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

DRAFT POTENTIAL RECOMMENDATIONS FOR CONSIDERATION - THEMED

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 the U of M 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 U of M and with community partners.

Potential recommendations for consideration in response to problem statement #1

University of Minnesota and Fairview partnership

Num.	Recommendation	Timeframe
1.1	Recommend that the UM/Fairview continue their partnership… with clear shared vision and governance, joint ownership/accountability for all metrics of the academic/clinical enterprise.	**Short-term**
1.2	Stabilize the current University and Fairview partnerships and address immediate needs.	**Short-term**
1.3	Consider supporting an extension on Fairview Partnership for the needs of Minnesotans, to retain key talent, and allow time to come to a future oriented negotiated agreement, and/or exploration of new models of partnership and funding.	**Short-term**
1.4	1) Implement principal partnership agreement with Fairview (or alternative) for operational expertise, needed shared service infrastructure. 2) Determine applicability of additional community consortium clinical partnerships, particularly with public entities with significant graduate medical education focus.	**Mid-term**
1.5	1) Feasibility of multi-system integration between UMN and public facing entities with single academic clinical staff (such as model in Washington State—analogous to having a principal partner system, HCMC, VA, one Children's coming together). 2) Additional long term model consideration, including community model collective ownership with single managing partner.	**Long-term**

Budgeting, budget requests, and oversight

Num.	Recommendation	Timeframe
1.6	Establish a joint legislative oversight committee that allows for more comprehensive understanding of all State appropriations that support activities of the University of Minnesota's health sciences programs regardless of the budget or committee the appropriations move through, with clear accountability measures and regular reporting on progress/outcomes.	**Short-term**
1.7	The University should establish a collective research and education strategy across the Health Professional Schools (Medical, nursing, pharmacy, vet, public health) at UMN. Annual Educational appropriation funding should be connected to annual health professions strategic planning throughout UMN. The current structure does not leverage the advantages of multiple schools in the system—a true strategic advantage at the UMN.	**Short-term**
1.8	Establish a more transparent process for developing holistic budgets for the health sciences schools to ensure needs are met, and for sharing information (internally and externally) about how budget allocation decisions are made across the health sciences schools and campuses.	**Short-term**
1.9	Any request for funding by the U of M to the legislature should be accompanied by thorough quantification of the funding gap to be filled. All current revenues must be identified, along with the associated costs, and with a description of how allocation decisions are made and how priorities are currently set and adjusted.	**Short-term**
1.10	Clear funds flow modeling from state, heath care ecosystem, philanthropy, for next generation.	**Long-term**

Public investment in the U of M health sciences programs

Num.	Recommendation	Timeframe
1.11	Underserved care expansion/stabilization: a. Extend rural training, education, research to underserved communities-especially rural for most critically needed expertise—mental health, dental, team care b. Advance telehealth and mobile services to extend care to underserved c. Supportive funding for UMN service areas in underserved metro patients—fund Community University Health Care Center	**Short-term**
1.12	Fund UMN academic library services. This was outlined in the 2015 Task Force report—if all educational facilities and researchers in the state could access this resource supported through state funding, it would support collaborative work to advance knowledge for the entire state. This funding benefits the UMN bottom line while simultaneously benefiting the unaffordable and redundant expenditure that smaller teaching hospitals and clinics are expected to also uphold.	**Short-term**

Num.	Recommendation	Timeframe
1.13	The legislature should commit to additional long-term funding for medical education and medical research at the UM. Suggestion of $25M/year for education.	**Short-term**

Contingencies or expectations if State appropriates additional funding to the U of M health sciences programs

Num.	Recommendation	Timeframe
1.14	Additional funding is likely needed from the State to support education & research at the U. Any State investment must include clear goals/specific and measurable outcomes on quality, safety, cost of care and efficiency, with clear accountability back to the State.	**Short-term**
1.15	Any additional short term public funding to the Medical School be contingent on the University moving purposefully to a new long-term approach with the health and wellness of Minnesotans and their communities paramount.	**Short-term**
1.16	Alongside any request for new State funding, the University of MN should provide a complete funds flow analysis the provides increased transparency on all funding sources for the University of MN medical school and how funds are managed by the University and its clinical partner(s).	**Short-term**
1.17	Further subsides for medical education in a hospital setting should include employer accountability measures that ensure jobs in an academic health setting meet or exceed existing labor standards, including neutrality for workers seeking to form unions) and provide robust career ladders for employees.	**Short-term**
1.18	If the State of Minnesota is going to provide additional, substantial funding to support the U of M Academic Health Center/Health Sciences Schools, there should be a process to develop goals and a vision that include State goals for population health improvement. Additional accountability measures should be developed from this to make sure there is a common understanding of desired outcomes.	**Mid-term**

Facilities and capital investments

Num.	Recommendation	Timeframe
1.19	Examine bonding request development process to enable better understanding of U of M Health Sciences Schools capital needs and how projects are tied to larger state goals for health improvement and health care cost reduction strategies.	**Short-term**
1.20	The State should fund a needs assessment for upgraded or new facilities for all of the health sciences programs, not just the medical clinical facilities. The needs assessment should look at statewide health care capacity in total, seriously exploring whether significantly more collaboration could happen among the health systems that might mitigate the need for new facilities.	**Mid-term**

Num.	Recommendation	Timeframe
1.21	Recommend that a feasibility study and legislative committee be assembled to answer the question of whether a new hospital, or major upgrades to existing facilities, is needed for the UM, particularly since funding is likely to be a state obligation.	**Mid-term**
1.22	Any change in the governance of the Riverside hospital or a future facility to be funded as part of this effort, should allow for [require?] the existing private sector labor agreements, pensions, and other benefits currently in place at Riverside to continue without disruption.	**Mid-term**
1.23	Determine on campus facility needs, right-sized for mission needs of UMN campus, unique expertise of University care services (example: transplant).	**Mid-term**
1.24	I would be open to/the State should consider an MDC-type *[does author mean DMC-type?]* arrangement for the creation of a new hospital and academic health infrastructure, but only if governed by a non-Regent structure. It will not be news to anyone that the *Board* of Regents does not enjoy a favorable political consensus at the Legislature. Regent selection is opaque and outmoded in a way that negates any accountability. A new governing structure, transparent, politically accountable would go a long way to secure major additional public funding.	**Long-term**

Other funding mechanisms

Num.	Recommendation	Timeframe
1.25	Financial support for academic health programs needs to extend beyond the primary clinical partner and the state. This should include all parties who depend on a robust health workforce, including but not limited to: other health systems, health plans, specialty groups, surgery centers, med tech firms, etc. The State should explore a graduated provider tax that credits those providing training slots and explore capturing community benefit dollars claimed by health systems for medical education to be used in a more coordinated, strategic way. The State could also consider raising and dedicating portions of the provider tax, premium taxes, and health-related taxes (tobacco, alcohol, sugared beverages, cannabis, fast food, etc) to health professions education. The legislature should request a study in 2024 to make recommendations for the next biennial budget.	**Short-term**
1.26	Original state investment to expand and grow the Biomedical Discovery District was $314M with an expectation to generate $100M in new research funding (2014). Has this been achieved? What is the ROI? What further investment could align with national funding strategies (beyond NIH?) both public and private matching to elevate our impact. The Federal 2024 budgeting for new science, technology and innovation is an opportunity for UMN and its med tech partners/corporations. These partnerships, if leveraged further, could advance med tech innovation for all of Minnesota. It would quickly become a strategic asset for the state.	**Short-term**

Num.	Recommendation	Timeframe
1.27	Medicaid reimbursements to reflect cost of care and consider disproportionate payments for those clinical settings training medical professionals.	**Short-term**
1.28	Consideration of funds flow from additional sources participating in health care ecosystem.	**Short-term**
1.29	Medicaid reimbursement rates need to increase, to better support sustainability of not-for-profit health care, education, research, and community benefit.	**Mid-term**

Problem Statement 2:

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 given how health care delivery is changing.

Potential recommendations for consideration in response to problem statement #2

Further problem definition

Num.	Recommendation	Timeframe
2.1	Get more precise estimates of workforce needs across all care settings based on population demographics, disease prevalence, risk factors, and technological and delivery model changes.	**Short-term**
2.2	The legislature should fund a significant study on how training programs across public and private institutions could better collaborate.	**Short-term**
2.3	Strategic clarification of how best to have the University meet the needs of Minnesotans, including workforce—define with clarity areas of strategic focus, outcomes, cost/benefit.	**Short-term**
2.4	Confirm health disparities/needs in Minnesota: We have received presentations on the work force needs, but have spent no time on why we need the work force. What is all this training for, to serve what community needs? Can MDH provide a presentation on the health care concerns/needs in Minnesota so that we can have a better sense of how the number and types of health care provider can help address these?	**Short-term**

Num.	Recommendation	Timeframe
2.5	Clarify immediate challenges: • Confirm the current and future healthcare worker shortfalls by discipline, role, and geography. (We have not received this in detail.) • Quantify the funding gaps specific to the University and Fairview (See my notes below in additional comments.) • Quantify the funding gaps within the health care education ecosystem (in addition to but beyond the University and Fairview.)	**Short-term**

Workforce planning

Num.	Recommendation	Timeframe
2.6	A comprehensive workforce plan for the state of Minnesota is essential. The State should consider convening a State Workforce Task Force that aligns community health professional needs, both current and projected, with training programs. This would align resources with needs and outcomes. HRSA has supported the Health Workforce Research Center Cooperative Program that leverages federal funding for state workforce data collection and the creation of programs to expand workforce development strategies to achieve it. The UMN National Center for Interprofessional practice +/- CTSI could align around this work.	**Short-term**
2.7	The State should establish a process, inclusive of the University but not just the University, to develop a long-term plan for health professional education in Minnesota, including measurable outcomes and funding requirements.	**Mid-term**
2.8	Design for the future: How can we design an Academic Health Ecosystem that can realize the defined vision and goals. The idea is to create a set of partnerships, funding, collaborations, spaces for research and innovation, etc. to meet the needs of 25-50 years from now; not just fix what isn't working today. I feel strongly that the Task Force should recommend that the State organize a process, inclusive of the University but not just the University, to develop a long-term plan for health professional education in Minnesota, including measurable outcomes and funding requirements.	**Long-term**

Removing barriers or strengthening pipelines to health workforce careers

Num.	Recommendation	Timeframe
2.9	In light of the critical workforce shortage Minnesota is experiencing, the State should invest in effective strategies to bring additional people into the health care workforce, including but not limited to: a. Investing in "pipeline" programs that work to increase awareness of the wide range of health care professions that exist, and to interest K-12 students in pathways that prepare them to enter the health care workforce b. Removing financial barriers to health care careers, including by expanding options to reduce or eliminate tuition for entry-level health care positions that offer opportunities for future advancement and for occupations or settings that are most in demand (primary care, behavioral health, long-term care, rural care), and expanding loan forgiveness programs for targeted professions and settings. c. Ensure that financial aid is targeted to individuals who plan to practice in MN, and who are from MN.	**Short-term**
2.10	Advance career opportunities for all aimed toward future- diversification of the workforce to reflect richness of Minnesota's people working in communities of care to advance whole person health a. Expand intra-professional training opportunities that include addressing health related social needs b. Expand step up programs for entry into professional schools	**Short-term**
2.11	A recommendation for the short term must include additional funding to address the primary care, mental health, dental, public health, nursing, and pharmacy workforce issues more purposefully and quickly. This must include building a diverse workforce.	**Short-term**
2.12	Implement a process to accelerate development or provide for expansion of existing programs that allow workers within U of M/Fairview facilities to acquire training to enter more advanced health professional roles.	**Short-term**
2.13	The State should support Federal GME funding growth for Minnesota, investment that supports ALL health professional education through increased CMS funding. MN DHS should convene the experts and expertise to revise GME Medicaid and Medicare matched funding formulas to expand the federal drawdown of funding. Other states have used alternative approaches to funding that MN has not supported or operationalized historically. MDH should continue to oversee grant funded programs targeting primary care/IMG and rural health strategies.	**Short-term**
2.14	The faculty pipeline is also integral. If you want to dramatically increase the number of students, you need to have a related increase in quality faculty. was also important to hear how integral the faculty pipeline is to all of this. The Dean of the School of Dentistry noted that we can't just add or enroll more students, because the 5:1 student to faculty ratio is tied to national accountability and certification.	**Mid-term**

Oversight

Num.	Recommendation	Timeframe
2.15	Establish (or expand an existing) entity that will be responsible for collecting and analyzing health professional workforce data and tracking health professional training funding. This entity also should provide recommendations to address gaps and set priorities. i. Require collaboration with U of M Health Sciences schools and other training entities in MN to ensure factors such as geographic, racial/ethnic, linguistic diversity needs are being addressed. ii. Require collaboration with the legislature or legislative review process to forward recommendations to the legislature for funding and implementation.	**Short-term**
2.16	The State should establish a taskforce to oversee workforce diversity and representation for health professions with UMN data scientists as a key partner. Coordination between licensing boards, state agencies and employers can help MN collect and leverage healthcare workforce data to assess the supply, demand, and distribution of health care providers and to plan for the future. At a minimum, the Board of Medical Practice should report workforce diversity, geographic distribution, and recruitment/retention data annually. Collective strategy to improve these outcomes could be connected to health professions development financing and to support the University's key role educating the future workforce.	**Short-term**

Other

Num.	Recommendation	Timeframe
2.17	Implement & fund recommendations flowing from studies funded as part of short-term strategies.	**Mid-term**
2.18	A coalition of entities involved in health professions education should advocate for significant redesign of national training requirements to streamline and integrate training, and make it more focused on patient and population health outcomes.	**Long-term**

Problem Statement #3

Revised: In addition to growing and diversifying Minnesota's health care workforce, it is imperative that the workforce be trained and deployed in new and more efficient and effective ways. **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.**

Potential recommendations for consideration in response to problem statement #3

Oversight

Num.	Recommendation	Timeframe
3.1	Establish a new, time-limited advisory body, including 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. Work to include identification of workflow, accreditation, and reimbursement barriers to interprofessional training and practice.	**Short-term**
3.2	Ask for a review of what the U could do differently to fund interdisciplinary training.	**Short-term**

Innovation

Num.	Recommendation	Timeframe
3.3	Innovation hub a. Interprofessional leadership in health sciences/value-based care model advancement, whole person health b. Expand translational research c. Neuroscience: developing brain, aging d. AI optimization for healthcare e. Inter-collegiate synergy (ex. Carlson school partnership on evolving value-based/outcomes based payment models)	**Short-term**
3.4	Set goals for development of x# of pilot projects that make use of existing Centers at the U of M Health Sciences Schools to address: • health care delivery reform • interprofessional teams • strengthening primary care and population health promotion	**Short-term**
3.5	Set up a process or entity that will be responsible for oversight of U of M Health Sciences Schools pilot projects, developing plans for taking them to scale and report out on outcomes to internal and external stakeholders.	**Mid-term**

Collaboration with Mayo

Num.	Recommendation	Timeframe
3.6	Strongly encourage, or require, more collaboration between the U and Mayo, and rationalization of care capacity with population needs across systems (look at needs across State/systems when making decisions to expand capacity).	**Long-term**

Long-term vision

Num.	Recommendation	Timeframe
3.7	The University of Minnesota Academic Health must evolve so that the focus is on state-wide primary and secondary prevention collaborations, while ensuring access to high quality tertiary and quaternary care. Of course, this focus must always guard against the inequitable systems and structures that develop and advantage some groups while disadvantaging others. This would require clinical and community collaborations, and new models across the state that are not currently in place.	**Long-term**