Testimony of Mary Krinkie
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Madame Chair and members of the Committee:

My name is Mary Krinkie and I am the Vice President of Government Relations for the Minnesota Hospital Association, representing hospitals and health systems statewide.

Thanks for this opportunity to share some perspectives today on how hospitals and health systems are doing in dealing with the COVID-19 pandemic and caring for our fellow Minnesotans who have become ill from this deadly virus.

On April 2, I testified at the first meeting of the Senate's COVID-19 response working group. There was undoubtedly a great deal of apprehension in my comments, as we knew that our hospitals and health systems needed to focus on preparing for a surge of patients and that this would involve development of spaces, acquiring of supplies, and preparing our health care workforce. Flattening an initial surge of cases relatively early here in Minnesota provided time for our health care heroes to better prepare. Overall, I would say that our health care systems, hospitals, physicians, nurses and staff have done an exemplary job of preparing and caring for patients.

I would like to provide an update on these three key resources: spaces, supplies and staffing and comment on the current challenges.

Spaces:
Hospitals and health systems across the state have retrofitted spaces and have nearly doubled the potential ICU bed capacity in the state. The availability of that additional ICU bed capacity is dependent, however, on the availability of staff specializing in critical care. Currently, there are 1,224 staffed ICU beds, with about 85% of those beds in use as of yesterday. At the last update, 17% of the ICU bed capacity was being used to care for COVID-19 patients. Within 72 hours, hospitals would be able to create an additional 943 beds to be used for surge capacity. While the number of COVID-19 cases is growing, the average age of those individuals testing positive is lower than it was three months ago, and, from what we know now, the severity of those cases for younger individuals is usually not as great, reducing the pressure on ICU bed usage. This could obviously change quickly with greater community spread to more vulnerable populations, but as of now, inpatient hospital bed capacity is not an issue, unless current critical care physicians, nurses and respiratory therapists availability changes.

Supplies:
1. **Ventilators:** Minnesota currently has approximately 980 ventilators in the state, with 419 in use, or about 43 percent. Shortages of ventilators has not been the problem that we thought it might be because Minnesotans flattened the curve. Drugs like Remdesivir have made an enormous difference in avoiding the use of ventilators. Health care providers have also seen success with placing patients in the prone position in order to allow the lungs to expand more effectively without mechanical ventilation.

2. **Personal Protective Equipment:** The supply of PPE is better than it was. However, the global supply chain will continue to be a problem for the whole country with states competing against each other and supplies being sent to states with current surges. While the supply has stabilized since the beginning of this crisis in March, hospitals are still following the guidance of the CDC and the Minnesota Department of Health to conserve Personal Protective Equipment. There is acknowledgment that this situation can change quickly, depending on caseloads and burn-rates. Federal stockpiles of PPE will continue to be allocated to national COVID hot-spots, and the national strategic stockpile has not been available to Minnesota. Minnesota health care providers are having to rely on their own supply chains of purchasing, which can change quickly, are less reliant, and more expensive than pre-COVID. The state continues to do what it can in this area and is working toward building a 60-day reserve. I would defer to MDH for questions regarding the state's current PPE supplies.

3. **Testing:** Testing continues to be a big challenge for health care providers, and with the growing number of COVID-19 cases around the country, the testing situation is getting worse and not better. For now, we are not hearing about a significant challenge with the sampling supplies, but with the lack of test processing supplies – specifically a shortage of the re-agents needed to process the tests and delayed laboratory turnaround times. This is a national problem that is not unique to Minnesota.

   Testing has a direct impact on staffing. This is true for both hospitals and long-term care settings. Delays in getting testing results is a growing concern. MHA members have shared with me that the timeframe for getting back test results can be as long as five to six days, and some are hearing it will soon be eight days. There is general agreement that patient testing needs to come first, but health care workers need to be a higher priority than general community testing. We have heard from several hospital HR directors who have asked the question, what about an asymptomatic employee, who knows they have been exposed to COVID-19, and are now not able to come to work. A 14-day quarantine for a health care worker can really be disruptive to a hospital, particularly to a rural hospital that may not have a pool of alternative employees who can be asked to work. Getting back test results in a timely manner is not only important to stop the spread of COVID-19, but also to preserving our health care workforce.

And finally staffing:
The first priority remains to keep our health care heroes healthy. This is dependent on training, adequate supplies of PPE and timely testing results. Two Executive Orders have been helpful; Executive Order 23 and Executive Order 46. Executive Order 23 allows for the delay of fingerprinting submission as part of a license renewal application and Executive Order 46 allows for out of state health care professionals during the peacetime emergency. Some hospitals have recruited highly trained ICU nurses and respiratory therapists to be part of their COVID-19 care teams and others have better utilized health care professionals from our border states. This has also assisted with telehealth. MHA would ask policymakers to extend these two Executive Orders through legislation for a time certain, 60 days, after the emergency powers end.

Hospitals and health systems are watching reopening and the resumption of activity in other states closely. Hospital capacity is still dependent on the intensity, duration and severity of an outbreak.

We are asking all Minnesotans to double down and help slow the spread of COVID-19 by following recommendations including wearing masks, social distancing and staying home when they are sick or while waiting for COVID-19 test results. We know these tools work to slow the spread.

MHA is grateful for the continued interest and support of state policymakers as we work to get through this COVID pandemic together. It is a marathon, and part of the challenge is not knowing what mile marker we are on.

Thank you.