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

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

January 2024

**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**

Minnesota Department of Health  
PO Box 64975  
St. Paul, MN55164-0975  
888-345-0823  
[www.health.state.mn.us](http://www.health.state.mn.us)

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## Executive summary

Through [Executive Order 23-09](#), Governor Tim Walz established the Task Force on Academic Health at the University of Minnesota (UMN) to develop recommendations for world-class academic health professions education, research, and care delivery by UMN's Health Sciences Programs that will support the state's public health goals.

The Task Force was convened during discussions about anticipated changes to the partnership between UMN and Fairview Health, the University's current primary health system partner. While the terms of that business relationship were not in scope for the Task Force, quick resolution is urged. The parameters of a revised partnership need to be clear before more detail can be added to many of the recommendations made by the Task Force.

Throughout its brief time together, the Task Force gathered information and heard from experts on a broad range of issues that impact UMN's six Health Sciences Programs, community health systems, the health care workforce and Minnesotans' health more broadly. The Task Force also heard directly from the University and its representatives about its vision for an expanded Academic Health System for Minnesota. Based on our discussions, the Task Force developed twenty recommendations for consideration by the Governor, Legislature, and the University.

**The recommendations cover a range of topics and have varying degrees of detail and consensus. While there were some differing opinions among members, the highest priority recommendations for the group as a whole were those calling for an integrated strategic plan across the UMN health sciences programs, increased emphasis and funding for health workforce initiatives, and qualified support for UMN's three priority proposals, which are described further below, as they continue to evolve through various decision- and policy-making processes. The degree of member support for these priority recommendations varied, but the group felt that these recommendations had the greatest potential for impact on the problem statements the Task Force identified.**

The Task Force agrees that the University of Minnesota's academic health programs are an essential resource for the state that deserve and require investment to stabilize, grow, and improve its capacity for the tripartite mission of health professions education, research, and care for patients and communities. UMN has played a central role in Minnesota's health care ecosystem and will continue to do so as Minnesota develops a vision for the future of health and health care. That vision requires not only a strong University of Minnesota, but also a well-coordinated system of public, private, and non-profit entities from across health care, public health, and education, designed to achieve maximum and equitable physical and mental wellbeing for all Minnesotans.

**Importantly, the Task Force is recommending strategic investments, within certain parameters, not just to support the UMN academic health system of today, but most significantly, to support the broader health system and workforce needs of the future.** Future education, health care, and workforce environments will be dramatically different from what we have today and will require new collaboration within UMN and across the community with other health care and educational partners.

Last year UMN developed a [five-point plan](#) to establish a more robust Academic Health System (AHS) to serve the State. If approved by the Regents, UMN plans to request funding and support from the Legislature in the 2024 session to begin to implement this plan. The University developed three recommendations that it proposed to the Task Force, and which are included in the recommendations section of this report: 1) annual

programmatic funding for six specific areas; 2) beginning to ensure that the AHS has “plans and adequate financial support for facilities and equipment/technology to meet current and emerging needs...”, focusing first on urgent improvements to current facilities; and 3) immediately begin planning for new facilities that would be built in future years. While the Task Force is generally supportive of these recommendations, members noted the need for additional financial details, transparency, and accountability measures, as these proposals are further developed by UMN for consideration by the Legislature. Some of the details of the University's proposals are contingent on the final terms of a new business agreement between UMN and Fairview. Therefore, as noted above, the Task Force urges UMN and Fairview to reach a new agreement as soon as possible. This will enable the Legislature to understand which funding requests are urgently required to stabilize current programs versus those that will expand and grow academic health programs to meet Minnesota's future needs.

**Several of the Task Force recommendations acknowledge a need for broader, forward-looking priorities and investments.** These include setting expectations for robust and transparent planning and needs assessments for capital improvements, recommending additional coordination as well as funding for effective statewide workforce development strategies, and better coordination and collaboration across the broader health care ecosystem.

Much more discussion, and broader inclusion of other key players in Minnesota's health care ecosystem, are now necessary to further vet and refine these ideas. Task Force members are grateful for the opportunity to serve in this capacity and welcome future opportunities to engage more deeply on these important issues for our state.

## 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. Our health care sector is obviously vital to the health of our people, and it is also a significant driver of the health of our economy. Unlike most states, many of our largest employers are health care companies.

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 health professionals practicing in the state, discovering new therapies that change the course of diseases, and providing highly specialized care to Minnesotans in need. Moreover, UMN is one of only four universities in the nation to have the full complement of medicine, dentistry, nursing, public health, pharmacy, and veterinary medicine.

At the same time, we have significant challenges: unsustainable trajectories in health care spending by governments and employers that crowds other needed investments, while at the same time costs experienced by patients also continue to grow; declining access for many; critical workforce shortages, burnout and stress; and deep structural inequities that contribute to health disparities that are among the worst in the nation. Demographic changes—including a tsunami of aging Minnesotans for whom we are still unprepared—will exacerbate these challenges.

This Task Force was convened by Governor Tim 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 through the Biomedical District on campus and Discovery Teams in priority health areas. 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 1997 with significant changes in 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. Minnesota needs and expects this from its public flagship academic health system, and this Task Force agrees that this will take added investments, in the University and in the health system more broadly, that will benefit all of us. As detailed in our recommendations, Task Force members had a range of positions on the purposes, amounts, sources and timing of such investments.

The Task Force had a short time to learn about the complexities of academic health, to define specific problems and to generate a range of ideas to address them. This is not a strategic plan, and not a proposed piece of legislation. This is just one phase of what must be ongoing dialogue, development and implementation of specific strategies and legislative proposals by the relevant stakeholders. These are directional ideas—some for the University's consideration and some for the Administration's and Legislature's.

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.

## **The needs of Minnesotans require a new vision**

The Task Force began our work by learning about the trends in our health workforce and how that affects Minnesotans' declining access to care—especially to primary care, mental health, and dental care as well as specialty care, and especially in rural Minnesota and for underserved populations everywhere.

We know that 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 and in home and community based services all across the state. We know there are unacceptable inequities in access and health outcomes for many communities, with particularly stark disparities for Native Americans and American-born Black Minnesotans. We discussed the need for whole-person care to improve equity and outcomes for all, and that the health of Minnesotans relies on factors beyond the boundaries of the health care system.

We know a great deal about what we need to do. We know that in addition to continued innovation and excellence in highly specialized tertiary and quaternary care, we need more and easier access to primary care, more mental health and dental health services, and more investment in the non-medical determinants of health that account for so much of the outcomes we get in the health of populations. We need to act on this knowledge with urgency.

The Task Force also acknowledges that how, where, and by whom health needs are addressed in the future requires new approaches and new thinking. The urgency of these issues is clear to our communities, and to the health professionals whose mission it is to serve them.

These learnings led us to frame our recommendations to strengthen academic health in the context of the need for changes in the whole ecosystem of health and health care in Minnesota. We believe this is a time of great *opportunity* in addition to great challenges.

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, educators, community health systems, public health agencies, health plans, and the biotech industry.

*Minnesotans deserve an even higher performing health care ecosystem,  
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.*

## **The unique role of UMN academic health programs**

Over the course of our meetings, UMN leaders presented a great deal of information to the Task Force about the strengths and challenges of its current health sciences programs, briefly summarized below.

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 care for patients and communities. They train the majority of all health professions practicing in the state, including 70 percent of the 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. UMPhysicians (UMP), the faculty practice, serves over one

million patients annually. Nurse practitioners and dental practitioners are also serving many thousands of patients who would otherwise go without care.

Every one of the six schools is accredited by their respective accreditation organizations, marking excellence in training. Each of them is highly ranked nationally by a variety of sources. For example, the Medical School consistently ranks among the top three in the United States for training rural physicians, family medicine physicians, and Native American physicians. The School of Nursing's Doctor of Nursing Practice (DNP) program is ranked #6, the Midwifery program is #2. (Notably, the DNP program trains the faculty who add capacity to train more nurses in the future). The School of Public Health is in the top five percent of all public health schools and programs nationally, ranked #6 among public universities. The School of Pharmacy is ranked #3, Dentistry #8, Veterinary Medicine #10 in the US and #13 in the world.

As well as its impact on the health of Minnesotans, the tripartite mission of Academic Health at UMN contributes significantly to the Minnesota economy and has for many decades, generating jobs and revenue.

With all six health sciences schools working together, the University has unique opportunities to explore inter-professional 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. For example, the School of Nursing has led in the creation of a nationally recognized Center for Nursing Equity and Excellence (CNEE). Over 75 partners are participating, including all Minnesota State colleges, private colleges, community colleges, health care delivery systems, health plans, associations, labor unions and government agencies. This is an example that could be tailored and replicated for other parts of the workforce.

As mentioned above, the 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. 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.

All UMN presentation materials can be found on the Task Force web page (<https://www.health.state.mn.us/facilities/academichealth/index.html>).

## **No one "best" model for academic health exists**

A part of our Task Force charge was to look at how other models of 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 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, 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 of goals and accountability for all three legs of the stool (education, research, and clinical services) across partner organizations from the leadership level on down. As noted in the University’s letter to Task Force Chair Malcolm dated January 12, 2004,<sup>1</sup> 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.” A large patient volume is needed to support the academic mission. The Minnesota health care market has a remarkable depth of health care capacity with the University, the Mayo Clinic, 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.

## **Broad factors to consider**

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

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<sup>1</sup> Letter is included as an attachment.

**Academic Health exists within a much larger complex set of issues in how health 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.** As noted above, the overall "system" is highly stressed and increasingly dysfunctional. It is fragmented, with misaligned incentives, and produces suboptimal health outcomes. Some of the main levers for systemic change exist at the federal rather than the state level.

**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. Ironically it is often the investments in the high-tech end of medicine and in building health care infrastructure that crowd out these upstream investments.

**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 other settings of care and other, non-physician health care professionals. UMN does not currently have specific training programs for the entire continuum of the workforce. In addition to their roles in training, other health systems also conduct research and provide complex critical care in Minnesota.

**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 in 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.

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 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.

## 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 UMN's vision for strengthening 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

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 in the report. Rather we have organized recommendations by topic area and by degrees of support. Some recommendations are for consideration by the Governor and Legislature, others are for the University's consideration.

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 summarized beneath each recommendation. We note that in many cases the fact that there were reservations did not necessarily mean lack of support for the importance of an idea, but rather either that the idea needed more fleshing out with the engagement of relevant stakeholders, or it fit better in some other policy domain, or for other specific reasons that are articulated in the comments.

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 of Minnesota. 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 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.

Broader stakeholder engagement with some of these ideas is clearly needed and will happen in the legislative process. For example, 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. 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 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.

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 as much 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, 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 is 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;

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- 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

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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

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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

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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

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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



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**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

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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

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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

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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

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**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

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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

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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

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**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



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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

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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
<b>10</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>100%</b>
<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 2 – U of M</li> <li>• 2 – Educ/Workforce</li> <li>• 2 – Primary/Rural</li> <li>• 1 – Equity</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Finance/Econ</li> <li>• 2 – Leg</li> <li>• 1 – Equity</li> </ul>			

#### Prioritization

High	Medium	Low
<b>12</b>	<b>0</b>	<b>0</b>

#### 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.*

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*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
<b>11</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>100%</b>
<ul style="list-style-type: none"> <li>• 2 – U of M</li> <li>• 2 – Primary/Rural</li> <li>• 2 – Leg</li> <li>• 1 – Equity</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – State agencies</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – State agencies</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Equity</li> <li>• 1 – Educ/Workforce</li> </ul>			

### Prioritization

High	Medium	Low
<b>9</b>	<b>2</b>	<b>1</b>

#### 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
<b>4</b>	<b>11</b>	<b>0</b>	<b>0</b>	<b>100%</b>
<ul style="list-style-type: none"> <li>• 2 – Leg</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – U of M</li> <li>• 2 – Equity</li> <li>• 2 – State agencies</li> <li>• 2 – Finance/Econ</li> <li>• 2 – Primary/Rural</li> <li>• 1 – Educ/Workforce</li> </ul>			

### Prioritization

High	Medium	Low
<b>6</b>	<b>4</b>	<b>2</b>

**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.*

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- *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
<b>13</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>93%</b>
<ul style="list-style-type: none"> <li>• 2 – U of M</li> <li>• 2 – State agencies</li> <li>• 2 – Primary/Rural</li> <li>• 2 – Finance/Econ</li> <li>• 2 – Equity</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Leg</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Educ/Workforce</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Leg</li> </ul>		

### Prioritization

High	Medium	Low
<b>9</b>	<b>2</b>	<b>0</b>

### 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;*

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- *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
<b>8</b>	<b>6</b>	<b>1</b>	<b>0</b>	<b>93%</b>
<ul style="list-style-type: none"> <li>• 2 – Equity</li> <li>• 1 – U of M</li> <li>• 1 – State agencies</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Leg</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Finance/Econ</li> <li>• 1 – State agencies</li> <li>• 1 – U of M</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Educ/Workforce</li> </ul>		

### Prioritization

High	Medium	Low
<b>7</b>	<b>3</b>	<b>1</b>

#### 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
<b>10</b>	<b>3</b>	<b>2</b>	<b>0</b>	<b>87%</b>
<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 2 – Educ/Workforce</li> <li>• 2 – Leg</li> <li>• 1 – UMN</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Equity</li> <li>• 1 – Primary/Rural</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Finance/Econ</li> </ul>		

### Prioritization

High	Medium	Low
<b>6</b>	<b>2</b>	<b>3</b>

**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



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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
<b>4</b>	<b>6</b>	<b>5</b>	<b>0</b>	<b>67%</b>
<ul style="list-style-type: none"> <li>• 2 – UMN</li> <li>• 1 – Equity</li> <li>• 1 – Finance/Econ</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Legislature</li> <li>• 2 Primary/Rural</li> <li>• 1 – State agencies</li> <li>• 1 – Educ/Workforce</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Educ/Workforce</li> <li>• 1 – Finance/Econ</li> <li>• 1 – State agencies</li> <li>• 1 – Equity</li> <li>• 1 – Chair</li> </ul>		

**Prioritization**

High	Medium	Low
<b>5</b>	<b>2</b>	<b>4</b>

**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.

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- 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
<b>6</b>	<b>4</b>	<b>2</b>	<b>3</b>	<b>67%</b>
<ul style="list-style-type: none"> <li>1 – UMN</li> <li>1 – Equity</li> <li>1 – Finance/Econ</li> <li>1 – Primary/Rural</li> <li>1 – State agencies</li> <li>1 – Educ/Workforce</li> </ul>	<ul style="list-style-type: none"> <li>1 – UMN</li> <li>1 – Legislature</li> <li>1 – Primary/Rural</li> <li>1 – Educ/Workforce</li> </ul>	<ul style="list-style-type: none"> <li>1 – Legislature</li> <li>1 – Equity</li> </ul>	<ul style="list-style-type: none"> <li>1 – Finance/Econ</li> <li>1 – State agencies</li> <li>1 – Chair</li> </ul>	

#### Prioritization

High	Medium	Low
<b>3</b>	<b>3</b>	<b>5</b>

#### 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.

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- 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
<b>4</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>53%</b>
<ul style="list-style-type: none"> <li>• 2 – Educ/Workforce</li> <li>• 1 – Leg</li> <li>• 1 – Finance/Econ</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Primary/Rural</li> <li>• 1 – State agencies</li> <li>• 1 – Finance/Econ</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – State agencies</li> <li>• 1 – Leg</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Equity</li> <li>• 2 – U of M</li> </ul>	

#### Prioritization

High	Medium	Low
<b>5</b>	<b>4</b>	<b>4</b>

#### 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.

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- 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*

## APPENDICES

- *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
<b>3</b>	<b>4</b>	<b>7</b>	<b>1</b>	<b>47%</b>
<ul style="list-style-type: none"> <li>● 1 – UMN</li> <li>● 1 – Equity</li> <li>● 1 – Finance/Econ</li> </ul>	<ul style="list-style-type: none"> <li>● 1 – UMN</li> <li>● 1 – Educ/Workforce</li> <li>● 1 – Primary/Rural</li> <li>● 1 – State agencies</li> </ul>	<ul style="list-style-type: none"> <li>● 2 – Legislature</li> <li>● 1 – Educ/Workforce</li> <li>● 1 – Finance/Econ</li> <li>● 1 – Primary/Rural</li> <li>● 1 – State agencies</li> <li>● 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>● 1 - Equity</li> </ul>	

### Prioritization

High	Medium	Low
<b>4</b>	<b>4</b>	<b>3</b>

#### 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

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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
<b>10</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>80%</b>
<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 2 – Equity</li> <li>• 2 – Primary/Rural</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Leg</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Educ/Workforce</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Finance/Econ</li> </ul>	

### Prioritization

High	Medium	Low
<b>7</b>	<b>2</b>	<b>2</b>

#### 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
<b>7</b>	<b>5</b>	<b>1</b>	<b>2</b>	<b>80%</b>
<ul style="list-style-type: none"> <li>• 2 – Primary/Rural</li> <li>• 1 – Equity</li> <li>• 1 – State agencies</li> <li>• 1 – U of M</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Finance/Econ</li> <li>• 1 – Leg</li> <li>• 1 – Equity</li> <li>• 1 – State agencies</li> <li>• 1 – Educ/Workforce</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Finance/Econ</li> </ul>	

### Prioritization

High	Medium	Low
<b>4</b>	<b>4</b>	<b>3</b>

**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
<b>6</b>	<b>6</b>	<b>3</b>	<b>0</b>	<b>80%</b>
<ul style="list-style-type: none"> <li>• 1 – Equity</li> <li>• 1 – U of M</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – State agencies</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Finance/Econ</li> <li>• 1 – U of M</li> <li>• 1 – State agencies</li> <li>• 1 – Leg</li> <li>• 1 – Primary/Rural</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Educ/Workforce</li> <li>• 1 – Equity</li> <li>• 1 – Leg</li> </ul>		

**Prioritization**

High	Medium	Low
<b>8</b>	<b>2</b>	<b>0</b>

**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
<b>8</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>60%</b>
<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 1 – Equity</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Primary/Rural</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Equity</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Finance/Econ</li> </ul>	

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Completely support	Mostly support	Somewhat support	Do not support	% completely or mostly support
<ul style="list-style-type: none"> <li>• 1 – Leg</li> <li>• 1 – Char</li> </ul>				

**Prioritization**

High	Medium	Low
<b>6</b>	<b>1</b>	<b>3</b>

**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
<b>3</b>	<b>1</b>	<b>8</b>	<b>3</b>	<b>27%</b>
<ul style="list-style-type: none"> <li>• 1 – Educ/Workforce</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 2 – Primary/Rural</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Equity</li> <li>• 1 – U of M</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Equity</li> <li>• 1 – Educ/Workforce</li> </ul>	

**Prioritization**

High	Medium	Low
<b>3</b>	<b>2</b>	<b>5</b>

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

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- 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
<b>8</b>	<b>6</b>	<b>0</b>	<b>1</b>	<b>93%</b>
<ul style="list-style-type: none"> <li>• 2 – U of M</li> <li>• 2 – Leg</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Equity</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Finance/Econ</li> <li>• 2 – State agencies</li> <li>• 1 – Equity</li> <li>• 1 – Primary/Rural</li> </ul>		<ul style="list-style-type: none"> <li>• 1 – Educ/Workforce</li> </ul>	

### Prioritization

High	Medium	Low
<b>7</b>	<b>3</b>	<b>1</b>

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**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
<b>10</b>	<b>2</b>	<b>3</b>	<b>0</b>	<b>80%</b>
<ul style="list-style-type: none"> <li>• 2 – U of M</li> <li>• 2 – Equity</li> <li>• 2 – Educ/Workforce</li> <li>• 1 – State agencies</li> <li>• 1 – Primary/Rural</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Primary/Rural</li> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Leg</li> <li>• 1 – State agencies</li> <li>• 1 – Finance/Econ</li> </ul>		

**Prioritization**

High	Medium	Low
<b>6</b>	<b>5</b>	<b>1</b>

**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

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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
<b>10</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>73%</b>
<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 2 – Primary/Rural</li> <li>• 2 – Educ/Workforce</li> <li>• 1 – Equity</li> <li>• 1 – Finance/Econ</li> <li>• 1 – Leg</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Finance/Econ</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Leg</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Equity</li> </ul>	

#### Prioritization

High	Medium	Low
<b>3</b>	<b>5</b>	<b>4</b>

#### 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.

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- 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
<b>10</b>	<b>4</b>	<b>1</b>	<b>0</b>	<b>93%</b>
<ul style="list-style-type: none"> <li>• 2 – State agencies</li> <li>• 2 – Educ/Workforce</li> <li>• 2 – Finance/Econ</li> <li>• 2 – Primary/Rural</li> <li>• 1 – Equity</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Leg</li> <li>• 1 – Equity</li> <li>• 1 – U of M</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – U of M</li> </ul>		

**Prioritization**

High	Medium	Low
<b>9</b>	<b>1</b>	<b>0</b>

**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
<b>3</b>	<b>2</b>	<b>8</b>	<b>2</b>	<b>33%</b>
<ul style="list-style-type: none"> <li>• 1 – U of M</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – Chair</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Equity</li> <li>• 1 – State agencies</li> </ul>	<ul style="list-style-type: none"> <li>• 2 – Primary/Rural</li> <li>• 2 – Leg</li> <li>• 1 – Educ/Workforce</li> <li>• 1 – State agencies</li> <li>• 1 – U of M</li> <li>• 1 – Finance/Econ</li> </ul>	<ul style="list-style-type: none"> <li>• 1 – Equity</li> <li>• 1 – Finance/Econ</li> </ul>	

### Prioritization

High	Medium	Low
<b>2</b>	<b>5</b>	<b>3</b>

**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.

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- 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.

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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<sup>2</sup>, “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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<sup>2</sup> 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.

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- **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

The following are included as attachments, in this order:

- Letter from UMN President Ettinger, dated January 8, 2024
- University of Minnesota Revised Recommendations for an Academic Health System
- Letter from UMN Senior Vice President Myron Frans, dated January 12, 2024
- Letter from Dean Jakub Tolar, Dean Connie Delaney, Dr. Julia Joseph-Di Caprio, Dr. Penny Wheeler, and Vance Opperman, dated January 17, 2024
- University of Minnesota Five-Point Plan for the Future of Academic Health slide deck, presented October 11, 2023, by UMN General Counsel, Doug Peterson
- Interprofessional Health Education ideas from the Deans of UMN health sciences programs, dated December 1, 2024
- Correspondence from Special Advisors Governor Mark Dayton and Governor Tim Pawlenty, including:
  - Letter from Governor Mark Dayton, dated January 23, 2024
  - Letter from Governor Tim Pawlenty, dated January 6, 2024
  - Letter from Governor Mark Dayton, Governor Tim Pawlenty, and Vance Opperman, dated December 19, 2023
  - Statement from Governor Mark Dayton, dated December 6, 2023
  - Comments from Governor Tim Pawlenty, dated December 6, 2023

January 8, 2024

**Via Email**

Dear Chair Malcolm, Members of the Governor’s Task Force, Governor Pawlenty, and Governor Dayton,

I want to thank you again for chairing this important task force and to express my appreciation to all the task force members for agreeing to serve. And an additional note of recognition for Governor Pawlenty and Governor Dayton for serving as special advisors to the Task Force.

As you begin to finalize the recommendations of the Task Force, I want to take this opportunity to reinforce the University’s vision and goals for its role in academic health. With the University’s five-point vision in mind, we have refined the University’s recommendations for the establishment of an Academic Health System at the University and the financing requirements around public facilities and UMMC in particular. Those revised recommendations are at the end of this letter.

We recognize that the emergence of our clear ‘ask’ for support of an Academic Health System occurred while the Task Force’s work was underway, and that this has complicated the process for the group’s arrival at consensus recommendations. The timeline to renegotiate the University’s clinical partnership with Fairview - and the recognition that the state’s interests would be best served with University control of UMMC – was unavoidable. The University views the establishment of the Task Force, and the Walz Administration’s willingness to take up these issues in 2024, as essential for the future health of our state. I hope the information below assists the Task Force as it concludes its work. As a reminder, any official requests to the state by the University are subject to Board of Regents approval.

**Establish a True Academic Health System**

“Academic Medicine” or “Academic Health” refers to the combination of research, training, and clinical care to use leading-edge technology, emerging therapies, and academic resources in the delivery of both patient care and the preparation of health professionals. Academic Health means patient-centered care, with multidisciplinary/interprofessional teams working together to advance

the standard of care and our models of care delivery. Academic Health means we attract physicians who are national or international leaders in their fields to teach, innovate, and provide care to Minnesotans.

Patients who come to the University for care experience this difference that academic medicine makes to their care. They and their referring physicians are assured of cutting-edge solutions for complex problems. Patients are cared for by doctors who not only treat the most vexing of medical problems but also investigate their causes and share their knowledge with future doctors who will practice throughout the state. Patients feel that mission. Walk into a University medical facility and you will experience the care and compassion tied to that mission, from valets and front desk clerks to our healthcare professionals. With our Medical School on the rise, Minnesota must seize this unique opportunity to build an academic health system on that foundation of high-quality, caring medicine.

The Academic Health System (AHS) we envision for Minnesota is a broader concept that goes beyond an individual academic medical center, current or future. Yes, it is first and foremost aligned and integrated with the University's Medical School. But our vision of an Academic Health System is also much broader, encompassing a network of healthcare facilities, which can include multiple hospitals, clinics, research institutes, and educational institutions. We envision collaboration among different healthcare entities and health sciences schools within the system.

To create an Academic Health System in Minnesota, we must make several advances. First, we believe that it requires the University to take ownership or control – likely in stages – of the University of Minnesota Medical Center (UMMC), which includes the East and West banks of UMMC, the Masonic Children's Hospital, and the Clinics and Surgery Center on our campus. The majority of the University faculty practice at the UMMC. The ownership and control question is essential because to be an Academic Health System, the University must have the ability to determine the programming and investments in these facilities, based on State priorities for the University's public mission, not based on a clinical partner's decisions alone. Minnesota's future public health needs to be in the care of stewards of a public mission that serves all and invests in what matters most to Minnesotans.

With this foundation, we envision an Academic Health System that has the ability to determine the operations of the hospitals and clinics and to develop new care models and training programs that fully leverage the breadth of health science schools at the University. We know that team care is the best patient care and a strong network of clinicians working together will drive the best outcomes.

Our vision for Minnesota's Academic Health System would also provide the ability to support and strengthen our partnerships with health systems across the state to enhance access to academic medicine, to support physicians and clinicians and to advocate for healthy communities. We depend on all systems in the state to train our health workforce and we know there are significant advantages to working together more closely in research and education, but also in clinical care delivery. This is particularly true with the "public" or mission-aligned systems that also are home to significant amounts of academic work and serve complex and underserved populations.

Notwithstanding the mutual notices that were given regarding the non-renewal of the current set of agreements, the University continues to have current, frequent and meaningful conversations with Fairview, with one of our goals being ownership of UMMC. We understand the timing of this resolution is critical for both the Task Force and state leaders. Resolution is also paramount to continuing to recruit and retain the more than 1,000 world-class faculty whose research and clinical practice takes place at UMMC. We are working diligently to reach an agreement framework with Fairview as soon as possible.

## **Invest in facilities for an Academic Health System**

As we discuss facilities, we must address three different issues.

First, we must address the current condition of the East Bank and West Bank Hospitals as part of the UMMC. Both facilities will require upgrades and expansion in the next few years to meet the current needs of the Minnesotans we serve. One of the University's requests is for the state to provide financial support for such mid-term investments in equipment and facilities. This request obviously requires the University and Fairview to reach an agreement about the UMMC.

Second, we must address the future of health care facilities at the University and with other public health systems. While the path to ownership of the current facilities at UMMC is being resolved, we must also prepare for the future. We want to do that collaboratively with the state and possibly other public partners. As you know, we have proposed a feasibility study to determine what facilities the Twin Cities market will need for generations to come, and how the University could partner with other public institutions to better utilize public funding. By thinking through other public partnerships, we could leverage federal, state, local and philanthropic dollars.

Third, we also propose starting a fund in 2024 that could 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. By building the fund over time, it will give the University and the state time to determine what parameters need to be reached and how best to fund this important project. In addition to the health benefits of a top-tier Academic Health System, we can expect to continue as an economic engine in partnership with the dynamic private sector ecosystem in our region.

As Governor Dayton has stated, Mayo has set the bar this year with the announcement of a new \$5 billion investment in their Rochester campus, and it makes clear the need to invest significantly to maintain Minnesota's claim to leadership in health. While both Mayo and the University play vital roles in advancing sought-after healthcare, the University's unique responsibility as a land grant institution requires that our mission be aligned with the state's goals to ensure access to equitable care for all. The University has a [five-point plan](#) for its vision of the future that specifically foresees a new hospital as part of the UMMC. We must begin planning for that new facility and how best to integrate it into a new UMMC, owned and operated by the University.

## **An Academic Health System supports the health of all Minnesotans**

We believe we have taken the opportunity you provided us to demonstrate that when the state invests in the University of Minnesota, we deliver. We deliver groundbreaking research that leads to better patient outcomes and we serve all who come to our campus. We are often the last stop for patients who need treatment for chronic conditions, rare diseases, and for complicated diagnoses such as cancer and transplant operations. But we are first to train the providers that will be needed to treat the health care challenges facing Minnesotans today, such as addiction, oral health and access to primary care providers. As I said when I addressed the Task Force last November: we hear, loud and clear, that the state is asking more of the University. We are committed to meeting that call for improving the state's capacity to ensure Minnesotans' health.

The University is requesting direct state support of \$80 million annually to fund the establishment and implementation of this next-generation framework for Minnesotans' access to care. Specific anticipated outcomes include an increased number of highly trained health professionals, with a focus on greater Minnesota; new interprofessional care models to drive outcomes, efficiency, and workforce solutions; a destination for complex/advanced care accessible to all Minnesotans; a focus on access for underserved communities and priority health care areas such as mental health; and collaboration across health systems to support a high-quality health care ecosystem.

Placing the University's Academic Health System on a solid footing goes hand-in-hand with ensuring that the State of Minnesota has a strong partner capable of delivering on the State's public health and workforce priorities. As the healthcare marketplace continues to grapple with misalignments between needs, capacity, and payment models, the State of Minnesota has in the University a partner committed to full alignment of our shared priority: meeting the health and health care needs of Minnesotans.

Thank you for your consideration of the University's vision for the future of health care in Minnesota.

A handwritten signature in black ink, appearing to read "Jeff M. Ettinger". The signature is written in a cursive, flowing style.

Sincerely,  
Jeff Ettinger



## **University of Minnesota Revised Recommendations for an Academic Health System**

The work of the Task Force illuminated the need for the University of Minnesota to serve the future of Minnesotans in powerful and transformative ways. We propose three primary recommendations that focus on recognition that Minnesota must commit to the establishment of an Academic Health System that is driven to ensure our collective capacity to meet the needs of people across the state, now and in the future. That commitment will require ongoing programmatic support and the assurance of facilities adequate to the task of preparing our future healthcare workforce.

**Recommendation #1:** 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.

**Rationale:** Recognizing that the University of Minnesota's Academic Health System (AHS) must be a statewide asset, the State of Minnesota and the University of Minnesota jointly establish timelines, and financial and governing models in 2024 to ensure the availability and operation of the AHS for generations to come. While clinical partnerships will continue to be a part of the model for preparation of physicians, evolution of the University's current model to a true AHS as a national leader based on both research and academic rank will enable the University to recruit top specialists and retain top trainees - and thereby ensure highly specialized care and supportive services are available across the state.

With increased annual state investment for academic health, the University of Minnesota can expand on its leadership and current successes as the state's only public academic medical center. Anticipated outcomes include: increased number of highly trained health professionals, with a focus on greater Minnesota; new interprofessional care models to drive outcomes, efficiency, and workforce solutions; destination complex/advanced care accessible to Minnesotans; a focus on access for underserved communities and priority health care areas such as mental health; and collaboration across health systems to support a high-quality health care ecosystem.

**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. This revised recommendation incorporates all or part of previous TF recommendations:

1,5,6,7,8,9,10,14,21]

**Recommendation #2:** 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.

[TF recommendations 10,11,12,20]

**Recommendation #3:** 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.

**Date:** January 12, 2024

**To:** Jan Malcolm, Chair, Governor's Task Force on Academic Health at the University of Minnesota

**From:** Myron Frans, Senior Vice President, Office of Finance and Operations

**RE:** State Support of the Academic Medical Centers

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This memo outlines some data on levels of support, and mechanisms of support that are being used by other states to sustain their public academic medical centers (AMCs).

We culled this data largely from Official Statements in bond offerings, but also checked publicly available University/AMC budgets. We also used Association of American Medical Colleges (AAMC) data for some cells of the chart on pages 4 and 5. The numbers given in various sources are quite inconsistent, perhaps due to varying characterizations of payments/support. I do not recommend focusing on any single number in the chart as being unarguable, but the overall pattern is reliable. In addition, the numbers are distorted by variations in structure. For example, at Temple, Oklahoma and Nebraska, the health system is separate, while at Ohio State, Missouri and North Carolina, it is consolidated with the University.

### **Funding Mechanisms**

Below are examples of the wide range of techniques states have used to support various University missions.

- In most cases, **State appropriation support flows to the University as a whole**, without being earmarked for the AMC, so tracking the cost allocations and flow-downs is not easy from public documents.
- Some States “**buy down’ tuition costs** via state appropriation. Some also provide **subsidies for the unusually rich University fringe benefits for employees**.
- Many states have two separate accounts, one for “**capital project support**” and another for “**annual operating support**”.
- Some have created “**trust funds**” to yield annual funding separate from annual appropriations.
- Some states impose special **permanent “millage” taxes** to support higher education institutions.

- Some states use **dormitory authority bonding** to separately support University buildings, well beyond dormitories (e.g. research buildings).
- A few states specifically earmark **funds for research**, or a special “leap forward” in biotechnology or creation of a bio-park, etc. whole.
- In some, though a minority of states, funding has been **specifically targeted at medical school or AMC uses**.
- Some Legislatures have preferentially funded **expanded access or clinical services to the disadvantaged**.
- In many States, there are special pools of funding for the medical center due to “**upper payment limit/intergovernmental transfer (UPL/it) arrangements** that nominally are not limited to the AMC, but in actual dollars primarily benefit it.
- Note that **in most cases, this funding is not statutorily mandated**. It is just the result of annual (or biennial) appropriation bills, and the tradition of funding the State University.

### **Flow Down from University to Medical Center or Medical School**

It is almost impossible to compare the finances of AMC institutions on an “apples to apples” basis, for several reasons.

- Some Universities (like Michigan and UVA) operate their health systems as part of the University, with consolidated financials. But in others (like Kansas and Maryland) the health system is a separate 501c3 with its own credit rating and budgeting. And in still others (like Indiana and Colorado), the University does not own the health system –it is truly separate.
- Some Universities (like Ohio State and Penn State) “own” the faculty practice, so that quite apart from the medical center there may be a funding mechanism to the faculty. In other AMCs (like Virginia and Indiana), the faculty practice is outside the University.
- In many public Universities, State funding just goes to the University, and its internal University budgeting then determines how much money flows done to the medical school or medical center or other uses. But in other States, the public appropriation is earmarked in part for the medical center.
- Universities do not engage in scientific or necessarily transparent cost allocations across their enterprises. Hence, sometimes the medical center revenues are drawn on to support other University functions, or there are asymmetric (i.e. subsidized) cost allocations based on which component can “afford’ to bear the burden. These implicit subsidies or taxes usually are not captured or reflected as such.

- In some Universities and AMCs, State budget “lines” for faculty are not fully reflected on the local entity budget, or State subsidies for excess fringe benefits are viewed as a State expense, not a University or AMC expense.
- Note, in any public AMCs, the University budgets report vastly different numbers for revenues and expenses. This is not due to operating losses, but to the recording annually of a massive “educational expense” or “pension expense” or “state employment expense” which is supported by some other part of the State budget. See below, under “Medical School Funding.”

### **Medical School Funding**

How much funding then really flows down to the medical school or AMC? With all these caveats, on a national basis, according to Association of American Medical Colleges (AAMC) data, the chart on the following pages shows the government and parent University support of total medical school revenue.

According to AAMC, total governmental and parent-University support to the University of Minnesota Medical School (UMMS) was about \$110 to \$115 M per year in each of the last five years. In 2020, that constituted about 8% of the medical school’s \$1.3 B in revenue (including UMPHysicians for this purpose).

In addition, University of Minnesota Medical School (UMMS) is **more highly dependent on hospital payments** (to UMPHysicians for services, and to UMMS for mission support) – totaling at least \$800 M or 60% of the \$1.3B UMMS budget –than are many medical schools. This is a structural reality, not a weakness. On the contrary, it reflects the fact that despite UMMS having increased its research portfolio faster than many other medical schools in recent years, the UMPHysicians’ clinical practice has also grown quickly.

## Data From Other States

The following chart shows some metrics for State support for 25 public Universities that have AMCs. See data caveat noted on page one of this memo.

### Public Funding of Universities and Their Academic Medical Centers

Institution (data year)	Total U. Rev	Med. C. Rev	MC as % of Total U	State Appropriation	Approp. as % of U budget	Med School Rev.	Parent and Gov't \$ to SOM	Parent and Govt \$ as % of SOM \$
1. Arizona (2023)	\$2.6 B	N/A	N/A	\$344 M	13%	\$210 M	\$25 M	11%
2. Colorado (2021)	\$4.2 B	N/A	N/A	\$569 M	14%	\$1.3 B	\$100M	9%
3. Florida (2023)	\$6.5 B	\$3 B	25%	\$838 M noncap and equal cap	13% or total of 25%	\$1.2 B	----	----
4. Indiana (2019)	\$3.8 B	N/A	N/A	\$582 M	15%	\$1.1 B	\$44 M	4%
5. Iowa (2023)	\$4.9 B	\$2.6 B	60%	\$231 M noncap plus 15-54 cap	5% -7%	\$640 M	\$130 M	20%
6. Illinois (2023)	\$7.2 B	\$1.2 B	17%	\$2.2 B	31%	\$502 M	\$128 M	20%
7. Kansas (2023)	\$5.0 B	\$3.3 B	70%	\$262 M	17%	\$700M	\$53 M	8%
8. Kentucky (2023)	\$3.8 B	\$2.5 B	66%	\$318	8%	\$525 M	\$25 M	5%
9. Maryland (2021)	\$5.5 B	N/A	N/A	\$1.5 B	27%	\$770 M	\$110 M	15%
10. Massachusetts (2022)	\$3.3 B	N/A	N/A	\$845 M	26%	\$660 M	\$58 M	9%
11. Michigan (2021)	\$8.4 B	\$4.8 B	57%	\$373 M	4%	\$1.3 B	\$126 M	10%
<b>12. Minnesota (2020)</b>	<b>\$4.2 B</b>	<b>N/A</b>	<b>N/A</b>	<b>\$694 M</b>	<b>17%</b>	<b>\$1.3 B</b>	<b>\$111 M</b>	<b>8%</b>
13. Missouri/Col. (2019)	\$3.0 B	\$1.1 B	37%	\$425 M	13%	\$260 M	\$40 M	15%
14. Nebraska (2020)	\$2.8 B	N/A	N/A	\$20 M	< 1%	\$710 M	\$120 M	17%
15. North Carolina (2019)	\$8.7 B	\$5.4 B	62%	\$535 M	6%	\$1.0 B	\$156 M	15%
16. New Mexico (2021)	\$2.8 B	\$1.4 B	50%	\$620 M	\$450 M (incl. \$115 mill levy)	\$400M	----	----
17. Ohio State (2023)	\$8.6 B	\$3.8 B	44%	\$485 M	6%	\$1.0 B	\$64 M	6%
18. Oklahoma (2020)	\$1.0 B	N/A	N/A	\$76 M	8%	\$420 M	\$17 M	4%
19. Penn State (2022)	\$7.9 B	\$3.5 B	44%	\$324 M	4%	\$550 M	\$15 M	\$3%
20. Temple (2023)	\$1.7 B	N/A	N/A	\$430 M	25%	\$550 M	\$44 M	8%

Institution (data year)	Total U. Rev	Med. C. Rev	MC as % of Total U	State Appropriation	Approp. as % of U budget	Med School Rev.	Parent and Gov't \$ to SOM	Parent and Govt \$ as % of SOM \$
21. Texas (2021)	\$19.9 B	\$8.6 B	43%	\$2.6 B	13%	\$900M	\$89 M	10%
22. Virginia (2022)	\$3.7 B	\$2.4B B	65%	\$215 M	5%	\$650 M	\$57 M	9%
23. VA.Comm (2022)	\$723 M	N/A	N/A	\$335 M	46%	\$490 M	\$84 M	17%
24. West VA (2021)	\$2.7 B	\$1.6 B	60%	\$192 M	7%	\$310 M	\$32 M	11%
25. Wisconsin (2023)	\$6.3 B	\$2.4 B	38%	\$1.0 B	16%	\$750 M	\$5M	1%

**KEY:**

- Total University Revenue (including medical center where financials are consolidated)
- Medical center revenue
- Medical center as % of total University revenue
- State appropriation amount in year indicated
- State appropriation as a % of total University budget
- Medical school revenue (as part of or separate from medical center)
- Parent University and governmental support to medical school per AAMC
- Parent University /governmental support as % of medical school budget

**Sources:** Official Statements for bond offerings

- University budgets and reported financial statements
- Medical center budgets and reported financial statements
- AAMC data
- Transaction histories, etc.



## **Some Broader Take-Aways**

- State budget support for Universities, as a percentage of their budgets, has been declining for many years, at least in most States.
- States look to all possible sources to replace State support –and “wealthy” large health systems are the easiest place. Hence, hospital-provided funds are under pressure to bear an increasing load. AMCs that own their own hospitals and are quite profitable –such as Colorado, Penn State, Texas, North Carolina and Indiana – are increasingly called on to support the medical school, in order to “backfill” declines in other source of funds.
- The main way this has been sustained in some of the more urban states or the AMCs with larger affiliated health systems, has been through prodigious growth of the health system. Where this is not demographically feasible, AMCs have struggled.
- Legislators have a widely known preference for capital projects. But of course, capital projects come with operating and maintenance (O & M) costs, and if these aren’t baked into the initial plans, they can be a massive downstream drag on the University of medical center. This commonly occurs with new research buildings.
- There has been a trend toward somewhat greater funding of access/equity/underserved population services. But that depends on renewed annual funding, unless there is a special State tax or trust fund.

## **Examples of Funding From Other States**

**Arizona.** Direct State funding to the University of Arizona (UA) has generally been about \$350 M/year in recent years. In 2025, UA sold its Tucson hospitals to Banner Health, and Banner largely funded the development of the second (Phoenix) campus of the UA school of medicine. Before that, UA received about 23% of its total net patient service revenue (NPSR) from the Arizona Health Care Cost Containment System, which was an alternative to traditional Medicaid funding. This was probably the highest percentage in the State and so one might regard it as a form of indigent cares subsidy; but in the end it was still payment for services. Since the Banner deal and creation of the second medical school campus, state support for the UA Tucson medical school has declined to about \$25 M/year.

Interestingly, recently, the Arizona Board of Regents approved authorization (with funding commitments to be determined in the future) for Arizona State University to create a new medical and bioengineering school, faculty practice group, and hospital affiliations –to expand series in the Phoenix area. Public funding will be in the hundreds of millions or more, but no plans yet exist.

**Colorado.** UC Health is ultimately controlled by Board appointments by the University, but operates as a largely independent 501c3 health system, and the University does not “own” UC health or consolidate its financials with those of the University. The State provided funding for the development (under gift and lease from the federal government) of the massive

“Fitsimmons” (now “Anschutz”) campus of UC Health and the medical school, so major capital costs were subsidized. Now, UC Health provides about \$50 M/year in academic support to the medical school. But it also supports about \$270 M in faculty purchased services, and the faculty pay a 10% Dean’s Tax, so impliedly there is added support. Total governmental and parent University support for the medical school was \$99 M in 2021. That constituted about 9% of the medical school’s total budget of \$1.1 B (which includes CU Medicine, the faculty practice).

**Florida.** The University of Florida does not “own” the affiliated health system -- UF Shand’s Healthcare. Instead, by special State statute, the President of the University of Florida personally appoints the entire health system Board. There are complex professional services agreements and management agreements linking the health system, faculty practice and medical school. The State of Florida provides massive funding to the University (e.g. more than \$800M in capital funds and \$800 M in operating funds in 2023). Some of the annual appropriations also contain lots of specific “buckets” of support, such as for nurse training, or cancer research or behavioral health.

**Indiana.** In 2019, total State appropriations to IU were about \$582 M (about 18% of its total budget), without differentiation as to component. But IU does not own or operate the hospitals or practice group. An independent health system (IU Health) is one of the larger (\$8 B) and most financially successful (credit rating: AA) AMC-affiliated systems in the nation. Under pressure from the Legislature, in 2022 it made an unrestricted gift of \$416 M to the medical school. This is in addition to annual mission support of about \$175 M/yr. and absorption of faculty practice deficits of \$280 M/year. In terms of a “flow down” of support, the total governmental and parent University support of the medical school in 2021 was \$44 M, out of the medical school’s overall budget of about \$1.1 B. Hence, increasingly, IU’s medical enterprise depends on IU Health rather than the State.

**Iowa.** The finances and operations of IU health are consolidated with those of the University and comprise about 60% of the total. IU Health has grown significantly in recent years. Total appropriations to the University in 2023 are about \$230 M in operating support and something like \$30-50 M in capital support. Total governmental and parent support to the medical school totaled \$130 M in 2021, or 20% of the medical school’s total budget of \$640M

**Illinois.** Total State appropriations to the University were \$665 M in 2022 but \$2.2 B in 2023. The University of Illinois medical center constitutes about 20% of the total economic activity of the University. A new Hospital Fund was created in 2022. Funds may be used for “hospital and pharmacy services, to reimburse practitioners who are employed by the University of Illinois, to reimburse other health care facilities, and health plans operated by the University of Illinois.” This fund participates in a UPL/IGT arrangement to attract federal funds. Total government and parent University funding to the medical school was \$128 M in 2021, or 20% of the medical school budget.

**Kansas.** Kansas is another University where the growth of the medical center has caused it to comprise an ever-increasing proportion of the total University finances -- in Kansas’ case, \$3.3 of \$5 B, or 70%. In 2023, total State appropriations to the University were about \$260 M. Total governmental and parent University support to the medical school in 2021 was

\$53 M -- or about 8% of the medical school's total revenue of \$710M. This is an unusually low amount.

**Kentucky.** In 2023, State appropriations to the University were \$318 M, without differentiation as to flow down to UK Health Care Hospitals System. In turn, governmental and parent University support to the medical school was about \$25 M, or about 5% of the medical school's total revenue of \$525 M. The UK health system has made one major acquisition in recent years and has explored a few others, but has not grown quite at the level of some other AMCs.

**Maryland.** In 2021 State appropriations to the University were \$1.5 B (about 30% of the total University budget). UMD in turn paid \$168 to the U Md. Medical System (a private non-profit) primarily for non-clinical services such as facilities management, environmental health and safety, IT service and shared costs of fundraising. Total governmental and parent university funding to the medical school totaled \$111 M in 2021 or about 15% of the medical school's total revenue of \$770 M. Despite operating in the geographic "shadow" of the larger Johns Hopkins Health System and MedStar Health, UMD's health system has grown impressively. It has also maintained solvency despite the draconian rate limitations of the unique Maryland Health Care Cost Commission, which limits hospital prices and margins.

**Massachusetts.** State funding to the University was about \$845 M in 2021 (27% of revenue). U Mass in turn pays U Mass Memorial Medical Center, a separate corporation, about \$160 M for various services. The U Mass medical school is of small to moderate size in terms of overall budget.

**Michigan.** State appropriations to the University were about \$373 M in 2021. The medical center's \$4.8 B revenue was about 57% of the University's total revenue of \$8.4 B. Total government and parental support for the medical school in 2021 was \$126M, out of the total medical school budget of about \$1.3 B. Much of the success of the UM medical enterprise has been fueled by the fast growth of the UM health system, including its affiliation with the Mid-Michigan Health system, and various joint ventures.

**Missouri.** State appropriations to the University were \$425 M in 2019. The medical center's revenues of \$1.7 B were about 52 % of the University's overall \$3.3 B budget. And total government and parent University support of \$40 M was 15% of the rather small \$260 M medical school budget.

**Nebraska.** Nebraska Medicine is an unusual structure because it is a joint operating agreement of the University medical center (UNMC) and Bishop Clarkson, a separate nonprofit. It received just \$16 M in State funding in 2022. (However, this may be affected by the fact that it has received very significant ongoing gifts from Warren Buffet's family, and this is widely known.) However, Nebraska Medicine's affiliation with the medical school contractually assures substantial support, under an annually agreed budget. This is especially so because a few years ago, the faculty practice, UNMCP, was incorporated into Nebraska Medicine. Total government and parent University support totaled about \$120 M in 2020, or 17% of the medical school's total revenue of \$710M.

**North Carolina.** In 2021, State appropriations to UNC-Chapel Hill were about \$535M. UNC controls UNC Health Care System, which in turn provides financial support to the medical school – in the range of \$100M/year, plus support for a large portion of faculty salaries. The system has grown enormously, although it has also made some missteps in acquisitions/divestitures. But it is financially very successful. Total governmental and parent University funding to the medical school was \$156 M in 2021, or about 15% of the medical school’s total revenues of about \$1 B.

**Ohio.** In 2023, State appropriations to Ohio State University were \$85 M. The medical center’s \$ 3.8 B revenue was 44% of the University’s total revenue of \$8.6 B. Total governmental and parent University support to the medical school was \$64 M, or 6% of the medical school’s overall revenue of about \$1.02 B. The OSU Wexner Medical Center, including especially the James Cancer Center, has been quite successful in its core market. But the medical school’s research rank (about #39) has not risen to an equivalent level of prominence.

**Oklahoma.** In 2022, State appropriations to the University totaled \$76 M (or just 8% of total University revenue). But the State also funds, formulaically, indigent care at OU Medicine. Total government and parent university support to the medical school in 2021 was about \$17 M -- or just 4% of the medical school’s total revenue of \$420 M. OU is hoping for more success in the future, having just a few years ago, through a separate hospital authority entity, reacquired its main hospitals from HCA.

**Pennsylvania (Temple U. of the Commonwealth of Pa. and Penn State/ Hershey).** In 2019, the Commonwealth provided \$406M in funding to **Temple**, plus \$24 M in support to **Temple’s** controlled Temple University health System. This was supplemental funding “to provide accessibility to health care services, including care for the noninsured and indigent population.” Other funding is provided in some years for operations and infrastructure.

In 2022, State funding to **Penn State University** totaled \$341 M. **Penn State Hershey Medical Center’s** revenue of \$3.5 B constituted about 44% of Penn State’s total revenue of \$7.9 B. The total government and parent University support of the medical school was about \$15 M –just 3% of the medical school’s total revenue of \$550 M. One reason support can be low is that given its somewhat isolated market, Penn State Hershey is unusually profitable (often running operating margins of 7-10%). Note the contrast to the relatively generous funding of the less- prestigious but needier Temple, which has a poor payer mix.

**Texas.** State appropriations to UT in 2022 were \$2.B B. In addition, the State’s permanent Health Care Fund is a pooled investment fund that provides funding for State health care institutions, education and research. The UT medical centers’ \$8.4 B in revenue was 42% of the University’s total revenue of about \$19.9 B. The medical centers vary, but largely are successful and profitable, and so can subsidize considerable academic activity.

**Virginia (Virginia Commonwealth U. and University of Virginia).** In 2022, **VCU** received State appropriations of \$335 M, divided into “operational”, “general “ and “research initiative” support. Total governmental and parent University support for the medical school was \$84 M -- or 17% of the total budget in 2022. The VCU Health System is separate from the University.

State appropriations to **UVA** were about \$215 M in 2022. Of UVA's annual revenue of \$3.7 B, the medical center constitutes about \$2.4 B (65%). Total governmental and parent University support to the medical school in 2021 was about \$57M, or 9% of the medical school's total revenue of \$650M. UVA's faculty practice is a non-controlled separate corporation. UVA has grown its medical enterprise by acquiring a joint venture interest, and later a full interest, in three hospitals in Northern Virginia, outside its core market. It also explored creating a second medical school campus, in the DC area, to be funded in collaboration with Inova Health System, as well as by the State, but that has not progressed well.

**West Virginia.** In 2021, State appropriations to the University totaled \$192 M. The WVUHS health system's revenues of \$1.6 B were about 60% of the University's total of \$2.7 B. Total government and parent University support to the medical school totaled \$32 M in 2021 – or 11% of the medical school's total budget of about \$310. The legislature seems willing to consider funding added WVUHS programs in part because many WVA hospitals are becoming financially non-viable and “adoption” by WVUHS seems the only solution.

**Wisconsin.** In 2023, State appropriations to the University totaled almost \$1 billion—for a series of major campus enhancements. In most years, the number is far lower. The UWHealth Hospitals and the UW Medical Foundation (faculty practice) together have about \$4B/year in revenue. In turn, they provide about \$80 M/year in mission support to the medical school. The medical center's \$2.4 B revenue is about 38% of the university's total of \$6.3 B. Total governmental and parent University support was just \$5.6 M in 2021 -- virtually trivial in light of the medical school's \$750 M revenue.

# UNIVERSITY OF MINNESOTA

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*Twin Cities Campus*

*Office of the Dean*

*Medical School*

*C607 Mayo, MMC 293  
420 Delaware Street S.E.  
Minneapolis, MN 55455*

*Office: 612-626-4949*

January 17<sup>th</sup>, 2024

Dear Task Force Members,

As we await the opportunity to finalize the report-out of the Governor's Task Force on Academic Health at the University of Minnesota, we feel it important to ask one more time for consideration of a clearer message of general support for the role of Academic medicine and health sciences in the ecosystem of Minnesota's health care delivery and preparation of its workforce.

At the outset of the Task Force's work, our chairperson accurately predicted that we would collectively raise a broad range of important issues and ideas – many beyond the charge we were given by Governor Walz and Lt. Governor Flannigan. The time spent by the Task Force and the staff has been valuable in creating a window into the myriad challenges facing the healthcare sector and we hope the materials generated for and by the Task Force are used as lawmakers contemplate policy changes to improve access to, and quality of, care for all Minnesotans.

The Executive Order specifically orders that the "Task Force will develop recommendations to support world-class academic health professions education, research, and care delivery by the Health Sciences Programs [at the University of Minnesota] to advance equity, center primary care, and ensure that Minnesotans can continue to receive the highest quality of care in a financially sustainable way."

The establishment of the Task Force provided an opportunity for both State leaders and the University to reaffirm the full alignment that must exist between the State's needs for preparation of healthcare professionals and drive research and innovation to meet future health care needs of Minnesotans. The University's articulation of the vision for a true Academic Health System for Minnesota is a response to the Executive Order and the challenge put to the University by State leaders.

At the last Task Force meeting and in their Jan. 8 letter, the University asked for support of three recommendations for its plans for the Academic Health System that will emerge in the years ahead:

- A stronger commitment to direct state support of academic health programs via annual funding.
- Consideration of funding support for equipment and facility upgrades as the University reacquires facilities on its Minneapolis campus that currently serve as University of Minnesota Medical Center (UMMC).
- Support for the University's intention to begin planning for the next generation of its academic health facilities in the Twin Cities. (Plans that would be informed by the feasibility/capacity study proposed earlier in the Task Force process.)

We urge the Task Force to make a clear statement of support for the University's plans to continue striving to meet its mission of providing high quality, innovative health care, accessible to all Minnesotans. This support is essential to maintaining Minnesota's commitment to the health of our families and communities.

Sincerely,

Dr. Jakub Tolar, Dean of the University of Minnesota Medical School and Vice President for Clinical Affairs

Connie Delaney, Dean of the University of Minnesota School of Nursing

Dr. Julia Joseph-Di Caprio, Leap Pediatric and Adolescent Care President

Dr. Penny Wheeler, University of Minnesota Regent

Vance Opperman, President and CEO of Key Investments

# University of Minnesota Five-Point Plan for the Future of Academic Health

Doug Peterson, General Counsel

October 11, 2023



UNIVERSITY OF MINNESOTA

**Driven to Discover®**

# Guiding Principles

1. World-Class Academic Health System
2. University Governance and Control
3. Opportunities for Strategic Partnerships
4. Future: New State-of-the-Art Hospital
5. Now: Investment in Current Facilities





# World-Class Academic Health System

The University wants to ensure Minnesotans have access to a first-rate academic health system, bringing them the benefits of integrated research, teaching, and top-level care.

- A world-class system provides patient-centered, innovative care.
- Brings sought after medical talent to Minnesotans.
- Provides leading edge clinical trials.
- Is a destination for several specialties, health conditions important to Minnesota.
- Leads in interprofessional training and care delivery
- Leads the nation in quality and safety, includes a strong ambulatory presences, innovates in care models and health care technology.



# University Governance and Control

- To provide a world-class academic health system, the University must govern, and control University flagship facilities.
- The flagship facilities (all three facilities are licensed as one hospital)
  - The University of Minnesota Medical Center - East Bank and West Bank
  - Masonic Children's Hospital
  - The Clinics and Surgery Center
- To ensure access to academic health for Minnesotans, the decisions about care delivery must be in the public interest.
- Leadership of the facilities ensures that programmatic, care delivery, and investment/financial decisions will be made by a public institution and aligned with the state of Minnesota's goals.



# Opportunities for Strategic Partnerships

- University seeks opportunities for partnerships and relationships with health systems that will allow us to maximize our mission-focused impact for the state.
- These partnerships are essential to our role as a state land-grant University seeking to bring benefits to all Minnesotans, and it also supports our teaching and research missions.
- Currently the health sciences train, innovate, and provide care delivery around the state and in nearly every health system.
- We are actively seeking new opportunities to partner in all ways that benefit patients and our health care ecosystem.



# Future: New State-of-the-Art Hospital

- Our current hospital facilities on the East and West Bank are old.
- In the coming years, we will need a newly designed state-of-the-art hospital complex on the East Bank to move clinical and academic medicine forward for the next 50 to 100 years.
- We need a building that:
  - Incorporates training and discovery into the delivery of care seamlessly
  - Provides for a patient-center, multidisciplinary care plan
  - Uses the latest in health care technology
  - Serves the State's needs for future generations



# Now: Investment in Current Facilities

- In the next five to ten years, our faculty and patients need well-functioning facilities.
- The University will seek State and community investments to upgrade the University flagship assets to “bridge” the present to the future and ensure a successful transition to a new hospital.
- UMPHysicians has increased market share and there is wait for services.
- We can use additional operating suites to provide needed acute and chronic care services in a more timely manner.
- We can reconfigure existing spaces to meet the needs of Minnesotans today
- We need additional behavioral health spaces.



# Moving toward the future

## 2024 Priority

The state's support of academic health  
at the University of Minnesota



# Interprofessional Health Education

December 1, 2023



UNIVERSITY  
OF MINNESOTA

*Request from Chair Malcolm: Considering the unique comprehensiveness of the health science programs at the University and the priority of interprofessional education and care by the task force, what are specific ideas to increase workforce capacity, improve equity, and remove barriers to collaboration?*

**Idea 1: Increase and enhance the pathway programs from K-12 and undergraduate education into the health professions with a focus on rural and urban underserved communities.** Goals. Ensure a robust, diverse and continually replenishing workforce for all areas of health and for all areas of the state. Rationale. Students from rural and underserved communities are more likely to return to those communities to practice; however, these students may lack the role models, opportunities, and support afforded to those from more well-resourced communities. The following successful examples bridge this gap and added funding would impact Minnesota more broadly.

- Support for K-12 programs to enhance interest of young people in the health professions by exposing them to the breadth of health programs at the University of Minnesota (UMN). Examples: [Public Health data science program](#), [VetCamp](#), [Pharmacy Pharm Camp](#), [Discover Dental School](#), [The Ladder](#).
- Expand programs to engage current UMN undergraduate students in the health professions, especially from underserved backgrounds, in partnership with the [PreHealth Student Resource Center](#) and the [Center for Interprofessional Health](#). Example: [Health Profession Pathways Initiative](#).
- Support for programs to facilitate the transition of students from MNSCU universities, community colleges, and technical schools and schools from within the UMN system — especially UM Rochester — to the UMN's bachelor's or professional programs in preparation for a health profession. Examples: [Public Health undergraduate transfer program](#), [Pre-Health M Simulation Bridge Initiative](#), [VetFAST](#).
- Expand and sustain Governor Walz's [MN Futures Together](#) program (e.g., stipends to support undergraduate students co-training in technical health programs such as pharmacy technician, veterinary technician, nursing assistant, emergency medical technician and medical assistant to get real-world experience in healthcare).

**Idea 2: Expand interprofessional health training sites with a focus on rural and urban underserved communities.** Goals. 1) Prepare a health care workforce poised for collaboration and interdependence to advance the health of all Minnesotans. 2) Minimize structural barriers that challenge or limit interprofessional practice. Rationale. Health profession students who learn with other professions in underserved communities are more likely to practice effectively across disciplines in these communities yet some barriers persist (e.g., limited capacity of preceptors).

- Financial support for clinical sites and preceptors to offset time educating health profession students.
- Funding to support expansion of interprofessional clinical training and care models which focus on underserved populations including, but not limited to, the [Community University Health Care Center](#), the [Phillips Neighborhood Clinic](#), and the [Mobile Health Initiative](#). With its expertise in interprofessional education, the UMN [Center for Interprofessional Health](#), in partnership with the UMN health sciences, health systems, local and statewide public health, and community organizations, can lead this expansion.
- Incentives for health systems and other partners to engage with the UMN [Center for Interprofessional Health](#) to expand interprofessional clinical partners and programs and operations and remove logistical barriers such as housing/transportation costs - especially in rural communities (e.g., [Mobile Dental Clinic](#), [Centra Care Dental Clinic](#), [Fairview Community Health and Wellness Hub](#)).

**Idea 3: Support and expand One Health<sup>1</sup> initiatives at the University of Minnesota and the State to bring all health sciences together in support of animal, human, and environmental health goals. Goals.**

Leverage the comprehensive array of UMN health sciences programs to influence health care practice, improve equity, remove barriers to collaboration, and enhance workforce capacity. Rationale. UMN, with its configuration of health profession schools, is uniquely poised to lead and partner with the state in initiatives that intersect animal health (companion and production), human health, and environmental health.<sup>2</sup>

- Create a One Health Center in partnership with all of the health science schools and other centers/institutes at UMN - along with state and local public health agencies - to prepare for future pandemics and other One Health issues that affect global security such as climate change, food security, and zoonotic/anthroponotic disease.
- Prioritize One Health projects involving diverse health professional learners in local public health, clinical care, and ecohealth initiatives targeting emerging and zoonotic threats, with UMN [Itasca Biological Station](#)<sup>3</sup> and UMN [Extension](#), the [Institute on the Environment](#), and others operating as hub/spoke/connectors for statewide engagement.
- Expand successful UMN-facilitated pilot programs within communities to improve One Health issues.
- Create One Health clinics which bring animal and human health together in one setting including support for removing regulatory barriers where possible and support for high risk/high reward care in community One Health delivery models.

**Idea 4: Establish a Health Workforce Development & Science Program. Goal.** Collaborate with educational partners in MNSCU and community colleges to identify workforce development needs, particularly via training needs assessments, pathway development, recruitment and retention, succession management, and organizational research. Rationale. The current healthcare ecosystem requires a formal, continuous monitoring to project future health workforce dynamics and needs in the state.

- Dedicate a program that would build on UMN research expertise, and the strengths of existing centers/efforts (e.g., nursing, public health, pharmacy) to describe/model healthcare and public health workforce trends for Minnesota, to inform ongoing legislative and other aligned workforce efforts. The program would support convening of statewide stakeholders committed to ensuring a sustained, diverse, healthy and adequate health workforce across MN.
- Leverage the research work already being done by the UMN [Center for Public Health Systems](#) in the School of Public Health and the workforce science and applied training models being deployed by the Office of Academic Clinical Affairs and the School of Nursing. Examples: [Center for Nursing Equity and Excellence](#), and the academic practice Nursing [Collaboratories](#).

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<sup>1</sup> One Health is a collaborative, multidisciplinary approach to achieving the goal of optimal health outcomes by recognizing the interconnectedness of humans, animals and the environment.

<sup>2</sup> It is worth noting that the MN Committee Legislative-Citizen Commission for MN Resources aligns their funding priorities to exposing Minnesotans (including UMN learners) to MN environment/nature; UMN is positioned to bring interprofessionalism to this work.

<sup>3</sup> The Center for Interprofessional Health (CIH) and the Office of Academic Clinical Affairs (OACA) has an existing interprofessional ecohealth student experience held at the Itasca Biological Station; more can be done with dedicated resources to expand this portfolio to leverage proximity to numerous tribal nations, engage with state universities, community/technical colleges, and partner the university with community care, practice, and research priorities.



January 23, 2024

Dear Chair Malcolm,

Thank you for leading the Governor's Task Force on Academic Health at the University of Minnesota to its successful conclusion. My remarks are based upon the draft, which I received last Friday, and which I understand might be revised.

I agree with the twenty recommendations, which the Task Force is making. However, the initiatives, which I believe are crucial to the Medical School's future success, are mixed in with other laudatory, but less essential, recommendations. I regret that the University has evidently failed to convince all the Task Force members of the urgency of its financial predicament and the serious consequences, if it is not immediately addressed.

The Interim President, the Dean of the Medical School, and several Faculty Members have all addressed this group about the deficiencies in the present facilities: building conditions, advanced medical technologies, and patient capacity. Left unaddressed, those conditions will only get worse. And, at best, it will take some time before improvements can be effectuated. Thus, it is imperative that those initiatives begin immediately, not after "a comprehensive needs assessment of health system facilities and infrastructure supporting public health throughout Minnesota." Such a study should be undertaken; however, it will take some time before it is authorized, funded, prepared, completed, and properly discussed. Meanwhile, the University hospitals' physical conditions will continue to deteriorate.

Steps must be taken immediately to begin to assemble the resources necessary to undertake those improvements, whatever they are determined to be. Such a fund would of necessity include State and/or University bonding, the University's Endowment Fund, and private participation. Eventually, that fund will be needed to support a new hospital, if the University's Medical School is to retain its premier status and continue to attract and retain the best faculty and students. Those students will likely comprise over 70 percent of Minnesota's future physicians. Don't we want and need them to be the best?

Similarly, I was disappointed in the lack of complete Task Force support for the Medical School's need for additional state funding to implement its five-point plan. Again, I attribute this result, in part, to the University's failure to articulate clearly and convincingly that such additional funding would be well-spent. Unfortunately, also, there has been a lack of expressed support from the Administration and the Regents, who must emphatically and unanimously back this request and then state to the Governor and the Legislature its priority among the University's other needs.

Absent the adequacy of capital investments and operating funds, none of the Task Force's other laudable aspirations for the Medical School will be realized. I would urge the group to recognize and acknowledge this reality, and give it deserved prominence in its recommendations.

Sincerely,

Mark Dayton

January 6, 2024

Jan and Diane:

Thanks for your continued leadership and support of the Task Force.

As only a non-voting advisor, I didn't feel it was appropriate for me to weigh-in on the "somewhat support" matters referenced in your recent message.

However, I did want to share my concern that the current draft recommendations may not provide the strategic vision or focus needed to significantly improve the U medical school and the broader UMMC (jointly referred to here as the "U") - and thereby increasing the value the U provides to MN in that regard.

Many of the draft recommendations either relate to the enormous challenges facing our broader healthcare ecosystem - or they relate to important but niche/tactical/process considerations.

While those issues absolutely matter as part of much-needed health care reform discussions, they don't seem specifically focused on the U's unique teaching and research mission - or the strategic value that mission obviously provides to MN.

Perhaps the "Parking Lot" you have referenced will mitigate some or all of my concerns - but I am hoping for more.

In my opinion, the U's differentiating and strategic value proposition lies primarily in operating MN's flagship medical school (as well as other important health science schools) and one of the largest NIH funded research programs in the country.

With that in mind, Task Force Recommendations could focus on addressing the need to **"Stabilize, Grow and Improve"** those functions. More specifically, Task Force recommendations could:

First, focus on the steps likely needed to simply **STABILIZE** the U in light of the likely outcomes of the pending U/Fairview discussions (i.e. less money for academic education/research from Fairview). Because this funding will (unfortunately) serve as replacement funding for a well-established and important public purpose, it should not be accompanied by many new duties/burdens/mandates since this funding will likely be needed just to preserve the U's current capabilities and status.

Second, set forth initiatives and expectations for the U (and its partners) to significantly **GROW** enrollment in and graduation from its medical school and other priority health science schools. This will help address the health care worker shortage.

Third, endorse the need to significantly **IMPROVE** the medical school and the UMMC more broadly. While the medical school and the other elements of the UMMC have improved somewhat in recent years, they're not where they need to be in terms of reputation, quality and impact. My earlier submission to the Task Force provides more detail in this regard. Some of the opportunities to improve include ensuring the quality and capacity of the U's key medical buildings reflect the importance of the mission and the aspiration to be a top tier medical center; committing to move more medical school and clinical programs into top tiers of quality; and asking the U to develop and beta test one or more new care delivery models.

Thanks again,

Tim Pawlenty

December 19, 2023

Dear Task Force Members:

It's been our privilege to serve with you as part of the Governor's Task Force on Academic Health at the University of Minnesota, well-chaired by Commissioner Jan Malcolm.

We generally support many of the recommendations now being considered by the Task Force.

However, we're concerned they don't sufficiently address some of the key issues affecting the University's Medical School. The quality of that school largely determines the quality of academic medicine in Minnesota and it greatly impacts the future quality of health care throughout our state.

Top quality, readily accessible, and affordable health care is the Number One Asset we offer our citizens. Since the U's Medical School teaches and trains over 70 percent of the state's doctors, it directly affects that quality. We cannot afford mediocrity.

Thanks to the dedication of Dean Tolar and the doctors, nurses, and other U health care staff, the Medical School's national standing has improved in recent years. However, if we want to provide Minnesotans with the best medical care, we should strive to have the country's best public medical school at our University. This challenge must be addressed immediately and urgently. Actions needed include:

#1. The University and Fairview appear unlikely to reach agreement regarding their future relationship by the original December 31, 2023 deadline. If so, the Governor should appoint a Mediator, who can help resolve their differences. A timely and successful mediation would allow the University to provide a better future roadmap to the Legislature before it reconvenes on February 12, 2024.

#2. The President of the University must tell the Governor and Legislature whether significant additional funding for the Medical School is among its highest priorities for the upcoming Session. If the University is not prepared to make such a statement, then pursuing #3 would be ill-advised.

#3. The Medical School needs to make a specific request (not a range) to the Legislature, which details the amount of money requested, its purposes, and how it will advance academic quality. All of us need to be told what the Medical School wants to specifically do to further improve its academic training, its patient care, and its research capabilities. At present, despite Senior Vice President Frans' most recent letter, that clarity is still lacking.

#4. The University and Fairview must begin immediately to address the growing deficiencies in its existing hospitals. President Ettinger recently described those deficiencies to the Task Force. A first-rate educational program and outstanding patient care cannot be housed in second- or third-rate facilities.

Mayo Clinic just announced an intended \$5 billion investment in its Rochester Campus to maintain its world primacy. That \$5 billion commitment establishes a marker for the level of capital investment needed to become or remain premier.

Therefore, the University should develop the wherewithal to issue \$1 billion in tax exempt bonds, backed by the University's Foundation, private philanthropy, and the State. That capital fund should grow in subsequent years to finance the building of a new hospital and other improvements.

The University's Medical School and medical center are absolutely critical to the quality and availability of health care in our state. Ensuring Minnesota has a nation-leading medical school at its flagship

University and providing the best possible care to Minnesotans are expensive propositions. What would be even more costly, however, is not achieving those goals.

The health of our state is dependent upon the health of our citizens. The future of Minnesota is at stake.

Sincerely,

Mark Dayton

Tim Pawlenty

Vance Opperman

cc: Governor Tim Walz  
President Jeffrey Ettinger  
Senior Vice President Myron Frans  
Ms. Kathy Tunheim

## **Statement from Governor Mark Dayton**

As Mr. Stromberg notes, there is no single organizational model that has been established for all medical schools and their attendant hospitals. Nor does there appear to be any correlation between a certain model and excellence in the medical school, as judged by its national rankings.

Thus, it seems to be incumbent upon Minnesota to devise its own unique system, taking the existing inter-relationships, updating them to reflect current realities, and then positioning them to improve the University's quality of education, patient care, and national standing.

What does seem to be consistent across all models is the sufficiency of funds to achieve and sustain their excellence. Undergirding that sufficiency must be the commitment of the principals to make those investments in capital improvements and operational proficiencies in state-of-the-art facilities and advanced medical practices.

The University's Medical School and the Fairview System presently lack that financial sufficiency, and those problems threaten to get even worse and cause even greater deficiencies in the years ahead. Fairview has been experiencing serious operating losses in recent years and has said it can no longer afford to continue its current level of financial support for the Medical School. It has also, reportedly, failed to make the capital investments necessary to provide adequate hospital facilities for patients, doctors, and hospital staffs.

It seems clear that major changes must be made immediately to correct those deficiencies, before, as I said earlier, they worsen and cause even greater damage to the Medical School's and its hospitals' quality and standing. Look at what Mayo Clinic has just announced: a \$5 billion investment to keep its world-premier status.

That is the scale of what the Medical School, Fairview, and the State of Minnesota must commit to and carry out over the next decade. Otherwise, the quality of medical training provided to over 70 percent of Minnesota's physicians will suffer irreparably.

This cannot be allowed to happen.

I believe that the future advancement of the Medical School depends, first and foremost, on adequacy of funding. Mayo's \$5 billion investment sets a marker for what is necessary to establish and maintain premier status. The State of Minnesota needs to set up a similar capital improvement fund, using a dedicated revenue stream to secure bonds that can rejuvenate the U's existing hospitals and then build a new one.

Then the Governor and the Legislature must be asked to provide the additional operating funds for the Medical School to make up for Fairview's withdrawal of financial support.

Those advances will be expensive; however, the cost of failing to make them would be far greater. For Minnesota to lose its medical pre-eminence would be catastrophic.

## Comments from Governor Pawlenty

Thanks for the invitation to submit suggested recommendations to the task force.

The challenges and opportunities facing our healthcare delivery system are enormous in quantity and scope. As a result, I think it's important for the Task Force to strategically focus its recommendations.

Specifically, I suggest the Task Force focus its recommendations on the key strategic roles the U uniquely (or at least semi-uniquely) plays in our broader MN health ecosystem. Those roles include operating:

- (1) MN's flagship medical school which educates and trains most MN doctors.
- (2) numerous other health science schools and colleges that provide essential training for MN's health care workforce.
- (3) one of the largest NIH funded research programs in the country.
- (4) a critically important school of public health and related information distribution channels.
- (5) hospitals, clinics and research labs of sufficient quality to attract and retain top talent to serve as faculty, conduct research and provide care for patients - including patients with complex cases most other MN providers are not well-suited to address.

The U's differentiating and strategic value proposition for MN lies primarily in the 5 roles noted above. Numerous other institutions and organizations can and do provide the bulk of the regular and customary health care services delivered in MN. Other than providing the clinical environments necessary for the U's training, research and revenue generating needs, the U will not provide differentiated or strategic value by just being another provider of such regular and customary services.

With that focus in mind, my initial suggested recommendations are listed below. Each of the recommendations are intended to be specific and measurable so it will be easy for policy makers to monitor progress against the stated goals. Each of the recommendations also assumes the State of MN and/or other stakeholders will provide the resources necessary to accomplish each goal.

### **A. DEVELOP AND IMPLEMENT A PLAN FOR TWO ADDITIONAL MAJOR MEDICAL SCHOOL PROGRAMS TO EARN A TOP 10 RANKING IN TEN YEARS OR LESS:**

While rankings are often blunt and incomplete measurements, they're undeniably a proxy for an institution's reputation and quality. They also provide meaningful and important signals in the competition for top talent. Dr. Tolar and his team should be recognized and applauded for



the remarkable progress that's been made at the medical school in recent years. However, the vision and work to further improve the U's medical school needs to continue with alacrity. U.S. News and World Report ranks the U's medical school programs as follows: 35th in research (note: the U is #9 in the *overall dollar amount* of NIH funding received); #2 in primary care; #7 in family care; #37 in cancer care). No other U medical school program currently earns any ranking at all. Of course, rankings vary somewhat based on the service or publication conducting the ranking. For example, the U fares much better in the The Blue Ridge Institute's rankings which focus on levels of NIH research funding. Nonetheless, the flagship medical school in arguably the nation's leading health care state should be better. As part of that effort, the U should identify 2 additional major medical school programs that are highly relevant to MN's health needs - and what it would take to transform those programs into top ranked programs in ten years or less.

***B. WHILE MAINTAINING QUALITY, SIGNIFICANTLY INCREASE THE NUMBER OF GRADUATES FROM THE U'S MEDICAL SCHOOL AND SELECT OTHER HEALTH SCIENCE SCHOOLS TO BETTER MEET MN'S HEALTH CARE NEEDS:***

MN is experiencing a significant shortage of doctors and other health care professionals. That shortage is particularly acute in certain communities. While new care delivery models, technology, and innovation are urgently needed and may eventually help address this shortage (see below), recruiting, training and deploying more providers remains essential. The Task Force heard testimony that MN's population doubled since 1972 - while the annual number of graduates from the U's medical school has barely changed since then. The U's medical school initiative with CentraCare in Saint Cloud represents some progress but more is needed. The U should significantly increase the number of graduates from its medical school and increase the related number of residents and fellows.

***C. MAINTAIN THE U'S STATUS AS A TOP 10 RECIPIENT OF NIH RESEARCH FUNDING:***

The extraordinary level of NIH research funding the U receives provides enormous health, academic and economic benefits to MN and beyond. That funding is also an important marketplace signal and magnet in the marketplace for top talent. That talent then contributes mightily to the quality and reputation of the U's training and research mission. The specific reasons the U receives such an extraordinary amount of NIH research funding should be more specifically identified and catalogued. The U should then receive the support it needs to ensure the capabilities that attract top levels of research funding are fortified, protected and expanded. The goal should be for the U to remain a top 10 recipient (on average) of NIH funding over the next ten years.

***D. THE U SHOULD DESIGN AND BETA TEST AT LEAST ONE SCALABLE BREAKTHROUGH PUBLIC HEALTH OR CARE DELIVERY MODEL INNOVATION IN THE NEXT 5 YEARS:***

The list of possibilities here is almost endless - but a leading contender for such an effort might include the U designing, implementing and beta testing a new care delivery model that is: asset

light, nimble, enabled substantially by technology, equitably available, scalable, with significantly lower demands on practitioners and relatively more efficient and economical than currently prevailing models. The funding and regulatory relief necessary to test such a model should be provided.

***E. ENSURE THE QUALITY AND CAPACITY OF THE U'S MEDICAL BUILDINGS REFLECT THE IMPORTANCE OF THE U'S MEDICAL MISSION TO MN AND THE U'S ASPIRATION TO BE A TOP TIER MEDICAL CENTER***

The U obviously needs and deserves a new hospital as well as other major capital improvements to its medical center buildings. Designing, funding and constructing a new hospital will take a long time - even under the best of circumstances. The Task Force could accelerate the first stage of that long timeline by highlighting the urgent need for a new U hospital and strongly recommend policy makers take the first steps as quickly as possible. Otherwise, it seems the plans will be slowly walked forward - if they advance at all. Now is the time to start this process.

I will reserve my recommendations regarding the Fairview/U matters since those topics are beyond the scope of the Task Force.

Thanks.

Tim Pawlenty