Recommendations to Support World-Class Academic Health Professions Education, Research, and Care Delivery

DRAFT

GOVERNOR'S TASK FORCE ON ACADEMIC HEALTH
AT THE UNIVERSITY OF MINNESOTA

Recommendations to Support World-Class Academic Health Professions Education, Research, and Care Delivery from the Governor's Task Force on Academic Health at the University of Minnesota

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Introduction from Task Force Chair Jan Malcolm

Minnesota has a proud history as a health care powerhouse—with nation-leading health care providers and public health agencies, a vibrant medical technology sector, strong health plans, and a tradition of forward-looking public policies related to insurance coverage and health care delivery. Over many decades the University of Minnesota (UMN) has contributed greatly to the evolution of our state's robust health and health care ecosystem—training the large majority of medical care and public health professionals practicing in the state, discovering new therapies, and providing highly specialized care to Minnesotans in need. At the same time, we have significant challenges with unsustainable trajectories in health care costs, declining access for many, critical workforce shortages and deep structural inequities that contribute to health disparities that are among the worst in the nation.

Minnesotans deserve a higher performing health system, with better access and outcomes for all at sustainable costs. As Minnesota's land grant university, UMN has a leadership role to play in creating that future.

This Task Force was convened by Governor Walz to make recommendations to support world class academic health at UMN, with a particular emphasis on the University's role in training health professionals. In dialogue with the task force over the course of our work, UMN has developed a vision for a stronger academic health system working in close partnership with the deep capabilities in Minnesota's public and private health care systems to build on our state's strengths and to meet its challenges.

The work of this Task Force follows two earlier commission efforts in recent years, one in 2008, under Governor Pawlenty, and another in 2015, under Governor Dayton. Those two efforts focused more specifically on aspects of the University's medical school; while not all of the recommendations were fully funded, the reports still resulted in valuable investments in the research and development function and in faculty recruitment. Governor Walz asked this Task Force to take a more comprehensive look at all of the Health Sciences Programs at the University and their role in health professions education, especially given larger changes in the overall health care system.

Following the ending of potential merger talks between Fairview Health Services (referred to as "Fairview") and Sanford Health that garnered much public discussion, UMN and Fairview have been renegotiating their current partnership, which has been in place since 2018 and is scheduled to end on December 31, 2026. Both parties have indicated that the agreement will not continue in its current form, but that they would like to agree on a modified set of terms. The details of this agreement are outside the scope of this Task Force. However, the current uncertainty about both the timeline and the contours of the post-2026 agreement created challenges for the Task Force and may limit the applicability of some of the recommendations in this report.

The Task Force urges the earliest possible resolution between the parties and believes this should happen before the Governor and Legislature are asked to take action on funding recommendations concerning academic health.

The University has proposed the need for increased public financial support so that its health sciences programs can expand their role in helping Minnesota meet the health challenges of today and into the future. This comes

at a time when Minnesota's entire health ecosystem is under considerable stress, facing unprecedented workforce shortages and critical financial challenges in acute and long term care delivery systems all across the state.

Task Force members and advisors have been generous with their time, diligent in their discussions and passionate about Minnesota's health. I am grateful to them, to colleagues at UMN, and to the excellent MDH staff who organized and supported this work.

Need for a new vision

The Task Force calls on Minnesota to envision a future system that is designed for better health outcomes —to achieve maximum and equitable physical and mental wellbeing for all Minnesotans, not designed solely for more or better health care. With so many assets and strengths when it comes to our whole health ecosystem, Minnesota has the opportunity to become nationally known as ***the*** "state of health."

Achievement of such a vision will require a shift in perspectives, priorities, and resources across multiple sectors, and will require coordination and collaboration across academic health, community health systems, public health agencies, health plans, and the biotech industry.

The Task Force's vision is that the University of Minnesota,
with its significant role in educating the current future workforce,
unique asset of six health science programs, and land grant mission,
will play an essential role in defining and reaching this new future.

The Unique Role of the UMN's Academic Health Programs and its vision for a next generation Academic Health System in Minnesota

Over the course of our meetings, UMN leaders presented a great deal of Information to the Task Force about the strengths and challenges in its current health sciences programs, briefly summarized below. In early 2023 UMN began developing a vision for a new and more robust Academic Health System (AHS) in Minnesota. Its vision has evolved in response to dialogue with the Task Force. The University of Minnesota has one of the largest, most comprehensive health science programs in the nation with graduate schools of medicine, public health, nursing, pharmacy, dentistry, and veterinary medicine. These programs shape the future of healthcare through three primary functions: education and workforce training, research, and patient care. They train over 70% of the state's physicians. They are at the forefront of clinical and public health breakthroughs through basic and translational research. And the University Medical Center provides highly specialized cutting edge care to Minnesotans in need.

The UMN Medical School has recently achieved an 8-year accreditation, marking excellence in medical training. The institution consistently ranks among the top three in the United States for training rural physicians, family medicine physicians, and Native American physicians. The faculty practice serves over 1 million patients annually. The tripartite mission of Academic Health at UMN contributes significantly to the Minnesota economy and has for many decades, generating jobs and revenue. education and innovation.

With all six health sciences schools working together, the University has unique opportunities to explore interprofessional health care models. The University's partnerships with over 2,000 clinical training sites across the state provide interdisciplinary training for Minnesota's health care workforce, many in underserved and rural communities. These collaborations help bridge the gap between patient care and research, resulting in multidisciplinary care by highly trained members of increasingly interdisciplinary care teams and advancements in the standard of care for healthier communities. Minnesota needs more of this innovation and impact.

UMN has articulated a vision to grow its capacity and deepen its partnerships. A letter from Interim President Ettinger regarding this new AHS, along with recommendations to the Task Force to support its implementation, is included as an appendix to this report, as are statements of support for bold action from Former Governors Dayton and Pawlenty. These recommendations were considered by the Task Force and are included in the next section. All UMN presentation materials including programmatic recommendations from the health sciences deans can be found on the task force web page.

No one "best" model for academic health exists

An important part of our Task Force charge was to look at other models of how academic medical or health centers (AHCs) are organized around the country — what kind of partnerships, ownership, or governance structures exist and how public support is structured.

While the scope of the Task Force does not extend to making specific recommendations regarding the final shape of or accountability metrics that are part of any negotiated agreement between the University of Minnesota and the entities comprising its AHC, these discussions helped to highlight elements of success that it will be crucial for the partners to consider as part of any new agreements.

The highest-level takeaway from the expert testimony and from staff research is that "If you've seen one academic health center, you've one academic health center." There are countless variables that shape the specific structural and funding arrangements between any two (or more) entities, including:

- histories of the medical school and/or hospital;
- leadership philosophy;
- donor base;
- market competition or consolidation in the service area;
- ownership and governance of facilities and physician practices;
- areas of clinical expertise and organizational relationship between the hospital, medical school, and physician practice;
- impact of the AHC on economic development in the regional marketplace; and
- political and financial support from the state.

The University states that Minnesota's financial support of the medical school, in particular, is not competitive with that of other states, although precise quantification is difficult given the complexity of AHC funding described in materials provided by UMN and its consultant.

These variables and several more result in a wide variety of different organizational structures and funding models in academic health. There are both successful and unsuccessful AHCs in which the university owns

and/or governs a health system component or partner, and successful and unsuccessful examples of where it does not.

Local market conditions play a critical role in what works and how, as does alignment across partner organizations on the overall mission from the leadership level on down. As noted in the University's letter to Task Force Chair Malcolm dates January 12, 2004,[1] successful AHC partnerships with private health systems require the "prodigious growth of the health system. Where this is not demographically feasible, the Academic Medical Centers have struggled." The Minnesota health care market has a remarkable depth of health care capacity with the University, Mayo, and other major health systems across the state. This underlies some of the Task Force's key recommendations to deeply explore possibilities for greater partnership and collaborations across all of these assets.

More information on academic health models, funding and structure can be found in Appendix D.

Complicating factors

At the outset of our meetings this Task Force noted several significant confounding challenges to our focus on academic health at the University.

Academic Health exists within a much larger complex set of issues in how heath care is delivered, accessed, and financed in our nation. Challenges facing academic health can't be "solved" in any sustainable way without changes in the macro system. The overall "system" is fragmented, with misaligned incentives, and produces suboptimal health outcomes. Some of the main levers for systemic system change exist at the federal rather than the state level.

Task Force members hope to see UMN play a larger role in pushing for transformational changes in the macro system but recognize the immediate constraints created by the current system.

Academic health is essential but not sufficient to improve the health of Minnesotans and address equity. Decades of health services research shows that health outcomes are primarily determined by factors outside of the clinical care system (safe and affordable housing, access to healthy food, living wages, environmental factors, etc.) and that we can't clinically treat our way to health no matter how good our providers or technologies are. We also know that barriers to access and unequal experiences in health care for marginalized populations in our current system make health disparities worse. Nevertheless, we underinvest in the community health and prevention strategies that could have the most impact on the health of the population as a whole. It is often the investments in the high-tech end of medicine and in building health care infrastructure that crowd out these upstream investments.

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[1] Letter is included as an attachment.

The Task Force believes that with its uniquely comprehensive set of health sciences programs and other disciplines, UMN in partnership with others in every sector and every part of the state, has the potential to help create a more holistic health system of the future.

While the Task force was focused on UMN's role in academic health, other educational institutions and some other health systems also play critical roles in producing and training the needed workforce. For the health care system to flourish, a wide variety of health care professionals are needed to work across the continuum of care. From certified nursing assistants in long term care, to highly specialized surgeons in large health systems, the system is only as strong as its weakest link. Minnesota's recent hospital capacity problems due to a lack of long-term care beds available for discharging patients is an example of how interdependent the system can be and how workers are critical across the full continuum. While much of the discussion in the Task Force was about hospital-level care and about the pipeline of physicians, some of the largest current and projected shortages are in nursing and nursing assistant positions across long term care and community-based services, as well as in acute care. UMN does not currently have specific training programs for these parts of the workforce. In addition to their roles in training, other health systems also conduct research and provide complex critical care in Minnesota.

Minnesota is unique in the breadth and depth of health and health care assets here, and the Task Force calls for maximum leverage and collaboration among all those assets, even as we recognize the competitive incentives that make it difficult.

The Task Force also recognizes that very significant changes are developing in how, where, and by whom care is delivered, with big implications for what the functions and measures of success for academic health will be in the future. Today's physician- and hospital-centric model is not likely to be the predominant mode of health care delivery in the future. Delivery model changes will significantly change projections of which types of health care workers are in shortage and are also likely to impact geographic accessibility and delivery of care in people's homes wherever they live.

Innovating care models and capitalizing on expertise in engineering, law, design, and other traditionally non-medical academic professions will be essential in creating a workforce for the health system of the future.

The pipeline for producing the needed health workforce for Minnesota extends beyond UMN's educational programs, both before students enter and after they graduate. A desire to increase the size of the medical school class is tempered by the availability of needed postgraduate or graduate medical education (GME) training slots. Medicare's GME funding is provided to teaching hospitals through a Per Resident Amount (PRA) and FTE resident cap. PRAs vary by hospital and have not changed since the 1980s; FTE resident caps have remained relatively unchanged since 1997 with a few recent exceptions to address severe workforce shortages.

The need for increased training slots and current federal funding leaves a funding gap to be addressed through teaching programs/sponsoring institutions, hospital, state, and other funding mechanisms.

The Task Force calls for Minnesota leadership in pushing federally for needed in graduate medical education funding and accreditation over the longer term.

Furthermore, the national accreditation requirements for physician training programs are themselves outmoded and in need of reform. They are designed in professional silos and focused on building competencies in doing volumes of certain tasks, and not around improving patient outcomes.

A healthy tension

All of these factors created a tension for the Task Force between the need to help make sure the University can deliver on its academic health mission on the one hand, and a desire to innovate and invest in new approaches that will produce better results for the health of all Minnesotans on the other. Robust Task Force discussions included both a desire to stabilize current programs at the University that some viewed as "in crisis," as well as arguments advocating strongly for investments in a very different model of workforce training that will be less physician and inpatient hospital focused and much more interdisciplinary.

The recommendations that the Task Force ultimately developed reflect this tension, in that some are more narrowly focused on the University of Minnesota's current programs, processes and infrastructure, while other recommendations are more broadly focused on creating new partnerships and structures to help develop the health workforce and care delivery systems we want to see in ten, twenty, or fifty years.

While Task Force members clearly agreed on an overarching vision for the health care system of the future and on a vital role for the University's aspirational Academic Health System, we did not always agree on the best path to achieve that future. Some members felt the case for additional funding is sufficiently clear now without condition, others felt additional funding should be contingent on a number of changes both within the University and in the broader market.

This is a time of great opportunity as well as of great challenge

The University has proposed to the Task Force an expanded view of its role in Minnesota's health ecosystem consistent with its land grant mission. Throughout the Task Force process there has been good dialogue with UMN and Health Sciences leaders. The University's proposals have evolved as a result, and the Task Force is broadly supportive of increased support for the important role of academic health within the ecosystem. Task Force members also feel that additional financial details from the University about their proposals is needed, including more clarity on how current funding streams work. Members have also stressed the need for accountability measures for how any additional funds would be spent. Specific recommendations are presented further in this report.

Our approach to the development of recommendations has been to welcome and include all ideas from Task Force members and our Special Advisors. We did not hold up or down votes or set a threshold for support on

what would be included. Rather we have organized recommendations by topic area, by degrees of support, and by significance or priority for action. Some recommendations are for consideration by the Governor and Legislature, others are for the University's consideration.

Problem statements

The Task Force felt it was important to agree on the nature of the problems that our recommendations are intended to solve. The problem statements ultimately developed by the Task Force are:

- **Problem Statement 1:** The current funding model for the University of Minnesota's academic health programs leaves critical gaps and is unsustainable. Regardless of the outcome of current negotiations between UMN and Fairview, new funding approaches and shared goals are needed to stabilize the educational, research, and clinical practices of the medical school and its collaborations with the other health science programs at the University and with community partners.
- **Problem Statement 2:** Given how health care delivery is changing, current health professions training programs at the University of Minnesota and other public and private institutions in Minnesota are neither producing the number nor types of health care providers needed to care equitably for all Minnesotans now and into the future.
- **Problem Statement 3:** Minnesota has unrealized potential in its broad health ecosystem to develop innovative models of prevention and care—from community-based to primary care to highly specialized care. Within that ecosystem, the University of Minnesota has a unique opportunity to use the breadth and strength of its health sciences schools collectively, and maximize collaboration with its schools of design, engineering, law, and technology, to design and implement the models of the future.

Recommendations

Task force recommendations reflect a few overarching themes. The task force generally supports the UMN's vision to strengthen academic health, with the majority expressing conditions on that support related to the need for full exploration of new models for health professions training and for stronger coordination and collaboration across health systems, particularly among those that are part of the publicly supported safety net. Task force members generally understood the need for capital investments, but most felt that a comprehensive needs assessment should be conducted before funding commitments are made, and that a deeper discussion on the sources for such funding is needed. And finally, most task force members felt that more detailed financial analysis as well as specific outcome goals will be needed in order for policymakers to evaluate the University's funding proposals.

Greater coordination and collaboration are also urged in order to achieve high priority health policy objectives, such as creating a statewide vision for the health care workforce in response to historic workforce shortages and making better use of the various health care workforce data sources to inform policymaking and investments.

How the recommendations are organized and presented

Given the Task Force's timeline, it was unlikely the group would be able to reach unanimous consensus on recommendations, and it was important to the Governor and Legislature to be presented with the views and opinions of all members. Therefore, any recommendation with the support of at least two Task Force members is presented here.

Each recommendation was voted on by Task Force members using the following scale of support:

- Completely support the recommendation
- Mostly support the recommendation
- Support the recommendation somewhat, but with reservations or suggested changes
- Do not support the recommendation

Where members said they "support the recommendation somewhat, but with reservations or suggested changes" any reservations or suggested changes have been documented and compiled beneath each recommendation.

The Task Force's recommendations are organized by the following topic or focus area: UMN, workforce, collaboration, and academic health funding. Recommendations ***within each category*** are presented in descending order according to level of support from the Task Force, based on the combined percent who are "completely" and "mostly" supportive. So, the order of the recommendations presented here is not meant to imply that recommendations with more consensus or more prioritization are all at the top.

Appendix B presents the recommendations in tables organized in several different ways, including in rank-order by percent of the Task Force in complete support and organized by responsible party.

The reservations or suggested changes for each recommendation, where provided by Task Force members who were not completely or mostly supportive are summarized here, and included verbatim in Appendix C.

More detail, including disaggregation of the levels of support for each recommendation based on Task Force member expertise or representation for which they were appointed to the Task Force, is included in Appendix C.

Recommendations related to the University of Minnesota

1. Resolving UMN and Fairview negotiations

Recommendation: *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.*

Percent of Task Force completely or mostly in support: 100%

Although the state or terms of a business partnership agreement between UMN, Fairview Health, and the University of Minnesota Physicians (UMP) is beyond the scope of this Task Force, support for recommendations

related to increased future investment in the University's Health Sciences Programs is contingent, in the minds of most Task Force members, upon successfully reaching new terms to extend the partnership beyond 2026.

As noted elsewhere regarding academic health centers/systems, what appears to be essential for a successful academic health center/system model is not the exact configuration of the model itself, but instead shared clarity of purpose and goals for the partners, along with transparent accountability mechanisms that support the virtuous cycle of research, training, and clinical care.

2. Shared Health Sciences strategic plan

Recommendation: *Develop a shared Health Sciences strategic plan for the six Health Professional Schools at UMN that includes goals and strategies to strengthen interprofessional learning and clinical 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 #6 (below), and updated at least every five years.

Percent of Task Force completely or mostly in support: 100%

One of the key assets of UMN identified by the Task Force is its six Health Professional Schools, but an integrated set of strategic plans, outcome measures, and budget alignment does not currently exist.

The University also has the ability to coordinate and innovate not just across the health sciences, but with its other colleges and programs, such as information technology, engineering, and business. Such interdisciplinary planning, coordination, resource sharing and implementation will be necessary to meet the health care delivery and workforce challenges of the future.

3. Health system facility and infrastructure needs assessment

Recommendation: *Request and fund a comprehensive needs assessment of health system facilities and infrastructure 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.*

Once completed and if supported by the results of the assessment, use the findings of the assessment to develop a prioritized bonding list to right-size and bring the physical infrastructure of UMMC and other public health system facilities into the 21st century, as well as to avoid waste and duplication of community assets, and to improve access and quality for Minnesotans.

Percent of Task Force completely or mostly in support: 100%

This recommendation acknowledges that the University is seeking support to begin planning for a new Academic Health System that will likely require a substantial investment from multiple sources to ultimately establish a new, state-of-the-art medical center, and that any decisions regarding investment in a new facility or facilities should be informed by a comprehensive assessment that considers the broader public health needs of Minnesotans. This type of assessment, or feasibility study, is also referenced in recommendation #7 below.

Although all Task Force members completely or mostly support this recommendation, one Task Force member suggests that the needs assessment is conducted by MDH, rather than the University itself, and that the assessment should include analysis of Minnesota’s clinical capacity across all hospitals and health systems, rather than just focusing on publicly funded facilities.

4. Expectations for planning and developing future appropriations requests

Recommendation: *Any request for additional public funding for UMN Health Sciences must first be approved by the Board of Regents and communicated to the Governor and Legislature as one of UMN’s highest priorities, if not the highest. Any appropriations request should detail:*

- *The specific dollar amount requested, including transparency around how that amount was calculated and funds flow analysis demonstrating why additional public funding, specifically, is necessary, including how UMN has already made internal budgeting decisions to shift or increase investment in academic health.*
    - *It should be clear whether the funding requested will be used to backfill current deficiencies in clinical revenue that are necessary to stabilize UMN’s training and research missions, or whether the funding will be used to further advance or innovate training, research – and thus, clinical care – to meet emerging and future needs. State funding should not be used to cover clinical revenue deficits, as this is the responsibility of the business partners to resolve.*
- *The goals and outcomes to be achieved with the funding, including performance measures for accountability, and how those outcomes are aligned to State goals for population health improvement.*
- *The specific strategies or programs to be funded, including transparent accountability mechanisms for monitoring, evaluating, and reporting on implementation progress.*

Percent of Task Force completely or mostly in support: 93%

The Task Force understands that, once approved by the Board of Regents, the University plans to seek additional public investment in its Health Sciences Programs. This recommendation outlines the expectations that the Governor and Legislature should have when assessing such a request. There is likely a need for the University, Governor’s Office, and Legislature to collaborate on identifying the specific goals and outcomes that are aligned to State goals for health improvement.

One Task Force member did not completely or mostly support this recommendation. While they said this is a good practice, the recommendation is overly prescriptive and may set a higher bar for UMN Health Sciences than required for other entities.

5. Contingencies for legislative approval of increased public investment

Recommendation: *It is likely UMN will request and require additional public investment to stabilize, and ultimately advance, its Health Sciences programs. Before approving new appropriation(s), the Legislature should ensure:*

- *UMN complies with recommendation #4 (above).*
- *UMN and Fairview Health have finalized a new partnership agreement that transparently articulates the funds flow of clinical revenues to training and research, and that includes shared goals and accountability mechanisms around the intertwining missions of training, research, and clinical care.*
- *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 #2 (above);*
- *The additional funding will be used to advance recruitment from, and training for, health professionals in Greater Minnesota and from underserved communities in metropolitan areas;*

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, such as through the joint legislative committee established under recommendation #6 (below).

Percent of Task Force completely or mostly in support: 93%

As noted above, the Task Force understands that, once approved by the Board of Regents, the University plans to seek additional public investment in its Health Sciences Programs. This recommendation outlines expectations regarding the type of preliminary actions or planning that the Legislature should look for in such a future request. The Task Force has emphasized the importance of interdisciplinary planning across the six health sciences schools, finalizing the UMN and Fairview agreement, alignment with Minnesota's needs and goals for health improvement, and accountability for results.

One Task Force member who was not completely or mostly supportive of this recommendation noted that labor unions would need recommendations #9 and #15 to also be implemented, in order to support further public investment for UMN academic health.

6. Legislative oversight of UMN appropriations

Recommendation: *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 distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.*

Percent of Task Force completely or mostly in support: 87%

This recommendation acknowledges that multiple Legislative committees and state agencies play a part in the appropriations and oversight of funding to UMN broadly, not just to the Health Sciences Programs, and it recommends a new mechanism to provide more transparent oversight and accountability over the totality of public funding that does, or could, support academic health.

The two Task Force members who did not completely or mostly support this recommendation indicated that this would be an unnecessary layer of government oversight and that this recommendation is beyond the Task Force's scope.

7. Advancement of UMN's Five-Point plan

Recommendation: *The Task Force endorses an effort commencing in 2024 to ensure that the Minnesota Academic Health System has plans and adequate financial support for facilities and equipment/technology required to meet the current and emerging needs of Minnesotans served by our healthcare ecosystem. The State of Minnesota can acknowledge the University's Five-point plan for its Academic Health System's facilities: (1) implementation of a world-class academic health system at the University; (2) university governance and control of the UMMC; (3) partnerships with health systems throughout Minnesota; (4) new state-of-the-art facilities; and (5) investment in current facilities/equipment of the UMMC.*

State support should include immediate advancement of those plans in the following ways:

- *State support to improve and expand the physical infrastructure and equipment of UMMC and other publicly-funded health care facilities for near-term use. The East Bank and West Bank Hospitals, and the equipment within, as part of the UMMC are overdue for upgrades. A UMMC capital investment fund would begin in 2024 and continue thereafter as needed. This request requires the University and Fairview to reach an agreement about ownership of the UMMC.*
- *Implementation of a capacity and feasibility study in 2024 to be completed by December 31, 2024. The study should assess and determine healthcare facilities needs that will require public funding in the next five years. This includes Task Force support of an effort to encourage heightened levels of public partnerships, with potential to leverage federal, state, local and philanthropic dollars. As the transformation of health care service delivery continues, the public systems can lead the way in ensuring optimal collaborations for facilities.*
- *Initiate a future facility fund in 2024 that will build toward the next generation of world-class facilities. This could be done through bonding, or by defining a new public health district with local, state and federal partners. The future facility fund would begin in 2024 and continue as needed.*

Percent of Task Force completely or mostly in support: 67%

This is the first of three recommendations brought forward by the University in early January for Task Force consideration. The second bullet regarding a capacity and feasibility study is similar to recommendation #3 above, but this recommendation also requests state support to address capital improvement needs at UMMC, as well as beginning to initiate a future facility fund. The Task Force heard from representatives of UMN that the current UMMC facilities are "embarrassing," as described by Dean Jakob Tolar, which is already impacting the University's ability to recruit and retain top faculty and students, which then impacts its ability to produce high-quality research and advance quality clinical care.

There were five Task Force members who were not completely or mostly supportive of this recommendation. Four of these members noted the need to complete the needs assessment described in recommendation #3 before committing public funding to UMMC capital investments or a future facility fund. Two members also indicated that while they may be supportive of part(s) of the recommendation, they were not supportive of it in

total. Lastly, one member again noted that labor unions would need recommendations #9 and #15 to also be implemented, in order to support further public investment for UMN academic health.

8. Planning for new state-of-the-art academic health facilities

Recommendation: *The Task Force supports planning for new state-of-the-art academic health facilities that will support interprofessional training and integration of the research mission, as part of the University's five-point plan for its vision of the future Academic Health System. The University will begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University. The long-term plan for a new hospital will be informed by the feasibility study completed in 2024.*

Percent of Task Force completely or mostly in support: 67%

This is the second of three recommendations brought forward by the University in early January for Task Force consideration. The recommendation asks only for support for UMN to begin planning for new health facilities as part of its five-point plan for a future AHS, not for public funding at this time.

There were five Task Force members who were not completely or mostly supportive of this recommendation. Like recommendation #7, two members said that the needs assessment (recommendation #3) should be completed first or that this recommendation assumes the results of such as assessment. One member said it was difficult to support this recommendation without knowing the results of negotiations between UMN and Fairview (Fairview currently owns UMMC). Two members support part, but not all, of the recommendation's wording, particularly the reference to UMMC being "owned and operated by the University."

9. Impact of facility ownership or governance changes on labor agreements

Recommendation: *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.*

Percent of Task Force completely or mostly in support: 53%

This recommendation acknowledges that current labor agreements for staff of M Health Fairview have been bargained with Fairview, and that should ownership of current facilities change, workers want assurance that their negotiated benefits, particularly related to pensions, will be honored. This includes bargaining units representing members of MMA, SEIU, and AFSCME.

There were six Task Force members who did not completely or mostly support this recommendation. Generally, their reservations were due to feeling that it was beyond the Task Force's scope or purview to make recommendations about labor agreements.

10. New annual direct state support for next-generation framework for access to care

Recommendation: *The Task Force supports the University's request for direct state support of $80 million annually to the University to fund the establishment and implementation of this next-generation framework for*

Minnesotans' access to care: Minnesota's Academic Health System. The University's request to the Legislature is subject to Board of Regent approval.

Specifically, the University has proposed the following areas of investment:

- *3 to 4 new Medical Discovery teams - $25 million/year*
  - *Mental health, infectious disease, cancer, cardiovascular programs, population health. This includes faculty/physician/interdisciplinary recruitments in key areas for Minnesota.*
  - *The outcomes of this investment will be new multidisciplinary faculty and discovery in key areas impacting health and health care in Minnesota. The ultimate impact will be new cures and treatments, delivered by world-class providers, and new training and research opportunities for Minnesota students.*
- *Invest in sustainability and access to underserved communities - $20 million/year*
  - *Community University Hospital Clinic (CUHCC), mobile health partnership with Hennepin County, University and UMP primary care clinics.*
  - *The outcomes will be more patients served in underserved areas in culturally appropriate ways, more students trained in primary care and health equity.*
- *Primary care transformation - $10 million/year*
  - *E-consults (or online medical consultation, typically where a primary care provider seeks a specialist's expert opinion about the appropriate diagnosis or treatment for a patient), transition from primary to specialty and back, build physician networks, continuing medical education, advanced telehealth.*
  - *The outcome is better access to primary care around the state, better support for physicians in rural and underserved communities, access to specialists for more patients.*
- *Workforce development $15 million/year*
  - *The University's six science programs can provide unique opportunities to develop and expand workforce development opportunities for additional medical student slots, new programming in high need areas such as mental health, respiratory therapy, advanced dental therapy program, expand addiction fellowship, addiction/mental health "track" in residencies, pathways/partnerships for high need professions such as nursing with Minnesota State and private colleges.*
  - *The outcome will be more physicians and other professionals, specifics developed with the state and Minnesota State to identify high needs and targets.*
- *New care model design - Center for Learning Health Systems expansion - $5 million/year*
  - *The outcomes will be better outcomes, cost efficiencies and the ability to share best practices in health care delivery across health systems.*
- *All systems innovation opportunities: rural health clinical trials network, pre-hospital care network - $5 million/year*
  - *Targeted, collaborative efforts to solve specific health challenges.*
  - *The outcomes will be innovative approaches to shared challenges.*

As these proposals underscore, this is our opportunity to advance these priorities, and Minnesota having a vibrant, mission-driven University health system is what provides the means to allow the State to turn these public priorities into action. Our public health is in the balance.

Percent of Task Force completely or mostly in support: 47%

This is the third of three recommendations brought forward by the University in early January for Task Force consideration. The recommendation outlines how an additional $80 million that UMN plans to request from the Legislature (presuming approval by the Board of Regents) to support their five-point plan would be spent, in alignment with the issues raised by the Executive Order and the Task Force regarding needs related to innovative care delivery, interdisciplinary training, workforce development, primary care, and access for rural and underserved communities.

Eight Task Force members did not completely or mostly support this recommendation. Their reservations included concerns about recommending a specific dollar amount without more transparent understanding of funds flow from Fairview to UMN, or without additional detail and context for how the funds would be used. One member suggested making the primary care transformation effort a competitive process, rather than allocating those funds directly to the University. Another member said this request should be contingent on recommendation #3 being fulfilled, and that the appropriations should be for a limited time pending an evaluation of outcomes, not automatically ongoing funding.

Recommendations related to workforce planning and development

11. Comprehensive health professions workforce planning

Recommendation*: 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, nursing, and dental providers in Greater Minnesota.*

Percent of Task Force completely or mostly in support: 80%

The Task Force acknowledges that there is a current health care workforce crisis that is only projected to get worse, and also acknowledges that it is beyond this Task Force's scope or timeline to make satisfactory recommendations for exactly how to address the growing crisis. This recommendation instead asks the Governor and Legislature to request and fund the development of a comprehensive health professions workforce plan. No such plan currently exists and is urgently needed to coordinate efforts across multiple agencies and organizations. The University of Minnesota is poised to be an important voice in that conversation.

Three Task Force members were not completely or mostly in support of this recommendation. Feedback from one of these members said that additional studies or plans are not necessary, and that the Legislature can make decisions based on other input provided by the University. Another said that we need to first understand what work has already done, so as not to be duplicative, and that maldistribution impacts more than Greater Minnesota.

12. Advisory body for interprofessional training and clinical practice

Recommendation: *Establish 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.*

Based on those recommendations, provide financial support to expand interprofessional clinical training and care delivery.

Percent of Task Force completely or mostly in support: 80%

Like recommendation #11, this recommendation acknowledges that expanding interdisciplinary training at UMN and beyond is an important step to increase the number and quality of our health care workforce, but that this Task Force cannot weigh in more specifically on how to move forward or how much funding might be required. Instead, this recommendation is for the creation of a new advisory body that would include the University of Minnesota as an essential player, to make recommendations for increasing interprofessional training and clinical practice.

Three Task Force members were not completely or mostly in support of this recommendation. Two said that this advisory body would be unnecessary, and the other said this work is important but should not be a key recommendation from the Task Force.

13. Increasing funding for effective workforce development strategies

Recommendation: *Increase funding for effective strategies to diversify and 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.*

Percent of Task Force completely or mostly in support: 80%

As said previously, there is a growing health care workforce crisis, and multiple efforts will be required to address it. This recommendation provides suggestions for ways to use additional public funding to diversify and fill current and future gaps in the workforce.

Three Task Force members were not completely or mostly in support of this recommendation. One indicated they would only support this recommendation if recommendation #15 was also implemented. Another said that these are interesting tactics but should not be a key recommendation from the Task Force. Finally, one said that there is never enough funding and this recommendation is not specific enough to be helpful.

14. Using workforce data to coordinate and plan future investments

Recommendation: *Build on existing collaborative efforts between UMN and other entities by establishing or identifying 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, with particular focus on critical areas of need within Minnesota.*

Percent of Task Force completely or mostly in support: 60%

The Task Force was only able to spend limited time reviewing the extensive data and reports that exist on the current successes and challenges facing the health care workforce. While recommendation #11 calls for the development of a one-time comprehensive workforce plan, this recommendation would establish an on-going coordinating and planning body to guide future investments in the health care workforce. The Office of Higher Education and MDH confirmed there is currently no such coordination across multiple data sources.

Six Task Force members were not completely or mostly in support of this recommendation. One said the recommendation is too vague, another that these efforts already exist, and another that they wanted to understand how this would fit within current governance structures. Finally, one expressed concern about who would establish it, and another wondered whether this entity would advise or regulate, with a hope expressed that it would be an advisory body.

15. Employer accountability for labor standards

Recommendation: *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.*

Percent of Task Force completely or mostly in support: 27%

Although federal and state law protects workers’ right to form a union, there was a concern brought to the Task Force by one member regarding employers’ stance toward new labor union formation in practice. This recommendation is intended to further strengthen workers’ safe ability to unionize.

There were 11 Task Force members who were not completely or mostly in support of this recommendation. These members’ reservations were mostly due to feeling that making recommendation regarding labor agreements is beyond the Task Force’s purview.

Recommendations related to increasing collaboration and coordination

16. Multi-system integration

Recommendation: *Assess the feasibility of multi-system integration between UMN and other health entities that both train a significant number of health professionals and are part of the publicly supported safety net to align resources and a shared commitment to the public good, and 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 ultimate goal is the creation of a more sustainable and resilient academic healthcare system, ultimately benefiting the public by maximizing the impact of available resources.

Percent of Task Force completely or mostly in support: 93%

As was described previously in this report, the Task Force faced a tension between making short-term recommendations that can immediately help stabilize UMN and position it for future growth and innovation around academic health, and making recommendations that would shift Minnesota toward a new vision for health and health care. This recommendation would move more toward a new, longer-term vision for multi-system integration across the state for health professions training, research, and care delivery.

Although one member was not supportive of this recommendation, there are no reservations or suggested changes to share as a result.

17. Broader relationships and coordination across systems

Recommendation: *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 other health systems, such as the Mayo Clinic.*

Percent of Task Force completely or mostly in support: 80%

Like recommendation #16, this recommendation is intended to take steps toward a new, longer-term vision for health and health care in Minnesota, and acknowledging UMN's importance within the larger system.

Three Task Force members were not completely or mostly in support of this recommendation. Two suggested that recommendations #16 and #17 should be combined, as they are seen as similar or overlapping. One

member was uncomfortable with referencing the Mayo Clinic by name. One member was concerned with the second bullet point regarding "rationalizing tertiary and quaternary clinical capacity," and wondered what definitions of primary, secondary, tertiary, and quaternary care are being used.

18. Statewide access to UMN academic library services

Recommendation: *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.*

Percent of Task Force completely or mostly in support: 73%

This recommendation is posed as one way to share services and reduce burdens on the system, but it also recommends that the Legislature consider other similar opportunities.

Four Task Force members were not completely or mostly in support of this recommendation, noting that this should come at a later phase or that it should not be a key recommendation from the Task Force. One member wondered why the academic library wouldn't already be a public resource or whether it's appropriate that connections are paid for with public funding.

Recommendations related to funding to support academic health

19. Maximizing use of Medicaid funding

Recommendation: *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;*
- *exploring expanded use of intergovernmental transfers and direct payments, where allowable, to support clinical training sites; and*
- *establishing clarity of MERC funds flow within the health systems.*

Percent of Task Force completely or mostly in support: 93%

Task Force members referenced several times that increasing Medicaid rates would help level out differences in payer sources (low government vs. higher commercial reimbursement rates) and bring more federal matching funds to the state, while acknowledging the challenge in finding new state funds to do so.

Although one member was only somewhat supportive of this recommendation, there are no reservations or suggested changes to share as a result.

20. Broaden funding base for health professions training

Recommendation: *Consider additional ways to increase financial support for health professions training and to broaden the funding base, such as modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax.*

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

Percent of Task Force completely or mostly in support: 33%

As described elsewhere, the current funding structure and mechanisms for health professions training is not meeting current needs and is not designed to address our future needs. There was broad support among the Task Force for diversification of the funding base for health professions training, but disagreement about how to achieve that result.

Ten Task Force members were not completely or mostly in support of this recommendation. Their concerns were related to the potential consequences of modifying the current provider tax or use of the provider tax, especially given the current financial conditions facing the health systems, in particular.

Conclusion

We hope that our framing of these issues and recommendations is helpful to our state's policymakers and to the University. Clearly, this report is just one phase of what must be ongoing work.

The task force does agree that increased and broadened funding support is needed for a robust academic health enterprise, so that academic health can help produce better health outcomes in a higher performing health care system for Minnesota. However the financial dimensions and the best sources of that support are not yet clear. Much will depend on what changes in the resolution of the UMN/Fairview partnership. And much will depend on whether and what new models of collaboration and partnership in training, research and care delivery can be forged across health systems.

Two recommendations on financing call for maximizing Medicaid funding and tapping new sources of revenue for academic health. The feasibility of those recommendations will depend on finding savings within the Medicaid system to redirect to improved reimbursement rates, and on building consensus for other revenue sources.

We are on the precipice of, if not already in, a health care workforce crisis. This is not something that UMN's Health Sciences Programs can solve alone, even with state-of-the-art facilities or innovative interdisciplinary training. The Task Force's discussions, problem statements, and recommendations reflect the fact that health care delivery is changing—and that the way we recruit, train, and develop health care workers must change to meet current and future needs, including what types of professions or credentials are most needed. A comprehensive state plan is currently lacking, and more coordination among agencies and entities working on this problem is needed, alongside increased collaboration by UMN and other educational providers.

While the task force members have brought expertise and a variety of perspectives to this table, a broader and deeper set of conversations is needed among leaders in the health and educational sectors in order to explore new partnership opportunities and revenue sources.

We also knew from the start that our discussions would raise many issues outside the scope of this Task Force but that are highly relevant to the future of health and health care in Minnesota. Fundamental transformation is needed in the way health care is financed, delivered, and accessed in the nation and the state. While some innovations are happening, the macro indicators are not good, and the pace of change needs to accelerate. The

current non-system in the U.S. is highly fragmented, much more costly and delivers lower health outcomes compared to peer nations. Incentives in clinical care financing skew strongly toward highly specialized and procedure-based services and away from prevention, primary care, and mental health. Both providers and patients are increasingly stressed and dissatisfied with the status quo. Despite spending more than twice on health care as much as any other country, the U.S. has actually fallen and continues to fall in international rankings on many measures of population health including average life expectancy. While Minnesota fares better than most US states on many measures, it still would not rank favorably against peer nations. And while Minnesotans are among the healthiest in the nation on average, but we also have some of the greatest gaps in health status between different groups within the population. We have one of the highest rates of insurance coverage in the nation, yet our out-of-pocket costs are also some of the highest. There have been many past commissions and task forces on health care access and health care financing, and they have generated many good ideas that have never been fully implemented. Perhaps it is time to revisit and refresh some of Minnesota’s “big ideas” on these issues.

At the same time, the health and health care sector is a huge positive economic force in our state, and it’s important to continue to build on that advantage. A task force of business and policy leaders could help to make sure Minnesota continues to lead in this regard as well.

Appendix A: Governor's Task Force on Academic Health at the University of Minnesota process and membership

Purpose and scope

Governor Tim Walz established the Governor's Task Force on Academic Health at the University of Minnesota (hereafter "Task Force") through Executive Order 23-09 which was signed August 10, 2023.

The Task Force's purpose was to develop recommendations to support world-class academic health professions education, research, and care delivery by the University of Minnesota's Health Sciences Programs ("Health Sciences Programs") that advance equity, center primary care, and ensure that Minnesotans can continue to receive the highest-quality care in a financially sustainable way. The Executive Order required the Task Force to provide a written summary of recommendations to the Governor for state policy and legislative changes.

To achieve its intended purpose, the Task Force was asked to:

- Review examples from other states to identify options for potential public funding of academic health and for partnerships (financial and clinical) with non-academic health systems.
- Consider collaborative financial support and partnership models for academic health that recognize both the costs of, and benefits to, health professions education for Minnesota patients, health care systems, and residents.
- Examine potential options for governance and oversight of any publicly funded health professions education at the Health Sciences Programs.
- Discuss short-, medium-, and long-term funding needs to support the vision for academic health and the role of the State of Minnesota and various clinical partners in meeting these funding needs.
- Develop goals and expectations for academic health performance related to equity, workforce diversity, geographic accessibility, and primary care and prevention that align with One Minnesota goals for Minnesota health care.

Membership and process

Executive Order 23-09 identified the Task Force's membership as:

- One member of the Minnesota House of Representatives, appointed by the Speaker of the House;
- One member of the Minnesota Senate, appointed by the Majority Leader of the Senate;
- One representative from the Minnesota Department of Health (MDH);
- One representative from the Office of Higher Education (OHE);
- Two members representation the University of Minnesota, including one representing the University of Minnesota Medical School, appointed by the Governor;
- Two members with expertise in health professions education or health care workforce issues, appointed by the Governor;

- Two members with expertise in delivering primary care or care in rural areas, appointed by the Governor;
- Two members with expertise in hospital or health system finances, state/federal health care reimbursement issues, health care spending, or health economics, appointed by the Governor; and
- Two members with expertise in health disparities or health equity, particularly as they relate to health professions education and access to health care.

The process of selecting members for the Task Force was overseen by the Minnesota Secretary of State's office through their Boards and Commissions Open Appointments process. The application process opened on August 11, 2023, and closed on September 21, with the official appointment of members. Interest in participating in the Task Force far outstripped the number of available seats. A total of 76 individuals applied for 10 open slots, with the remaining five seats (MDH and OHE representatives, House and Senate representatives, and chair) appointed directly by either the Governor's Office, the House of Representatives, the Minnesota Senate, or a state agency.

Governor Walz designated Jan Malcolm, former MDH Commissioner, to act as Chair of the Task Force. Former Governors Mark Dayton (2011-2018) and Tim Pawlenty (2003-2010) served as Special Advisors.

The Task Force met nine times between October 2023 and January 2024. Each meeting was three hours long. Meetings were held in-person with a remote participation option for members, were open to the public, and time was dedicated at most meetings for public comment. The meetings were facilitated by Chair Malcolm, with support from MDH staff, who also assisted with drafting and revising this report. MDH provided administrative support and coordinated meeting space and logistics.

Speakers, panelists, and Task Force member expertise were used at meetings to ground members in a common understanding of:

- the purpose and duties of the Task Force,
- the current state of health care training and workforce needs,
- the University of Minnesota's Health Sciences Programs and future vision for academic health,
- learnings from other fiscal/clinical partnership models, and
- funding and revenue issues for academic health programs and health care generally.

The scope of the Task Force's work was not intended to include consideration of, nor recommendations regarding, negotiations of the private business relationship between the University of Minnesota and Fairview Health Services ("Fairview"), the University's current primary health system partner. However, since the Task Force was asked to review examples from other states and consider partnership models for academic health, it was necessary for the Task Force to hear, both at meetings and in writing, from the University and Fairview on their current partnership model and the progress of negotiating a new partnership agreement. The challenges of achieving the purpose of the Task Force while the University and Fairview were conducting closed negotiations of a future partnership are described more in the next section of this report.

As the meetings progressed, Task Force members worked to refine and come to consensus on a set of problem statements to frame their recommendations. Starting in December, the Task Force began to develop and refine

recommendations based on the problem statements. The problem statements and recommendations are provided further below in this report.

Members of the Task Force

Chairperson: Jan Malcolm

Member representing the Minnesota Department of Health: Carol Backstrom

Member representing the Minnesota Office of Higher Education: Dennis Olson

Member representing the Minnesota Senate: Melissa Wiklund – Bloomington

Member representing the Minnesota House of Representatives: Tina Liebling – Rochester

Members representing the University of Minnesota of Minnesota:

- Jakub Tolar
- Penny Wheeler

Members with expertise in delivering primary care or care in rural areas:

- David Herman
- Meghan Walsh

Members with expertise in health disparities and health equity, particularly as they relate to health professions education and access to health care:

- Pahoua Hoffman
- Julia Joseph-Di Caprio

Members with expertise in health professions education and health care workforce issues:

- Brenda Hilbrich
- Connie Delaney

Members with expertise in hospital or health system finances, state/federal health care reimbursement issues, health care spending, or health economics:

- Barbara Joers
- Vance Opperman

Special Advisors:

- Mark Dayton – Minnesota Governor (2011-2018)
- Tim Pawlenty – Minnesota Governor (2003-2010)

Appendix B: Recommendation tables

The following tables present the twenty recommendations from the Task Force organized in multiple ways, including organized in:

- Descending order based on percent of "completely support"
- Descending order based on percent of "completely support" combined with "mostly support"
- Descending order based on percent of "completely support" for each responsible party
- Descending order based on priority for each responsible party

Please note: The full recommendation text may not be provided in the tables. Refer to Appendix C or the body of the report for full recommendation text.

Table 1. Descending order based on percent of Task Force who "completely support"

Percent completely support	Number	Recommendation	Responsible party/ies	Priority
87%	4	Any request for additional public funding for UMN Health Sciences must first be approved by the Board of Regents and communicated to the Governor and Legislature as one of UMN's highest priorities, if not the highest. …	UMN	High
73%	2	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 clinical 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: …	UMN	High
73%	17	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: …	UMN, Health Systems	Med-High
67%	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.	UMN, Fairview, UMP	High

Percent completely support	Number	Recommendation	Responsible party/ies	Priority
67%	6	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 distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.	Legislature	Med-High
67%	11	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, nursing, and dental providers in Greater Minnesota.	Legislature	High
67%	18	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.	Legislature	Medium
67%	19	Maximize use of Medicaid funding to support health professions education, by: …	Legislature	High
53%	5	It is likely UMN will request and require additional public investment to stabilize, and ultimately advance, its Health Sciences programs. Before approving new appropriation(s), the Legislature should ensure: …	Legislature	Med-High
53%	14	Build on existing collaborative efforts between UMN and other entities by establishing or identifying 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, with particular focus on critical areas of need within Minnesota.	Legislature	High
53%	16	Assess the feasibility of multi-system integration between UMN and other health entities that both train a significant number of health professionals and are part of the publicly supported safety net to align resources and a shared commitment to the public good, and benefit our State towards: …	UMN	Med-High
47%	12	Establish 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.	Legislature	Medium

Percent completely support	Number	Recommendation	Responsible party/ies	Priority
40%	8	The Task Force supports planning for new state-of-the-art academic health facilities that will support interprofessional training and integration of the research mission, as part of the University's five-point plan for its vision of the future Academic Health System. The University will begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University. The long-term plan for a new hospital will be informed by the feasibility study completed in 2024.	UMN	Medium
40%	13	Increase funding for effective strategies to diversify and fill current and future gaps in the health care workforce, such as: …	Legislature	High
27%	3	Request and fund a comprehensive needs assessment of health system facilities and infrastructure 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.	Legislature, UMN	Med-High
27%	7	The Task Force endorses an effort commencing in 2024 to ensure that the Minnesota Academic Health System has plans and adequate financial support for facilities and equipment/technology required to meet the current and emerging needs of Minnesotans served by our healthcare ecosystem. The State of Minnesota can acknowledge the University's Five point plan for its Academic Health System's facilities: (1) implementation of a world-class academic health system at the University; (2) university governance and control of the UMMC; (3) partnerships with health systems throughout Minnesota; (4) new state-of-the-art facilities; and (5) investment in current facilities/equipment of the UMMC. …	Legislature, UMN	High
27%	9	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.	UMN, Fairview, UMP	Med-High
20%	10	The Task Force supports the University's request for direct state support of $80 million annually to the University to fund the establishment and implementation of this next-generation framework for Minnesotans' access to care: Minnesota's Academic Health System. The University's request to the Legislature is subject to Board of Regent approval. Specifically, the University has proposed the following areas of investment: …	Legislature	Med-High
20%	15	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.	Legislature	Med-Low

Percent completely support	Number	Recommendation	Responsible party/ies	Priority
20%	20	Consider additional ways to increase financial support for health professions training and to broaden the funding base, such as modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax. …	Legislature	Medium

Table 2. Descending order based on percent of Task Force who "completely support" combined with "mostly support"

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
100%	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.	UMN, Fairview, UMP	High
100%	2	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 clinical 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: …	UMN	High
100%	3	Request and fund a comprehensive needs assessment of health system facilities and infrastructure 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.	Legislature, UMN	Med-High
93%	4	Any request for additional public funding for UMN Health Sciences must first be approved by the Board of Regents and communicated to the Governor and Legislature as one of UMN's highest priorities, if not the highest. …	UMN	High
93%	5	It is likely UMN will request and require additional public investment to stabilize, and ultimately advance, its Health Sciences programs. Before approving new appropriation(s), the Legislature should ensure: …	Legislature	Med-High
93%	16	Assess the feasibility of multi-system integration between UMN and other health entities that both train a significant number of health professionals and are part of the publicly supported safety net to align resources and a shared commitment to the public good, and benefit our State towards: …	UMN	Med-High
93%	19	Maximize use of Medicaid funding to support health professions education, by: …	Legislature	High

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
87%	6	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 distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.	Legislature	Med-High
80%	11	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, nursing, and dental providers in Greater Minnesota.	Legislature	High
80%	12	Establish 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.	Legislature	Medium
80%	13	Increase funding for effective strategies to diversify and fill current and future gaps in the health care workforce, such as: …	Legislature	High
80%	17	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: …	UMN, Health Systems	Med-High
73%	18	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.	Legislature	Medium

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
67%	7	The Task Force endorses an effort commencing in 2024 to ensure that the Minnesota Academic Health System has plans and adequate financial support for facilities and equipment/technology required to meet the current and emerging needs of Minnesotans served by our healthcare ecosystem. The State of Minnesota can acknowledge the University's Five point plan for its Academic Health System's facilities: (1) implementation of a world-class academic health system at the University; (2) university governance and control of the UMMC; (3) partnerships with health systems throughout Minnesota; (4) new state-of-the-art facilities; and (5) investment in current facilities/equipment of the UMMC. …	Legislature, UMN	High
67%	8	The Task Force supports planning for new state-of-the-art academic health facilities that will support interprofessional training and integration of the research mission, as part of the University's five-point plan for its vision of the future Academic Health System. The University will begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University. The long-term plan for a new hospital will be informed by the feasibility study completed in 2024.	UMN	Medium
60%	14	Build on existing collaborative efforts between UMN and other entities by establishing or identifying 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, with particular focus on critical areas of need within Minnesota.	Legislature	High
53%	9	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.	UMN, Fairview, UMP	Med-High
47%	10	The Task Force supports the University's request for direct state support of $80 million annually to the University to fund the establishment and implementation of this next-generation framework for Minnesotans' access to care: Minnesota's Academic Health System. The University's request to the Legislature is subject to Board of Regent approval. Specifically, the University has proposed the following areas of investment: …	Legislature	Med-High
33%	20	Consider additional ways to increase financial support for health professions training and to broaden the funding base, such as modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax. …	Legislature	Medium

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
27%	15	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.	Legislature	Med-Low

Table 3. For each responsible party, descending order based on percent of Task Force who "completely support" combined with "mostly support"

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
93%	5	It is likely UMN will request and require additional public investment to stabilize, and ultimately advance, its Health Sciences programs. Before approving new appropriation(s), the Legislature should ensure: …	Legislature	Med-High
93%	19	Maximize use of Medicaid funding to support health professions education, by: …	Legislature	High
87%	6	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 distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.	Legislature	Med-High
80%	11	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, nursing, and dental providers in Greater Minnesota.	Legislature	High
80%	12	Establish 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.	Legislature	Medium
80%	13	Increase funding for effective strategies to diversify and fill current and future gaps in the health care workforce, such as: …	Legislature	High
73%	18	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.	Legislature	Medium

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
60%	14	Build on existing collaborative efforts between UMN and other entities by establishing or identifying 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, with particular focus on critical areas of need within Minnesota.	Legislature	High
47%	10	The Task Force supports the University's request for direct state support of $80 million annually to the University to fund the establishment and implementation of this next-generation framework for Minnesotans' access to care: Minnesota's Academic Health System. The University's request to the Legislature is subject to Board of Regent approval. Specifically, the University has proposed the following areas of investment: …	Legislature	Med-High
33%	20	Consider additional ways to increase financial support for health professions training and to broaden the funding base, such as modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax.	Legislature	Medium
27%	15	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.	Legislature	Med-Low
100%	3	Request and fund a comprehensive needs assessment of health system facilities and infrastructure 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.	Legislature, UMN	Med-High
67%	7	The Task Force endorses an effort commencing in 2024 to ensure that the Minnesota Academic Health System has plans and adequate financial support for facilities and equipment/technology required to meet the current and emerging needs of Minnesotans served by our healthcare ecosystem. The State of Minnesota can acknowledge the University's Five point plan for its Academic Health System's facilities: (1) implementation of a world-class academic health system at the University; (2) university governance and control of the UMMC; (3) partnerships with health systems throughout Minnesota; (4) new state-of-the-art facilities; and (5) investment in current facilities/equipment of the UMMC. …	Legislature, UMN	High

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
100%	2	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 clinical 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: …	UMN	High
93%	4	Any request for additional public funding for UMN Health Sciences must first be approved by the Board of Regents and communicated to the Governor and Legislature as one of UMN's highest priorities, if not the highest.	UMN	High
93%	16	Assess the feasibility of multi-system integration between UMN and other health entities that both train a significant number of health professionals and are part of the publicly supported safety net to align resources and a shared commitment to the public good, and benefit our State towards: …	UMN	Med-High
67%	8	The Task Force supports planning for new state-of-the-art academic health facilities that will support interprofessional training and integration of the research mission, as part of the University's five-point plan for its vision of the future Academic Health System. The University will begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University. The long-term plan for a new hospital will be informed by the feasibility study completed in 2024.	UMN	Medium
100%	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.	UMN, Fairview, UMP	High
53%	9	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.	UMN, Fairview, UMP	Med-High
80%	17	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: …	UMN, Health Systems	Med-High

Table 4. For each responsible party, descending order based on priority

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
80%	11	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, nursing, and dental providers in Greater Minnesota.	Legislature	High
80%	13	Increase funding for effective strategies to diversify and fill current and future gaps in the health care workforce, such as: …	Legislature	High
60%	14	Build on existing collaborative efforts between UMN and other entities by establishing or identifying 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, with particular focus on critical areas of need within Minnesota.	Legislature	High
93%	19	Maximize use of Medicaid funding to support health professions education, by: …	Legislature	High
93%	5	It is likely UMN will request and require additional public investment to stabilize, and ultimately advance, its Health Sciences programs. Before approving new appropriation(s), the Legislature should ensure:	Legislature	Med-High
87%	6	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 distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.	Legislature	Med-High
47%	10	The Task Force supports the University's request for direct state support of $80 million annually to the University to fund the establishment and implementation of this next-generation framework for Minnesotans' access to care: Minnesota's Academic Health System. The University's request to the Legislature is subject to Board of Regent approval. Specifically, the University has proposed the following areas of investment: …	Legislature	Med-High

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
80%	12	Establish 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.	Legislature	Medium
73%	18	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.	Legislature	Medium
33%	20	Consider additional ways to increase financial support for health professions training and to broaden the funding base, such as modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax.	Legislature	Medium
27%	15	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.	Legislature	Med-Low
67%	7	The Task Force endorses an effort commencing in 2024 to ensure that the Minnesota Academic Health System has plans and adequate financial support for facilities and equipment/technology required to meet the current and emerging needs of Minnesotans served by our healthcare ecosystem. The State of Minnesota can acknowledge the University’s Five point plan for its Academic Health System’s facilities: (1) implementation of a world-class academic health system at the University; (2) university governance and control of the UMMC; (3) partnerships with health systems throughout Minnesota; (4) new state-of-the-art facilities; and (5) investment in current facilities/equipment of the UMMC. …	Legislature, UMN	High
100%	3	Request and fund a comprehensive needs assessment of health system facilities and infrastructure 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.	Legislature, UMN	Med-High
100%	2	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 clinical 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: …	UMN	High

Percent completely or mostly support	Number	Recommendation	Responsible party/ies	Priority
93%	4	Any request for additional public funding for UMN Health Sciences must first be approved by the Board of Regents and communicated to the Governor and Legislature as one of UMN's highest priorities, if not the highest. …	UMN	High
93%	16	Assess the feasibility of multi-system integration between UMN and other health entities that both train a significant number of health professionals and are part of the publicly supported safety net to align resources and a shared commitment to the public good, and benefit our State towards: …	UMN	Med-High
67%	8	The Task Force supports planning for new state-of-the-art academic health facilities that will support interprofessional training and integration of the research mission, as part of the University's five-point plan for its vision of the future Academic Health System. The University will begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University. The long-term plan for a new hospital will be informed by the feasibility study completed in 2024.	UMN	Medium
100%	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.	UMN, Fairview, UMP	High
53%	9	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.	UMN, Fairview, UMP	Med-High
80%	17	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: …	UMN, Health Systems	Med-High

Appendix C: Full recommendation voting results

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.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
10	**5**	**0**	**0**	**100%**
• 2 – State agencies • 2 – U of M • 2 – Educ/Workforce • 2 – Primary/Rural • 1 – Equity • 1 – Chair	• 2 – Finance/Econ • 2 – Leg • 1 – Equity			

Prioritization

High	Medium	Low
12	**0**	**0**

Reservations or suggested changes from members not completely or mostly in support:

All Task Force members completely or mostly supported this recommendation, so there are no reservations or suggested changes to share for this recommendation.

Recommendation 2

Develop a shared Health Sciences strategic plan for the six Health Professional Schools at UMN that includes goals and strategies to strengthen interprofessional learning and clinical 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.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
11	**4**	**0**	**0**	**100%**
• 2 – U of M • 2 – Primary/Rural • 2 – Leg • 1 – Equity • 1 – Finance/Econ • 1 – Educ/Workforce • 1 – State agencies • 1 – Chair	• 1 – State agencies • 1 – Finance/Econ • 1 – Equity • 1 – Educ/Workforce			

Prioritization

High	Medium	Low
9	**2**	**1**

Reservations or suggested changes from members not completely or mostly in support:

All Task Force members completely or mostly supported this recommendation, so there are no reservations or suggested changes to share for this recommendation.

Recommendation 3

Request and fund a comprehensive needs assessment of health system facilities and infrastructure 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.

Once completed and if supported by the results of the assessment, use the findings of the assessment to develop a prioritized bonding list to right-size and bring the physical infrastructure of UMMC and other public health system facilities into the 21st century, as well as to avoid waste and duplication of community assets, and to improve access and quality for Minnesotans.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
4	**11**	**0**	**0**	**100%**
• 2 – Leg • 1 – Educ/Workforce • 1 – Chair	• 2 – U of M • 2 – Equity • 2 – State agencies • 2 – Finance/Econ • 2 – Primary/Rural • 1 – Educ/Workforce			

Prioritization

High	Medium	Low
6	**4**	**2**

Reservations or suggested changes from members:

- This should be broken into two separate recommendations. If a comprehensive needs assessment of health system facilities is conducted, it should be done independently by MDH, and not UMN. This statement does not provide clarity on who would conduct the assessment. If this is conducted by MDH, it should include analysis of the state's current tertiary and quaternary clinical capacity across all hospitals and health systems to determine unmet needs, as well as excess capacity. For the second portion, why are only other "public" health system facilities included and not all health system facilities statewide? If a market feasibility study is done by UMN, it should be shared.

Recommendation 4

Any request for additional public funding for UMN Health Sciences must first be approved by the Board of Regents and communicated to the Governor and Legislature as one of UMN's highest priorities, if not the highest.

Any appropriations request should detail:

- *The specific dollar amount requested, including transparency around how that amount was calculated and funds flow analysis demonstrating why additional public funding, specifically, is necessary, including how UMN has already made internal budgeting decisions to shift or increase investment in academic health.*
    - *It should be clear whether the funding requested will be used to backfill current deficiencies in clinical revenue that are necessary to stabilize UMN's training and research missions, or whether the funding will be used to further advance or innovate training, research – and thus, clinical care – to meet emerging and future needs. State funding should not be used to cover clinical revenue deficits, as this is the responsibility of the business partners to resolve.*

- *The goals and outcomes to be achieved with the funding, including performance measures for accountability, and how those outcomes are aligned to State goals for population health improvement.*
- *The specific strategies or programs to be funded, including transparent accountability mechanisms for monitoring, evaluating, and reporting on implementation progress.*

Reservations or suggested changes from members not completely or mostly in support:

- This describes is good practice and would increase the likelihood of a success—especially the section about backfilling and not using state funds for clinical deficits. However, as written the recommendation is overly prescriptive, to the point of sounding patronizing, and may set a higher bar for UMN Health Sciences than is met by other entities.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
13	**1**	**1**	**0**	**93%**
• 2 – U of M • 2 – State agencies • 2 – Primary/Rural • 2 – Finance/Econ • 2 – Equity • 1 – Educ/Workforce • 1 – Leg • 1 – Chair	• 1 – Educ/Workforce	• 1 – Leg		

Prioritization

High	Medium	Low
9	**2**	**0**

Recommendation 5

It is likely UMN will request and require additional public investment to stabilize, and ultimately advance, its Health Sciences programs. Before approving new appropriation(s), the Legislature should ensure:

- *UMN complies with recommendation #3.*
- *UMN and Fairview Health have finalized a new partnership agreement that transparently articulates the funds flow of clinical revenues to training and research, and that includes shared goals and accountability mechanisms around the intertwining missions of training, research, and clinical care.*
- *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 #2;*

- *The additional funding will be used to advance recruitment from, and training for, health professionals in Greater Minnesota and from underserved communities in metropolitan areas;*
- *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, such as through the joint legislative committee established under recommendation #6.*

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
8	**6**	**1**	**0**	**93%**
• 2 – Equity • 1 – U of M • 1 – State agencies • 1 – Primary/Rural • 1 – Educ/Workforce • 1 – Leg • 1 – Chair	• 2 – Finance/Econ • 1 – State agencies • 1 – U of M • 1 – Primary/Rural • 1 – Leg	• 1 – Educ/Workforce		

Prioritization

High	Medium	Low
7	**3**	**1**

Reservations or suggested changes from members not completely or mostly in support:

- In general, we support investments in academic health and the incumbent workforce. Any additional funding for UMN Academic Health program must satisfy the concerns raised by incumbent workers that are addressed in Recommendation #9 (below). Without this we will be unable to support such a proposal and would encourage other labor unions to take a similar position. Depending on the form additional public investment takes, we would also need the concerns expressed by workers in Recommendation #15 (below) to be addressed.

Recommendation 6

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 distribution and impact of appropriated funding on advancing the University's mission and impact on health of Minnesotans.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
10	**3**	**2**	**0**	**87%**
• 2 – State agencies • 2 – Educ/Workforce • 2 – Leg • 1 – UMN • 1 – Finance/Econ • 1 – Primary/Rural • 1 – Chair	• 2 – Equity • 1 – Primary/Rural	• 1 – U of M • 1 – Finance/Econ		

Prioritization

High	Medium	Low
6	**2**	**3**

Reservations or suggested changes from members not completely or mostly in support:

- Do not need another layer of government oversight.
- This is the Legislature's jurisdiction to decide.

Recommendation 7

The Task Force endorses an effort commencing in 2024 to ensure that the Minnesota Academic Health System has plans and adequate financial support for facilities and equipment/technology required to meet the current and emerging needs of Minnesotans served by our healthcare ecosystem. The State of Minnesota can acknowledge the University's Five point plan for its Academic Health System's facilities: (1) implementation of a world-class academic health system at the University; (2) university governance and control of the UMMC; (3) partnerships with health systems throughout Minnesota; (4) new state-of-the-art facilities; and (5) investment in current facilities/equipment of the UMMC.

State support should include immediate advancement of those plans in the following ways:

- ***State support** to improve and expand the physical infrastructure and equipment of UMMC and other publicly-funded health care facilities for near-term use. The East Bank and West Bank Hospitals, and the equipment within, as part of the UMMC are overdue for upgrades. A UMMC capital investment fund would begin in 2024 and continue thereafter as needed. This request requires the University and Fairview to reach an agreement about ownership of the UMMC.*
- ***Implementation of a capacity and feasibility study in 2024** to be completed by December 31, 2024. The study should assess and determine healthcare facilities needs that will require public funding in the next five years. This includes Task Force support of an effort to encourage heightened levels of public partnerships, with potential to leverage federal, state, local and philanthropic dollars. As the*

transformation of health care service delivery continues, the public systems can lead the way in ensuring optimal collaborations for facilities.

- ***Initiate a future facility fund in 2024*** *that will build toward the next generation of world-class facilities. This could be done through bonding, or by defining a new public health district with local, state and federal partners. The future facility fund would begin in 2024 and continue as needed.*

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
4	**6**	**5**	**0**	**67%**
• 2 – UMN • 1 – Equity • 1 – Finance/Econ	• 2 – Legislature • 2 Primary/Rural • 1 – State agencies • 1 – Educ/Workforce	• 1 – Educ/Workforce • 1 – Finance/Econ • 1 – State agencies • 1 – Equity • 1 – Chair		

Prioritization

High	Medium	Low
5	**2**	**4**

Reservations or suggested changes from members not completely or mostly in support:

- Acknowledgment of the U's 5 point plan should not be interpreted as support for all of it. I do not support the first paragraph but am ok with the 3 bullet points. However the feasibility study should be conducted by a qualified independent entity, not the U and arguably not a state agency.
- As currently written, this recommendation is overly broad and should be separated out into three recommendations each requiring a separate vote. The support of one should not assume the support of another as these are vastly different. I do support implementation of a capacity and feasibility study in 2024, but only if it is conducted by MDH; this is necessary before any decisions related to state spending are made. I do not support the current request to expand the physical infrastructure and equipment of UMMC and other "publicly-funded" health care facilities for near-term use without first having the findings of a capacity and feasibility study which then inform fiscal requirements. I also don't have clarity as to how the term "other publicly-funded" is being used here and which facilities in Minnesota this would apply to. I do not support the initiation of a future facility fund in 2024. A capacity and feasibility study has not been conducted and the need has not been made clear, referencing again to my previous comments and asks at various meetings.
- Feasibility study [recommendation #3 (above)] needs to be completed prior to any funds being appropriated for capital improvements.
- The UMN first introduced the concept of a capacity and feasibility study - not the Task Force. That said, I quite agree we need a capacity and feasibility study as this will provide us more information to determine IF and WHEN to stand up these two possible funds.

- Any additional funding for UMN Academic Health program must satisfy the concerns raised by workers that are addressed in Recommendation #9 (below). Without this we will be unable to support such a proposal and would encourage other labor unions to take a similar position. Depending on the form additional public investment takes, we would also need the concerns expressed by workers in Recommendation #20 to be addressed.

Recommendation 8

The Task Force supports planning for new state-of-the-art academic health facilities that will support interprofessional training and integration of the research mission, as part of the University's five-point plan for its vision of the future Academic Health System. The University will begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University. The long-term plan for a new hospital will be informed by the feasibility study completed in 2024.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
6	**4**	**2**	**3**	**67%**
• 1 – UMN • 1 – Equity • 1 – Finance/Econ • 1 – Primary/Rural • 1 – State agencies • 1 – Educ/Workforce	• 1 – UMN • 1 – Legislature • 1 – Primary/Rural • 1 – Educ/Workforce	• 1 – Legislature • 1 – Equity	• 1 – Finance/Econ • 1 – State agencies • 1 – Chair	

Prioritization

High	Medium	Low
3	**3**	**5**

Reservations or suggested changes from members not completely or mostly in support:

- The needs assessment should be completed prior to planning for new facilities or capital investments.
- I would suggest removing the words "as part of the University's five-point plan for its vision of the future Academic Health System" and "owned and operated by the University" because I do not feel that the Task Force is endorsing the entire five-point plan. One specific example of this is that I do not believe we reached consensus that we agree with the statement "To provide a world-class academic health system, the University must govern and control campus facilities" which is point #2. I am not sure that there is a clear understanding of what "govern and control" means.
- Hard to support this without knowing how negotiations will go between UMN and Fairview.

- As written this is a recommendation for the University and not linking additional State funding. Adding the last sentence confuses the recommendation. As currently written, it also states 'integrating into a new UMMC' which seems to contradict the feasibility study or assumes the study will inform a new facility (does this mean new beds to the 16,000+ already licensed in Minnesota?), Related to state capacity and licensed acute care beds, as written "owned and operated by the University" how does this work with the bed moratorium? Per the MN bed moratorium, this rule was enacted on the construction of new hospitals and the addition or redistribution of hospital beds in the state. The hospital construction moratorium prohibits the establishment of a new hospital or any construction or acquisition by a hospital that increases or redistributes the number of licensed beds in the hospital. Also, is the "owned and operated by the University" statement fair if negotiations between Fairview and the University were just reported to be occurring in good faith. https://www.health.state.mn.us/data/economics/moratorium/index.html

Recommendation 9

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.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
4	**4**	**3**	**4**	**53%**
• 2 – Educ/Workforce • 1 – Leg • 1 – Finance/Econ	• 2 – Primary/Rural • 1 – State agencies • 1 – Finance/Econ	• 1 – State agencies • 1 – Leg • 1 – Chair	• 2 – Equity • 2 – U of M	

Prioritization

High	Medium	Low
5	**4**	**4**

Reservations or suggested changes from members not completely or mostly in support:

- Support as a separate policy discussion related to workforce strategies; any public funding conditions should apply to both public and private unions.
- Does the Task Force need to/should they weigh-in on labor agreements?
- I would move to “mostly support” based on the explanation about pensions from Brenda. Look forward to further clarification.
- Support conceptually, but not in scope – nor do I understand recommendation’s full implication. Moved to “somewhat support” based on Brenda’s explanation.

- This feels out-of-scope for the Task Force, and there are many unknowns. I don't believe this is the place to negotiate labor agreements.

Recommendation 10

The Task Force supports the University's request for direct state support of $80 million annually to the University to fund the establishment and implementation of this next-generation framework for Minnesotans' access to care: Minnesota's Academic Health System. The University's request to the Legislature is subject to Board of Regent approval.

Specifically, the University has proposed the following areas of investment:

- *3 to 4 new Medical Discovery teams - $25 million/year*
    - *Mental health, infectious disease, cancer, cardiovascular programs, population health. This includes faculty/physician/interdisciplinary recruitments in key areas for Minnesota.*
    - *The outcomes of this investment will be new multidisciplinary faculty and discovery in key areas impacting health and health care in Minnesota. The ultimate impact will be new cures and treatments, delivered by world-class providers, and new training and research opportunities for Minnesota students.*
- *Invest in sustainability and access to underserved communities - $20 million/year*
    - *Community University Hospital Clinic (CUHCC), mobile health partnership with Hennepin County, University and UMP primary care clinics.*
    - *The outcomes will be more patients served in underserved areas in culturally appropriate ways, more students trained in primary care and health equity.*
- *Primary care transformation - $10 million/year*
    - *E-consults (or online medical consultation, typically where a primary care provider seeks a specialist's expert opinion about the appropriate diagnosis or treatment for a patient), transition from primary to specialty and back, build physician networks, continuing medical education, advanced telehealth.*
    - *The outcome is better access to primary care around the state, better support for physicians in rural and underserved communities, access to specialists for more patients.*
- *Workforce development $15 million/year*
    - *The University's six science programs can provide unique opportunities to develop and expand workforce development opportunities for additional medical student slots, new programming in high need areas such as mental health, respiratory therapy, advanced dental therapy program, expand addiction fellowship, addiction/mental health "track" in residencies, pathways/partnerships for high need professions such as nursing with Minnesota State and private colleges.*
    - *The outcome will be more physicians and other professionals, specifics developed with the state and Minnesota State to identify high needs and targets.*
- *New care model design - Center for Learning Health Systems expansion - $5 million/year*

- *The outcomes will be better outcomes, cost efficiencies and the ability to share best practices in health care delivery across health systems.*

- *All systems innovation opportunities: rural health clinical trials network, pre-hospital care network - $5 million/year*
    - *Targeted, collaborative efforts to solve specific health challenges.*
    - *The outcomes will be innovative approaches to shared challenges.*

As these proposals underscore, this is our opportunity to advance these priorities, and Minnesota having a vibrant, mission-driven University health system is what provides the means to allow the State to turn these public priorities into action. Our public health is in the balance.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
3	**4**	**7**	**1**	**47%**
• 1 – UMN • 1 – Equity • 1 – Finance/Econ	• 1 – UMN • 1 – Educ/Workforce • 1 – Primary/Rural • 1 – State agencies	• 2 – Legislature • 1 – Educ/Workforce • 1 – Finance/Econ • 1 – Primary/Rural • 1 – State agencies • 1 – Chair	• 1 - Equity	

Prioritization

High	Medium	Low
4	**4**	**3**

Reservations or suggested changes from members not completely or mostly in support:

- Consistent with how I voted on other recommendations that stated a specific dollar amount, I cannot support this. I believe a specific amount should be decided by the Governor, Legislature and the University NOT this Task Force. I could not agree to a specific amount even if I wanted to because the Task Force has not been provided a detailed quantification of the actual current funding gap at UMMC and UMN Health Sciences program - could it be possible to learn UMN needs more than $80 million? Like Chair Malcolm, I was further confused when interim President Ettinger presented at the last meeting that the activities listed here were NEW activities. Should we take this to mean there is no current funding gap?
- Continued concern that additional, annual funding being is requested without clear understanding of total funding and organizational controls to work within a budget. This is being presented as an all or nothing approach. $80 million is a large financial request to come out of a state budget at any point in time, and thus any request at this level should clearly demonstrate both an unequivocal need, and that funding is not already available to the requesting entity that could be used towards this same purpose if

redirected. This is of heightened importance after the release of the November 2023 state budget forecast (https://mn.gov/mmb/forecast/forecast/). It is difficult to endorse this level of funding without having been provided documentation of current funds flow. The Task Force has not been provided with detailed information on how the University is using the state money that they already receive from the Higher Education budget, as well as the $22,250,000 they continue to receive each year from the tobacco settlement to support the Academic Health Center, etc.

  - For illustration, a few examples:
    - University of Minnesota General Fund Appropriations in Higher Education Bill. https://www.health.state.mn.us/facilities/academichealth/umngfappro.pdf
    - Current University of Minnesota Operations and Maintenance Riders. https://www.health.state.mn.us/facilities/academichealth/umngfrider.pdf
    - (Tobacco settlement funds dedicated to the Academic Health Center listed under Historical Notes and also referenced in the 2023 Omnibus Health Finance Bill – 2023 Minnesota Session Laws Chapter 70, Article 5, Section 15.). https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/70/2023-08-07%2011:36:33+00:00/pdf
  - If allocating specific funds for specific use, and this is within scope of the taskforce, I would also recommend that each of these requested funding initiatives be broken down and voted on separately. Each should be discussed in the context of need and timing.

- Several suggestions: Primary care transformation could be a competitive process rather than allocated to the U. I understand the $20M for the underserved, it is very much needed, yet most health systems are doing this work and the structural issues with Medicaid payments in MN inhibit their ability to deliver this care. This seems like a work-around for the U that is not available to support this more broadly across MN.
- Should be contingent on all of the conditions in rec #3 (above) being met. Also should not be ongoing, but initially only for 2 years (or whatever period Governor and Legislature choose) with evaluation of outcomes before continued appropriations would be made.
- Suggested changes: 1. remove "of $80 million annually", 2. add a sentence that states: Initial estimates of support are $80M annually. Prior to submission of a request to the legislature, the University will work with legislative leaders to develop more detailed estimates for the proposed areas of investment to achieve mutually understood public priorities."
- There is still not enough transparency about how this intersects with current FV funding to the U of M.
- While the ideas in the proposal are appealing, I still don't feel like there is enough information here, especially for an ongoing appropriation. Many of these ideas seem scalable. With scarce dollars available this session (if any), prioritization will be necessary.
- In general, we support investments in academic health and the incumbent workforce. It is impossible to comment on the specific allocation of the $80 million dollars since it is new and lacks any context. Any additional funding for UMN Academic Health program must satisfy the concerns raised by workers that are addressed in Recommendation #9 (above). Finally, any specific appropriation might compete with other organizational priorities.

Recommendation 11

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, nursing, and dental providers in Greater Minnesota.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
10	**2**	**1**	**2**	**80%**
• 2 – State agencies • 2 – Equity • 2 – Primary/Rural • 1 – Educ/Workforce • 1 – Finance/Econ • 1 – Leg • 1 – Chair	• 1 – U of M • 1 – Educ/Workforce	• 1 – Leg	• 1 – U of M • 1 – Finance/Econ	

Prioritization

High	Medium	Low
7	**2**	**2**

Reservations or suggested changes from members not completely or mostly in support:

- Do not need additional studies or plans. The Legislature can fashion from UMN's other input.
- Before we embark on something like this, we need to understand what work has already been done so we can build on and not duplicate it. Also, maldistribution is not only in Greater Minnesota.

Recommendation 12

Establish 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.

Based on those recommendations, provide financial support to expand interprofessional clinical training and care delivery.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
7	**5**	**1**	**2**	**80%**
• 2 – Primary/Rural • 1 – Equity • 1 – State agencies • 1 – U of M • 1 – Educ/Workforce • 1 – Chair	• 1 – Finance/Econ • 1 – Leg • 1 – Equity • 1 – State agencies • 1 – Educ/Workforce	• 1 – Leg	• 1 – U of M • 1 – Finance/Econ	

Prioritization

High	Medium	Low
4	**4**	**3**

Reservations or suggested changes from members not completely or mostly in support:

- Another advisory board we don't need.
- It's important this work continue but should not be a key recommendation.
- It seems like someone could do interviews, read literature, and write a report on this. An advisory body seems necessary.

Recommendation 13

Increase funding for effective strategies to diversify and 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.*

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
6	**6**	**3**	**0**	**80%**
• 1 – Equity • 1 – U of M • 1 – Educ/Workforce • 1 – State agencies • 1 – Primary/Rural • 1 – Chair	• 2 – Finance/Econ • 1 – U of M • 1 – State agencies • 1 – Leg • 1 – Primary/Rural	• 1 – Educ/Workforce • 1 – Equity • 1 – Leg		

Prioritization

High	Medium	Low
8	**2**	**0**

Reservations or suggested changes from members not completely or mostly in support:

- Only support if Recommendation #15 (below) is included with #13.
- These are interesting tactics but should not be included a top recommendation.
- We need all of this—there is never enough funding. My reservation is that recommending funding increases for "effective strategies to" is not very helpful. It is really just restating what the legislature and governor have already been trying to do.

Recommendation 14

Build on existing collaborative efforts between UMN and other entities by establishing or identifying 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, with particular focus on critical areas of need within Minnesota.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
8	**1**	**4**	**2**	**60%**
• 2 – State agencies • 1 – Equity • 1 – Finance/Econ • 1 – Educ/Workforce • 1 – Primary/Rural	• 1 – Equity	• 1 – U of M • 1 – Educ/Workforce • 1 – Primary/Rural • 1 – Leg	• 1 – U of M • 1 – Finance/Econ	

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
• 1 – Leg • 1 – Char				

Prioritization

High	Medium	Low
6	**1**	**3**

Reservations or suggested changes from members not completely or mostly in support:

- This proposal is too vague to mostly support, and not sure what impact it would have.
- Advising or regulating? I would hope “advising.”
- Already in place.
- Need to understand how this fits in relation to current governance.
- I don’t know enough about this proposal. What entity would establish this?

Recommendation 15

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.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
3	**1**	**8**	**3**	**27%**
• 1 – Educ/Workforce • 1 – Finance/Econ • 1 – Leg	• 1 – Leg	• 2 – State agencies • 2 – Primary/Rural • 1 – Finance/Econ • 1 – Equity • 1 – U of M • 1 – Chair	• 1 – U of M • 1 – Equity • 1 – Educ/Workforce	

Prioritization

High	Medium	Low
3	**2**	**5**

Reservations or suggested changes from members not completely or mostly in support:

- Like #9 (above), this is a valid issue that belongs in the workforce planning discussion in recommendations #11, 13, and 14 above.
- Labor is critical, but such agreement should be negotiated.
- Does this mean additional monies? Does this take a political stance? Seems good, but too broad. Not clear.
- Recommendations about labor issues are not the purview of this committee.
- Outside of scope of Task Force, but again needed to follow.
- Again, I agree for the most part, but do not feel this is in scope for the Task Force. There should be assurance elsewhere to address this.
- I don't think the Task Force should weigh-in on employer issues.

Recommendation 16

Assess the feasibility of multi-system integration between UMN and other health entities that both train a significant number of health professionals and are part of the publicly supported safety net to align resources and a shared commitment to the public good, and 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 ultimate goal is the creation of a more sustainable and resilient academic healthcare system, ultimately benefiting the public by maximizing the impact of available resources.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
8	**6**	**0**	**1**	**93%**
• 2 – U of M • 2 – Leg • 1 – Primary/Rural • 1 – Educ/Workforce • 1 – Equity • 1 – Chair	• 2 – Finance/Econ • 2 – State agencies • 1 – Equity • 1 – Primary/Rural		• 1 – Educ/Workforce	

Prioritization

High	Medium	Low
7	**3**	**1**

Reservations or suggested changes from members not completely or mostly in support:

There are no reservations or suggested changes from Task Force members to share for this recommendation.

Recommendation 17

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 other health systems, such as the Mayo Clinic.*

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
10	**2**	**3**	**0**	**80%**
• 2 – U of M • 2 – Equity • 2 – Educ/Workforce • 1 – State agencies • 1 – Primary/Rural • 1 – Finance/Econ • 1 – Chair	• 1 – Primary/Rural • 1 – Leg	• 1 – Leg • 1 – State agencies • 1 – Finance/Econ		

Prioritization

High	Medium	Low
6	**5**	**1**

Reservations or suggested changes from members not completely or mostly in support:

- While it is a high priority for UMN to seek broader relationships and collaboration with health systems across the state, I do not support this recommendation as currently written, as I have concerns about the phrase "help rationalize tertiary and quaternary clinical capacity." It is not the role of UMN to help rationalize tertiary and quaternary clinical capacity in the state. I also don't understand why and how the word "rationalize" is used and am concerned about how this word would be interpreted in implementation. Additionally, what definition of primary, secondary, tertiary, and quaternary care is being used? Task Force members and all decision makers should have a common definition, that is an

industry standard definition. I don't feel that we can vote on this until this is clearly defined and understood by all Task Force members. Care delivery systems have missions that drive their clinical scope. In our review of the 2015 Blue Ribbon Report and subsequent 2018 M Health dealings, the Task Force learned 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, if undertaken, would most appropriately fall under the scope of MDH. I recommend removing this portion of the statement in total. If not removed, I suggest this point be re-written and then moved to a new recommendation, separate from #5, for a separate vote.

- It seems like #16 (above) and #17 should be combined, or we should just have one.
- I don't think Mayo should be called out by name. I also think that this recommendation is now similar to #16 (above) since they are both about multi-system collaboration/integration related to academic health.

Recommendation 18

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.

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
10	**1**	**1**	**2**	**73%**
• 2 – State agencies • 2 – Primary/Rural • 2 – Educ/Workforce • 1 – Equity • 1 – Finance/Econ • 1 – Leg • 1 – Chair	• 1 – Finance/Econ	• 1 – U of M • 1 – Leg	• 1 – U of M • 1 – Equity	

Prioritization

High	Medium	Low
3	**5**	**4**

Reservations or suggested changes from members not completely or mostly in support:

- I don't know enough about this, especially the funding to non-University entities. I don't know why UMN academic library would not be available as a public resource, but that does not necessarily mean connections would be paid by public funds.
- I don't support this being a key recommendation from the Task Force.

- Phase to follow scope of this Task Force.

Recommendation 19

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;*
- *exploring expanded use of intergovernmental transfers and direct payments, where allowable, to support clinical training sites; and*
- *establishing clarity of MERC funds flow within the health systems.*

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
10	**4**	**1**	**0**	**93%**
• 2 – State agencies • 2 – Educ/Workforce • 2 – Finance/Econ • 2 – Primary/Rural • 1 – Equity • 1 – Chair	• 2 – Leg • 1 – Equity • 1 – U of M	• 1 – U of M		

Prioritization

High	Medium	Low
9	**1**	**0**

Reservations or suggested changes from members not completely or mostly in support:

There are no reservations or suggested changes from Task Force members to share for this recommendation.

Recommendation 20

Consider additional ways to increase financial support for health professions training and to broaden the funding base, such as modifying or establishing provider taxes, premium/claims taxes, and other health-related taxes, including potentially creating a graduated provider tax.

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

Levels of support

Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
3	**2**	**8**	**2**	**33%**
• 1 – U of M • 1 – Educ/Workforce • 1 – Chair	• 1 – Equity • 1 – State agencies	• 2 – Primary/Rural • 2 – Leg • 1 – Educ/Workforce • 1 – State agencies • 1 – U of M • 1 – Finance/Econ	• 1 – Equity • 1 – Finance/Econ	

Prioritization

High	Medium	Low
2	**5**	**3**

Reservations or suggested changes from members not completely or mostly in support:

- We are open to using 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.
- Concerned about funding mechanism.
- While hospitals support the current provider tax and current use of the provider tax, 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 that clinical "profit" are going down and are near zero, if not negative, for the majority of Minnesota hospitals. Minnesota's hospitals and health systems do benefit from having a trained health care workforce, but recognition must be made that hospitals and health systems are already contributing financially to UMN's academic health programs. Hospitals currently pay UMN to train UMN students. Hospital training sites are required to make stipend and benefit payments to UMN to cover all, or substantially all, of the compensation paid to 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 these 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, fellow) outside of UMN. Meaning UMN is not the sole provider of GME in Minnesota, even though it is the majority provider.
- Need more definition of the needs and magnitude of funding necessary to meet the needs. Seems like other work needs to happen before this.
- The provider system is exceptionally stressed right now – would look to other parts of the ecosystem. Fragility of non-profit providers.

- I still don’t feel as though I know enough to fully support this. What are the long-term impacts on other components of the system? What are the impacts on health care costs and costs overall? Does something suffer on the other side of the equation?
- Fully support the first paragraph. Not sure I support the second paragraph.

Appendix D: Background on academic health center/system models

As directed by the Executive Order, the Task Force considered a variety of different models for clinical partnership and governance between academic health centers (AHC) and non-academic health system partners. In response to member inquiries, the Task Force met twice with Cliff Stromberg and Mark Werner, consultants with expertise on such partnerships, on academic health center operations and organization. In addition to hearing from national experts, staff for the Task Force presented articles and reports on trends on medical school and academic health center financing, as well as trends in academic health organizational structures.

For the purposes of this report Academic Health Centers (AHCs) or Academic Medical Centers (AMCs) are entities generally comprised of some combination of a medical school and hospitals, health systems, physician practice groups and sometimes health plans. The number and type of entities structurally aligned with the medical school to form an AHC varies widely. The relationships between those entities also vary widely; from full ownership of the hospital, health system or physician practice group by the university, to practice arrangements in which the university does not have any hospital ownership, to informal partnerships with community health care entities to full mergers with community organizations with a single leader and board overseeing the entire enterprise and many more arrangements.

While the scope of the Task Force does not extend to making specific recommendations regarding the final shape of or accountability metrics that are part of any negotiated agreement between the University of Minnesota and the entities comprising its AHC, these discussions helped to highlight elements of success that it will be crucial for the partners to consider as part of any new agreements.

The highest-level takeaway from the expert testimony and from staff research is that “If you’ve seen one academic health center, you’ve seen one academic health center.” There are countless variables that shape the specific structural and funding arrangements between any two (or more) entities, including:

- histories of the medical school and/or hospital,
- leadership philosophy,
- donor base,
- market competition or consolidation in the service area,
- ownership and governance of facilities and physician practices,
- areas of clinical expertise and organizational relationship between the hospital, and
- medical school and physician practice.

These variables and several more result in a wide variety of different organizational structures and funding models in academic health. Many of these AHCs are successful and some are not.

Though the differences are many, there are a few recurring themes affecting all AHCs.

First, all AHCs are facing tremendous pressure in the current health care environment and are needing to adapt. According to a 2014 report from the Association of American Medical Colleges[2], "Every aspect of AMCs will undergo transformation in the decades ahead: how care is delivered, how students and residents are educated and integrated into clinical care, how the research enterprise is organized and funded, and how the missions come together in a new and meaningful way."

Much of that pressure is financial. In 1980, federal research, state & local support and clinical services revenue equally supported academic medicine. Today, revenue from clinical services makes up the majority of funding for academic medicine, far eclipsing the other two sources of support. As a percentage nationally, federal research funding makes up a small share with state and local support now the smallest share of support for academic health.

As funding for academic medicine has shifted to be more reliant on clinical revenue as the primary funding source, the pressure to increase clinical revenue, or to partner with a large and successful health system, has increased as well. This can lead AHCs to a focus on more highly-reimbursed specialties and procedures, leaving less attention and funding for rural, primary care and mental health services. Since states often need more primary care services to address population health needs there can be a mismatch between state goals related to addressing workforce shortages or maldistributions, access challenges, or disparities and AHC needs to generate the clinical income they require for survival.

The second high level theme to emerge is that all AHCs struggle to align the cultures and business operations of their tripartite missions; education, research and clinical care. Some AHCs fare better than others. The odds of success increase when their leadership and organizational structures are aligned to manage the 3 missions, but there is an inherent tension in different parts of the organization that often result in issues for the AHC.

In terms of the structural differences between among the entities comprising an AHC, Mr. Stromberg provided a framework to group AHCs into three organizational categories. Some examples are provided below.

1. **AHCs having a medical school affiliation with a primary independent health system:**
    - **Washington University and BJC Health in St. Louis MO:** The faculty practice is owned by the medical school.
    - **University of Pittsburgh/UPMC Health System:** The health system is independent, but the University appoints one-third the Board. The health system operates the faculty practice, and it operates an enormous affiliated health plan.
    - **Indiana /IU Health:** The University appoints three of 17 health system Board members. IU Health is very large and extremely profitable.
2. **AHCs where the university owns or controls the health system:**
    - **Duke University:** Controls Duke Health System. They now seeking to incorporate the previously external faculty group practice.
    - **Michigan:** Fully integrated system that is highly respected and growing moderately.

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[2] Enders, Thomas, and Joanne Conroy. "Advancing the Academic Health System for the Future: A report from the AAMC Advisory Panel on Health Care." *Association of American Medical Colleges*. 2014.

- **Wisconsin:** Modest sized AMC, but well regarded in its markets.

3. **AHCs where the university governs the health system in part:**
    - **Johns Hopkins:** Faculty practice and health system are operated together by one executive and one board by contractual agreement even though they remain separate corporations. Funds flows continue to be an issue.
    - **Vanderbilt University:** The university spun off the medical center and faculty practice into Vanderbilt University Medical Center in 2015. The same person serves VU as medical school Dean and VUMC as CEO. The university appoints 30% of the VUMC Board.
    - **Wake Forest:** The medical school joined NC Baptist Hospital in a joint operating agreement then merged that into Atrium (now Advocate) and became a minority member of the parent. University still controls separately the medical school.

While the Task Force focused mainly on successful models from other states, there are a couple of examples of AHCs that are not succeeding. A notable example is the Oklahoma University (OU) Health System, where the University reacquired the AHC after its relationship with a private health care management organization failed. The OU Health System now has hundreds of millions of dollars of debt and asked the legislature to help pay off significant portions of that debt.

UMN submitted a letter to Task Force Chair Jan Malcolm dated January 12 that provides additional detail about funding levels and mechanisms in other states. This letter is included as an attachment.

Because the health care environment, medical school cultures and academic organizational structures are so varied across states and models, it can be difficult to distill key success factors for academic health centers. With that caveat, the 2014 AAMC report had several recommendations for academic health systems of the future including (provided here verbatim):

- *"Academic health systems require strong and aligned governance, organization, and management systems committed to a unified direction, transparency, and internal and external accountability for performance.*
- *Growth and complexity of academic health systems requires an enhanced profile and responsibilities for department chairs, new roles for physician leaders, and evolution of practice* structures to focus on organizational leadership designed to lead clinicians into a new era.
- *Competitive viability and long-term mission sustainability will require radically restructuring the operating model for cost and quality performance.*
- *Academic health systems must conduct candid assessments of strengths and weaknesses essential to achieve change; and must revamp organizational culture if necessary."*

Attachments

To include as attachments:

- *Jan 12 letter to the TF from UMN*
- *Five-point plan*