



Special Committee on Academic Medicine

December 2014

December 11, 2014

8:00 a.m. - 10:00 a.m.

West Committee Room, McNamara Alumni Center

CAM - DEC 2014

1. The Future of Graduate Medical Education and its Financing

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2. Trends and Impact of Health Care Reform on Clinical Education

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BOARD OF REGENTS DOCKET ITEM SUMMARY

Special Committee on Academic Medicine

December 11, 2014

Agenda Item: The Future of Graduate Medical Education and Its Financing

Review

Review + Action

Action

Discussion

This is a report required by Board policy.

Presenters: John Andrews, Associate Dean for Graduate Medical Education, Medical School

Purpose & Key Points

Graduate Medical Education (GME) is the clinical training and education of physicians after Medical School and before specialty certification. The docket materials and committee presentation will provide an overview of the University's GME programs and include a discussion of the implications of a recent Institute of Medicine Report (IOM) report and other reform efforts for the Medical School and its GME programs.

Key points include:

- *The University's current GME programs:* The Medical School has 910 residents and fellows in its 85 accredited GME programs. Our primary training sites are: University of Minnesota Medical Center, Hennepin County Medical Center, Regions, Veterans Administration Medical Center, Children's Hospitals and Clinics, HealthEast, Methodist, North Memorial, and Duluth. 61% of our GME residents stay in Minnesota to practice.
- *Funding for GME is complex:* Hospitals cover the bulk of the cost: pay residents/fellow stipends, training costs and other direct/indirect expenses. The hospitals' primary funding source is Medicare. Other revenue sources include MERC (a State of Minnesota program), Medicaid, and clinical revenues. The Veterans Administration pays stipends for residents rotating through its medical centers. Hospitals have a cap on the number of slots and federal funding based on 1996 resident numbers. To innovate, add training in emerging fields, and meet workforce demands, hospitals and the University must invest other funds above the cap.
- *The growing challenge:* As the U.S. population ages and becomes increasingly diverse, and the Affordable Care Act extends coverage to more Americans, it has become even more critical that the nation's GME system produces a physician workforce that meets the country's evolving health care needs.

- *Institute of Medicine Report:* Earlier this year, the national Institute of Medicine (IOM) issued a far-reaching report on the nation's GME system, calling for major reform. IOM and earlier studies have raised a range of concerns about the current system:
 - A mismatch between the health needs of the population and the specialty make-up of the physician workforce.
 - Persistent geographic maldistribution of physicians.
 - Insufficient diversity in the physician population.
 - A gap between new physicians' knowledge and skills and the competencies required for current practice.
 - Lack of fiscal transparency.
- *Workforce projections:* Although not part of its formal charge, the IOM reviewed recent projections and analyses of future physician workforce needs. While some projections predict imminent physician shortages because of the aging of the population and expansion of health coverage under the Affordable Care Act, the IOM report questions the underlying methodology and assumptions used in these studies.

These studies generally assume historical provider-patient ratios, current technology, and current care models. IOM found that physician workforce analyses that consider the potential impact of changes in health care delivery draw different conclusions. These studies suggest that an expanded primary care role for other health providers such as advanced practice nurses and physician assistants, a redesign of care delivery, and use of other innovations, such as telehealth, may ultimately reduce the demand for physicians despite the added pressure from the aging population and coverage expansions.

- *Unintended consequences of current GME payment system:* The current GME system – which is hospital-based, tied to historical Medicare and Medicaid hospital volumes, and the distribution of resident/fellow slots in 1996 – undercuts the nation's ability to respond to current and future health care needs such as the need for an increasing proportion of physicians to practice primary care, provide care for underserved populations, or locate in underserved rural and urban communities. The current payment system also means that almost all GME training occurs in hospitals – even for primary care residencies – in spite of the fact that most physicians will spend most of their careers in ambulatory, community-based settings. A fundamental rethinking of GME and state financing is needed to support clinical training in ambulatory settings where physicians practice.

Background Information

The December 2013 meeting of the Special Committee on Academic Medicine focused on a general overview and discussion of the University's health professional education programs.

Graduate Medical Education

John S. Andrews, M.D.
Associate Dean
Graduate Medical Education

December 11, 2014



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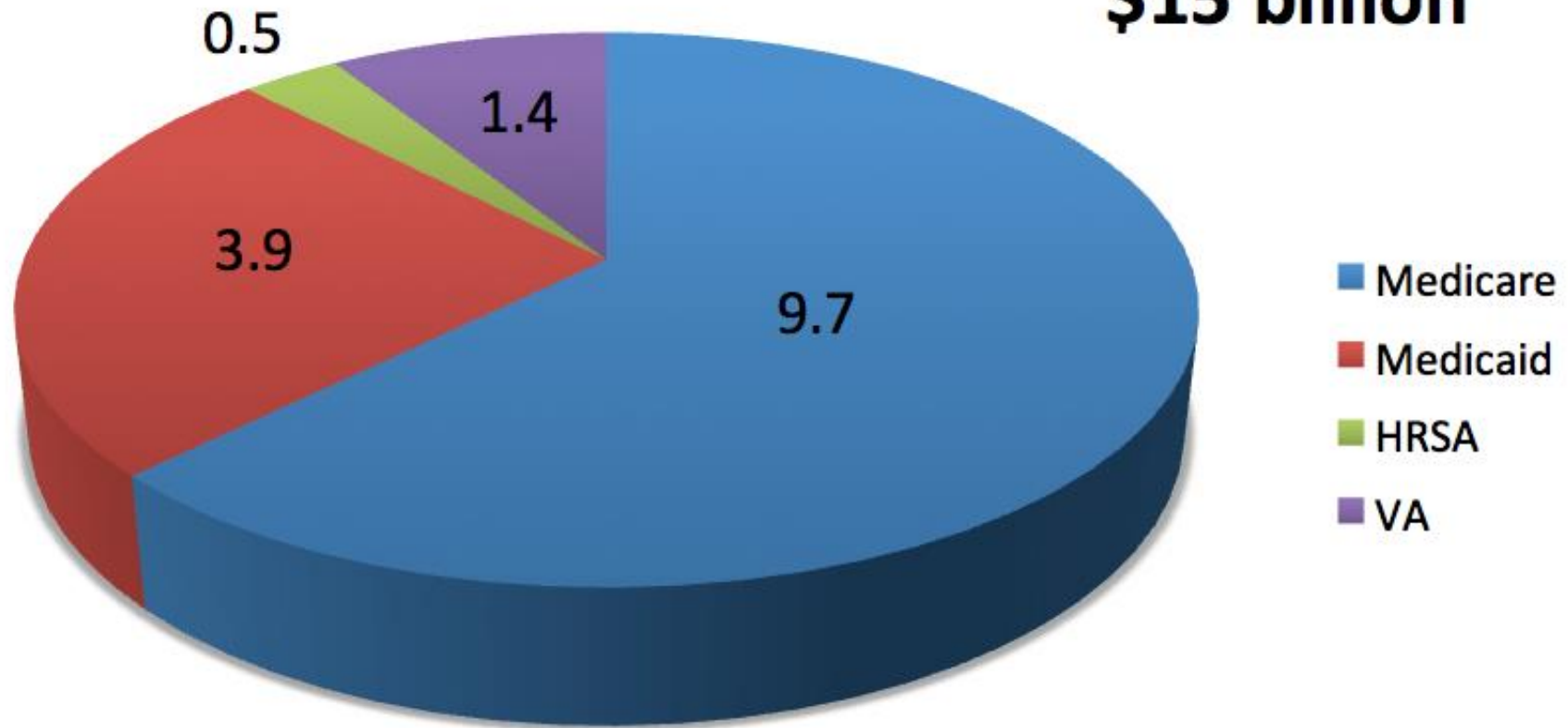
GME programs at UMN

- 85 ACGME-accredited programs
- 910 trainees
- 203 residency graduates in 2014
 - 117 entered practice
 - 88 in Minnesota
- 95 fellowship graduates in 2014
 - 73 entered practice
 - 32 in Minnesota



Federal funding of GME

\$15 billion



Funding

- DME (\$2.6 billion)
 - Hospital cost report
 - Medicare's share of residency education
 - Resident/faculty salary & fringe
 - Overhead and direct costs
- IME (\$6.8 billion)
 - Higher patient care costs
 - Increased inpatient DRG rates
- Varies by hospital
- Fellows $\frac{1}{2}$ DME



Federal funding history

- Medicare 1965
 - Support for GME until society undertook to “bear such education costs in some other way.”
- Balanced Budget Act 1997
 - Support capped
- Obama budget 2013
 - Reduce IME by \$9.7 billion over 10 years
 - IME adjustments “significantly exceed the actual added patient care costs these hospitals incur” (MedPAC)
 - Incentives
 - Reduced CHGME IME



The Cap

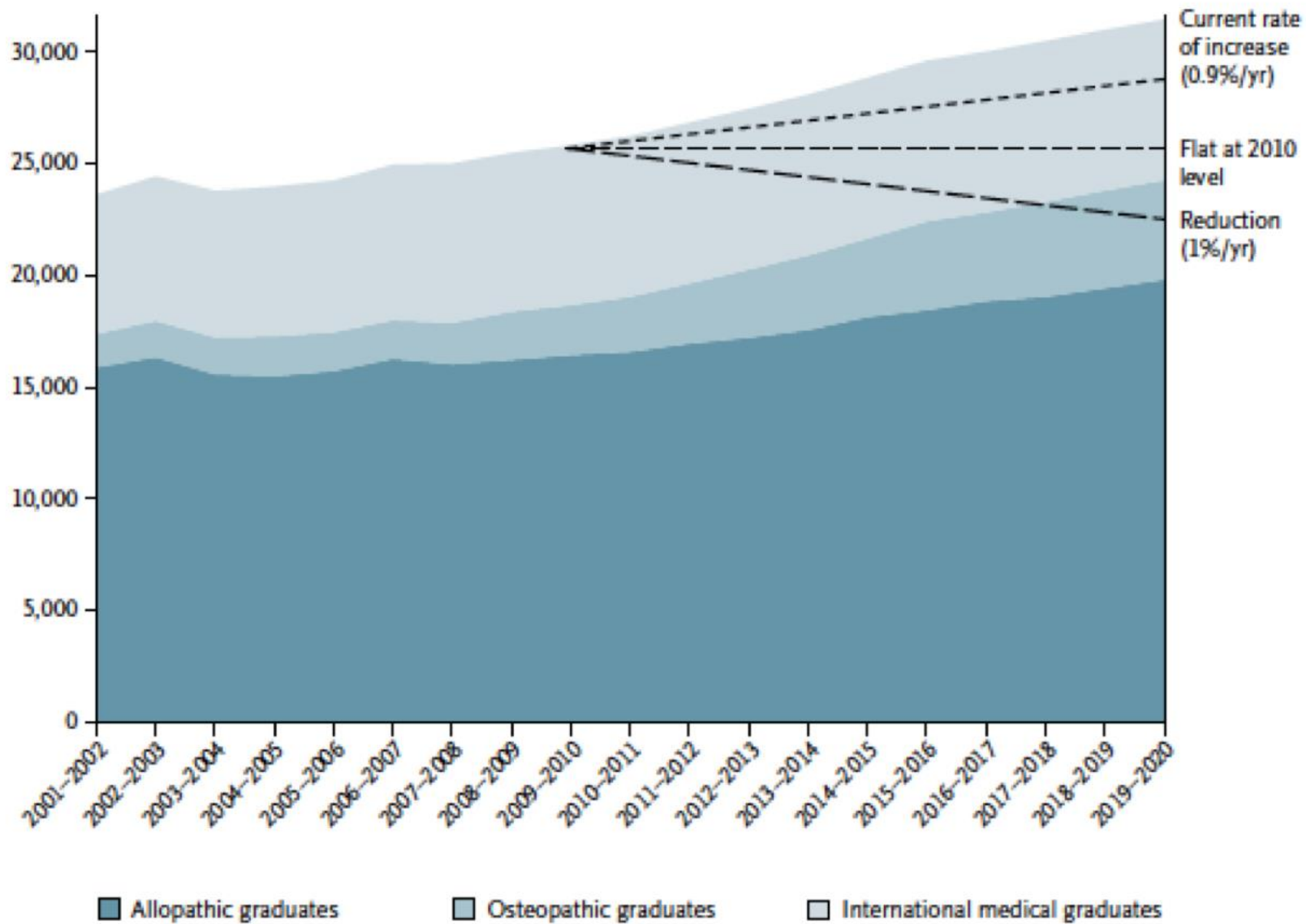
- Locally
 - Federally funded cap = **1091**
 - Budgeted FTE 2013-14 = **1275**
- Nationally
 - 9000 over cap
- Additional resources are ***already*** being committed to GME



Workforce

- AAMC: Shortage of 62,900 physicians by 2015
 - 15% increase in federally-funded GME slots
- Affordable Care Act
- 16 new medical schools
- National Healthcare Workforce Commission
- IOM Committee on Governance and Financing of Graduate Medical Education

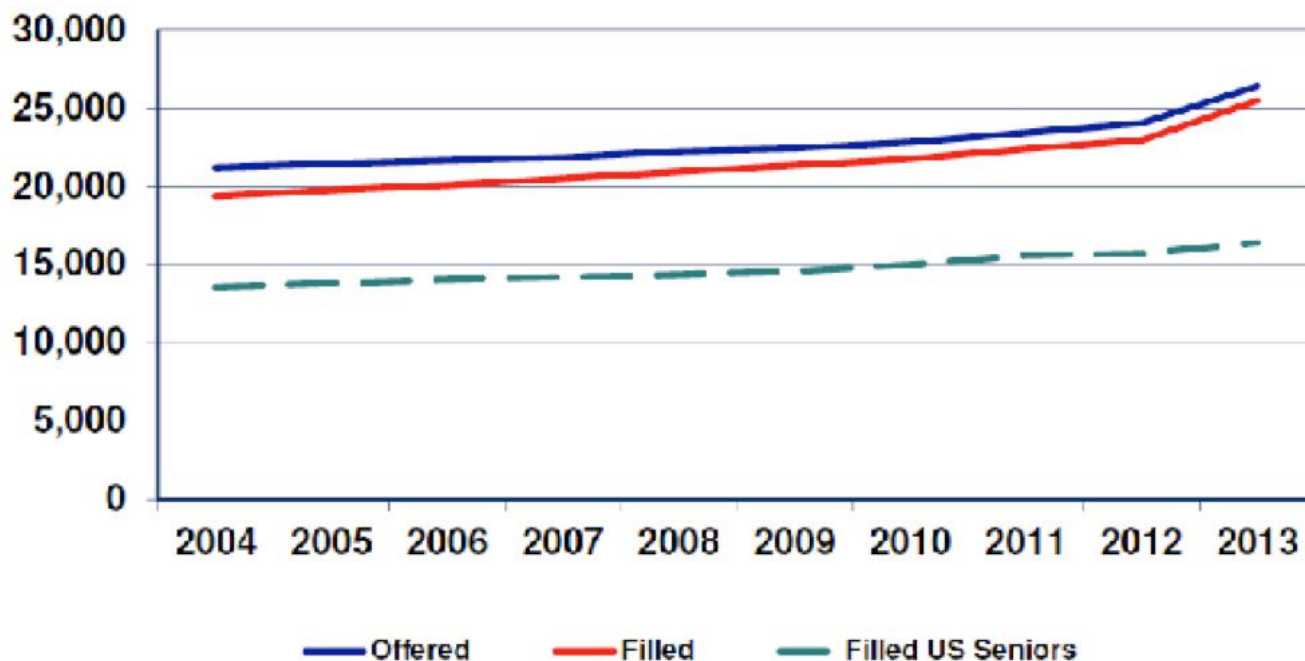




Main Residency Match

PGY-1 Positions Offered and Filled

All In Policy Created a Rising Tide



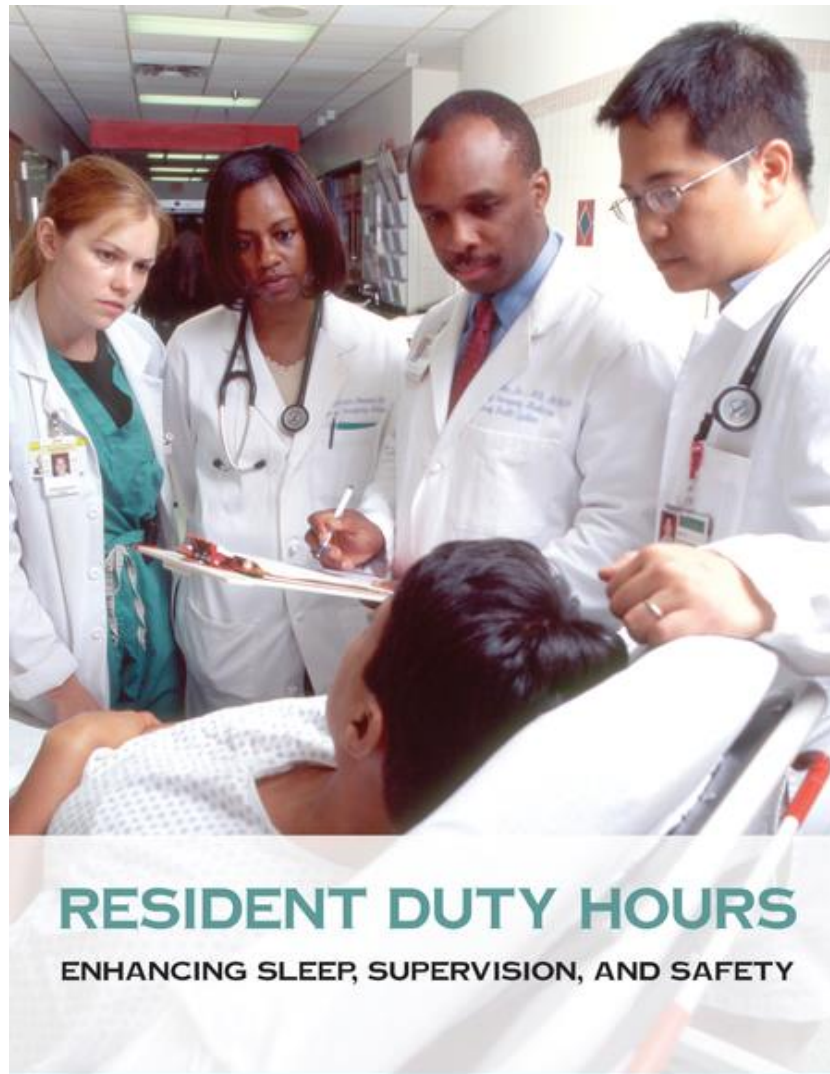
IOM Report: Governance and Financing of GME



Institute of Medicine (IOM)

- Independent, nonprofit organization
- Works outside of government to provide unbiased and authoritative advice to decision makers and the public.
- Health arm of the National Academy of Sciences
- Specific mandates from Congress
- Requests from federal agencies and independent organizations
- 1900 members





RESIDENT DUTY HOURS

ENHANCING SLEEP, SUPERVISION, AND SAFETY

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES



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Governance and Financing of GME

- Follow up on 2 Macy Foundation reports
- 11 private foundations
- Appointed summer 2012



Charge

An ad hoc IOM committee will develop a report aimed at:

- Improving GME with an emphasis on the training of physicians
- Increasing capacity to deliver efficient and high-quality health care
- Meet the needs of our diverse population



Charge

The committee will consider:

- The current financing and governance structures of GME
- The residency pipeline
- The geographic distribution of generalist and specialist clinicians
- Types of training sites
- Relevant federal statutes and regulations
- The respective roles of safety net providers, community health/teaching health centers, and academic health centers



Members

DONALD BERWICK (Cochair), Former President and CEO, Institute for Healthcare Improvement

GAIL R. WILENSKY (Cochair), Senior Fellow, Project Hope

BRIAN ALEXANDER, Director, Neuro-radiation Oncology, Brigham and Women's Hospital and Dana-Farber Cancer Center

DAVID A. ASCH, Executive Director, Penn Medicine Center for Health Care Innovation, University of Pennsylvania and Philadelphia VA Medical Center

DAVID ASPREY, Professor and Chair, Department of Physician Assistant Studies, Assistant Dean, Office of Student Affairs and Curriculum, University of Iowa Carver College of Medicine

ALFRED O. BERG, Professor, Department of Family Medicine, University of Washington School of Medicine

PETER BUERHAUS, Valere Potter Distinguished Professor of Nursing and Director, Center for Interdisciplinary Health Workforce Studies, Institute for Medicine and Public Health, Vanderbilt University Medical Center

AMITABH CHANDRA, Director of Health Policy Research, Kennedy School of Government, Harvard University

DENICE CORA-BRAMBLE, Chief Medical Officer and Executive Vice President, Ambulatory and Community Health Services, Children's National Health System

MICHAEL J. DOWLING, President and CEO, North Shore–Long Island Jewish Health System

KATHLEEN A. DRACUP, Dean Emeritus, University of California, San Francisco School of Nursing

ANTHONY E. KECK, Director, South Carolina Department of Health and Human Services

OCTAVIO N. MARTINEZ, JR., Executive Director, Hogg Foundation for Mental Health

FITZHUGH MULLAN, Murdock Head Professor of Medicine and Health Policy, Department of Health Policy, The George Washington University

ROGER PLUMMER, Retired Telecommunications Industry Executive

DEBORAH E. POWELL, Dean Emeritus and Professor of Laboratory Medicine and Pathology, University of Minnesota Medical School

BARBARA ROSS-LEE, Vice President for Health Sciences and Medical Affairs, New York Institute of Technology

GLENN D. STEELE, JR., President and CEO, Geisinger Health System

GAIL L. WARDEN, President Emeritus, Henry Ford Health System

DEBRA WEINSTEIN, Vice President for GME, Partners Health System

BARBARA O. WYNN, Senior Policy Analyst, The RAND Corporation



Goals

1. Encourage production of a better-prepared physician workforce
2. Encourage innovation
3. Provide transparency and accountability of GME programs for GME funding and achievement of goals
4. Clarify and strengthen public policy planning and oversight of GME
5. Ensure rational, efficient, and effective use of public funds
6. Mitigate unwanted and unintended negative effects



Recommendation #1

Maintain Medicare graduate medical education (GME) support at the current aggregate amount



Recommendation #2

Build a graduate medical education (GME) policy and financing infrastructure

- Create a GME Policy Council in the Office of the Secretary of the U.S. Department of Health and Human Services
- Establish a GME Center within the Centers for Medicare & Medicaid Services with the following responsibilities in accordance with and fully responsive to the ongoing guidance of the GME Council



Recommendation #3

Create one Medicare graduate medical education (GME) fund with two subsidiary funds:

- GME Operational Fund
- GME Transformation Fund



Recommendation #4

Modernize Medicare graduate medical education (GME) payment methodology

- Replace the separate indirect medical education and direct GME funding streams with one payment to organizations sponsoring GME programs, based on a national per-resident amount (PRA)
- Set the PRA to equal the total value of the GME Operational Fund divided by the current number of full-time equivalent Medicare-funded training slots
- Redirect the funding stream so that GME operational funds are distributed directly to GME sponsoring organizations
- Implement performance-based payments using information from Transformation Fund pilot payments



Recommendation #5

- GME funding should remain at the state's discretion
- Congress should mandate the same level of transparency and accountability in Medicaid GME as it will require under the changes in Medicare GME herein proposed



Reaction

- AHA
 - Money to entities that don't treat Medicare patients
- AAFP, AAP
 - Better alignment of training with needs
- AMA
 - Doesn't address projected shortage
- AAMC
 - Will compromise vital clinical services



Physician shortage?

- Focusing on numbers of physicians ignores:
 - evolving models of care
 - geographic and specialty maldistributions
 - health outcomes
- Are we training enough of the right kind of physician?





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Special Committee on Academic Medicine

December 11, 2014

Agenda Item: Trends and Impact of Health Care Reform on Clinical Education

Review **Review + Action** **Action** **Discussion**

This is a report required by Board policy.

Presenters: Marilyn Speedie, Dean, College of Pharmacy
Connie Delaney, Dean, School of Nursing
Mark Rosenberg, Vice Dean for Education, Medical School

Purpose & Key Points

With 6,200 students in 62 degree programs, the University of Minnesota educates and trains 70% of the health professionals in Minnesota. The University is a national leader in interdisciplinary education and care – the future of health care in this country and internationally. Its top-ranked health professional schools and long history of innovation positions it well for the future.

That said, health professional education in Minnesota and nationally faces enormous challenges and is undergoing fundamental change in response to the changing health care environment and ever-tighter fiscal resources. This change requires a redesign of education and clinical practice. Health care delivery is moving from:

- Uninsured to insured: increasing access and demand.
- Non-integrated to integrated care delivery.
- Independent to employed providers.
- Fee-for-service to value-based financial models and payment systems.
- Hospital-based to outpatient-based care.
- Emphasis on disease to an emphasis on health and preventive care.
- Treatment-oriented specialty care to primary care.
- Autonomous providers to interprofessional teams.

Changes in health care delivery will require changes in clinical education and training:

- Training will shift from inpatient to more outpatient care and from subspecialty training to primary care.
- Increasing emphasis on interprofessional training, online and simulation training, and working as teams in clinical settings to deliver care with each member of the team working at the top of their license and degree.

- Demand for more training in underserved urban and rural primary care outpatient settings as well as in international health settings.

How can the University of Minnesota meet the growing and rapidly changing health professional workforce needs of Minnesota? Among the many policy issues the University must address are these:

- Mix of health providers needed in the state.
- Skills and expertise required of providers in a changing health care environment.
- Access to rotation sites for experiential education.
- Financing of health professional education and training programs.

The presentation will provide an overview of the University's health professional programs and tee up a discussion of the state's demand for health professionals in a changing health care environment; the challenges we face as the state's primary educator of Minnesota's health workforce; the implications of health care reform on clinical education and training; our accomplishments to date; and future plans.

Background Information

The December 2013 meeting of the committee focused on a general overview and discussion of the University's health professional education programs. In October 2014 the committee discussed the impact of health care reform on the clinical market place and the University's clinical enterprise.

Trends and Impact of Health Care Reform on Clinical Education – Medical School Perspective

Mark Rosenberg, M.D.
Vice Dean for Education
Medical School

December 11, 2014

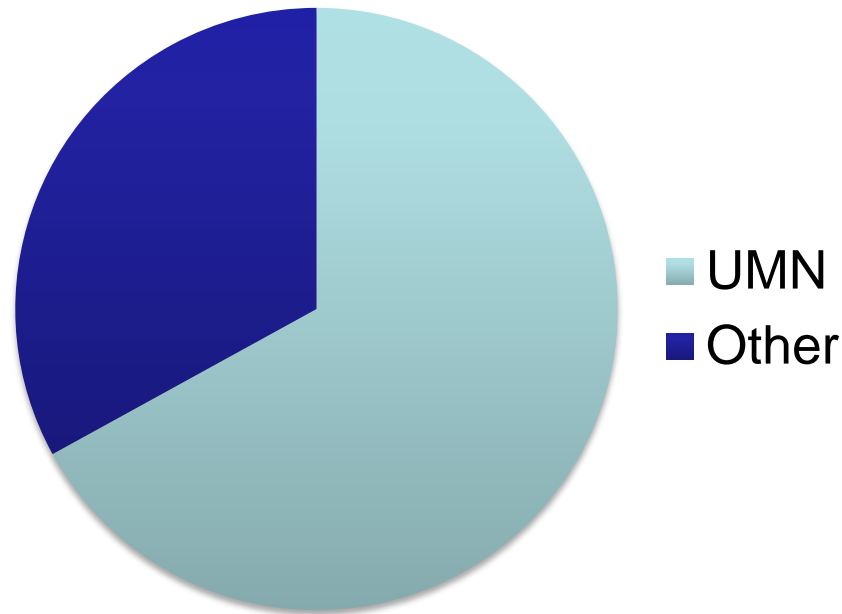


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Minnesota Physicians



67% of Minnesota physicians have trained at the University of Minnesota Medical School

Active Minnesota license with Minnesota practice site as of December 2012 (n=12,044)



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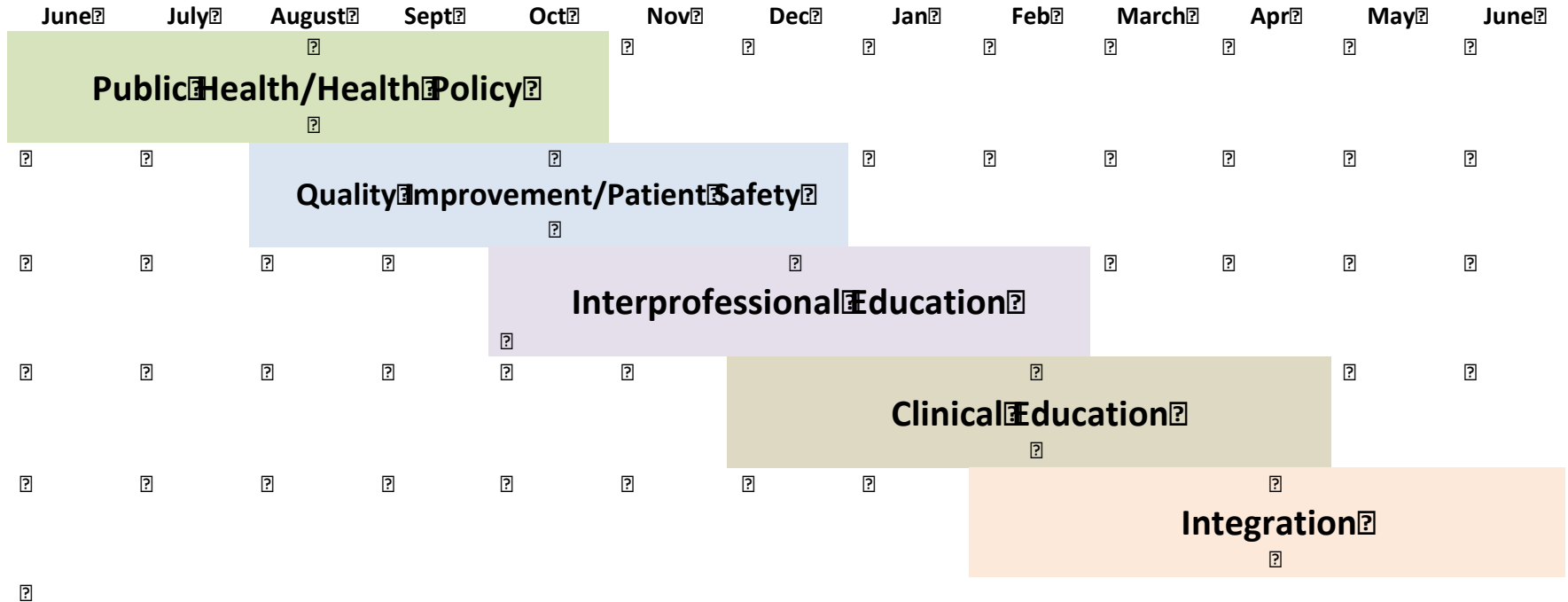
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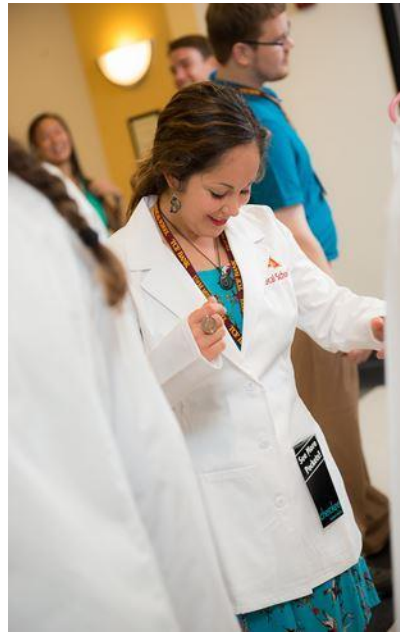
Impact of Health Care Reform

- Workforce needs
- New models of care
- Emphasis on higher quality at lower cost
- Movement to population health
- Greater emphasis on preventive services



Workgroups

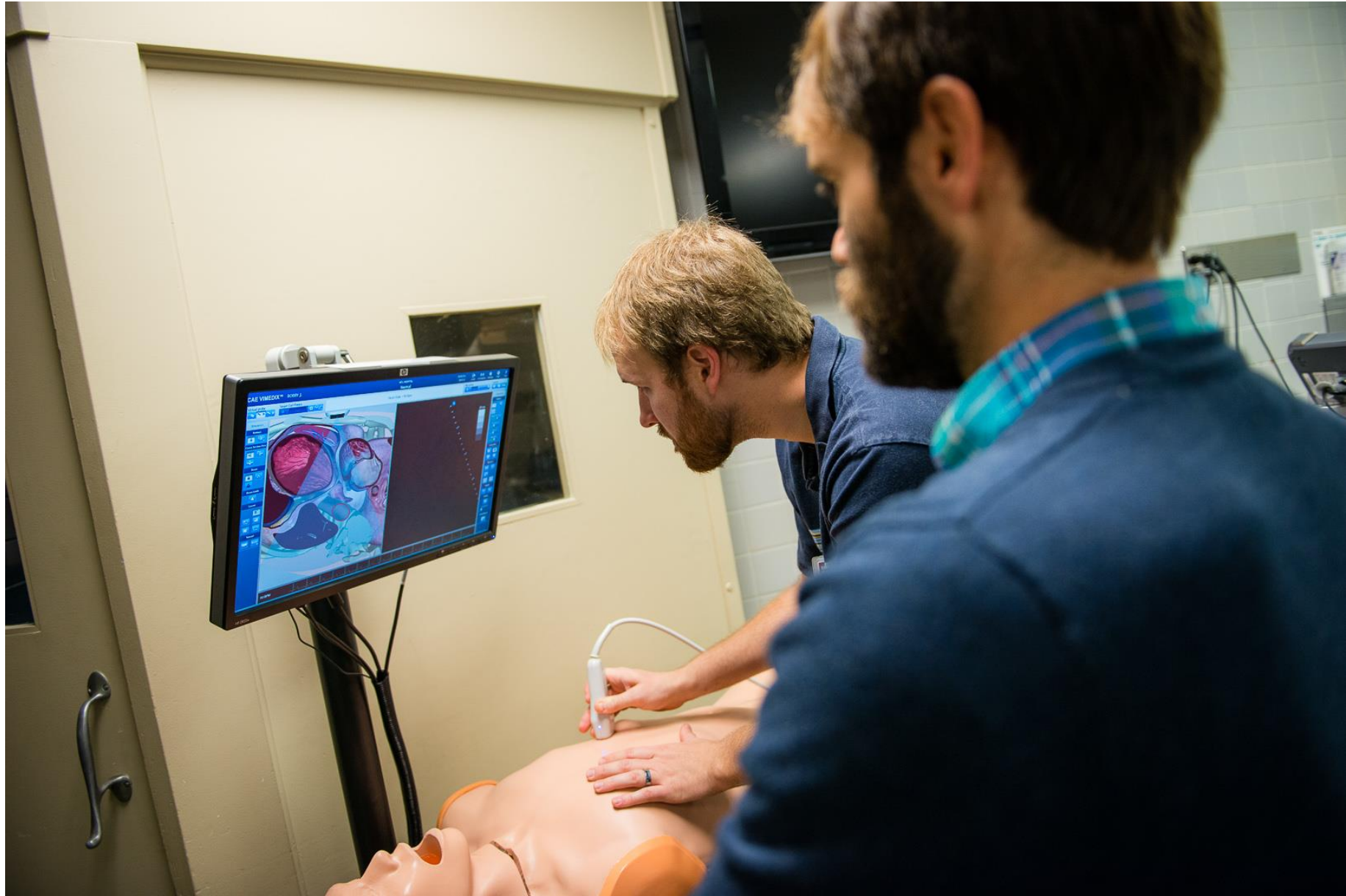




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Teaching Partnerships



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Community Partnerships

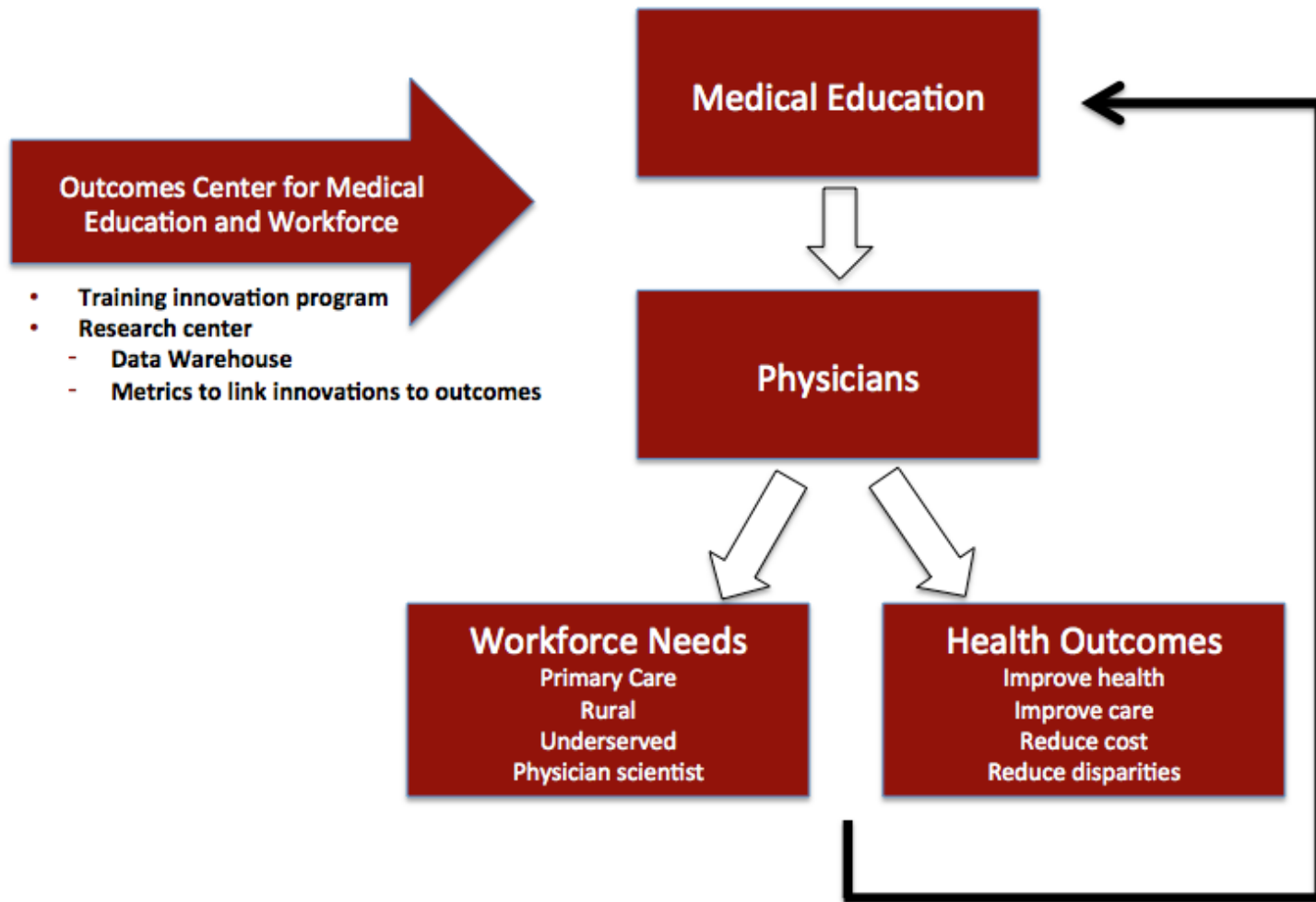


Medical Education Outcomes

- Judge education programs by the quality of care graduates deliver
- Design education to improve care



Healthy Minnesota Initiative



M.D. Applications

	National Applications	National Enrollment	UMTC Applications	UMTC Enrollment	UIM
2014	49,480	20,343	3716	170	18.8%
2013	48,014	20,055	3,852	170	10.5%
2012	45,266	19,517	3,669	170	8.8%
2011	43,919	19,230	3,550	170	9.4%
2010	42,741	18,665	3,361	169	8.3%
2009	42,268	18,390	3,259	169	7.1%
2008	42,231	18,036	3,212	170	11.8%

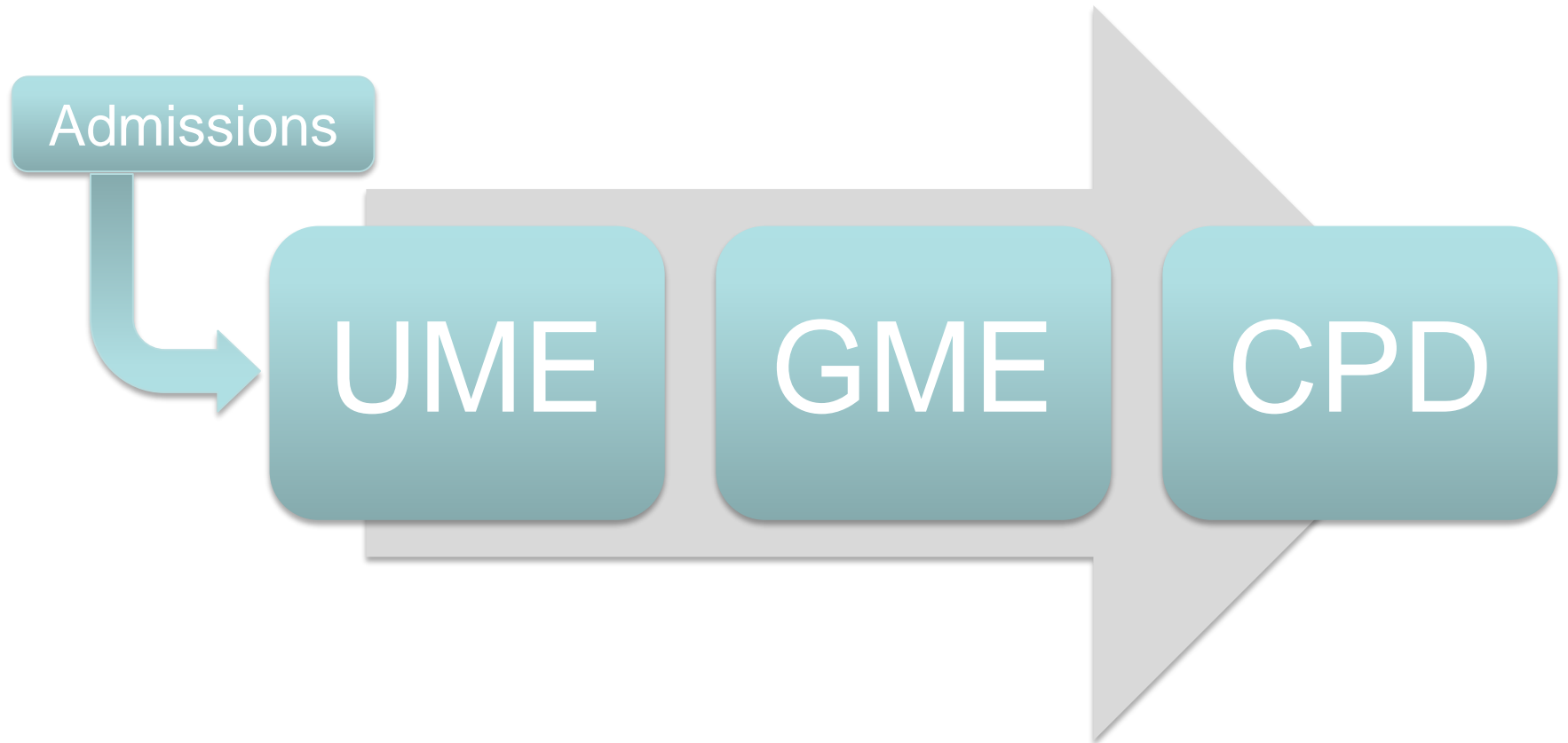




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Office of Medical Education



The Impact of Health Care Reform on the College of Pharmacy

Marilyn Speedie

Dean, College of Pharmacy

December 11, 2014



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College of Pharmacy

Over the past 20 years, drug therapy has become more complex:

- More medications per patient
- More complex medications available
- More types of prescribers
- Drugs purchased over the internet; mail order
- More physician specialists seen per patient

All Minnesota pharmacists who have graduated since 1996 are educated to provide direct patient care that gets desired results from medications.

Pharmacists Have Many Years Experience with Providing Medication Management to Minnesotans

- Since 2006 Minnesota DHS has paid for medication management for Medicaid patients with 2 or more chronic diseases and/or 4 or more medications.
- Medication management results in improved therapeutic outcomes as well as physician and patient satisfaction. Some pharmacists prescribe under the collaborative practice provision. Physicians are freed to deal with more acute issues.
- Medication management can be performed as part of a medical home/clinic; home health; or in a community pharmacy setting, providing there is a private consultation area and adequate connection to the medical record.

Health Care Reform Will Dramatically Affect How Pharmacists Practice

Pharmacists are increasingly being asked to use the full scope of their strong clinical skills AND to:

- participate in collaborative care settings, in interprofessional teams,
- help lead change in the new health systems,
- contribute to achieving the “triple aim” (lower cost, better health, improved patient experience) that is the goal of health care reform,
- be part of “pay for performance” systems,
- and use technology effectively.

Pharmacy: This Is Our Time

- Pharmacists are well-positioned to play a major role in health reform.
 - Pharmacists are the most accessible health care provider: 275 million Americans visit a pharmacy per week.
 - 80% of patients receive prescriptions for at least one drug; drug therapy is the most cost-effective mode of treatment.
 - Pharmacists have proven value and have expanded their roles on the health care team, especially in meeting primary care needs.
 - MN is leading change as to where and how pharmacists practice and in documenting positive financial and health outcomes.

Forbes: Pharmacist Best Healthcare Job in 2015

The Best Jobs In Healthcare In 2015

1 of 10



AP Photo/Houston Chronicle, Gary Coronado

Pharmacist

Median salary: \$116,670

Projected growth in the field by 2022: 14%

Source: Bureau of Labor Statistics

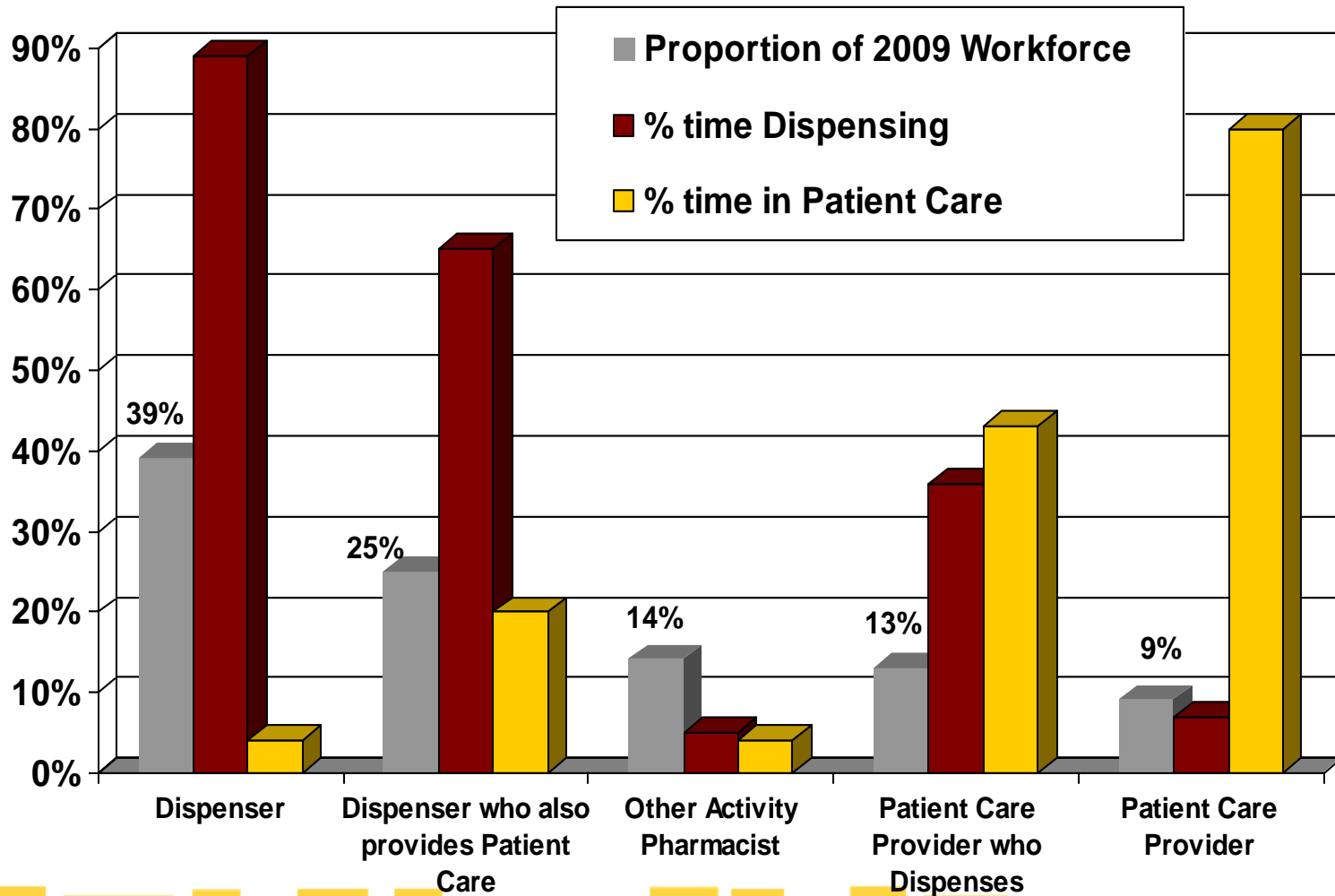
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College of Pharmacy ^{50 of 87}

Pharmacists in Healthcare in Minnesota

- Pharmacists are increasingly involved in transitions of care from hospitals to TCUs and home. Examples:
 - Minnesota Visiting Nurse Agency (MVNA):
 - 30% reduction in re-hospitalizations
 - 50% reduction in Emergency Department visits
 - Hennepin County Medical Center (HCMC):
 - Increased primary care visits vs. Emergency Department for high risk populations

U.S. Pharmacist Segments in 2009



Overview of College of Pharmacy

- Four year Doctor of Pharmacy degree program is the only program for the preparation of pharmacists (true all over the U.S.)
- Ranked #3 by *U.S. News & World Report*
- 640 Doctor of Pharmacy students on two campuses, Twin Cities and Duluth, connected by interactive television

Our Commitment to Minnesota

- We are maintaining our commitment to produce outstanding pharmacists for the whole state of Minnesota, as exemplified by our expansion to Duluth.
- One driving force for the expansion in 2003 was a study conducted by collegiate faculty that showed 126 communities that were at risk of losing pharmacy services all together because of a shortage of pharmacists willing to work in a rural setting.

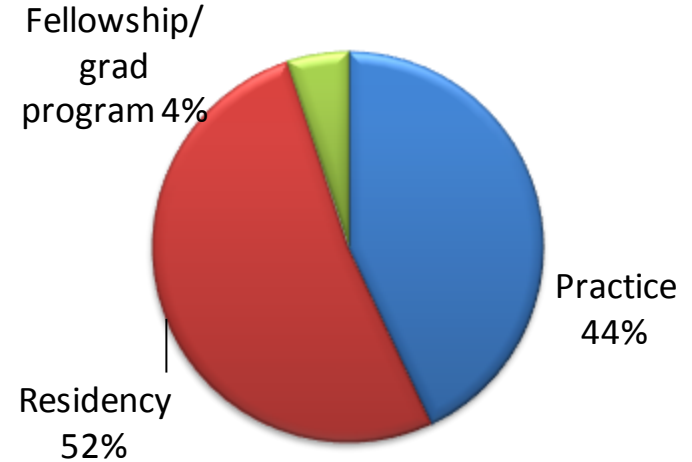
Helping to Develop the Health System and Advance the Profession So Graduates Have a Place to Apply Their Skills

- MTM Network – bringing patients needing medication management to pharmacists
- Collaboration with the health systems and individual pharmacists to advance the ability of pharmacists to practice to their full abilities to help patients; documenting outcomes.
- Developing and evaluating new models of care – e.g. home health, transitions of care, participation in new nursing primary care clinic.

Class of 2018

- 3.53 avg. GPA
- 90% bachelor's
- 64% female
- Age range: 19-39
- 26% non-Caucasian
- 5% international
- 67% MN resident
- 13% WI resident

Class of 2014



88% of those who go into practice remain in MN (30% in Duluth and Greater MN)

81% of students surveyed

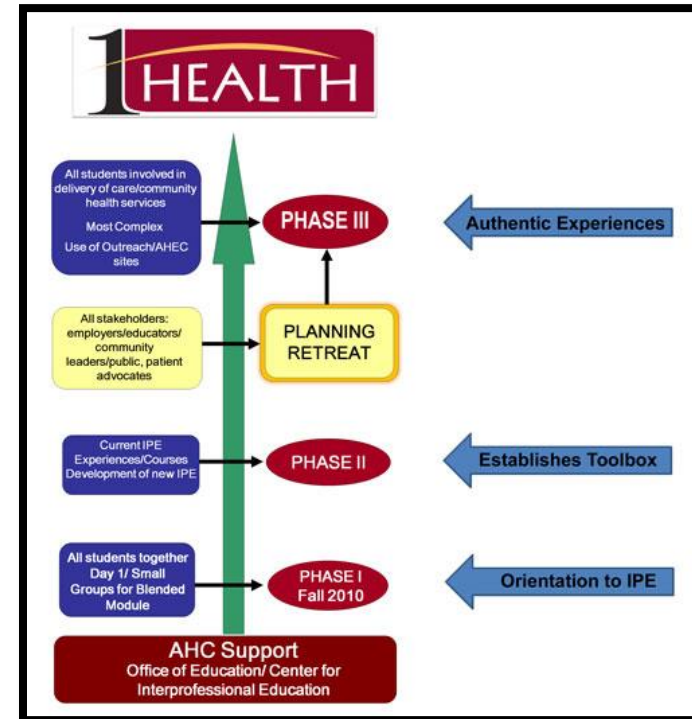
Curriculum Revision is Happening!

- Begins with “Becoming a Pharmacist”: Aimed at developing professionalism and an understanding of the context of healthcare and the patient experience
- Ends with “Being a Pharmacist”: Focuses on health systems and professionalism
- Involves much more integration of all courses
- Goals: To produce pharmacists who are outstanding clinicians with a strong scientific foundation, but who can:
 - Participate in collaborative care settings, providing patient-centered care
 - Survive and lead in a dynamic health care environment
 - Document their patient care outcomes for pay-for-performance and model development
 - Use technology effectively
 - Be life-long learners for a 40 year career

Design of the New Curriculum

- Competency “domains” are threaded throughout the four years of highly integrated courses:
 1. Patient-centered care
 2. Population health and vulnerable communities (cultural competency)
 3. Health systems management
 4. Leadership and engagement
 5. Professional and interprofessional development
 6. Scientific inquiry and scholarly thinking

Active learning (“flipped” classrooms) will become predominant mode of delivery, coupled with significant use of technology and online materials.



Design of the New Curriculum

- It also prepares students more intensely for the “new biology” and personalized medicine:
 - Cell biology and genetics
 - Nanomedicine
 - Pharmacogenomics
 - Cellular, gene and protein therapies
- And with a global perspective

Medical Missions:

Haiti

Puebla Mexico

Experiential Education sites:

Germany

Tanzania



Curriculum Revision Involves Physical Changes

- Needed appropriate classrooms and technology to support new curriculum.
- Solution: Renovate two classrooms (one on Duluth, one on Twin Cities campus) to support active learning with two-campus technology.

*Renovated
Duluth classroom*



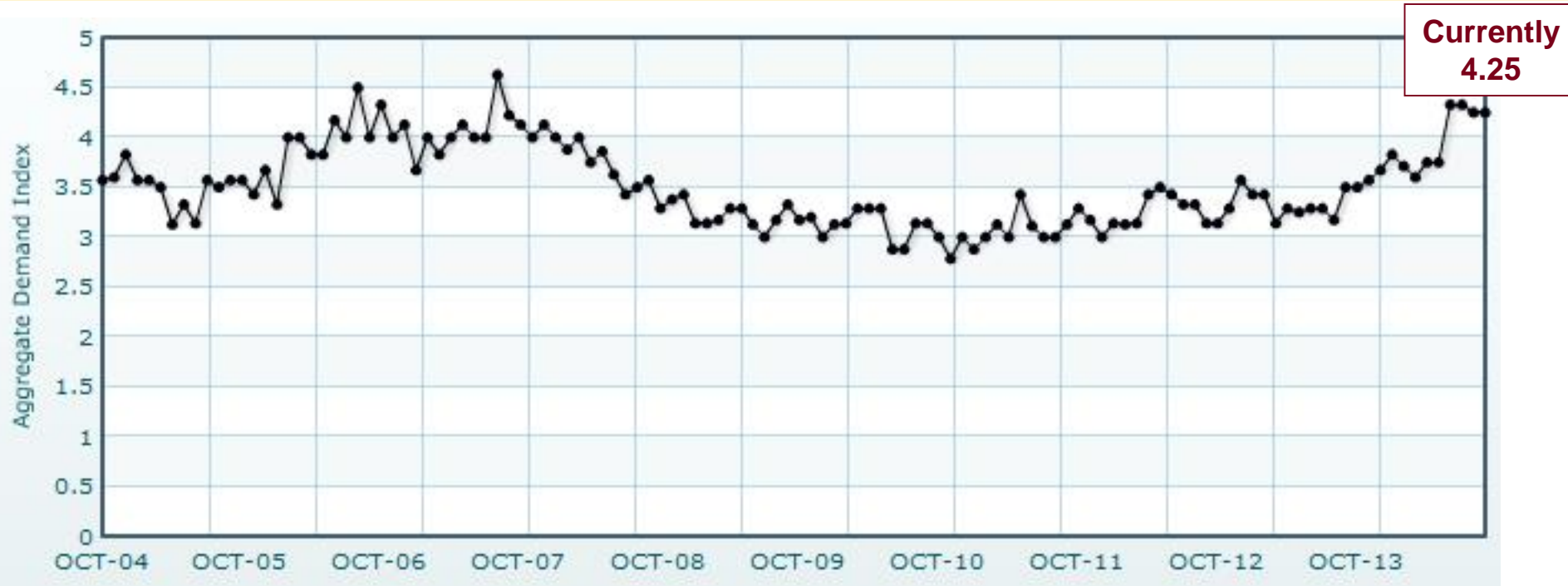
Workforce Issues

- Progress is being made in expanding the employment of pharmacists in patient care roles, but pharmacists are not fully utilized to the full extent of their education.
- The public, patients, payors and some health professionals do not fully understand what a pharmacist can do.
- Anticipate that health care reform and interprofessional education will expand the employment of pharmacists on health care teams.

Opportunities from Expanded Use of Pharmacists

- Lowered total health care costs for chronic illness.
- Better outcomes for patients.
 - Improved health for chronically ill
 - Prevention of illness (immunizations, etc.)
- Improved patient satisfaction.
- Other team members can spend their time on what they do best.
- Help fill the primary care gap.

Demand for Pharmacists in Minnesota Over 10 Years



- 5 = High demand
- 4 = Moderate demand
- 3 = Demand in balance with supply
- 2 = Demand less than supply
- 1 = Demand much less than supply

Do We Need to Graduate More?

- Depends upon full utilization of pharmacists in patient care
- 25% of current pharmacists are older than 60, so retirement may play a factor
- All graduates are finding employment
- Before further expansion we must know increase in demand is not temporary



Trends and Impact of Health Care Reform on Nursing Education

Connie White Delaney, PhD, RN
Dean, University of Minnesota School of Nursing

December 11, 2014



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School of Nursing

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Nursing Degree Programs & Enrollment

Program	Enrollment	2014 graduates
Bachelor of Science in Nursing	422	118
Master of Nursing	126	62
Doctor of Nursing Practice	334	104
PhD in Nursing	44	4
Total	925	288

Nursing Workforce Trends

Program Preparation	Trends
<p>Registered Nurses</p> <ul style="list-style-type: none"> • Bachelor of Science in Nursing • Master of Nursing 	<ul style="list-style-type: none"> • Graduates with baccalaureate degrees are in high demand compared to associate degree (2-year) Associate Degree graduates. • School cannot accommodate 66% of qualified applicants each year • BSN prepared RNs being utilized more strategically in health care. • Shortage of preceptors at clinical sites able to commit the time
<p>Advanced Practice nurses</p> <p>Doctor of Nursing Practice grads</p> <ul style="list-style-type: none"> • Nurse practitioners • Clinical nurse specialists • Nurse anesthetists • Certified nurse midwives 	<ul style="list-style-type: none"> • 21% of graduates report being employed in “underserved areas” • 2014 landmark State of MN legislation passed provides greater autonomy to advanced practice nurses • Nurse Practitioners and Certified Registered Nurse Anesthetists are in high demand in underserved communities/rural areas. • Psychiatric mental health nurse practitioners in high demand • Shortage of preceptors at clinical sites able to commit the time
<p>Nursing faculty</p> <ul style="list-style-type: none"> • PhD graduates • DNP graduates 	<ul style="list-style-type: none"> • Hiring qualified faculty to teach is a persistent and acute challenge that limits enrollment due to faculty shortage and non-competitive salaries • U of M is the primary provider of nursing faculty for State

Nursing Skills, Knowledge and Abilities in High Demand

Employers today value nurses with:

- Critical thinking ability
- Leadership, innovation, executive management skills
- Electronic Health Records expertise
- Analytical skills – safety, outcomes, system accountability
- Interprofessional practice & education; capacity for team-based care
- Mental health experience
- Cultural competence
- Care coordination expertise
- Telehealth/telemedicine
- Integrative health (complementary, non- invasive)

Nursing Clinical Placement Statistics

- 395 students in clinical placements at 342 sites today (BSN and Master of Nursing)
- 137 doctoral students at 163 clinical sites today (Doctor of Nursing Practice)
- Shortage of preceptors at clinical sites able to commit the time

Trends at the School of Nursing

- Nurse-led clinics (School's first clinic opening in Minneapolis, including interprofessional practice with pharmacy, medicine, dental)
- Students entering graduate nursing programs younger
- Prolonged vacancies in faculty positions
- Creative partnerships:
 - Coordinate System campuses
 - Minneapolis Veteran's Administration BSN partnership
 - Nursing Collaboratory (Fairview, UMP, School of Nursing, Mhealth)

What changes are needed?

Our programs need to grow without compromising quality. How?

- Supporting more clinicians to become preceptors
- Increasing the amount of classroom, simulation and clinical learning space on campus for nursing
- Growing simulation experiences
- Growing enrollment in the PhD in Nursing program to expand the pool of nursing faculty statewide
- Enhance competitive compensation packages for nursing faculty



BOARD OF REGENTS DOCKET ITEM SUMMARY

Special Committee on Academic Medicine

December 11, 2014

Agenda Item: Health Workforce Issues: How Minnesota is Responding

Review

Review + Action

Action

Discussion

This is a report required by Board policy.

Presenters: Brooks Jackson, Vice President for Health Sciences and Dean of the Medical School
Terry Bock, Associate Vice President, Academic Health Center

Purpose & Key Points

The committee presentation will provide a review of the University's Healthy Minnesota initiative and a discussion of the other state initiatives and task forces underway and their implications for the University of Minnesota. Key points include:

The Challenge

With an aging U.S. population and health care workforce and increased access to and demand for health care, there has been an intense focus in Minnesota and nationally on workforce issues. Among the key issues are whether there will be a shortage of physicians and other health care professionals, how large the shortages will be, in what fields, and in what areas of the state and country.

Workforce Projections

As noted in the presentation on Graduate Medical Education, while some projections predict imminent physician shortages because of the aging of the population and expansion of health coverage under the Affordable Care Act, other analyses question the underlying methodology and assumptions used in these studies.

Generally, studies predicting a shortage of physicians assume historical provider-patient ratios, current technology, and current care models. Analyses that consider the potential impact of changes in health care delivery draw different conclusions. These studies suggest that an expanded primary care role for other health providers (such as advanced practice nurses and physician assistants), a redesign of care delivery, and use of other innovations such as telehealth, may ultimately reduce the demand for physicians despite the added pressure from the aging population and coverage expansions.

Minnesota and other states are working to determine how best to respond to current and future health workforce needs: the need for primary care providers, the need for more providers focused on underserved populations, and more providers willing to practice in underserved rural and urban communities.

State Health Workforce Proposals

Many organizations and task forces are currently working on proposals for addressing Minnesota's health workforce needs. They include:

- University of Minnesota's Healthy Minnesota Legislative Initiative
- Governor Dayton's Committee on the University of Minnesota's Medical School
- Legislative Health Care Workforce Commission
- The State Mental Health Workforce Initiative
- Minnesota Medical Association Taskforce on Physician Workforce Expansion
- Minnesota Hospital Association Report on Health Care Workforce Needs
- The State's Foreign Trained Doctors Taskforce
- Department of Health's MERC Advisory Taskforce
- Governor's Taskforce on Health Workforce Planning (a National Governor's Association project)

The task forces and organizations are at varying stages in completing their work before the upcoming 2015 legislative session. The emerging common themes are:

- Addressing workforce shortages, especially in primary care:
 - Increased loan forgiveness programs.
 - Public/private partnerships with hospitals and clinics for clinical training.
 - Public/private task forces to address health industry workforce needs.
 - Initiatives to attract more health care students into primary care.
 - Initiatives to attract more K-12 students into STEM and healthcare fields.
 - Initiatives to revamp health care curricula and training programs and make them more flexible.
- Serving underserved populations:
 - Initiatives to meet health care needs of rural and underserved urban communities.
 - Greater focus on meeting the state's mental health needs.
 - Greater focus on training providers to care for the elderly.
 - Initiatives to increase diversity of the health care work force.
- Advocating for increased and more flexible funding for health care training and work force development.

Background Information

The December 2013 meeting of the committee focused on a general overview and discussion of the University's health professional education programs.

Health Workforce Issues: How Minnesota is Responding

Brooks Jackson, M.D., M.B.A.,
Dean of the Medical School
Vice President for Health Sciences

Terry Bock, Associate Vice President,
Academic Health Center

December 11, 2014



UNIVERSITY OF MINNESOTA

Driven to DiscoverSM

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The Challenge

Minnesota faces health workforce challenges due to:

- An aging baby boomer population (patients and health professionals)
- Longer life expectancy
- Health care reform
- The Affordable Care Act – Increased demand
- Health disparities and an increasingly diverse population



The Challenge

Key questions include:

- Are there, in fact, workforce shortages?
- In what fields or professions?
- In what areas of the state?
- How do we address disparities?



Workforce Projections

Different models yield different projections

- Severe physician shortages based on:
 - Historical provider-patient ratios
 - Current medical technology
 - Current care models
- Reduced need for physicians due to:
 - Changes in health care delivery, particularly an expanded primary care role for advanced practice nurses and physician assistants
 - A redesign of care delivery models
 - Other innovations in technology or care delivery



Minnesota Health Work Force Proposals

Current efforts underway:

- U of M Healthy Minnesota Legislative Initiative
- Governor's Committee on the U of M Medical School
- Legislative Health Care Workforce Commission
- The State Mental Health Workforce Initiative
- Minnesota Medical Association Taskforce on Physician Workforce Expansion
- Minnesota Hospital Association Report on Health Care Workforce Needs
- The State's Foreign Trained Doctors Taskforce
- Department of Health's MERC Advisory Taskforce
- Governor's Taskforce on Health Workforce Planning (a National Governor's Association project)



Common Themes

- Addressing workforce shortages, with a focus on primary care:
 - Increased loan forgiveness programs
 - Public/private partnerships with hospitals and clinics for clinical training
 - Public/private taskforces to address health industry workforce needs
 - Initiatives to attract more health care students into primary care
 - Initiatives to revamp health care education and training programs to be more flexible



Common Themes

- Serving underserved populations:
 - Focus on disparities in rural Minnesota and underserved urban population
 - Greater focus on meeting the state's mental health needs
 - Greater focus on training providers to care for the elderly
 - Initiatives to increase diversity of the health care workforce
- Advocating for increased and more flexible funding for health care training and work force development



Healthy Minnesota Initiative and Legislative Request

- Meeting the State's Health Professional Work Force Needs:
 - Revamp curriculum and clinical training programs to incorporate new models of health promotion and care
 - Develop a statewide network of interdisciplinary primary care teaching clinics
 - Expand our dentistry training programs to meet the need for dentists in rural and underserved urban communities
 - Increase education/training programs providing mental health services
 - Strengthen education/training programs to care for the elderly
 - Expand pipeline programs to prepare and encourage students from groups underrepresented in health professions
 - Increase scholarships/loan forgiveness for students/residents who will practice in underserved urban and rural communities



Healthy Minnesota Initiative and Legislative Request

- Targeted Investments to Accelerate Research in Chronic Diseases and Conditions
 - Support early stage data collection and analysis by clinical investigators
 - Support clinical investigators' use of critical biomedical core research services
 - Build a comprehensive repository for collection and storage of essential bio-specimens for chronic disease research
 - Expand development of a comprehensive clinical data repository to link electronic medical records, bio-specimen data, genomics data, and other data sources
 - Support research on chronic diseases in underserved rural and urban communities
 - Leverage technology to foster increased research opportunities across the state including a tele-research platform and a mobile research unit



Healthy Minnesota Initiative and Legislative Request

- New Models of Health Promotion and Care
 - Develop and pilot new models of interprofessional health care to optimize
 - Access
 - Coordination of care
 - Affordability
 - Create a Minnesota Electronic Health Library to provide online access to licensed, evidence-based, clinical care resources for all Minnesotans





BOARD OF REGENTS DOCKET ITEM SUMMARY

Special Committee on Academic Medicine

December 11, 2014

Agenda Item: Update on the Governor's Committee on the University of Minnesota Medical School

Review

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Discussion

This is a report required by Board policy.

Presenters: Larry Pogemiller, Chair of the Governor's Committee on the University of Minnesota Medical School and Commissioner, Office of Higher Education

Purpose & Key Points

The purpose of this item is to update the committee on the progress of the Governor's Committee on the University of Minnesota Medical School, the direction of the committee's discussions, and next steps.

The Governor's Committee has held five meetings focused on learning about the Medical School and the challenges the Medical School faces in education, research, clinical care, faculty recruitment and retention, and finances. The Governor's Committee is currently considering a list of possible recommendations.

Background Information

Governor Dayton issued an Executive Order on July 30, 2014 establishing a blue ribbon committee to develop recommendations for the Medical School. The Governor requested recommendations focused on: ensuring the Medical School's national preeminence; sustaining the University's leadership in health care research, innovation, and delivery; expanding the University's clinical services to strengthen its ability to serve as a statewide resource; and addressing the state's health care workforce needs.

Brooks Jackson briefed the Special Committee on Academic Medicine at its October 2014 meeting on the early discussions of the Governor's Committee, its charge, and membership.

STATE OF MINNESOTA

EXECUTIVE DEPARTMENT



MARK DAYTON
GOVERNOR

Executive Order 14-13

Establishing the Governor's Committee on the University of Minnesota Medical School

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, the University of Minnesota Medical School plays a crucial role in ensuring Minnesota remains a leader in health care transformation and provides quality health care to its citizens; and

Whereas, the University of Minnesota Medical School's continued success is vital in achieving Minnesota's goals of improving patient and population health, lowering costs, and improving health care experiences.

Now, Therefore, I hereby order that:

1. The Governor's Committee on the University of Minnesota Medical School is created to advise the Governor and Legislature on future strategies, investments, and actions to strengthen the position of the University's Medical School.
2. The Committee will consist of a Blue Ribbon Commission of members appointed by the Governor.
3. The purpose of the Blue Ribbon Commission is to:
 - a. Ensure the Medical School's national preeminence by attracting and retaining world-class faculty, staff, students, and residents.

- b. Sustain the University's national leadership in health care research, innovation, and service delivery, capitalizing on the State's investments in biomedical research and technology.
 - c. Expand the University's clinical services to strengthen its ability to serve as a statewide health care resource for providers and patients, as a training site for health professional students and residents, and as a site for cutting-edge clinical research.
 - d. Address the state's health workforce needs to serve Minnesota's broad continuum of health care needs, including primary care, a growing aged population, and increased chronic health needs.
4. The Blue Ribbon Commission will provide recommendations and convey its findings in a report to the Governor's Office, the Legislature, and the public by December 15, 2014.
 5. The Commissioner of the Office of Higher Education will provide general administrative and technical support to the Blue Ribbon Commission.
 6. The Blue Ribbon Commission will make its meetings open to the public and provide opportunities for public comment.

This Executive Order is effective fifteen days after publication in the State Register and filing with the Secretary of State, and shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 30th day of July, 2014.



Mark Dayton
Governor

Filed According to Law



Mark Ritchie
Secretary of State



Governor's Committee on the University of Minnesota Medical School

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