DEPARTMENT OF HEALTH

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

DRAFT CONTEXT, PROBLEM STATEMENTS, AND QUESTIONS

Context statements

General context that is reflected nationally

- There is a serious health care worker shortage, exacerbated by burnout across settings and provider types. This is particularly true for primary care, and mental and dental health providers. The shortage is as bad or worse in long term care (LTC) and home and community-based settings (HCBS) and creates concerns for the ability to continue to deliver safe, high-quality care.
- Care settings across the entire continuum are interdependent for patient flow and outcomes. This became especially obvious during the COVID-19 pandemic.
- There are barriers and challenges throughout the current pathway to health care careers. The pathway starts early in the K-12 system and ends post-medical or other health profession training, often in a residency or other post-graduate apprentice program.
- It will take new models of care delivery, and new investments in recruitment and retention, to prevent these shortages from getting worse.
- Technological advances will undoubtedly change both the way health professionals are trained and how/where care is delivered.
- There has been a dramatic shift in the sources of revenue for medical schools over the last several decades. As a result, academic health centers have become increasingly reliant on profitable clinical care revenues to support their programs.
- The dominant payment models for patient care, with a predominantly fee-for-service structure, produce high profit margins for some services and large losses for others. Procedural and technological care is more profitable, while more cognitive and relational care is not.
- The predominant funding source for clinical graduate medical education is the federal Medicare program.
- Increasing competition in health care, higher labor costs, and changes in patterns of care utilization have led to more pressure to reduce less profitable spending.

Minnesota-specific context

- Minnesota has the same workforce and care delivery challenges as other states across the nation.

- The breadth of the health sciences programs at the University of Minnesota, with six health sciences schools, is a unique asset that may contribute to addressing workforce and care delivery challenges.
- The University of Minnesota Medical School has risen significantly in national rankings – rising from being ranked in the low 30s twenty years ago to #28 ten years ago, to #21 in 2023. Sustaining or building on this improvement will be important.
- The largest trainer of physicians in the state, the University of Minnesota medical school is currently discussing partnership renewal options with its primary partner. Although a change or ending of the partnership would not take effect for a few years, medical school staff say the uncertainty of the situation is already impacting their ability to recruit and retain staff.
- While these negotiations are beyond the Task Force's scope, the continuum of possible outcomes may require a continuum of possible legislative and/or policy solutions to strengthen academic health.

Problem statements

1. *The University of Minnesota medical school is facing challenges in its relationships with private clinical partners. Given these challenges, support for health professions training, including financial support, needs to be re-evaluated*.
    - There is a gap between current funding for the University of Minnesota medical school and what is needed for it to achieve their planned goals related to its academic health programs.
    - There is a need to determine what, if any, changes are needed in public direct and indirect funding to support health professions training at the University of Minnesota.
    - Many entities benefit from having a robust health professions pipeline and a strong research infrastructure at the University of Minnesota. In recognition of that, the Task Force should consider possible sources of funding beyond traditional State sources.
    - The outcomes expected for any investment of public funding needs to be defined (for example, numbers/types of providers, rural training opportunities, health outcomes, health equity, medical school ranking, numbers of grants, etc.).

Questions to shape recommendations (#1)

- What are the University of Minnesota's most important functions to meet the health needs of the public, as it relates to both health professions training and clinical research?
- What can the University of Minnesota's health professions education and clinical research programs be most pre-eminent in, knowing that no one university can be the best at everything?
- What parts of the problem(s) can we expect the market to solve versus what will require public policy or funding solutions?
- Where are the opportunities for increased collaboration across health systems to support Minnesota's health care workforce needs and desired health outcomes?
- If there were to be any increased public investment in the University of Minnesota's health professions programs, what outcomes related to quality, geographic distribution, access to high-

quality, affordable care, focus on primary care, mental health, and non-physician provider types, and health equity should the University be held accountable for in return?

- How would any potential increased public investment in the University of Minnesota's health professions programs be overseen, and by whom?
- How are possible funding solutions sustainable and adaptable to changing care delivery models, technological advances, etc.?

2. *Current health professions training programs at the University of Minnesota and other institutions are not producing the number nor types of health care providers needed to care equitably for all Minnesotans now and into the future given how health care delivery is changing.*

- There is a serious geographic maldistribution of the health care workforce. Rural, and underserved areas are disproportionately impacted, as are LTC settings, primary care, mental health, and dental care.
- The diversity of providers being trained is also not reflective of the diversity of the populations of Minnesota.
- Financial concerns (tuition, student debt, availability of career pathways) remain a barrier for many people entering the health care profession.

Questions to shape recommendations (#2)

- What types of innovative partnerships or collaborative training models with other academic institutions or training providers could be considered to meet the health care needs of the future?

3. *The University of Minnesota has unrealized potential to develop innovative care models that build on the breadth and strength of the University's health sciences schools as well as engineering and technology programs. These interprofessional programs will likely be essential in building the health workforce of the future and new models of prevention and care to improve health outcomes for all Minnesotans.*

- Current payment structures for clinical care result in a mismatch between the revenue needs and incentives toward specialty training of academic health centers on the one hand, and what is needed to improve population health and equity (geographic as well as racial and ethnic) on the other hand.
- Current health professions education systems may not be adequately preparing students for the way care will be delivered in the future (technology, insurance literacy/billing, process/quality improvement, equity, rural care delivery, team-based care, expanded use of non-physician providers. etc.).

Questions to shape recommendations (#3)

- How can new training models or partnerships at the University of Minnesota and with other training providers help to solve intractable workforce problems in all care settings?

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