively impact research on oral health and dental benefit trends in Minnesota.

While the MDA supports the bill, the MDA is concerned about how the data may be used and made publicly available. Primarily, the MDA is concerned that a disclosure of data may lead to the inadvertent disclosure of provider identities, particularly in clinics in which there are only one or two dental providers. Additionally, many dental clinics include the name of the dentist in the clinic name. Should this provision be amended, the MDA requests that any disclosure of claim data which may inadvertently identify a particular dental provider be explicitly prohibited.

Should you have any questions, please contact the MDA's Government Affairs Manager Dan Murphy at dmurphy@mndental.org or 612-767-4255.

Sincerely,

Carmelo Cinqueonce, MBA
Executive Director

The Minnesota Dental Association is a statewide professional membership organization representing Minnesota-licensed dentists and dental students, with a membership of over 3,000.

Minnesota Association of
COMMUNITY HEALTH CENTERS

March 30, 2023

RE: Comments on SF2995A2, 2023 Senate Health and Human Services Omnibus Bill

Dear Members of the Senate Health and Human Services Committee:

Thank you for your work preparing the omnibus bill. We recognize the needs in Health and Human Services area and appreciate the care and attention you have put into crafting this bill.

MNACHC represents the state's 17 federally qualified health centers or FQHCs. FQHCs provide primary medical, behavioral health, and oral health services to 200,000 Minnesotans regardless of ability to pay. For over five decades, FQHCs have tailored their services to address the social drivers of our patient's health outcomes.

Thank you for including a number of provisions that will have positive impact on the primary care safety net.

MA/DA Apprenticeship

We would like to thank you for including Article 4 Section 51, the MNACHC MA/DA Apprenticeship program. In 2022, MNACHC, created a small apprenticeship program for Medical and Dental Assistants. This 12-month program allows apprentices to work full-time at their FQHC while earning a living wage and benefits.

This program recruits apprentices from the communities that they serve and removes barriers around GED or higher education for individuals to apply. This creates economic opportunities for a diverse workforce while enhancing access to health care in medically underserved communities.

The program started with 10 Medical Assistant apprentices and 2 dental apprentices. This year there are 8 medical assistance apprentices and 10 dental apprentices with a 40% increase in participating health centers. Of the apprentices trained health centers have seen a 100% retention rate of apprentices now serving patients statewide.

We appreciate your support as we continue to grow the healthcare workforce with a more diverse workforce.

There are a number of provisions in HF2995 that will **enhance FQHC patients' access care:**

Medicaid Services Expansion: MNACHC appreciates the expansion of available services for individuals enrolled in public programs. Specifically, the adult benefit set.

Continuous Eligibility: Many FQHC patients "churn" on and off Medicaid and MinnesotaCare even though they are eligible for these programs. This churn causes significant distress for patients, administrative burden on FQHC staff, and confusion in the health care system. Thank you for providing continuous eligibility for children , birth to 21, who can achieve better health outcomes with routine and dependable primary care coverage.

Additional Investment in School Based Clinics: An additional barrier to accessing health care can be the ability of a parent to take off work to transport children to care. By expanding school-based clinics, children are able access primary care in in locations familiar to them. This investment will support positive health outcomes for all children.

MNACHC also appreciates the following provisions that will **support FQHCs**:

Thank you for including the **pharmaceutical dispensing fees** in addition to the fee-for-service pharmacy payment for FQHC pharmacy services. This payment will help financially sustain the availability of in-house pharmacy services and access at FQHCs.

We also thank you for including grants to **support workforce safety**. Safety issues at FQHCs are increasingly a concern as we ensure a safe space for patients and staff alike. The cost to keeping health centers staff and patients safe has been a significant financial strain for FQHCs.

Thank you so much for your consideration and your continued work and dedication to this process.

Always,

Rochelle Westlund
Director of Public Policy
Minnesota Association of Community Health Centers

MINNESOTANS FOR A SMOKE-FREE GENERATION

March 31, 2023

Senate Health and Human Services

RE: SF2995

Dear Chair Wiklund and Committee Members:

Minnesotans for a Smoke-Free Generation (MSFG) is a coalition of more than 50 organizations that share a common goal of advancing justice by striving toward a future where every person is free from commercial tobacco's harms and can reach their full health potential.

MSFG strongly supports the inclusion of SF2520 (Morrison) in SF2995. This language (Article 4, Sections 3 and 33) would dedicate any potential funds from the JUUL Lawsuit to youth tobacco prevention, help those addicted to commercial tobacco quit, and address tobacco-related health disparities. JUUL developed sleek-looking products with menthol and candy flavors designed to appeal to kids, with sky-high nicotine levels to addict users. Investigations found that JUUL used several pages from Big Tobacco's playbook and targeted kids as young as eight with a marketing program including summer camp, school programs and hundreds of social media influencers.

The 2022 Minnesota Student Survey found fourteen percent of 11th-graders and seven percent of 8th-graders reported currently using e-cigarettes. Especially concerning is the use of these products by youth reporting mental health challenges including stress, anxiety, and depression. The JUUL Lawsuit presents an opportunity to invest more state funds in tobacco prevention and treatment.

On behalf of Minnesotans for a Smoke-Free Generation, thank you for including this important health policy in your omnibus bill. We look forward to supporting your efforts in the weeks ahead to ensure this language is included in any final health omnibus bill.

Sincerely,

Emily Myatt
Tri-Chair, Minnesotans for a Smoke-Free Generation
Regional Government Relations Director, American Cancer Society Cancer Action Network

LaTrisha Vetaw
Tri-Chair, Minnesotans for a Smoke-Free Generation

Janelle Waldock
Tri-Chair, Minnesotans for a Smoke-Free Generation
Director of Racial and Health Equity Policy, Blue Cross and Blue Shield of Minnesota

MSSA Minnesota Social Service Association

March 31, 2023

Re: SF2995

Chair Wiklund and Members of the Senate Health and Human Services Committee,

Thank you for the opportunity to share our comments on SF2995. The Minnesota Social Service Association (MSSA) is made up of over 4,000 health and human service professionals statewide. Our members cover the health and human service spectrum—mental health providers, social workers, case managers, etc.—and are employed by for-profit and nonprofit entities, as well as state and local government agencies.

We are grateful for numerous provisions and investments included in SF2995 aimed at improving health and human services in Minnesota, such as those to provide continuous Medical Assistance eligibility for children, funding for background studies operations, workplace violence prevention grants for health care entities, and the grant to the Center for Rural Behavioral Health.

However, we urge the committee to consider the addition of human services workplace safety grants, as outlined in SF1489, in your final omnibus bill. Provisions in SF1489 would help address a critical component of HHS provider burnout and the workforce shortage by providing human services agencies with the resources they need to ensure the safety of their employees.

We are supportive of the additions to SF2995 to provide workplace violence prevention grants for health care entities but are disappointed that similar provisions were not included in any Senate Committee omnibus bills with jurisdiction over human services. This sends a clear message to human services providers that while we value safety of employees in other professions such as health care, their safety in professions where safety incidents are ubiquitous and growing, is not valued.

Thank you again for the opportunity to share our support on behalf of our members and the clients they serve. Please reach out to us with questions, comments, or concerns at msancartier@mnssa.org.

Sincerely,

Michelle SanCartier
MSSA Director of Public Policy & Advocacy
Minnesota Social Service Association

Beth Ringer
MSSA Executive Director
Minnesota Social Service Association

Dear Members of the Senate Health & Human Services Committee, 3/30/23

My name is Karin Miller. I write to you as a concerned parent from Dakota County. I passionately care not only about my own children, but also about the future generations of Minnesotan children who could be hurt by the School Based Health Centers and the Family Planning Grants that SF 2995 supports.

I assure you that I am not alone in expressing these concerns. If time allowed for more parents across Minnesota to be aware of the changes this bill creates regarding the sexual health care available to minors and the challenges it presents to parents' awareness and consent in their medical care, this hearing room would be overflowing.

The first reason I am writing in opposition to SF 2995 is because it seeks to establish **School Based Health Centers** in Lines 103.24—105.25. This will form an unholy alliance between the MDH and the MDE – conflagrating the education of children's minds with the medical treatment of their bodies – in a way that further drives a wedge of government bureaucracy between parents and children.

Schools are supposed to EDUCATE our children – PERIOD! Schools are supposed to educate our children's minds – not medically treat their bodies! Especially NOT without parental presence, awareness, consent, and support! Keep medical care OUT of public schools. It does not belong there. For the sake of our children who are falling behind, only ACADEMIC initiatives should be prioritized and funded in our schools.

Secondly, I strongly oppose the **Family Planning Grant** portion of SF 2995 on lines 105.26—109.26. I oppose it because it will include minors and all "persons of reproductive age." I oppose it because it will include abortion, which is the antithesis of reproductive health, and is the intentionally killing of human offspring.

I also oppose it because this section will strike through, delete and eliminate:

1. Parental Notification -- if their child is advised on abortion or sterilization. -- lines 107.32-108.3.
2. Individual Employee Rights to refuse to perform family planning services that are contrary to their personal beliefs without fear of discrimination or dismissal – lines 108.17-108.22.
3. Informed Consent – Grant providers will not be required to provide information on health hazards, risks, discomforts, etc. which a procedure might involve – or to provide alternative methods. Lines 108.30 – 109.13.
4. Penalties for COERSION in the case of abortion or sterilization! Lines 109.9-109.13.

The changes this bill would make through the establishment of School Based Health Centers and these revised Family Planning Grants would only create a direct threat to the health and well-being of children, further sever the parent-child relationship, and divert the needed focus on academics in our schools.

Let's not play politics with the lives of the children in Minnesota and give families one more reason to leave our state. Please remove the School Based Health Care and Family Planning Grants from this Health Omnibus Bill before passing it onward.

Thank you very much for your consideration.
Sincerely,
Karin Miller

foster
advocates

1425 Minnehaha Ave E, #600761
St Paul, MN 55106

fosteradvocates.org

March 30, 2023

Dear Chair Wiklund,

I would like to express my sincere gratitude to you and the Health & Human Services Committee for including SF 2464 - which will establish a Foster Children Benefits Trust - in the committee's omnibus bill.

Fosters across the state are impacted by this current harmful practice of social security benefits being used to pay for their care. This inclusion will allow Minnesota to right this wrong, and give back what is owed to Fosters. Additionally, it will make the State of Minnesota compliant with federal law.

Thank you again for your commitment to Fosters. If you have any questions or need any further information, please contact me at any time.

Sincerely,

Hoang Murphy
Executive Director
hoang@fosteradvocates.org
(218) 415-0332

Foster Advocates

Peer Reviewed Literature on Nurse Staffing and Patient Care Outcomes

Aiken, L. et al. 2011

- Could not access text. Abstract promising.
- "Results: The effect of decreasing workloads by 1 patient/nurse on deaths and failure-to-rescue is virtually nil in hospitals with poor work environments, but decreases the odds on both deaths and failures in hospitals with average environments by 4%, and in hospitals with the best environments by 9% and 10%, respectively. The effect of 10% more Bachelors of Science in Nursing Degree nurses decreases the odds on both outcomes in all hospitals, regardless of their work environment, by roughly 4%."
- Citation: Aiken, Linda H. PhD, RN*; Cimiotti, Jeannie P. DNSc, RN*; Sloane, Douglas M. PhD*; Smith, Herbert L. PhD†; Flynn, Linda PhD, RN‡; Neff, Donna F. PhD, APRN§ Effects of Nurse Staffing and Nurse Education on Patient Deaths in Hospitals With Different Nurse Work Environments, Medical Care: December 2011 - Volume 49 - Issue 12 - p 1047-1053 doi: 10.1097/MLR.0b013e3182330b6e

Ball, J., Murrells, T., Rafferty, A. M., Morrow, E., Griffiths, P. 2014. 'Care left undone' during nursing shifts: associations with workload and perceived quality of care. BMJ Quality & Safety 2014;23:116-125.

- Self-report by nurses, cross sectional study

Brooks Carthon JM, Lasater KB, Sloane DM, et al. 2015. The quality of hospital work environments and missed nursing care is linked to heart failure readmissions: a cross-sectional study of US hospitals. BMJ Quality & Safety 2015;24:255-263.

- Could not access text. Logistical regression shows relationship of nursing environment and readmissions. Does not discuss staffing
- Conclusions Missed care is an independent predictor of heart failure readmissions. However, once adjusting for the quality of the nurse work environment, this relationship is attenuated. Improvements in nurses' working conditions may be one strategy to reduce care omissions and improve patient outcomes.

Bruyneel, L, 2015. Sermeus, W. Organization of Hospital Nursing, Provision of Nursing Care, and Patient Experiences With Care in Europe

- "...patients report better experiences with care in hospitals with more favorable nursing work environments and lower patient-to-nurse ratios. Performing nonnursing tasks, years of experience, type of employment, and performing overtime did not relate to patient experiences with care.... more favorable work environments, lower patient-to-nurse ratios, and performing less overtime significantly relate to fewer clinical nursing care tasks left undone and fewer planning and communication activities left undone... clinical care left undone is associated with patient experiences of their hospitals and their willingness to recommend them,"
- Citation Bruyneel, L, Li, B., Ausserhofer, D., Lesaffre, E., Dumitrescu, I., Smith, H. L., Sloane, D. M., Aiken, L. H., Sermeus, W. Organization of Hospital Nursing, Provision of Nursing Care, and Patient Experiences With Care in Europe. Med Care Res Rev. 2015 December ; 72(6): 643–664. doi:10.1177/1077558715589188.

Griffiths, P., et al. 2018. The association between Nurse staffing and omissions in nursing care: A systematic review. Journal of Advanced Nursing. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6033178/pdf/JAN-74-1474.pdf

- Downloaded to Z drive
- NEGATIVE: Study results inconclusive d/t lack of strong evidence, inability to correlate survey responses to actual outcomes
- POSITIVE: British study, excluded atypical care eg ICU (positive for arguing for safe staffing across all units)
- Missed care (missed care, unfinished care, implicit rationing, care left undone, task left undone) could be earlier indicator of quality of care before adverse events are detectable
- "In the face of excessive workloads, nurses may be unable to complete all necessary care activities and must, in effect, engage in what is described as "implicit rationing""
- Caution: Missed care, proxy measure for quality of nursing care (personal opinion – be careful that this does not get used against individual nurses as cause for discipline that a nurse did not get all cares done, instead of being an argument for more nursing so that nurses CAN get all cares done)
- Jones, T., Hamilton, P., Murry, N. 2015. Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. International Journal of Nursing Studies. https://doi.org/10.1016/j.ijnurstu.2015.02.012
- "Most nursing personnel (55–98%) reported leaving at least 1 task undone…
- "Patterns of unfinished care were consistent with the subordination of teaching and emotional support activities to those related to physiologic needs and organizational audits. Predictors of unfinished care included perceived team interactions, adequacy of resources, safety climate, and nurse staffing. Unfinished care is a predictor of: decreased nurse-reported care quality, decreased patient satisfaction; increased adverse events; increased turnover; decreased job and occupational satisfaction; and increased intent to leave."

Jones, T., Hamilton, P., Murry, N. 2015. Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. Volume 52, Issue 6, June 2015, Pages 1121-1137. https://doi.org/10.1016/j.ijnurstu.2015.02.012

- Abstract only, review article
- Reviewed literature included 42 quantitative reports; 7 qualitative reports; 1 mixed method report; and 4 scientific reviews.
- Predictors of unfinished care included perceived team interactions, adequacy of resources, safety climate, and nurse staffing. Unfinished care is a predictor of: decreased nurse-reported care quality, decreased patient satisfaction; increased adverse events; increased turnover; decreased job and occupational satisfaction; and increased intent to leave.

Kalisch, B. J., Xie, B., Waller Dabney, B. 2013. Patient-Reported Missed Nursing Care Correlated with Adverse Events. American Journal of Medical Quality. 2014;29(5):415-422. doi:10.1177/1062860613501715

- Could not access text, only abstract
- "Patients who reported skin breakdown/pressure ulcers, medication errors, new infections, IVs running dry, IVs infiltrating, and other problems during the current hospitalization reported significantly more overall missed nursing care."

Kalisch, B. J., Gosselin, K., Choi, S. H. 2012. A comparison of patient care units with high versus low levels of missed nursing care, Health Care Management Review: October/December 2012 - Volume 37 - Issue 4 - p 320-328 doi: 10.1097/HMR.0b013e318249727e

- Could not access text, only abstract
- Study of Focus Groups of units with the most and least missed care – low scientific quality but informative
- **Staffing level one theme identified with missed care**

Kalisch, B. Tschannen, D., Lee, K. H. 2012. Missed Nursing Care, Staffing, and Patient, Falls Journal of Nursing Care Quality: January/March 2012 - Volume 27 - Issue 1 - p 6-12 doi: 10.1097/NCQ.0b013e318225aa23

- Could not access text, only abstract
- 124 patient units in 11 hospitals
- Hours Per Patient Day **negatively associated** with patient falls ($r = -0.36$, $P < .01$), and **missed nursing care was found to mediate** the relationship between HPPD and patient falls.
- Mediate = correlate, play a role in

Lake, E., et al. 2016. Missed nursing care is linked to patient satisfaction: a cross-sectional study of US hospitals. BMJ Quality and Safety. Available at https://www.nursing.upenn.edu/live/files/110-%20lakegermackviscardi2016missed-nursing-care-and

- Study correlating self-reported missed care and HCAHPS results; see Griffiths et all 2018 for systematic review of this issue

Scott Blouin, A., et al., 2019. The Continuing Saga of Nurse Staffing Historical and Emerging Challenges. Journal of Nursing Administration

- PDF available: https://cookcountyhealth.org/wp-content/uploads/SP-discussion-Nursing-article-3-04-16-19.pdf
- Downloaded to Z Drive
- Note: Recent review article with good references, argues staffing shortages are a self-perpetuating cycle and impact bottom line and pt care
- Argument supporting MNA position: adequate nurse staffing reduces readmissions and complication rates -> lost revenue d/t CMS payment penalties for high readmission rates and complications/deaths after discharge -> nurses generate this revenue, which is lost when there are fewer nurses and more readmissions/complications

Shekelle, P. 2013. Nurse–Patient Ratios as a Patient Safety Strategy. Annals of Internal Medicine. Available at https://www.acpjournals.org/doi/10.7326/0003-4819-158-5-201303051-00007

- Findings:
- 2007 meta-analysis data showed consistent relationship b/w increased RN ratios and decreased hospital-related mortality rates; meta-analysis data did not support CAUSAL relationship:
- "An increase of 1 RN full-time equivalent (FTE) per patient day was related to a 9% reduction in the odds of death in the ICU, a 16% reduction in the surgical setting, and a 6% reduction in the medical setting."
- Narrative 2011 literature review described 17 studies r/t staffing and mortality

- "14 of 17 studies found a statistically significant relationship between nurse staffing variables and lower mortality rates."

Sloan, D., Smith, H., McHugh, M., Aiken, L., 2018. Effect of Changes in Hospital Nursing Resources on Improvements in Patient Safety and Quality of Care: A Panel Study. Effect of Changes in Hospital Nursing Resources on Improvements in Patient Safety and Quality of Care: A Panel Study

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Spetz J, Harless DW, Herrera CN, Mark BA. Using minimum nurse staffing regulations to measure the relationship between nursing and hospital quality of care. Med Care Res Rev. 2013 Aug;70(4):380-99. doi: 10.1177/1077558713475715. Epub 2013 Feb 11. PMID: 23401064.

- Abstract only, could not access text;
- Can't tell, does not seem like support for ratios, maybe neutral/negative
- Compares before and after ratios implemented in California
- California Patient Discharge Data from 2000 through 2006 with Agency for Healthcare Research and Quality Patient Safety Indicators (PSI)

Research Articles on Racial Disparities and RN Staffing

1. **Racial Disparities in Postoperative Readmission May Be Reduced By Improving Nurse-to-Patient Staffing**

   https://www.nursing.upenn.edu/details/news.php?id=645

   "What is striking about these findings is that we find this relationship even in a

   cohort of relatively healthy adults undergoing an elective surgery. The protective benefit of higher nurse-to-patient staffing for minorities may be related to gaps in health care access, financial flexibility, and social support systems. If individuals lack resources to mobilize ongoing support following discharge, the quality and intensity of care received during the hospitalization may help to address such gaps," says Lasater.

2. **Reducing Hospital Readmission Disparities of Older Black and White Adults After Effective Joint Replacement**

   https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.14367

   Conclusion Older BIPOC individuals are more likely than their white counterparts to experience an unplanned readmission after elective orthopedic surgery. More-favorable nurse staffing was associated with lower odds of readmission of older black and white patients, but better-staffed hospitals had a greater protective effect for older black patients.

3. **Better Nurse Staffing Is Associated With Survival for Black Patients and Diminishes Racial Disparities in Survival After In-Hospital Cardiac Arrests**

   https://pubmed.ncbi.nlm.nih.gov/33201082/#:~:text=A%20significant%20interaction%20was%20found,CI%2C%200.93%2D1.00)

   Conclusions: Our findings suggest that disparities in IHCA survival between black and white patients may be linked to the level of medical-surgical nurse staffing in the hospitals in which they receive care and that the benefit of being admitted to hospitals with better staffing may be especially pronounced for black patients.

4. **Racial Disparities in Stroke Readmissions Reduced in Hospitals With Better Nurse Staffing**

   https://pubmed.ncbi.nlm.nih.gov/34534185/

Results: Our sample included 98,150 ischemic stroke patients (87% White, 13% Black). Thirty-day readmission rates were 10.4% (12.7% for Black patients, 10.0% for White patients). In models accounting for hospital and patient characteristics, the odds of 30-day readmissions were higher for Black than White patients. A significant interaction was found between **race** and nurse staffing, with Black patients experiencing higher odds of 30- and 7-day readmissions for each additional patient cared for by a nurse. In the best-staffed hospitals (less than three patients per nurse), Black and White stroke patients' **disparities** were no longer significant.

5. **Distinguishing High-Performing from Low-Performing Hospitals for for Severe Maternal Morbidity: A Focus on Quality on Equity**

https://www.ingentaconnect.com/content/wk/aog/2022/00000139/00000006/art00012

Results: Six themes distinguished high-performing from low-performing hospitals. High-performing hospitals were more likely to have: 1) senior leadership involved in day-to-day quality activities and dedicated to quality improvement, 2) a strong focus on standards and standardized care, 3) strong nurse-physician communication and teamwork, 4) adequate physician and nurse staffing and supervision, 5) sharing of performance data with nurses and other frontline clinicians, and 6) explicit awareness that racial and ethnic disparities exist and that racism and bias in the hospital can lead to differential treatment.

6. **Nursing Care Disparities in Neonatal Intensive Care Units**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6056573/#hesr12762-sec-0008title

Nurses in high-black hospitals missed nearly 50 percent more required nursing care activities than nurses in low-black hospitals ($p = .03$). Further, a significantly higher percentage of nurses in high-black hospitals missed at least one required activity (52 percent vs. 38 percent). Although the differences in mean activities missed were numerically small (1.05 in the low-black cohort to 1.51 in the high-black cohort), research has shown that small differences can have a significant impact on patient outcomes (Schubert et al. 2009). The results from this sample, comprising 16 percent of U.S. NICUs, generalize principally to NICUs in large teaching hospitals.

The disparities in missed care were principally due to poorer nurse staffing in high-black hospitals. The patient-to-nurse ratio was significantly higher in high-black hospitals (2.5 and 2.2 patients-per-nurse, respectively). The odds of missed care increased by 40 percent in units with poorer staffing (one patient more per nurse). It is likely that staffing is worse in the high-black hospitals because many treat a disproportionately high percentage of Medicaid and unfunded patients, which creates financial strain. Financial strain may affect clinical processes through allocation of staffing resources

7. **Effect of Nurse Staffing and Education on the Outcomes of Surgical Patients With Comorbid Serious Mental Illness**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2596648/

Records indicated that 4.7% (N=10,666) of the sample had a diagnosis of serious mental illness. A higher level of nurse staffing had a stronger effect on prevention of death among patients with serious mental illness than among those without it. Length of stay for patients with serious mental illness was shorter in hospitals with higher proportions of baccalaureate-prepared nurses.

Conclusions Better nurse staffing and higher education level mitigated poor patient outcomes among highly vulnerable patients with serious mental illness.