DEPARTMENT OF HEALTH

Governor's Task Force on Academic Health at the University of Minnesota

12/20 STRAW POLL TOTALS & MEMBER FEEDBACK ON DRAFT RECOMMENDATIONS

Recommendation 1

Quickly resolve negotiations to continue the University of Minnesota's primary partnership with Fairview Health. UMN, UMP, and Fairview must establish clarity of purpose, shared goals, and transparent accountability mechanisms around the three intertwining missions of research, teaching, and clinical care.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
8	6	1	0	93%

Comments, reservations, or requested changes from Task Force members

- Currently the contract allows through 2026/ approx. 2 years. Why would mediation happen so soon in that process as both parties stated they are negotiating in good faith? Any agreement should include clear strategy, ops planning, and budgeting to prioritize and right size the academic model of clinical care, training, and research.
- Proposed redraft: Quickly resolve negotiations to continue the University of Minnesota's primary partnership with Fairview Health. UMN, UMP, and Fairview must establish clarity of purpose, shared goals, and transparent and aligned accountability mechanisms around the three intertwining missions of research, teaching, and clinical care. Any agreement should indicate that Fairview cannot enter into an agreement which alters the control and ownership of UMMC without the approval of the University and the State.
- Add "and the Health Sciences" to the end of the sentence.

Recommendation 2

If UMN and Fairview do not reach a new partnership agreement by December 31, 2023, Governor Walz should appoint a Mediator to help resolve their differences and reach an agreement before the Legislature reconvenes on February 12, 2024.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
7	**2**	**3**	**3**	**60%**

Comments, reservations, or requested changes from Task Force members

- Delete reference to December 31 date.
- The Governor has not indicated this as an option. We've also already asked who would pay, and there would need to be assurances that both parties would actually agree to mediation. Much like the previously suggested December 31 deadline, the February 12 deadline seems very tight as well.
- Remove reference to December 31.
- M Health & UMN can ask for a mediator but no point in forcing one on them.
- Why agreement before this session? What urgency factor is the author stating? Current agreement provides approx. 2 years to negotiate. Also, if a mediator appointed, who will select? Clear conflicts of interest and pay as M Health includes both a public partner (UMN) and a private partner (Fairview).

Recommendation 3

If there are ownership or governance changes between UMN, UMP, and Fairview, existing private sector labor agreements, pensions, and other benefits currently in place must continue without disruption.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
4	1	9	1	33%

Comments, reservations, or requested changes from Task Force members

- I generally agree and support this recommendation, but this labor contracts seem a bit out of scope for this task force.
- Common language needs to be used. Overall, there are 'change in ownership' provisions in most fiduciary agreements. If this is recommended for some contracts, would this create issues for other types of contracts? If Fairview is not the future clinical partner, would enforcing all agreements be a hurdle in finding a new partner? Unless this assumes UMN and UMP would build their own clinical system.
- Remove. While important, I don't think the Task Force should weigh in on labor agreements between UMN, UMP, and Fairview.
- Fairview's partnership resolution is clearly in everyone's interest. I like the wording of recommendation #1. I am concerned about the political divisiveness of how #3 is worded. I need to understand "private sector" vis a vis public labor agreements. That said, I do not believe it wise to include this stipulation in our recommendation without better understanding implications.
- Establishing the expectation that labor agreements will not change is beyond the purview of this body. It could affect the future alignment of organizations depending on academic/community/business needs. Would advise removal of item OR "Develop a plan for impacted personnel should a business transition occur prior to setting of agreement."

Recommendation 4

Assess the feasibility of a longer-term model for multi-system integration between UMN and other public health entities, with single academic clinical staff. Such a model could include a principal partner system, with UMMC, HCMC, VA, and Children's coming together, or a community model of collective ownership with a single managing partner.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
1	3	7	4	27%

Comments, reservations, or requested changes from Task Force members

- Delete this recommendation.
- This one just felt a bit too soft, like kicking the can. The words "assess the feasibility" may be tripping me up a bit.
- I am open to changes and think Meghan and Penny were trying to avoid naming specific systems. I think these changes, however, make it sound too lofty and general.
- Seems to conflict with technical advice and could greatly disrupt existing labor relations.
- Does this one also need the words "Regardless of the outcome of negotiations with Fairview," like #5 to make it more clear?
- The definition of public health entity is different than how illustrated in this recommendation. Also are we using formal definitions of public versus private appropriately here? Were the top administrators (CEO, Secretary, other) notified before their organizations were listed in a Governor's Taskforce recommendation? Does this assume consolidation or collaboration? Where is the option that UMN provides within scope education and teaching and specific research, but clinical care is done at external / other facilities not owned or operated by UMN? 4 is covered under 5 well enough. What other public organizations would be in scope? Who would decide and govern? Regarding the 4 systems listed:
    - UMN is state public but remember Fairview is not public system
    - Hennepin Health is county public
    - VA is federal public, and links up through the President's Cabinet.

  - Children's Minnesota is not public, it is a nonprofit independent.
- This discussion should be part of the feasibility study (#11).
- Proposed redraft: Assess the feasibility of an integrated system/collaborative model that aligns academic resources and a shared commitment to the public good to benefit our State towards the creation of a skilled and diverse future workforce; reduced health disparities and improved outcomes for all; and expanded healthcare services with increased access to specialized care for our most vulnerable populations. The goal is the creation of a more sustainable and resilient academic healthcare system, ultimately benefiting the public by maximizing the impact of available resources.
  - Just want to be sure there is a hard look at collaborating between those entities that do much to academically train/educate and disproportionately serve underserved populations. Perhaps that criteria of entities that do significant training and are part of the publicly supported safety net, could narrow the scope of the feasibility assessment without undue specificity.
- Why limit to those named here? Proposed redraft: Assess the feasibility of a longer-term model for multi-system integration between UMN and other health entities.
- Suggest deleting reference to VA, a national entity.

Recommendation 5

Regardless of the outcome of negotiations with Fairview, UMN should seek broader relationships and collaboration with health systems across the state to best leverage all of Minnesota's considerable health care assets to:

- *help address current access challenges and disparities in particular communities and for specific types of services;*
- *help rationalize tertiary and quaternary clinical capacity; and*
- *explore optimal collaboration in teaching and research with the Mayo Clinic.*

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
9	**1**	**3**	**0**	**77%**

Comments, reservations, or requested changes from Task Force members

- Add another bullet point: Explore optimal collaboration with HCMC, VA, and Children's.
- Does collaboration mean joint governance?
- As written is this stating that it is role of UMN to help rationalize tertiary and quaternary clinical capacity and why is the word rationalize used? Recommend removing this statement in total. If not removed, suggest that this point be rewritten and then moved to a new recommendation separate from #5. Care delivery systems have missions that drive their clinical scope. In 2015 Blue Ribbon and subsequent 2018 M Health dealings, we learned at taskforce that it was intentional to focus UMN on primary, preventive, and rural type care - why now the pivot and expectations that other systems are 'rationalized'? Reviewing acuity/CMI and other service and volume data, this would be a major hurdle for this Task Force and or administration. Is it within scope of MDH to analyze the state's current primary, tertiary and quaternary clinical capacity across all hospitals and health systems to determine any unmet needs as well as excess capacity? What definition of primary, secondary, tertiary and quaternary care is being used; taskforce members and all decision makers should have common definition, industry standard definition.
- No issues with Mayo but they should be consulted before being named. Proposed redraft of last bullet: "explore other collaborations in teaching and research."
- Revise last bullet point: "explore optimal collaboration in teaching and research with these health systems, including with the Mayo Clinic."

Recommendation 6

Develop a shared Health Sciences strategic plan for the six Health Professional Schools at the UMN that includes goals and strategies to strengthen interprofessional learning and practical training, as well as goals and strategies to innovate for the future of health care through partnerships with other University programs and MN State. The strategic plan should include goals and/or strategies related to:

- *increasing the number of graduates from Health Professional Schools while maintaining quality;*
- *setting and achieving targeted and specific goals for national rankings of the Health Sciences programs (e.g. Top 10), in terms of academic standing, researching funding, and social mission impact;*
- *designing and piloting breakthrough public health and care delivery models.*

This plan should establish the foundation for transparent budgeting and inform appropriations requests to the legislature. The plan should be monitored, reported to the joint legislative oversight committee established under recommendation #7, and updated at least every five years.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
4	8	4	0	75%

Comments, reservations, or requested changes from Task Force members

- Delete this recommendation.
- This seems like a question internal to the UMN and do not have a strong feeling about it.
- If not already in a strategic plan period, can't UMN start this now, independently? It's a basic function of management. Should academic standing be more narrowly focused? Primary care? Rural care? Mental and behavioral health? Does designing and piloting breakthrough public health and care delivery models assume public funding for designing or not? Does it assume pilots would be publicly funded? What is oversight? Assuming any new models would need to go through the legislature? If Medicaid included would require state plan amendment and CMS approval? To better achieve results and acknowledging can't do everything and do everything well, should this be narrowed to primary, rural and mental and behavioral health public health and care delivery models? (Linking back to Blue Ribbon report).
- Define interprofessional; including clarifying that this is conceptual and can be manifest in multiple ways; it is not about creating a single umbrella governance. Change "practical training" to "clinical training."

Recommendation 7

Establish a joint legislative oversight committee to monitor the totality of State appropriations to the University of Minnesota across funding sources and budget areas. This committee should establish an accountability and reporting structure to receive regular updates on the impact of appropriated funding on advancing the University's mission.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
13	**1**	**1**	**0**	**93%**

Comments, reservations, or requested changes from Task Force members

- Delete this recommendation.
- Please include detailed funds flow documents. It is critical that level of funding is clear, as is the flow of clinical dollars.
- Proposed revision: This committee should establish an accountability and reporting structure to receive regular updates on the distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.

Recommendation 8

Consider appropriating additional funding to the UMN for academic health, if:

- *UMN and Fairview have finalized a new partnership agreement that includes shared goals and accountability mechanisms;*
- *the appropriation request is directly aligned to a strategic plan for Health Sciences at UMN that includes shared goals and strategies for the six Health Professional Schools, as described in recommendation #6;*
- *the appropriation request includes a thorough funds flow analysis and clear quantification of the funding gap to be filled;*
- *the additional funding will be used to advance training in, and clinical care for, Greater Minnesota and underserved communities in metropolitan areas;*
- *uses for the additional funding are aligned to State goals for population health improvement; and*
- *there is a clear accountability mechanism for reporting back to the State on the impact of this, as well as other, appropriations for academic health.*

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
6	9	1	0	94%

Comments, reservations, or requested changes from Task Force members

- Proposed redraft: Consider appropriating additional funding to the UMN for Academic Health if: UMN and Fairview have finalized a new partnership agreement that includes shared goals and accountability mechanisms; uses for the additional funding are aligned to state goals for population health improvement; and there is a clear accountability mechanism for reporting back to the state on the impact of this, as well as other, appropriations for academic health.
- Would require recommendation #3 & the labor clause of #19. With any public investment would need to be sure that investments would produce good jobs with strong worker voice.
- If a tax, add a qualification that the funding does not come from an additional provider tax on hospitals and health systems. MA is for clinical care, not the academic mission. This is another reason why funds flow needs to be clear. MA goes to clinical care, and GME dollars to GME, NIH to research etc - - the funds flow of MA dollars should follow direct patient care. Minnesota Medicaid is already a challenge for a

myriad of reasons – there should be clarity on aims and priorities of the Medicaid program for clinical funding, and this is not under purview of Task Force (but need to see final problem statements to confirm).

- Proposed additional bullet points:
    - the University provides benchmarking data relative to levels of state support for medical schools from other states;
    - benchmarking information relative to faculty clinical, research and teaching productivity is provided to the State; and
    - the University provides a formal financial forecast, prepared by an outside firm, relative to its strategic plans for the medical school and other health sciences schools. The forecast should identify the gaps which the State is being requested to fill.
- Refer to “academic health sciences,” rather than just “academic health.”

Recommendation 9

Begin appropriating in FY2025 the additional requested $60-80 million annually to UMN to be used as described in the UMN Vision for Academic Health System.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
2	1	10	2	20%

Comments, reservations, or requested changes from Task Force members

- Delete recommendation.
- The $60-80M range gives me pause. I'm also concerned about the "what for?" Also, it's a prioritization question for me since this has not been approved by the BOR and could be in direct conflict with the U's ask for $45M in ongoing O&M funding this supplemental budget session.
- We may have other conflicting funding requests this year. Would require recommendation #3 & the labor clause of #19. With any public investment would need to be sure that investments would produce good jobs with strong worker voice.
- I support #8 and I don't feel that we have the information needed to say how much should be appropriated annually nor the definition needed in a vision statement to support #9.
- Task Force doesn't have a clear idea of entirety of state funding currently received by UMN and how it is being used. HHS budget has many needs, and this is a significant amount of money with no documentation of how it would be used and why this amount is needed. If any additional funding is provided to UMN it should not come from a provider tax or in any way at the expense of other hospitals and health systems. The ask has not yet been vetted by University governance. What impact analysis has been done by the State for adding this dollar amount to a saturated market?
- Completely support, as long as there is an explanation of what the funding will be used for.
- Prefer recommendation #8.
- This is more of the same, old system focuses. U claimed money accomplished goals, currently lack of clarity on what funds would be used for.

- My acceptance would be based on: The 60-80 million incremental ask requires further definition in relation to community needs defined, measures of success, approval by the Board of Regents, and a top priority of the University President.
- Any state allocation must be accompanied by a specific line item request by the UMN and plan for use (ie expected outcomes/accountability).

Recommendation 10

The President of UMN must tell the Governor and Legislature if significant additional funding for the University's Medical School is among its highest priorities for the 2024 session. If so, the Medical School should make a specific funding request (not a range) to the Legislature for 2024 that details the money requested, its purposes, and how it will advance academic quality.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
11	**0**	**4**	**0**	**73%**

Comments, reservations, or requested changes from Task Force members

- Would like to see "Medical School" removed and replaced with "Health Sciences schools"
- Again, clear and direct funds flow.
- Proposed redraft: The President of UMN and the Board of Regents must tell the Governor and Legislature if significant additional funding for the University's Medical School is among its highest priorities for the 2024 session. If so, the Medical School should make a specific funding request (not a range) to the Legislature for 2024 that details the money requested, its purposes, and how it will advance academic quality and health outcomes.
- This seems better stated that it is up to the University how and for what they develop legislative requests

Recommendation 11

Request and fund a comprehensive needs assessment of public health system facilities and infrastructure throughout Minnesota. The study should consider statewide health care capacity, emerging future needs, opportunities for shared services/facilities across public systems, and existing labor agreements.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
4	3	8	1	44%

Comments, reservations, or requested changes from Task Force members

- Delete recommendation.
- Very vague, not sure what it means, and not sure we need more 'study' vs. 'action'.
- Can this recommendation be linked with #5 to make sure the work happens in a coordinated way?
- Needs assessment should be conducted independently by MDH. Should include analysis of the state's current tertiary and quaternary clinical capacity across all hospitals and health systems to determine any unmet needs as well and excess capacity. Why is the word 'public' used versus a state wide study? If left as is Fairview is excluded, as an example.
- Why limit to "public" systems? And again, I don't think the Task Force should weigh in on labor agreements. Proposed redraft: Request and fund a comprehensive needs assessment of health care need, health care capacity, emerging future needs, and opportunities for shared services/facilities across health systems.
- Proposed revision: Request and fund a comprehensive needs assessment of system facilities, infrastructure, and human resources supporting public health throughout Minnesota. The study should consider statewide health care capacity, emerging future needs, opportunities for shared services/facilities across public systems, and existing labor agreements.
- I believe the outcome of this would be to avoid waste and duplication of community assets, and improve access and quality. I believe this aligns well with the intent of #4 above. Facilities on the UMMC need to be right sized for unique programs and those that capture regional referrals clinically.

- Consider adding a comma “public, health system facilities” (public hospitals/health systems are healthcare institutions that are owned, operated, and funded by the government or a public entity) providing essential services to a broad and diverse population with a focus on accessibility, affordability, and public health. Add: “with a focus on creation of centers of excellence in focus areas and removal of duplication/redundancy of services fostering unnecessary competition.”

Recommendation 12

Begin immediately addressing the growing deficiencies in existing hospitals.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
0	8	7	0	53%

Comments, reservations, or requested changes from Task Force members

- Delete recommendation.
- I'm still not 100% clear what this is referring to? Which deficiencies? And, what does it mean to "address" them? Is this infrastructure?
- Not enough detail and disagree with the urgency.
- We support upgrades to or replacement of the Riverside facility. Would require recommendation #3 & the labor clause of #19. With any public investment would need to be sure that investments would produce good jobs with strong worker voice. Would also need to not unfairly advantage mHealth.
- I would need to see more definition of what constitutes a deficiency and how addressing them can address key problems Minnesotans face in accessing health care.
- Confirm if 'existing hospitals' is limited to MHealth or all Minnesota inpatient acute care facilities. Community standard was referenced in the meeting – which community standard? Or is this just comparing to Mayo Clinic investment?
- This needs additional detail to define scope.
- Proposed revision: Begin immediately to identify, synthesize, share, and address the growing deficiencies in existing hospitals.
- Need to be quantitated and cross-walked with anticipated HEAPR ask from the U.
- Remove. Don't understand this one.

Recommendation 13

Issue $1,000,000,000 ($1 billion) in tax exempt bonds, backed by the University's Foundation, private philanthropy, and State support, to grow and finance the building of a new hospital and other improvements.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
2	1	9	3	20%

Comments, reservations, or requested changes from Task Force members

- Proposed redraft: The need for a new hospital is separate from the funding requests in #8 above, and this need is immediate. Therefore, issue $1,000,000,000 ($1 billion) in tax-exempt bonds, backed by the University's Foundation, private philanthropy, and state support to grow and finance the building of a new hospital and other improvements.
- Similar to #9, it's a prioritization question for me. How does this rank when considering the U's existing bonding request?
- Not enough detail to justify that exact amount. Would be willing to support bonding request but not blank check.
- We support upgrades to or replacement of the Riverside facility. Would require recommendation #3 & the labor clause of #19. With any public investment would need to be sure that investments would produce good jobs with strong worker voice. Would also need to not unfairly advantage mHealth.
- I would need to see more details of a new hospital before I could more strongly support this.
- What is market need? Looking at MHA data, Minnesota has significant number of beds for its population etc. – can we see data? MDH should determine market need first and complete analysis of existing hospital capacity. First focus should be renovations and improvements to current infrastructure before consideration of a new hospital. Any funding requests should include analysis of what types of beds are needed.
- I do not support because this figure has no meaning and was chosen by people without understanding about how much a new hospital would cost. This funding mechanism can be part of a feasibility study.
- Remove. Need hard numbers and thorough quantification of funding and needs gap analysis to justify this expense.
- I believe this should be deleted, as we need greater specificity about the needs and intended outcomes before a funding target is pursued.

- Not in support of issuing $$ for bonding until there is an understanding of the strategy moving forward—what is to be built, how does it benefit the state, etc. Perhaps a better offering, is establish a plan and necessary funding recommendation by x to support the modernization of academic health infrastructure.

Recommendation 14

Establish shared, statewide access to UMN academic library services as a shared service for clinics, academic health programs, and health systems and provide funding to non-University entities to connect to the service. Also identify and implement other similar shared services opportunities.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
9	4	2	0	87%

Comments, reservations, or requested changes from Task Force members

- Definition of what services are within the UMN academic library services needed. Most have a level of this, and or use PubMed or other mainstream medical library service.
- No major issues with this one, but it is very specific - would like to know the cost savings given the way library subscriptions work.

Recommendation 15

Consider additional ways to increase financial support for academic health statewide and to broaden the base to reduce dependence of this critical function on clinical services profits, including:

- *modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax; and*
- ~~*developing a program to match NIH funding.*~~

Any changes to provider or claims taxes should include ways to credit providers, health plans, or other entities for participation in academic health functions.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
2	4	5	4	40%

Comments, reservations, or requested changes from Task Force members

- Maybe delete second bullet based on lack of clarity.
- We are open to the use of the provider tax to support academic health, but we are likely to prefer using those revenues to support other health care programs, especially expanding access to public health insurance.
- Remove “to reduce dependence of this critical function on clinical services profits.”
- Minnesota hospitals support the existing provider tax and fought to continue the provider tax when it was at risk. A provider tax dedicated for the use of one health care entity would serve a very different purpose and come at the cost of the state’s other hospitals and health systems. This would strain existing hospital financial resources and create an imbalance in our current system of care. The national and regional reality is clinical ‘profits’ are going down and near zero, if not negative for majority of Minnesota hospitals. Minnesota’s hospitals and health systems may benefit from having a trained healthcare workforce, but hospitals and health systems are already contributing financially to UMNs academic health programs. Hospitals already pay UMN to train their students. Training sites are required to make stipend and benefit payments to UMN to cover all, or substantially all, of the compensation paid to the trainees. Hospitals also pay UMN to cover administrative costs. GME/CHGME and MERC are sources of funding that can be used by hospitals to make payments to UMN. Hospitals also have their own administrative costs for training. In addition, several hospital/clinic systems have their own funded training

positions (residents, fellows) outside of UMN. Meaning UMN is not the sole provider of GME but is a majority provider. Matching NIH funding may make sense if research is prioritized by strategic plan and have fiscal limits/budget that is held. Open ended funding is not sustainable. But asking the State to match (cover the gap) is an issue without clarity of controls.

- Remove. Concerns: a) This will likely raise health care costs, b) State General funds are the right source of funding for what is a public benefit, c) Difficult to fairly administer a tax….who pays how much? (rural hospitals, small private physician practices, community health centers, nursing homes are already struggling). We already train many health professionals at an additional cost to our system.
- Revise second bullet: "developing a program to match NIH funding for all health systems that engage in NIH funding."
- Given the fragility of the provider system, any additional taxes would be further detrimental to community health, in my opinion. I do believe other parts of the health care ecosystem (payers as an example) are in a better position. Much of the training of professionals occurs outside the U and credit should be given. It may be feasible for providers to give scholarship support with a post-training work commitment. As research doesn't stand on its own bottom line, a state match of sorts to NIH funding/other research funding to keep Minnesota's leadership position in health innovation, would be attractive.
- Remove the NIH funding match section. Consider addition of items such as increased financial support for statewide academic investment such as preceptor recruitment and retention in health professions education.

Recommendation 16

Maximize use of Medicaid funding to support health professions education, by:

- *increasing Medicaid reimbursement rates;*
- *maximizing federal drawdown of GME Medicaid and Medicare matched funding; and*
- *exploring expanded use of intergovernmental transfers and direct payments, where allowable, to support clinical training sites.*

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
11	**3**	**1**	**0**	**93%**

Comments, reservations, or requested changes from Task Force members

- Medicaid in Minnesota needs increased reimbursement rates and better coverage for enrollees by insurers. Any Medicaid recommendations should flow through HHS and consider state landscape. Again to funds flow, Medicaid is clinical dollars, GME is training/education dollars, NIH is research dollars - - Don't comingle as in this recommendation - - Medicaid is not designed to support education.
- Add another bullet point: "Establishing clarity of funds flow within health systems of MERC."

Recommendation 17

Request and fund a statewide comprehensive health professions workforce plan that includes short-term strategies, as well as a long-term plan for aligning health professions training programs with a vision for the future of health care delivery. The plan should analyze and make recommendations for increasing the diversity of health professions workers to reflect Minnesota's communities, as well as addressing the maldistribution primary, mental health, and dental providers in Greater Minnesota.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
12	**1**	**2**	**0**	**87%**

Comments, reservations, or requested changes from Task Force members

- Delete recommendation.
- Very vague, not sure what it means, and not sure we need more 'study' vs. 'action'.
- The process should be broadly inclusive of health professional teaching organizations, in addition to the University.
- Add "nursing." Revised: "as well as addressing the maldistribution primary, mental health, nursing and dental providers in Greater Minnesota."

Recommendation 18

Establish or identify a coordinating and planning entity responsible for using existing and new health professions workforce data to guide future investments and make on-going recommendations to increase the supply of health care professionals in critical areas of need within Minnesota.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
8	2	4	1	67%

Comments, reservations, or requested changes from Task Force members

- Delete recommendation.
- (Also in reference to #19) Based on Val DeFor's comments, this should specify, or refer to the collaborative efforts with the U and other entities like Minnesota State, HealthForce, and private institutions, especially since this is a statewide workforce issue that impacts more than the U.
- Very vague, not sure what it means, and not sure we can create a body with this power. Might be supportive if it was a vehicle for greater labor/management partnership over workforce training.
- Proposed revision: Establish or identify a coordinating and planning entity responsible for using existing and new health professions workforce data to guide future investments and make on-going recommendations to increase the supply of health care professionals for the State with particular clarity of supply in critical areas of need within Minnesota.

Recommendation 19

Increase funding for effective strategies to fill current and future gaps in the health care workforce, such as:

- *expanding pathway programs to increase awareness of the wide range of health care professions and engage the current workforce, as well as K-12 students, undergraduate students, and community college students, in those pathways;*
- *reducing or eliminating tuition for entry-level health care positions that offer opportunities for future advancement in high-demand settings, and expanding other existing financial support programs such as loan forgiveness and scholarship programs;*
- *incentivizing recruitment from Greater Minnesota and recruitment/retention for providers practicing in Greater Minnesota;*
- *expanding existing programs, or investing in new programs, that provide wraparound support services to existing health care workforce, especially people of color and professionals from other underrepresented identities, to acquire training and advance within the care workforce; and*
- *addressing the need for increased quality faculty to train an increased workforce.*

Further subsidies for workforce development should include employer accountability measures that ensure jobs in academic health settings meet or exceed existing labor standards and include neutrality for workers seeking to form a union.

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
1	**7**	**6**	**0**	**57%**

Comments, reservations, or requested changes from Task Force members

- (Also in reference to #18) Based on Val DeFor's comments, this should specify, or refer to the collaborative efforts with the U and other entities like Minnesota State, HealthForce, and private institutions, especially since this is a statewide workforce issue that impacts more than the U.
- Last statement doesn't seem to belong with this recommendation. Maybe it should be considered as a stand-alone recommendation that states: "Subsidies for workforce development should include … to form a union."
- Need to be certain this is a funded mandate to increase and further diversify the needed workforce.

Recommendation 20

Using the findings from the comprehensive needs assessment in recommendation #11, consider *prioritizing bonding support to bring the physical infrastructure of UMMC and other publicly funded health care facilities into the 21st century.*

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
3	**4**	**5**	**1**	**54%**

Comments, reservations, or requested changes from Task Force members

- Delete recommendation.
- We support upgrades to or replacement of the Riverside facility. Would require recommendation #3 & the labor clause of #19. With any public investment would need to be sure that investments would produce good jobs with strong worker voice. Would also need to not unfairly advantage mHealth or other hospitals.
- Remove “consider prioritizing bonding support” and replace with “develop a prioritized bonding list,” then add “UMN” responsible parties.
- Remove. Is it the State’s responsibility to fund the VA, county, and other public facilities?
- Supportive of defining the community facility needs and assure operational partnership/operational acumen before prioritizing bonding.
- Merge with #11.

Recommendation 21

Promote interprofessional training by:

- *establishing a new advisory body, including the University of Minnesota as well as other public and private schools that train health professionals in Minnesota, to develop recommendations for how to move towards more interprofessional training and clinical practice;*
- *advocating for a redesign of national training requirements to emphasize interprofessional training and focus on patient/population outcomes; and*
- *providing financial support to expand interprofessional clinical training and care delivery.*

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
3	8	2	0	85%

Comments, reservations, or requested changes from Task Force members

- This seems like a question internal to the UMN and do not have a strong feeling about it.
- Not sure how elected official play out in this? The statement is not clear, and what does 'promote' mean in this case. The first and third examples differ from the second. Consider moving the second statement into its own recommendation, now it is sandwiched between Minnesota constraints.
- Second bullet point has already been integrated into health professions standards.

Other comments from Task Force members:

- In 22 states, Walmart is the biggest employer, but in Minnesota the biggest employer is Mayo, quickly followed by the Allina Health System. In fact, of the top five employers in the State of Minnesota, three are healthcare related. This is a "usually" cold state with few natural resources and a small tourist base. I was hoping that we would take this opportunity to recommend a bold plan to make Minnesota the center of healthcare for America. We have a model of how this could work in the Destination Medical City (DMC) which points to a different governing structure. A state-wide initiative would allow us to direct funds to those parts of the healthcare system best designed to advance medical care, medical teaching, and medical research. The Board of Regents of the University of Minnesota would be ill-prepared for that task, as would the Board of Directors of the Fairview Health System. A state-wide initiative, publicly-led, but involving representatives from the major health care systems, major payors and the MedTech community would be involved.