SENATOR GREG CLAUSEN, 57
Senator Michelle Benson, 31
Senator Mary Kiffmeyer, 30
Senator Tony Lourey, 11
Senator Melissa Wiklund, 50

REPRESENTATIVE TARA MACK, 57A
Representative Tony Albright, 55B
Representative Laurie Halvorson, 51B
Representative Joe Schomacker, 22A
Representative Jennifer Schultz, 7A

89th Legislative Session
THE LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION

2016
Final Report on
Strengthening Minnesota's Health Care Workforce

December, 2016

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I. Introduction and Recommendations

Established by the 2014 legislature, in 2016 the Legislative Health Care Workforce Commission completed its third and final year of hearings and deliberations on Minnesota's health workforce situation and needs. The Commission sunsets December 31, 2016. In 2016 the Commission reviewed the health professions education and workforce developments landscape, collected data on state spending of health professions education and workforce development and sought testimony on health workforce topics of interest. This final report provides details of the Commission's work in 2016.

The Commission's recommendations to the 2017 legislature, and future legislatures, are below.

RECOMMENDATIONS

Goals and Principles to Guide Legislative Action
1. With healthcare the fastest growing employment sector in Minnesota's economy for the next ten years, the legislature must have sustained oversight of health workforce education and development policy and spending. The legislature should adopt a continuing strategy for coordinating health workforce issues, through a legislative commission, statewide health workforce council or other mechanism to engage legislative leaders and other stakeholders in assuring the state has the health workforce it will need. The legislature's strategy should include monitoring state workforce investments and addressing health care workforce education and training, trends in health care delivery, practice and financing and recommending appropriate public and private sector efforts to address identified workforce needs. The legislature should also address health care workforce supply and demand, rural issues, diversity and workforce data analysis.
2. The legislature should support continuation of proven programs with measurable outcomes like loan forgiveness for physicians, advanced practice nurses, physician assistants, pharmacists, dentists and health faculty; Rural Physicians Associate Program, etc., and expand such programs where additional investment would likely have a direct effect on improving workforce supply and distribution.
3. The legislature should support programs that expose K - 12 students to health careers, such as the state Summer Health Care Intern Program, HealthForce Scrubs camps, summer enrichment programs, [STEM related programs such as Project Lead The Way] and other programs that prepare and recruit rural students and nontraditional students into medical school, nursing and other health careers.
4. The legislature should invest in strategies that will lead to a more diverse health care workforce.
5. The legislature should continue to support the PIPELINE/dual training grants to develop the Health Support Specialist occupation. The program received base funding from the 2015 Legislature.
6. The legislature should encourage nursing schools to consider prior health care experience, such as nursing home employment, in admissions.

Priority Recommendations for Action by the 2017 Legislature
1. The legislature should identify and study expanding the scope of practice for health care professions a) The legislature should adopt the common framework for evaluating scope of practice proposals developed by the 2015/16 National Conference of State Legislators/National Governors' Association-sponsored scope of practice project. The Commission recommends that 2017 incoming chairs use the framework and edit it as necessary after the close of next session based on user feedback and experience. b) The legislature should encourage use of the tool developed by the 2015/16 National Conference of State Legislators/National Governors' Association-sponsored scope of practice project for assessing progress made following scope of practice changes and assessing barriers that remain to achieving the change's goal.
2. The legislature should review the effectiveness of the MERC program and consider alternate models of Graduate Medical Education funding. a) Assess the effectiveness of the current MERC distribution of funds in meeting high priority state workforce needs, supported by in depth data on the current distribution of MERC funds. Where needed, consider revisions to the MERC formula to better target training priorities. b) Direct DHS to examine the feasibility of seeking a waiver from the Centers for Medicare & Medicaid Services (CMS) that would provide for state management of Graduate Medical Education distribution in Minnesota.
3. The legislature should address the multiple factors that create challenges recruiting and retaining the range of nursing education, skill and experience needed in long term care settings. a) Encourage or incentivize nursing education programs and higher education systems to maintain a balance between associate and baccalaureate Registered Nurse degree programs so both levels of nursing graduate will remain available to meet workforce needs in long term care settings. b) Encourage nursing education programs to consider reinstating the requirement that Licensed Practical Nurse/Registered Nurse students become certified as Certified Nursing Assistants.
4. The legislature should monitor implementation of the 2015 telehealth parity law and state-funded broadband grants to track progress and barriers to the growth of telehealth to meet health workforce needs.
5. The legislature should strongly consider those recommendations of the 2015 Mental Health Workforce Summit that have not become law. Per the 2016 Governor's Mental Health Task Force, the Department of Human Services and the Minnesota Department of Health should also work with the steering committee responsible for the Mental Health Workforce Plan to ensure progress on those recommendations.

2016 Report Recommendations for Additional and Future Consideration

Charge 1: Identify current and anticipated health care workforce shortages, by both provider type and geography

1. Executive branch agencies, led by MDH, and other entities engaged in health workforce data collection, should establish a formal structure to coordinate and integrate the collection and analysis of health workforce data to provide the legislature and other policymakers integrated health workforce information and analysis.
    a. MDH should explore measurement approaches to documenting workforce shortages that capture indicators such as wait times for appointments, Minnesota scope of practice variations and better reflect the full range of professions in Minnesota's health workforce, in addition to using federal Health Professional Shortage Area indicators.
2. The legislature should review the findings of the study "Causes and Impacts from Delayed Hospital Discharges of Children with Medical Complexity," conducted by researchers from four hospitals and the University of Minnesota School of Public Health and to be completed in Spring, 2017, to determine if there may be documentable savings from providing additional state support to home nursing services for medically fragile children.
3. Palliative Care Placeholder recommendation, if needed following 12/6 presentation
4. Pharmacy placeholder recommendation, if needed following 12/6 presentation

Charge 2: Evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce

Recommendations addressing this charge are included in the priority recommendations above.

Charge 3: study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce

1. The legislature should explore public/private partnership opportunities to develop, attract and retain a highly skilled health care workforce.
2. Health professions education programs in all higher education sectors should inventory their online Masters programs in health fields and create additional online Masters Programs to provide rural residents with career ladder and advancement additional opportunities they may cannot find within a reasonable distance of their communities
3. The legislature should consider a range of state responses to meeting the workforce needs of the long term care and home and community based services sectors.
    a. The legislature should monitor workforce effects of 2015 nursing home reform legislation.
    b. The legislature could consider the recommendations of the 2016 Direct Care and Support Workforce Summit
4. Address barriers to more widespread use of volunteer health care providers, such as a deduction for charity care, addressing liability issues, etc.
5. The legislature, MDH, DHS and other relevant state agencies should monitor and evaluate the effects of the growth of team models of care, Accountable Care Organizations, health care homes, and other new developments on the state's workforce supply and demand. Data is becoming available on the cost effects of these new models, but little analysis is yet being conducted on the workforce effects.
6. The legislature, MDH and DHS should work to evaluate the workforce implications of health care homes and Accountable Care Organizations.

Charge 4: Identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to: Training and residency shortages; disparities in income between primary care and other providers and negative perceptions of primary care among students
1. The legislature should increase funding for Family Medicine residencies and similar programs, including both rural family medicine programs and those serving underserved urban communities. Funding should include support of APRN and physician assistant clinical placements in rural and underserved areas. The legislature, higher education institutions and health care employers should increase the number of available clinical training sites for medical students and advanced practice nursing, physician assistant and mental health students in Minnesota.
2. The legislature should consider preceptor incentives such as tax credits and other approaches that respond to challenges recruiting and retaining preceptors.
3. Researchers should continue to seek compete information on the number of health professions preceptors in Minnesota
4. The legislature should examine the role of state law and regulation in assuring students obtain required clinical experiences and precepting, including supporting the use expanded use of simulation training methods to stretch training capacity. The legislature and the Office of Higher Education should strengthen and/or enforce education program responsibilities to ensure placements.
5. The legislature should remove reimbursement and other barriers to more widespread use of doulas in Minnesota.

II. Legislative Charge for the Commission's Final Report

> *"Many policy levers that affect the supply, distribution and skill mix of the health workforce are state-based, including licensure and scope of practice regulations, state loan repayment programs, and Medicaid reimbursement rates. State-level decisions about whether to enact or change policies directed at training, recruiting, and retaining health professionals affect a wide range of stakeholders….*
>
> *-Dr. Erin Fraher, Director of the North Carolina Health Professions Data System*

The 2014 Legislature created the Legislative Health Care Workforce Commission to study and make recommendations to the legislature on how to achieve the goal of strengthening the workforce in health care and gave it the following charge:

- Identify current and anticipated health care workforce shortages, by both provider type and geography.
- Evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce.
- Study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce.
- Identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:
  - training and residency shortages;
  - disparities in income between primary care and other providers; and
  - negative perceptions of primary care among students.

The Commission legislation directed it to provide a preliminary report making recommendations to the legislature by December 31, 2014, and a final report by December 31, 2016.

III. Overview of Minnesota's Health Care Workforce, 2016 Update

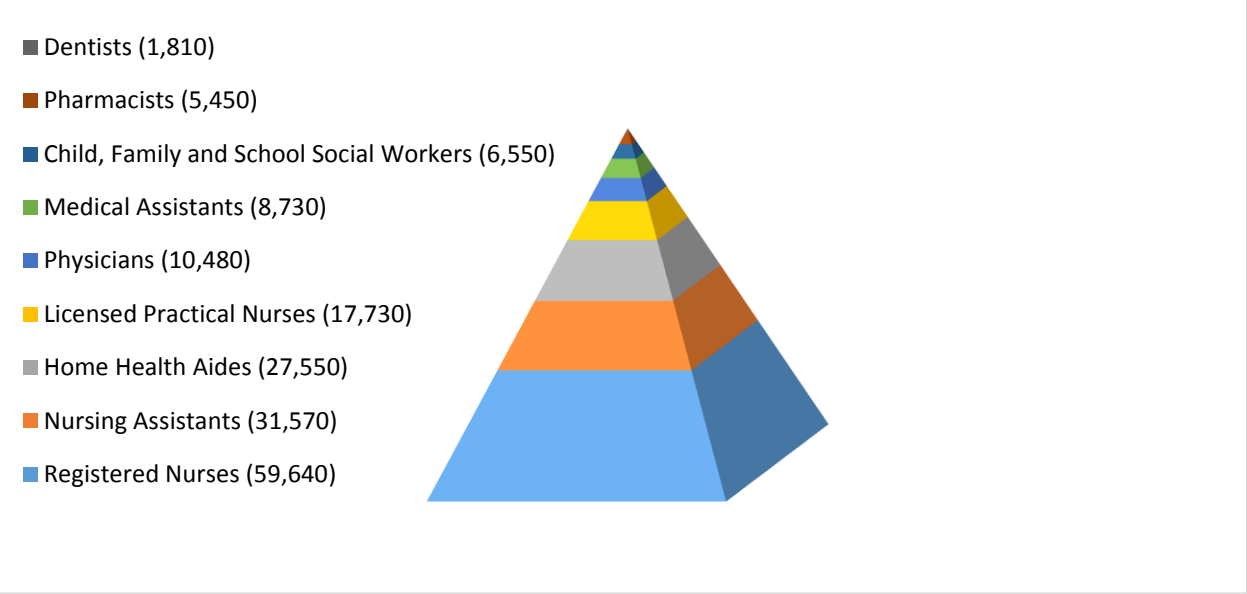
In 2016 the Commission received an update on the state's health care workforce from the Minnesota Department of Health; and highlights are included below. The 2016 update builds on the in depth analysis of Minnesota's health workforce landscape[1] the Commission conducted in 2014, which remains useful background for policy makers.

[1] 2014 Report and Recommendations on Strengthening Minnesota's Health Care Workforce, Legislative Health Care Workforce Commission, pages 9 - 17

Health care is a growing industry, adding 2.2 million jobs nationally since December 2007[2], the largest of any US industry. In Minnesota it employs 466,077 people (15.9 percent of state employment), and increased 4.3 percent in the last year[3].

Many occupations make up the health care workforce, with nursing related occupations foundational. The chart below presents a portion of the occupations important in meeting primary care needs based on Minnesota employment figures. Some occupations such as dentists and pharmacists are also significant because of the roles they play in oversight of other primary care occupations.

MINNESOTA HEALTH CARE EMPLOYMENT



Minnesota Department of Employment and Economic Development 2016, Occupation Employment Statistics First Quarter; Employment Data from 2015, Second Quarter

A varied occupations is needed to support the health and mental health care of Minnesotans. Included in the table below are large occupations, including pharmacy technicians and oral health occupations, physical therapists, and EMTs among others.

2 America's Divided Recovery, Georgetown University Center on Education and the Workforce, 2016

[3] Minnesota Department of Employment and Economic Development Current Employment Statistics, August 2016

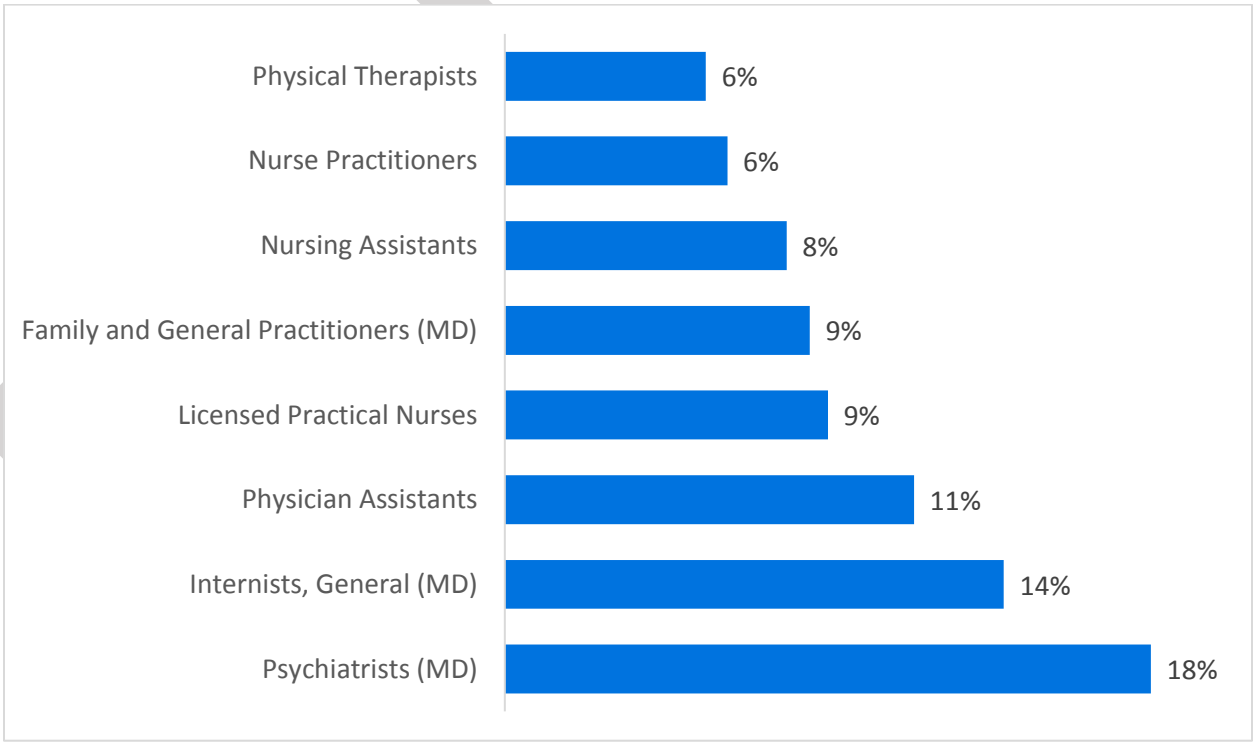
Occupation	2015 Employment
Pharmacy Technicians	**7,290**
Dental Assistants	**5,520**
Dental Hygienists	**4,620**
Emergency Medical Technicians and Paramedics	**4,380**
Physical Therapists	**3,960**
Nurse Practitioners	**3,290**
Clinical, Counseling, and School Psychologists	**3,110**
Physician Assistants	**2,010**

Minnesota Department of Employment and Economic Development 2016, Occupation Employment Statistics First Quarter; Employment Data from 2015, Second Quarter

JOB VACANCIES: CURRENT HIRING DEMAND

The Minnesota Department of Employment and Economic Development (DEED) conducts a job vacancy survey twice a year to help understand current occupation demand. Many of the openings are turn-over while others are new openings. The state-wide average percent of occupation currently open is 3.6 percent. A number of health care occupations have higher percentages open ranging from 6 to 18 percent, which can indicate difficulty filling the occupations, especially at the higher end.

PERCENT OF OCCUPATION WITH JOB OPENING



Minnesota Department of Employment and Economic Development, Job Vacancy Survey, 2nd quarter, 2016

NURSING: IN-DEPTH

Nursing occupations are expected to continue to play an important role with the health care industry. Registered nurses, home health aides and nursing assistants are all on the list of the occupations with the most openings through 2024[4]. Nursing occupations vary in their initial education requirements with home health aides needing less than a high school education, nursing assistants and college certificate and registered nurses a bachelor's degree[5]. With the variety of education levels in nursing, it is possible for people to gain experience and education and move on to higher levels within the profession.

2013-2014	Education Program Length and Graduates				
Education Program Type	**Up to 1 Year**	**Over 1 & Under 4 Years**	**4 Years**	**Graduate Level**	**Total**
Registered Nurse		1,939	1,901	293	**4,133**
Licensed Practical Nurse		2,013			**2,013**
Nursing Assistant/Aide	1,862	1			**1,863**
Nurse Practitioner			7	217	**224**

LMIwise Minnesota Statewide data 2013-2014 program year

Looking at Minnesota's education institutions graduation numbers can provide a sense of what pipeline for nurses is like. Education programs in Minnesota are graduating registered nurses with a variety of degrees. Since not all nursing assistants require education, the numbers trained are smaller.

MINNESOTA RESIDENCY SLOTS

Physicians are more likely to stay in the area where they completed their residency and with Minnesota residency numbers providing context for our state pipeline. Overall, residency slots are increasing in Minnesota. Although, looking at only primary care slots, there was a drop in the early 2000s, and the numbers have not quite rebounded. There are only a small number of psychiatry residency slots, which has also increased slightly. The largest increase has been in other (non-primary) types of residency slots. Additionally, with the primary care count, one International Medical Graduate (IMG) spot was added in 2016 with two residents funded.

[4] Minnesota Department of Employment and Economic Development Occupations with the Most Openings From Employment Growth and Replacement Needs,2014-2024

[5] LMIwise Minnesota Statewide data 2013-2014 program year and DEED Occupations In Demand

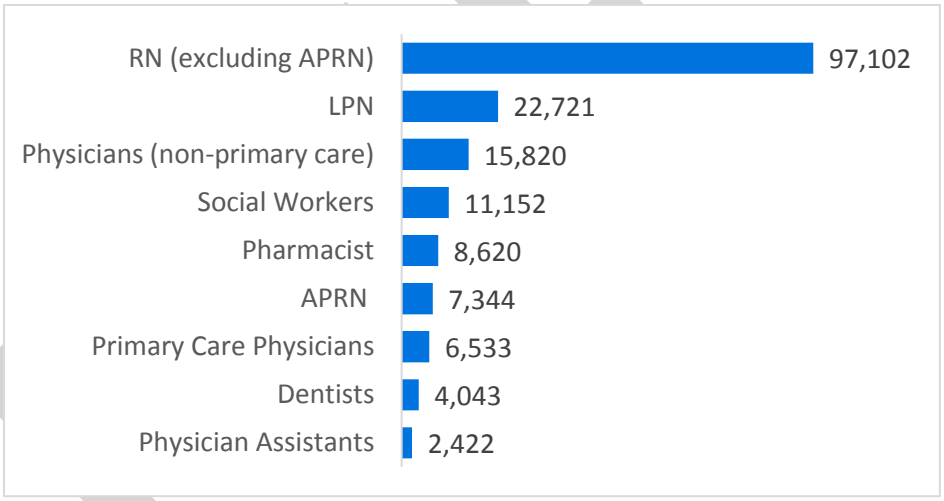
Minnesota Residency Slots	*2004*	*2012*	*2013*	*2014*	*2015*	*2016*	**Change from 2004**
Primary Care Residencies	248	221	231	232	233	241	**-7**
Psychiatry Residencies	21	21	23	24	24	24	**3**
All other Residencies	202	250	249	253	248	249	**47**
Total	471	492	503	509	505	514	**43**
Positions filled (primary care)	88%	100%	100%	97%	100%	100%	-

National Residency Matching Program, Main Residency Match: Match Results by State and Specialty, 2003-2014. All residencies reflect PY-1 unless otherwise specified.

ACTIVELY LICENSED HEALTH CARE PROFESSIONALS

ORHPC works closely with the licensing boards and monitors licensed professionals with a lens to rural and primary care needs. The number of licensed professionals can also be an indicator of supply and is always higher than those employed and a number of those licensed are retired, temporarily not working, working out of state, or are in a role that doesn't currently require their licensed. Those working out of state tend to be in states nearby, but are spread across the country. If currently not working in their licensed field, professionals may return to working in Minnesota workforce at a later date. ORHPC also surveys these occupations at the time of their license renewal to better understand workforce trends.

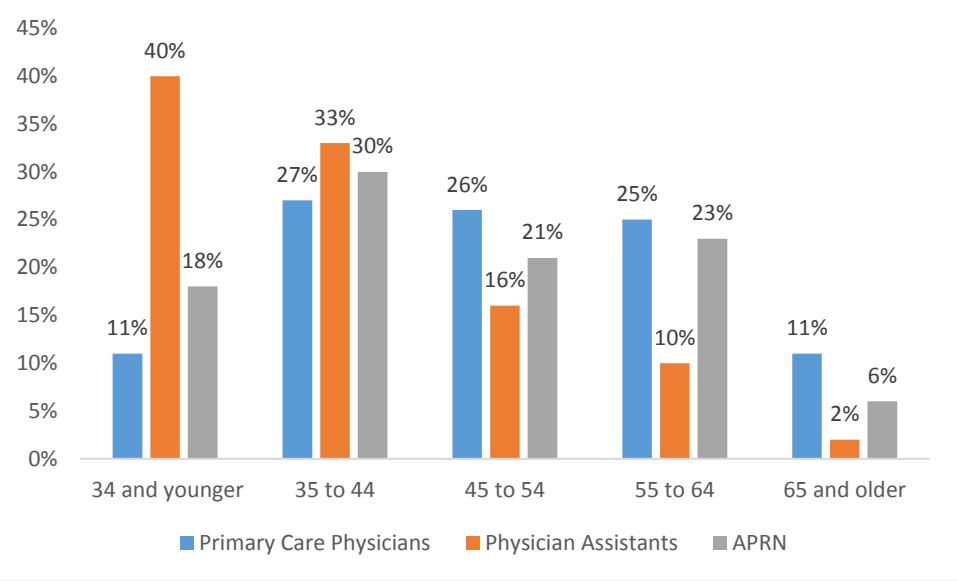
NUMBER OF ACTIVELY LICENSED PROFESSIONALS



Data from Minnesota Board of Nursing, Minnesota Board of Social Work, Minnesota Board of Pharmacy, Minnesota Board of Medical Practice, and Minnesota Board of Dentistry 2016

PRIMARY CARE WORKFORCE: PHYSICIANS ARE OLDEST

Given the aging workforce trend, it is important to track the age of health care and mental health professionals. Primary care physicians and advance practice registered nurses (APRNs) require more education so they will be a bit older than Physician Assistants (PAs). Consequently, PAs may remain in practice as primary care physicians and APRNs retire. It is uncertain if new physician graduates will be sufficient in number to replace retirees.

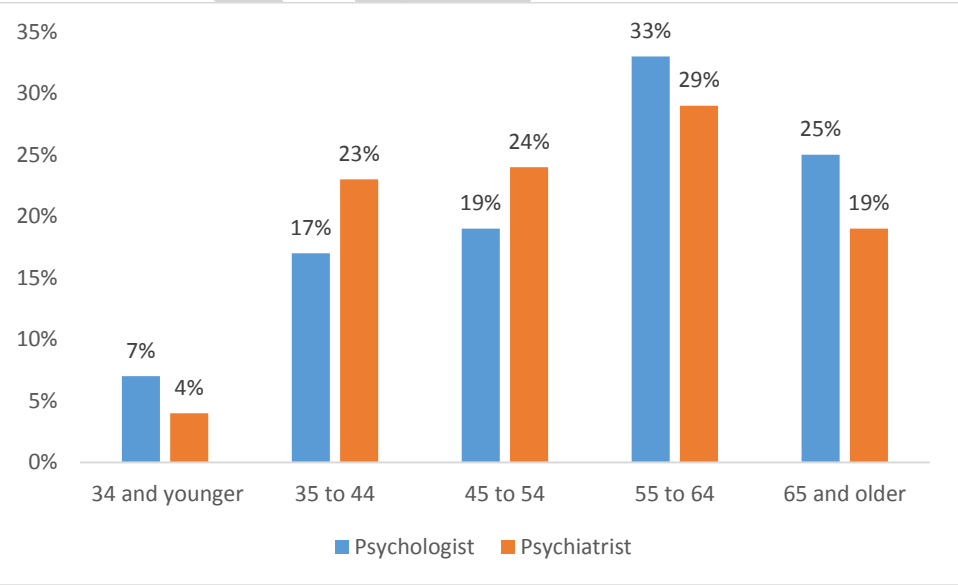


Minnesota Board of Nursing and Medical Practice data analyzed by MND ORHPC, 2016

AGING OF MENTAL HEALTH OCCUPATIONS

Psychologists and psychiatrists are quickly aging with few replacements in the pipeline. Although there are other mental health occupations that have younger age profiles, they can't fill all the same specialized roles.

AGE OF PSYCHOLOGISTS AND PSYCHIATRISTS



Minnesota Board of Psychology and Medical Practice analyzed by MDH ORHPC staff, 2016

OTHER KEY WORKFORCE DATA

The ORHPC workforce surveys are conducted when licensed health and mental health professionals renew their licenses. Surveys currently ask how often professionals provide clinical training or supervision to students, interns or residents. Forty-four percent of Minnesota physicians occasionally provide training and 18 percent never provide training, indicating room for more training time[6].

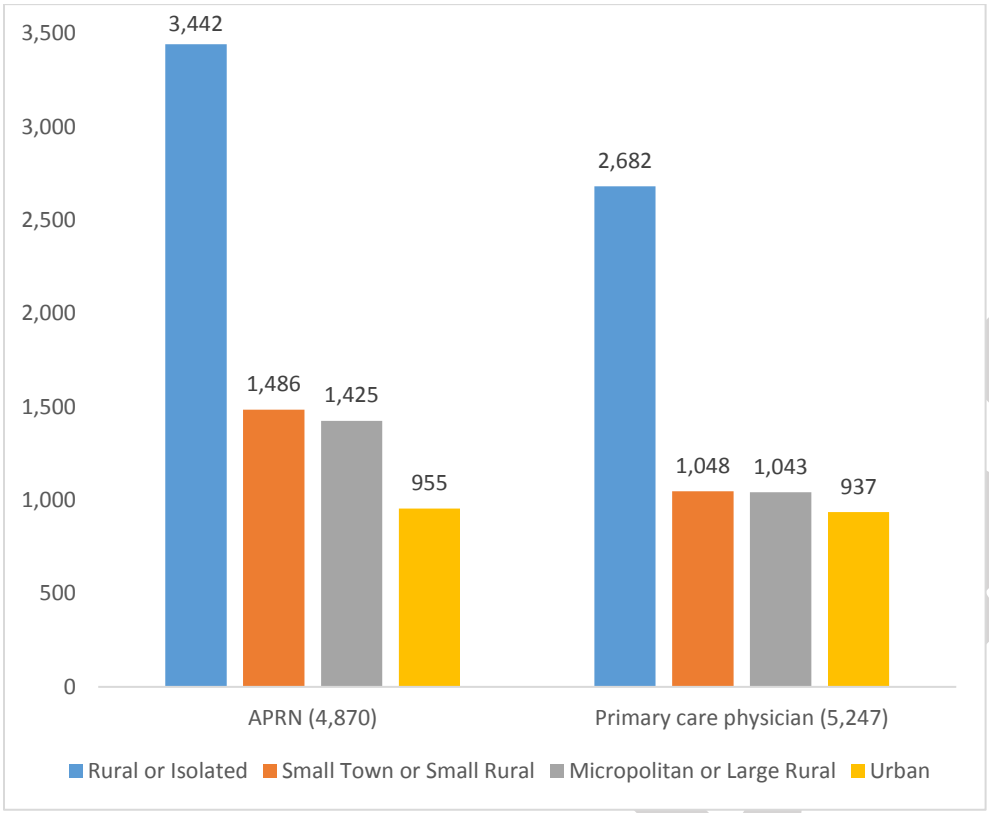
Respondents are also asked about where they went to school which can help to indicate if a profession is more of a local-only labor market or if Minnesota draws professionals from outside the state. The percent educated in Minnesota varies by occupation with 93 percent of licensed practical nurses, 77 percent of registered nurse, 75 percent of social workers and 34 percent of physicians responding they got their education in Minnesota[7]. Scope of practice changes can also play an important role in workforce changes. As advanced practice registered nurse independence has increased, so have their numbers; between first quarter 2015 and second quarter 2016 they increase 15 percent[8].

REGIONAL HEALTH PROFESSIONAL DISTRIBUTION

In Minnesota, not all areas of the state experience the same access to health care professionals. One way of better understating the distribution across the state is by looking at population to provider ratios. Licensed professionals with a Minnesota address are compared to the total population in different regions (lower is better). Based on data in the charts below, licensed practical nurse and registered nurses are more focused in rural areas compared to advanced practice registered nurse and primary care physicians which are more concentrated in urban areas.

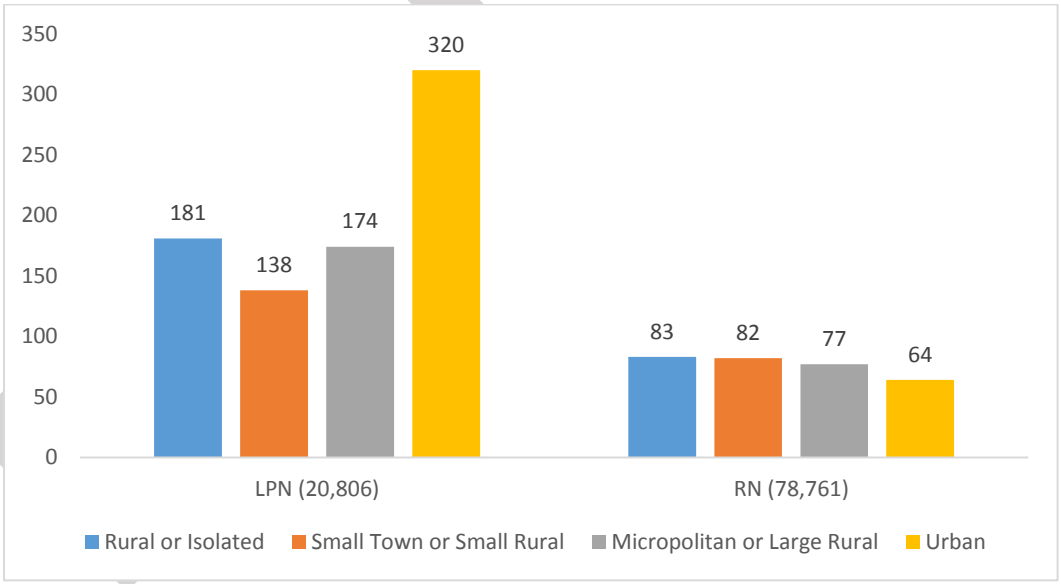
[6] Minnesota Department of Health Workforce Survey, 2016
[7] Minnesota Department of Health Workforce Survey, 2014-2016
[8] Minnesota Board of Nursing, 2016

APRN and Primary Care Physician Population to Provider Ratios



Minnesota Board of Nursing data analyzed by MDH ORHPC staff 2015-2016

LPN and RN Population to Provider Ratios



Minnesota Boards of Nursing and Medical practice data analyzed by MDH ORHPC staff 2015-2106

EMERGING PROFESSIONS

Emerging professions are small but growing professions often supportive of new models of care and filling holes in the workforce. See the chart below for estimated number of emerging professionals. Since these are newer professions that are often unlicensed it can be hard to track the number of professionals out in the field. Many efforts are taking place to continue to understand the best way to use these professionals and initial indicators are they are starting to make a difference.

Profession	Estimated Number
Community Health Worker	990[9]
Dental Therapist	64 (26 are advanced dental therapists)[10]
Community Paramedic	115[11]
Doula (on MDH registry allowing Medicaid billing)	55[12]
Mental health Peer Support Specialists (Certified Peer Specialist)	385[13]

WORKFORCE TRENDS AND TAKE-AWAYS

Looking at all this data together, there are a few key trends and take-aways that are important.
Workforce Trends:

- Continued job growth, especially in nursing occupations
- Investing in and attracting an educated workforce is key
- Rural areas have different occupation distributions
- New and innovative solutions such as emerging occupations and scope of practice changes are helpful
- Aging is a factor in many professions, but some positive signs

In a changing time of healthcare it is harder to understand shortages and predict what will happen next, but the data does point to some challenges. Some of the key changes happening are Accountable Care Organizations, medical homes, team care, and billing for outcomes. Care is also becoming more reliant on non-physician occupations than ever before. For those organizations that have already shifted to something new, there is still learning taking place. Others have not yet made changes. Given this context, some key take-aways include:

- Team care is important: Variety of occupations will play roles
- Primary care physicians: Early signs of improvement but outlook uncertain
- Nursing workforce: Continued attention needed
- Mental health workforce aging: New data makes difficulties even more clear

[9] MDH Toolkit report, 2015
[10] Number of licensed dental therapists, Minnesota Board of Dentistry, August 2015
[11] Emergency Services Regulatory Board, 2016
[12] MDH Doula Registry, September 2016
[13] Use of Certified Peer Support Specialists MN DHS February 2016

IV. Commission History and Timeline

The Commission held seven meeting meetings in 2014 and six meeting meetings in 2015, during which it complied and reviewed detailed information about Minnesota's health care workforce, the state's workforce needs and issues affecting the adequacy of Minnesota's health care workforce. The Commission heard testimony from a wide variety of stakeholders each year, and issued 2014 and 2015 reports to the legislature.

A 2014 Commission Recap

Much of 2014 was dedicated to in-depth background work, identifying and describing issues facing the health care workforce in Minnesota. Issues the Commission examined included:

- Projected needs
- Demand and supply
- Pipeline issues

In its 2014 report to the Legislature in December, the Commission made a variety of findings and issued recommendations to the 2015 legislature.

2014 Commission findings included:

1. Health workforce shortages are found in a variety of professions Shortages are exacerbated by distribution problems in rural and other underserved areas, and there are extensive long term care workforce shortages.
2. The health care workforce is not as diverse as the general population and is not diversifying as fast as the general population.
3. There are disparities in income between primary care physicians and other specialties, with primary care paying less. There are also fewer primary care providers available in rural areas; 10 to 11 percent live in small and isolated rural areas, though 17 percent of the state's population is located there.
4. The long-term care sector has unique and significant shortages and issues. The long-term care sector typically includes workers with lower education levels than required for other health care professions and is more diverse than rest of health care sectors.
5. State government invests significant resources in health care workforce education, training and development, approximately $494 million in 2014.
6. Scope of practice law and regulation affects the contribution health professions make to meeting workforce needs.

A number of the Commission's recommendations were considered in legislation introduced in the 2015 Legislature, and a number of those became law. In addition, other health workforce provisions were enacted by the 2015 Legislature.

Commission-related. Successful legislation directly related to Commission recommendations included:

- Loan forgiveness program expanded
- Primary care residency expansion grant program created

- International Medical Graduates Assistance program created
- Mental Health Workforce Summit recommendations partially enacted
- Telemedicine expanded and interstate physician licensure compact passed
- Medicaid long term care reform enacted, with significant workforce implications
- PIPELINE project for health care apprenticeship programs enacted
- $15 million appropriated for University of Minnesota Medical School, in part dedicated to physician workforce programs

Other 2015 legislative action on health care workforce issues included:

- Significant long term care reform
- MERC appropriation increased $1 million
- Emeritus Licenses for social workers
- Home and community based services/long term care scholarship program established
- Community Emergency Medical Technician established as a profession

A complete 2015 session recap is included in the Commission's 2015 Report to the legislature.

B 2015 Commission Recap

Significant issues identified and examined by the Commission in 2015 included:

Health Workforce Planning and Coordination - The Commission reviewed the need for state-level workforce planning and coordinating body. Despite periodic activity to bring together key stakeholders such as legislators, state agencies, higher-education partners, third-party payers, and professional associations, stakeholders tend to pursue goals independently. Minnesota continues to lack a sustained, central, statewide workforce planning structure, and more consistent agency coordination with stakeholders is needed to meet health workforce requirements. The Commission heard from recommendations and options for coordination from a recently completed National Governors Association Health Workforce Policy Academy and from the Minnesota Medical Association.

Preceptor and Clinical Training Challenges and Strategies - All higher education, employer and clinical training sites that communicated with the Commission in both 2014 and 2015 identified the availability, sustainability, and access to clinical training sites for students as their greatest challenge, with the exception of the aging services sector, which identified recruitment and retention as its greatest challenge. The cost and availability of clinical sites was identified as a major bottleneck to producing more providers to meet state workforce needs.

The Commission also heard testimony that some colleges and universities require students to secure their own placements, sometimes delaying students' ability to graduate. State law and regulation requires education programs to arrange training that is needed for progressing towards a degree and graduation, and the Commission heard that some college and university programs may not be in compliance with this responsibility.

As in 2014, in 2015 the Commission made a variety of findings and issued recommendations for the next session of the legislature in its 2015 report to the Legislature.

V. 2016 Commission Activities

PROGRESS REPORT ON 2015 HEALTH WORKFORCE INVESTMENTS

The Commission reviewed progress to date on workforce investments enacted in 2015.

As is noted in the summary of this report, in 2014 the Health Care Workforce Commission published a list of recommendations to strengthen the health workforce. These recommendations included aspirational goals for the legislature to consider, as well as targeted funding for specific programs. This section of the report will focus on the latter, detailing the preliminary outcomes achieved with the new programs and additional funding that was enacted.

In 2015 the Legislature created three new workforce programs and expanded the scope and funding of the existing Health Professions Loan Forgiveness program. The new programs are:

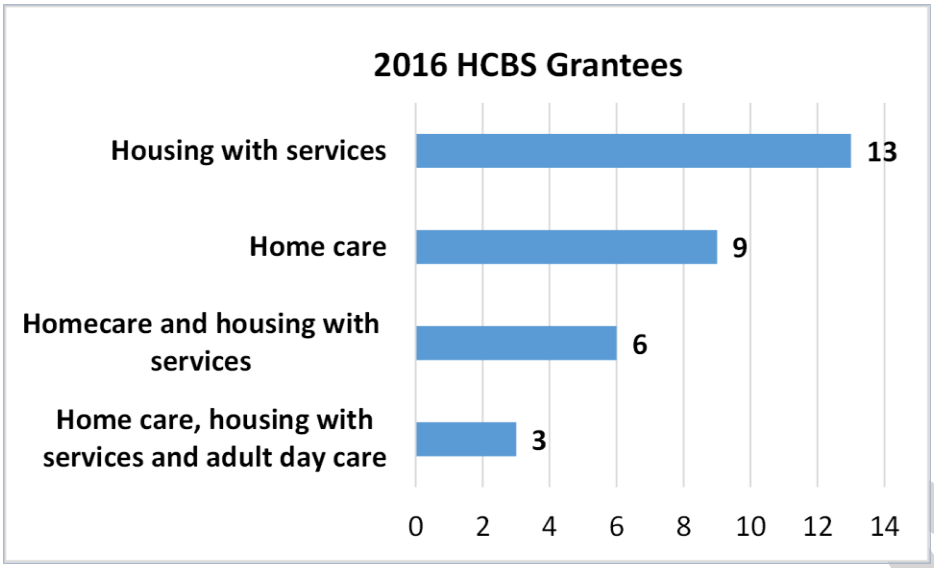
- Home and Community-Based Services (HCBS) Scholarship program
- International Medical Graduate (IMG) Assistance program
- Primary Care Residency grant

Home and Community-Based Services (HCBS) Scholarship program

HCBS providers and facilities – defined by statute as Home Care agencies, Housing with Services (Assisted Living) facilities, and Adult Day Care facilities – often experience acute workforce shortages. In some cases, these critical providers try to manage the care of difficult patients while dealing with over 100% turnover of care-giving staff annually. Many patients are on public programs, and Medicaid reimbursement typically does not cover the cost of doing business. This translates to non-competitive wages and low staff retention rates, as care-givers migrate to nursing home, clinics, and hospitals that pay better.

In 2015, a scholarship program for HCBS providers, that supports education and training to increase the professionalization of their staff, was enacted with $950,000 in funding annually in the form of a grant program administered by the Department of Health. The first Request for Proposals was published in August of 2015. Eligible applicants can receive up to $50,000 for their own scholarship programs that fund education and/or training activities for their care-giving staff. Each applicant must either have a scholarship program in place, or develop one based on the specific needs of the organization. Scholarship grant funding cannot be used for basic training that a facility needs to obtain or maintain licensure, and it cannot be used to pay wages directly. Eligible education and training activities include: achieving degrees in nursing, social work, or physical therapy; receiving training in dementia care, wound care, or English as a second language; and participating in apprenticeship programs such as the Health Support Specialist.

In the first cycle of the grant, a panel of community reviewers selected 31 grantees for funding. Sixty-one percent are rural, 39 percent are within the 7-county metropolitan area, and reviewers sought to fund a blend of provider types.



The FY 2017 grant cycle is currently in the review phase. MDH received 49 applications, requesting over $1.6 million in scholarship grants – demand for the program remains high.

International Medical Graduate (IMG) Program

Minnesota is the first state in the nation to implement a comprehensive program to integrate IMGs into the physician workforce, taking an important and innovative first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, workforce shortages, an aging and diversifying population and rising healthcare costs.

MDH has implemented the following program elements which address the barriers to residency by making IMGs more competitive for residency positions and by providing a very limited number of residency positions dedicated for IMGs:

Program Administration

The program is being implemented in consultation with a stakeholder group including representatives from state agencies (the Board of Medical Practice, the Office of Higher Education, Minnesota Department of Employment and Economic Development), the health care industry, provider associations including the Minnesota Academy of Physicians Assistants, community- based organizations, higher education, and the Immigrant International Medical Graduate (IIMG) community. The stakeholder group meets every quarter and has subgroups, which meet as needed.

Program Components

1) **Roster:** With the help of community organizations, the program has developed a list of 170 immigrant physicians currently interested in entering the Minnesota health workforce. This number is expected to grow as the program becomes more established.
2) **Collaboration to address barriers to residency:** A major barrier to residency is the recency of the year of graduation from medical school. Stakeholders have surveyed primary care residency program directors at the University of Minnesota and all reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they passed a rigorous clinical assessment and participated in an in-depth clinical experience in the United States.

3) **Clinical Assessment:** MDH has entered into a contract with the University of Minnesota Simulation Center to provide clinical assessment for IMGs.
4) **Career Guidance and Support:** This component includes information on training and licensing requirements for physicians and non-physician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduates' skills, experience, resources and interest; support in becoming proficient in medical English; support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology; and support for increasing knowledge and familiarity with the United States health care system and preparation for the licensing exams. Workforce Development Inc., and Women's initiative for Self-Empowerment in collaboration with New American Alliance for development are serving 170 program participants.
5) **Clinical Preparation and Experience:** MDH has entered into a grant agreement with the University of MN to provide clinical experience for selected IMGs. A prerequisite to participation is completing the clinical assessments. IMGs will then participate in a post assessment which will lead to a certificate of clinical readiness.
6) **Dedicated Residency Positions:** The University of Minnesota Pediatric Program was selected as the first recipient of funding from the IMG Primary Care Residency Grant Program. They selected two IMGs who began residency in June 2016. A second round of funding is now available and we have received two grant applications, one from the University of Minnesota Pediatric Program and one from Hennepin County Medical Center – Internal Medicine.

The program is positioned to have great impact, for the individual immigrant medical graduates who participate in it, for the future patients they may serve, and ultimately for Minnesota's health workforce.

Primary Care Residency Expansion Grant Program

The looming shortage of physicians in Minnesota – particularly in primary care specialties – generated multiple recommendations from the Commission. These recommendations, and the growing concern that limited residency slots created a bottleneck in the physician pipeline, led to a proposal to create a new source of state funding for physician residency programs. Residency programs are traditionally funded by federal sources, but are subject to a cap in funding. The Legislature agreed to appropriate $1.5 million to fund additional residents, or "slots" in residency programs which graduate physicians in the following specialties:

- Family medicine;
- General internal medicine;
- General pediatrics;
- Psychiatry;
- Geriatrics; or
- General surgery

Eligible residency programs must apply for competitive review process. Up to $300,000 is available per slot, over a three-year period. Funding is tiered, with $150,000 available in the first year, $100,000 in the second year, and $50,000 in the third – the intent being to use the grants as start-up, and encourage programs to transition to other funding sources over time. In selecting awards, the statute creates priority for psychiatric, family medicine, general internal, and general pediatric residents, if sufficient applications are received.
In the first cycle of the grant, MDH received seven applications, of which a panel of community reviewers

selected five for awards. Here is a breakdown of the awards:

Residency Program	Description	# of new MDs funded
United Family Medicine (St Paul)	Family Medicine Residency Program in St Paul FQHC, with frequent rural rotations	3
HCMC -- Psychiatry	Joint program between HCMC and Regions	2
HCMC -- Family Medicine	Program with a strong track record of training physicians who work in underserved areas	2
U of M -- General Surgery	Rural surgeon track, operated in coordination with Essentia in Duluth	2
U of M – Pediatrics (EPAD)	A flexible pediatrics program that can expedite training for pediatricians – could have added up to 4 new residents	1

It will take three years for the program to be at full strength, at which time it is anticipated that grant funds will have sparked the creation of up to 30 additional residency slots, and therefore 30 additional primary care physicians.

Loan Forgiveness

Minnesota's Loan Forgiveness program has existed since the 1990s, starting with assistance to nurses and physicians who agreed to practice in nursing homes and in underserved rural areas, respectively. Over time the program grew to include dentists, pharmacists, "midlevels", and nurse faculty. Funding for the program fluctuated from year to year, and its impact had waned considerably.

In 2015, based on the recommendation of the Commission and other reports, the Legislature expanded the scope of the program to include public health nurses, dental therapists, and mental health professionals who agree to work in rural areas. Also, funding for the program was quadrupled, bringing the annual total to $3.25 million.

The state's Loan Forgiveness program provides debt relief in exchange for working in an underserved area or facility. Recipients must apply to a competitive review process, and if selected by a panel of community reviewers, must agree to serve a minimum of three years, with an optional fourth year. (Nurses working in nursing homes are required to serve a minimum of two years with the option of extending to four years.) Details of current annual award amounts, and eligibility criteria are listed in the next table.

<table>
<tr><th>Eligible Health Professions</th><th>Required Practice Locations</th><th>Annual Award</th></tr>
<tr><td>Rural Public Health Nurse</td><td rowspan="6">According to Minnesota Statute, a "rural designated area" is defined as outside the seven metro counties with the exception of Northfield, Hanover, Rockford and New Prague, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

Urban Mental Health Professionals and Physicians Only: Underserved urban communities in Minneapolis, St. Paul, Duluth, Mankato, or Moorhead designated as a mental health or primary medical care health professional shortage area (HPSA) or medically underserved area (MUA), or with medically underserved populations (MUPs).</td><td>$5,000</td></tr>
<tr><td>Rural Dental Therapist/Advanced Dental Therapist</td><td>$10,000</td></tr>
<tr><td>Rural or Urban Mental Health Professionals
LICSW, LMFT, LPCC, Licensed Psychologist, Psych NPs</td><td>$12,000
Psych NPs or Psychologist

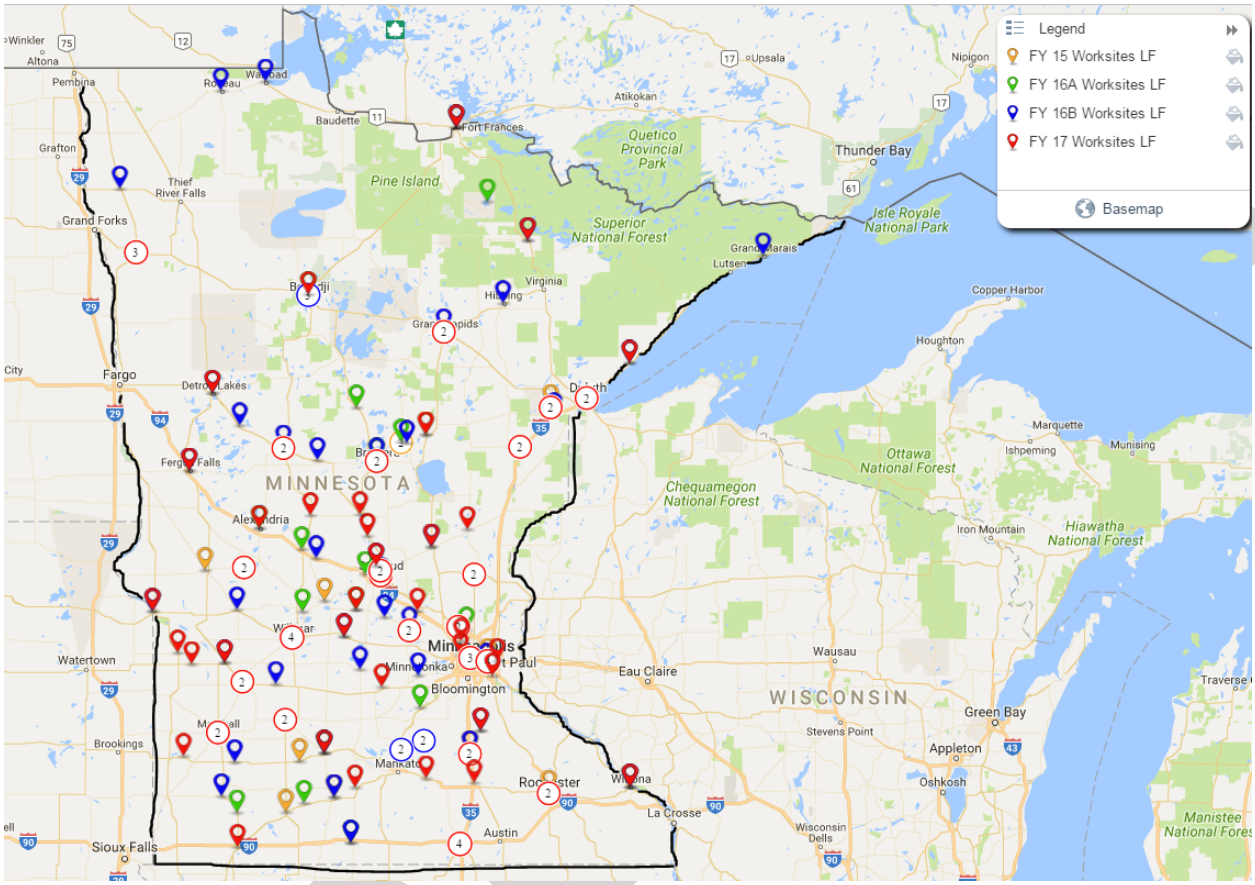
$7,000
LICSW, LMFT, LPCC</td></tr>
<tr><td>Rural Midlevel Practitioners
Nurse Practitioner Students/Graduates, Certified Nurse Midwife Students/Graduates, Nurse Anesthetist Students/Graduates, Advanced Clinical Nurse Specialist Students/Graduates, Physician Assistant Students/Graduates</td><td>$12,000</td></tr>
<tr><td>Rural Pharmacist
Students/Residents in a Pharmacy Program
Licensed Pharmacists</td><td>$20,000</td></tr>
<tr><td>Rural or Urban Physician
Primary Care Residents, Licensed Physicians (Family Practice, Internal Medicine, OB/GYN, Pediatrics, Psychiatry)</td><td>$25,000</td></tr>
<tr><td>Nurse
Licensed Practical Nurse/Nurse Students
Registered Nurse/Nurse Students</td><td>Licensed Nursing Home, Intermediate Care Facility for the Developmentally Disabled, OR
Hospital if owns/operates a Licensed Nursing Home (must work 50% time in Nursing Home)</td><td>$5,000</td></tr>
<tr><td>Faculty
Students studying to become Allied Health Care Instructors or Nursing Instructors</td><td>Post-secondary Allied Health Care or Nursing Program</td><td>$9,000</td></tr>
<tr><td>Dentist
Students/Residents in a Dental Program
Licensed Dentists</td><td>Twenty-five percent of annual patient encounters are public program or sliding fee scale patients</td><td>$30,000</td></tr>
<tr><td>Minnesota State Loan Repayment (SLRP)
Primary care physician, dentist, dental hygienist, certified nurse midwife, certified midwife, nurse practitioner, physician assistant, clinical psychologist, clinical social worker, psychiatrist, licensed professional counselor, psychiatric nurse specialist, marriage and family therapist</td><td>Federally designated Health Professional Shortage Area (HPSA), rural or urban</td><td>$20,000</td></tr>
</table>

In order to ramp up the program's new funding as quickly as possible, MDH decided to market the program heavily and open up two rounds of applications in FY 2016. The overall results of the selection process are listed below:

Profession	**2015**	**2016A**	**2016B**	**2017**
Physician	2	3	5	6
Pharmacist	2	3	6	3
Dentist	1	2	1	2
Nurse Faculty	3	2	2	3
MidLevel	4	3	11	11
Nurse in NH	2	5	11	20
PHN	-	-	10	7
DT/ADT	-	-	6	4
RMHP	-	-	4	24
UMHP	-	-	6	9
New Contracts	**14**	**18**	**62**	**89**
# of Applications	53	51	117	234
Field Strength	**59**	**56**	**118**	**207**

In the chart, "Field Strength" means the total number of Loan Forgiveness participants under contract, including those selected in prior years. Once fully implemented, MDH anticipates between 250 and 300 participants in the program.

The number of awards per profession is dictated by a formula defined in statute, but community reviewers are asked to consider other factors such as cultural competency, length of time after graduation, and geography. Below is the current field strength, mapped by year selected.



MENTAL HEALTH WORKFORCE ISSUES

In 2014 and 2015 the Commission heard testimony about the Mental Health Workforce Development Plan released in late 2014. The Plan was chartered by the 2013 legislature and guided by the Minnesota State system and a broad stakeholder group. The plan documented extensive mental health workforce shortages in Minnesota and made comprehensive recommendations to improve Minnesotan's access to mental and behavioral health care. In its 2014 and 2015 reports, the Commission recommended the legislature enact the plan's recommendations.

In 2016 the Commission received an update from HealthForce Minnesota on the status of the plan's recommendations. According to HealthForce Minnesota, notable progress has been made implementing the plan, while many of the plans recommendations have yet to receive action by the legislature or others. The full 2016 update is available on the Commission's website.

TELEHEALTH AND BROADBAND

In 2014 and 2015 the Commission expressed interest in removing any barriers to expanded use of telehealth to improve access and extend the reach of the state's health workforce. The 2015 legislature passed legislation providing payment parity between health services delivered in person or via telehealth, and in 2016 the Commission sought an update on implementation of the telehealth parity law. The Commission learned that because the effective dates in the law are January 1, 2016 for reimbursement by Medical Assistance and January 1, 2017, for commercial payers, there is not yet sufficient experience to evaluate the law. The Commission recommends monitoring the law's impact as more information becomes available.

The Commission also heard testimony from the Minnesota Office of Broadband Development in the Department of Employment and Economic Development. The Office of Broadband Development reported that:
54% of clinics statewide use telemedicine
74% of rural clinics use telemedicine
Primary uses include:
Chronic disease management
Remote patient monitoring
Staff medical education
Barriers include cost to provide service, cost of equipment, and insufficient reimbursement.

The Office of Broadband Development also provided an update on the Border to Border Broadband Development Grant Program. The program's purpose is to provide financial incentives for the acquisition and installation of broadband infrastructure into unserved and underserved areas of Minnesota. The program awarded $41.3 million for broadband projects in Greater Minnesota in 2014 and 205 and will be finalizing another round of awards in 2016.

The full presentation is available online.

LONG TERM CARE WORKFORCE ISSUES

In 2014 and 2015, the Commission heard testimony on pressing long term care workforce issues. The Commission heard testimony that Minnesota's long term care sector employs 129,000 workers, demand for older adult services will increase between 45 – 65 percent for there will be a 71 percent growth in home/community based health services nationally. The Long Term Care Imperative reported that Minnesota's long term care sector currently had over 1,800 positions open in its top four job categories in nursing homes.

In 2016 the Commission continued its review of workforce issues in the long term care sector. It received an update from the Department of Human Services that data is not yet available to document workforce effects of 2015 nursing home reform legislation.

Direct Care and Support Workforce Issues

The Department of Human Services reported to the Commission on the 2016 Direct Care/Support Workforce Summit it sponsored, attended by 181 stakeholders. The summit focused supply/demand, wage and retention

issues in the home health aide, nursing assistant and personal care aide occupations. Solutions were identified with the following themes:

- Increase workers' wages and/or benefits
- Expand the worker pool
- Enhance direct care/support worker training
- Increase job satisfaction and elevate profession
- Conduct a public awareness campaign

The full presentation is available online.

The Minnesota Home Care Association testified on similar issues its members face, and also addressed nursing issues due to pay differentials and increasing acuity of patients increasing. The Association reported its members are turning down referrals because they are unable to staff. The Association recommends addressing the reimbursement deficit in home and community-based services, creating innovative funding for training, competency-based certification for workers in home and community-based services, and new grad nursing programs in home care and developing incentives for academic health care organizations and industry partnerships. The full presentation is available online

SCOPE OF PRACTICE

The Commission received a report on the results of a 2015- 16 National Conference of State Legislators/National Governors Association scope of practice technical assistance project nearing completion, with the goal of addressing some of the scope of practice challenges and issues presented to the Commission. The project developed a common framework for evaluating scope of practice proposals. Initiate a community discussion that works toward a consensus framework for legislative and executive branch leaders. The core team, with stakeholder input, will develop a consensus framework or guiding principles to inform policy discussions around these issues. To better analyze and support scope of practice changes recently enacted in Minnesota, it also produced an assessment to identify barriers that hinder the goals scope of practice changes are intended to accomplish.

The project convened about 70 state government and other leaders to review these tools for policy makers, and the documents presented to the Commission were the result of stakeholder consensus. Several health professions organizations are already using the framework as they prepare proposals for the 2017 legislative session. Staff from the National Conference of State Legislators and the National Governors Association testified that the materials promise to be of interest to other states. The National Conference of State Legislators reported it is launching a new scope of practice website, scopeofpracticepolicy.org, and hopes to feature Minnesota's work on this site for other states to learn from Minnesota's experience.

Commission members agreed the legislature should adopt the common framework for evaluating scope of practice proposals developed by the 2015/16 National Conference of State Legislators/National Governors' Association-sponsored scope of practice project. The Commission recommends that 2017 incoming chairs use the framework and edit it as necessary after the close of next session based on user feedback and experience.

There was also support for encouraging use of the tool developed by the 2015/16 National Conference of State Legislators/National Governors' Association-sponsored scope of practice project for assessing progress made following scope of practice changes and assessing barriers that remain to achieving the change's goal.

The project also queried stakeholders to identify scope of practice proposals expected to be introduced in the 2017 legislative session, and this list was shared with the Commission. The list is included in the Appendix

MERC (MEDICAL EDUCATION AND RESEARCH COSTS PROGRAM)

MERC is Minnesota's Clinical training support Program. MERC grants $59 million to hospitals, clinics, pharmacies and other clinical training sites to subsidize part of their training costs. Funds are distributed through a formula based largely on each sites Medicaid revenue relative to all other applicant sites. MERC is the largest health professions program in the Health and Human Services budget. The program is administered by the Minnesota Department of Health through a partnership with twenty sponsoring education and training institutions, 248 teaching programs and 350 – 400 training sites.

In 2015 Commission members expressed interest in understanding the distribution of MERC funds between primary care and specialist trainees and in understanding how alternative distribution approaches would affect MERC's ability to better respond to changing workforce needs and health care delivery trends. Building on program details presented to the Commission in 2014 and 2015, in 2016 the Commission discussed options for better targeting MERC funds to accomplish policy goals more precisely. Testimony from MDH presented three broad course of action available for the legislature to revise the MERC program.

1. Amend the current Medicaid-based formula. This approach offers some opportunities for change, but because of Medicaid restrictions, there are limits. This approach requires a close tie to Medicaid enrollees and providers, the approval process is lengthy and uncertain, and the effects of changes can be indirect and not entirely predictable. Of course this current framework is what allows Minnesota to receive almost half of the program's funds as matching funds from the federal government.

2. Re-create a clinical training program from scratch through new Medicaid waivers. Other states have done this, as part of broad reform waivers.

3. Invest state funds for education and training outside of the MERC formula. The legislature has appropriated an additional $2 million dollars to the program over the last two years, even though these funds were not eligible for federal match. The legislature also made significant health workforce development appropriations outside of MERC over the last two years.

The MDH MERC presentation is available online.

PHARMACY INNOVATION

Summary to be inserted following presentation on December 6

PALLIATIVE CARE WORKFORCE ISSUES

Summary to be inserted following presentation on December 6

PIPELINE DUAL TRAINING/ APPRENTICESHIP PROGRAM

Summary to be inserted following presentation on December 6

Ongoing Legislative Involvement in Health Professions Education and Workforce Development

The Commission discussed the appropriate ongoing role for the legislature and others in health professions education and workforce development following the Commission sunset December 31, 2016. With healthcare the fastest growing employment sector in Minnesota's economy for the next ten years, Commission members discussed the need for the legislature to have sustained oversight of health workforce education and development policy and spending. The believes the legislature should adopt a continuing strategy for coordinating health workforce issues, through a legislative commission, statewide health workforce council or other mechanism to engage legislative leaders and other stakeholders in assuring the state has the health workforce it will need.

The value of state-level coordination was discussed each year by the Commission, with options and components suggested by a variety of stakeholders and Commission members. The most detailed discussion of health workforce planning and coordination took place in 2015 and is discussed in the Commission's 2015 report. Discussions of the issue suggests the legislature's strategy should include monitoring state workforce investments and addressing health care workforce education and training, trends in health care delivery, practice and financing and recommending appropriate public and private sector efforts to address identified workforce needs, as well as addressing health care workforce supply and demand, rural issues, diversity and workforce data analysis.

VI. State Spending on Health Professions Education and Workforce Development – 2016 Update

The Commission continued its exploration of state government spending on health professions education and workforce development, begun in 2014.

As in 2014 and 2015, according to the House Fiscal Analysis department, the Higher Education committees continue to spend the most on health professions education and workforce development, but do not focus greatly on details of the need for health professionals and strategies to meet the need through the higher education pipeline. The Health & Human Services Committees are more focused on workforce needs and gaps in the workforce. The Health & Human Services Committees spend less on health-related higher education and workforce development than the Higher Education Committees. The two committees do not regularly communicate in an organized way to address pipeline and workforce needs. There are also several related programs under the jurisdiction of the Jobs and Economic Development Committees.

Direct state government total for spending on health professions educations and workforce development is an estimated $342 million per year. As part of its role the Commission conducted a tally of direct state spending on health professions education and workforce development in 2014, and that analysis has been updated to reflect results of the 2015 and 2016 legislative sessions. Eighty-seven percent of the appropriations identified originate in the Higher Education divisions. The Commission noted that some state investments and activities not explicitly identified as workforce development spending have an indirect effect on health workforce dynamics. Examples include scope of practice regulation and state support of health care home and accountable care organization models. The Commission found this research complex, and recommends continued work to compile a complete picture of state investments in this area.

State Government Spending On Health Professions Education and Development – 2016 Update

Higher Ed Division

Program Name	Agency or Institution	Division	Fund	Pipeline Segment	2016 Appropriation
1. HealthForce, includes Scrubs Camps	MNSCU	Higher Ed	GF	Prepare students	Incl in MNSCU
2. U of M Duluth Med School Campus- rural focus	U of M	Higher Ed	GF	Recruit students	4,510
3. Center of American Indian & Minority Health	U of M	Higher Ed	GF	Recruit students	391
4. Future Doctors Program	U of M			Recruit students	0
5. Academic Health Center	U of M	Higher Ed	Cig Tax	Recruit/educate	22,250
6. Primary Care Education Initiatives	U of M	Higher Ed	HCAF	Recruit/educate	2,157
7. Health Science "Specials"	U of M	Higher Ed	GF	Recruit/educate	8,858
8. United Family Medicine Residency	OHE	Higher Ed		Clinical Training	501
9. St. Cloud Hospital family practice residency program	MMB	Higher Ed	GF	Clinical Training	346
10. Mayo Clinic Medical School	Mayo	Higher Ed	GF	Clinical Training	665
11. HCMC graduate family medicine program	OHE	Higher Ed	GF	Clinical Training	645
12. New U of M Med School funding	U of M	Higher Ed	GF	Research	14,000
13. Foreign Born Nurses	MNSCU	Higher Ed	G	Recruit/educate	35
14. Dual training "PIPELINE" PROGRAM	DOLI/OHE	Higher Ed	GF	Recruit/retain	2,200
15. Veterinarian loan forgiveness	OHE/MDH	Higher Ed	GF – 1 time	Recruit/educate	250
16. Mayo Family Medicine & General Residency Programs	Mayo	Higher Ed	GF	Clinical Training	686
17. Rural Physician Associate Program (RPAP), Metro PAP, Duluth Future Scholars	U of MN	Higher Ed	GF	Clinical Training	1,693
18. MNSCU Health Professions Programs	MNSCU	Higher Ed	GF	Credit-based	60,360
19. Health Training Restoration	U of M	Higher Ed	GF	Clinical Training	800
20. Other state appropriations to U of M medical school and other health professions education programs	MN Legislature	Higher Ed	GF	Clinical Training	132,354
21. State financial aid to health professions students	OHE	Higher Ed	GF		16,000
TOTAL				**TOTAL**	**268,701**

HHS Division

Program Name	Agency or Institution	Division	Fund	Pipeline Segment	2016 Appropriation
1. MERC Clinical Training	Health	HHS	Various	Clinical Training	59,127
2. Summer Health Careers Intern	Health	HHS	HCAF	Prepare students	300
3. Nursing Facility Scholarship Program	DHS	HHS	GF	Recruit students	2,603
4. MA reimb: Adult Basic Ed in nursing asst. programs	DHS	HHS	GF	Recruit students	2
5. Primary Care Residency Expansion	Health	HHS	HCAF	Clinical Training	1,500
6. Home & Community Based Services Scholarships	Health	HHS	HCAF	Retention	1,000
7. Greater Minnesota Family Medicine Program	Health	HHS	GF	Clinical Training	1,000
8. Int'l Medical Graduates	Health	HHS	HCAF	Clinical Training	1,000
9. Clinical Dental Education Grants	Health	HHS	HCAF	Clinical Training	1,122
10. HCMC Clinical Medical Education	Health	HHS	GF	Clinical Training	1,035
11. Teaching hospital MA add on	DHS	HHS	GF	Clinical Training	tbd
12. MN Health Professional Loan Forgiveness Program	Health	HS	HCAF	Employment High Need Settings	3,371
13. National Health Service Corps – state match	Health	HHS	HCAF	Employment High Need Settings	100
14. Community EMT –MA reimbursement	DHS	HHS	GF	Retention	4
15. Volunteer Ambulance Award Program (Cooper Sams)	EMSRB	HHS	GF	Retention	700
16. MA Primary Care Rate add-on	DHS	HHS	GF	Retention	expired 12/2014
17. Emerging professions support	MDH	Federal		Redesign	900
18. Telemedicine parity		HHS	GF	Improve access	170
TOTAL				**TOTAL**	**73,934**

Other Finance Divisions

Program Name	Agency or Institution	Division	Fund	Pipeline Segment	2016 Appropriation
1. Foreign-trained health worker test prep	DEED – 1 time funds	Jobs/Ec. Devel	WF Devel	Recruit students	200
2. FasTRAC	DEED	Jobs/Ec.Devel	WF Devel	Recruit students	1,500
TOTAL				**TOTAL**	**1,700**

Grand Total

GRAND TOTAL				**GRAND TOTAL**	**344,335**

The University of Minnesota reported that it distributes the $9.2 million in Health Science "Specials" in the table above as follows:

PROGRAM	SCHOOL	Amount
Biomedical Engineering	MED	$76,742
Rural Physicians Associate Program(RPAP)	MED	$193,064
St Cloud Residency Program	MED	$346,000
Hennepin County Pass Through	MED	$0
Dental Care	DENT	$100,000
Health Sciences Research	PUBHL	$340,743
Health Sciences Research	AHCSH	$2,124,211
Regenerative Medicine/Mayo	AHC Health Specials	$4,350,000
Veterinary Diagnostic Lab	VETMD	$1,673,240
Subtotal Health Sciences		**$9,204,000**

Additional state spending affects health workforce education and promotion, and also affects the workforce needed to serve state residents, even though the workforce effects of this spending is not easily identifiable within specific appropriations. Examples include:

- Team care approaches such as state-certified Health Care Homes
- Medicaid alternative payment demonstrations that provide indirect incentives to use non-physician staff for care coordination and patient follow-up
- Visa Waivers for foreign medical grads ("J-1")
- Medicaid reimbursement of telehealth and services by emerging professions such as dental therapists, community paramedics, community health workers, doulas, peer mental health support workers, etc.
- Scope of practice regulations and modifications administered by Health Licensing Boards
- Portions of broadband grants that improve the capacity of health facilities and patients to participate in telehealth
- Dept. of Education programs such as Career and Technical Education, Adult Basic education, etc.
- DEED Workforce Development Programs

VII. Health Professions Education Enrollment and Graduation – 2016 Update (Updated data to be added)

Each year the Commission studied health professions education in Minnesota, received background information from each of the state's higher education sectors – the University of Minnesota, Minnesota State Colleges and Universities, private colleges, and career colleges, and reviewed data on the number of students graduating with health professions credentials. The Commission learned that 25,684 students received a health professions certificate or degree at some level from Minnesota higher education programs in the 2012 - 2013 academic year, according to the data from the Integrated Postsecondary Education Data System (IPEDS), provided by the Minnesota Office of Higher Education.

In the 2013 – 2014 academic year, 23,087 students received a health professions certificate or degree at some level from Minnesota higher education programs. 42,753 students were enrolled in health professions education programs in Minnesota in the 2013 – 2014 academic year. Because students at the beginning of their education may not have yet declared majors, this figure undercounts the number who will go on to graduate from health professions programs.

Students in the disciplines below received the largest number of awards during 2013 - 2014:

Registered Nursing/Registered Nurse	6586
Psychology (largely bachelors and masters)	5116
Licensed Practical/Vocational Nurse Training	2013
Nursing Assistant/Aide and Patient Care Assistant/Aide	1863
Health/Health Care Administration/Management	1071
Medical/Clinical Assistant	960
Mental Health Counseling/Counselor	900
Public Health, General	560
Dental Assisting/Assistant	392
Substance Abuse/Addiction Counseling	387
Massage Therapy/Therapeutic Massage	384

APPENDICES

I. 2014 Law establishing the Legislative Health Care Workforce Commission
II. Framework for Describing and Evaluating Scope of Practice and/or New Licensure Proposals for Policymakers
III. Tentative Scope of Practice Proposals for the 2017 Legislative Session

APPENDIX I

2014 LAW ESTABLISHING THE LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION

Minnesota Laws 2014, Ch 312, Art 30, Sec 3, Subd 3

Subdivision 1. **Legislative oversight.** The Legislative Health Care Workforce Commission is created to study and make recommendations to the legislature on how to achieve the goal of strengthening the workforce in healthcare.

Subd. 2. **Membership.** The Legislative Health Care Workforce Commission consists of five members of the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration and five members of the House of Representatives appointed by the speaker of the house. The Legislative Health Care Workforce Commission must include three members of the majority party and two members of the minority party in each house.

Subd. 3. **Officers.** The commission must elect a chair and may elect other officers as it determines are necessary. The chair shall alternate between a member of the senate and a member of the House of Representatives in January of each odd-numbered year.

Subd. 4. **Initial appointments and meeting.** Appointing authorities for the Legislative Health Care Workforce Commission must make initial appointments by June 1, 2014. The speaker of the House of Representatives must designate one member of the commission to convene the first meeting of the commission by June 15, 2014.

Subd. 5. **Report to the legislature.** The Legislative Health Care Workforce Commission must provide a preliminary report making recommendations to the legislature by December 31, 2014. The commissioner must provide a final report to the legislature by December 31, 2016. The final report must:

(1) identify current and anticipated health care workforce shortages, by both provider type and geography;

(2) evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce;

(3) study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce; and

(4) identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

(i) training and residency shortages;
(ii) disparities in income between primary care and other providers; and
(iii) negative perceptions of primary care among students.

Subd. 6. **Assistance to the commission.** The commissioners of health, human services, commerce, and other state agencies shall provide assistance and technical support to the commission at the request of the commission. The Minnesota Medical Association and other stakeholder groups shall also provide advice to the commission as needed. The commission may convene subcommittees to provide additional assistance and advice to the commission.

Subd. 7. **Commission member expenses.** Members of the commission may receive per diem and expense reimbursement from money appropriated for the commission in the manner and amount prescribed for per diem and expense payments by the senate Committee on Rules and Administration and the House Committee on Rules and Legislative Administration.

Subd. 8. **Expiration.** The Legislative Health Care Workforce Commission expires on January 1, 2017.

FRAMEWORK FOR DESCRIBING AND EVALUATING SCOPE OF PRACTICE AND/OR NEW LICENSURE PROPOSALS FOR POLICYMAKERS

Introduction

This framework is designed to aide policymakers in the objective analysis of legislative proposals relating to scope of practice changes for regulated health professions/occupations.

The framework was developed for the State of Minnesota by a core team of professional health care associations, health licensing boards, state legislators, and the Minnesota Department of Health, Office of Rural Health and Primary Care in partnership with the National Governors Association and the National Conference of State Legislatures. The core team remains interested in the use and applicability of this framework. Please send any feedback on the framework and examples of its use to: Nitika.moibi@state.mn.us. Thank you.

Summary of Tools

The framework is organized into two parts:

Part 1 (Summary and Details): This part is intended to summarize and organize key information about the scope of practice proposals to facilitate an objective review for legislators. **It is intended to be completed by the author(s) of the proposed statutory change**.

Part 1 includes two sections:

Section I (Proposal Summary/Overview): This section is designed to provide an overview of the rationale for the proposal, including a summary (500-word count limit).

Section II (Proposal Details): This section includes a series of structured questions capturing and organizing key information on the proposed change and its impact on dimensions important to analyzing such changes. Proposal author(s) may complete only those questions relevant/pertinent to the proposal (not all questions will be applicable in all situations).

Part 2 (Legislator Review/Evaluation Tool): This part is meant to support legislators in the process of reviewing and evaluating the proposed legislative changes. It includes a series of open-ended questions designed to provoke critical review of key information. **It is meant to be completed by the legislator(s) reviewing the proposal** and serve as a quick reference.

Part 1

Section 1- Proposal Summary/ Overview

To be completed by proposal sponsor. (500 Word Count Limit)

State the profession/occupation that is the subject of the proposal.

For existing professions, briefly describe the proposed statutory change or expansion and its intended outcomes, including a brief statement of importance. For currently unregulated or emerging professions, briefly describe the proposed scope of practice and/or other regulatory requirements.

Section 2 – Proposal Details

To be completed by the proposal sponsor. Please respond to applicable questions. A response is not required for questions which do not pertain to the profession/occupation (may indicate "not applicable" or leave the response area blank). Where applicable, please provide supporting evidence (including source of information and citations, where appropriate). Please note, this section has been designed to provide more detailed information about the proposal. Some overlap with the summary provided in Section 1 is expected.

Public Safety and Well-Being

Describe, using evidence to the extent possible, how the proposed scope and regulation may improve or may harm the health, safety, and welfare of the public?

Is there any research evidence that the proposed change(s) might have a risk to the public? Please cite.

Will a regulatory entity/board have authority to discipline practitioners?

Describe any proposed disciplinary measures to safeguard against unethical/unfit professionals. How can consumers access this information?

Access, Cost, Quality, Care Transformation Implications

Describe how the proposed change(s) will affect the availability, accessibility, cost, delivery, and quality of health care.

Describe the unmet health care needs of the population (including health disparities) that can be served under this proposal and how the proposal will contribute to meeting these needs.

Please describe whether the proposed scope includes provisions to encourage or require practitioners to serve underserved populations.

Describe how this proposal is intended to contribute to an evolving health care delivery and payment system (e.g. interprofessional and collaborative practice, innovations in technology, ensuring cultural agility and competence in the profession, value based payment etc.)

Regulation

If the services or individuals are currently unregulated, what is the proposed form of credentialing/regulation (licensure, certification, registration, etc.)? State the rationale for the proposed form/level of regulation.[i] If there is a lesser degree of regulation available, state why it was not selected.[ii]

Describe if a regulatory entity/board currently exists or will be proposed. Does/will it have statutory authority to develop rules related to a changed/expanded scope or emerging profession, determine standards for education and training programs, assessment of practitioners' competence levels? If not, why not?[iii]

Is there model legislation for the profession available at the national level? If so, from what organization? Which states have adopted it? Briefly describe any relevant implementation information.

Does the proposal overlap with the current scope of practice for other professions/practitioners? If so, describe the areas of overlap. (This question is not intended to imply that overlap between professions is negative.)

Education and Professional Supervision

Describe the training, education, or experience that will be required for this professional based on this proposal, including plans for grandfathering in prior qualifications and/or experience where appropriate.

Is the education program available, or what is the plan to make it available? Is accreditation or other approval available or proposed for the education program? If yes, by whom?

Do provisions exist or are they being proposed to ensure that practitioners maintain competency in the provision of services? [iv] If so, please describe.

Is there a recommended level/type of supervision for this practitioner—independent practice, practice needing formal agreements or delegated authority, supervised practice? If this practitioner will be supervised, state by whom, the level, extent, nature, terms of supervision.[v]

Finance Issues – Reimbursement, Fiscal Impact to state, etc.

Describe how and by whom will the new or expanded services be compensated (e.g., Medical Assistance, health plans, etc.)? What costs and what savings would accrue and to whom (patients, insurers, payers, employers)?

Describe whether reimbursement is available for these services in other states? [vi]

What are the projected regulatory costs to the state government, and how does the proposal include revenue to offset those costs?

Do you anticipate a state fiscal impact of the proposed bill?

☐No ☐Yes

If, yes, describe briefly and complete table below to the extent possible:

Fund (specify)	FY2017	FY2018	FY2019	FY2020
Expenditure				

Workforce Impacts

Describe what is known about the projected supply/how many individuals are expected to practice under the proposed scope?[vii] If possible, also note geographic availability of proposed providers/services. Cite any sources used.

Describe, with evidence where possible, how the new/modified proposal will impact the overall supply of the proposed services with the current/projected demand for these services.

Proposal Supporters/Opponents (Sponsor should understand and attempt to address the concerns of the opposition before submitting the document)

What organizations and groups have developed or reviewed the proposal?

Note any associations, organizations, boards, or groups representing the profession seeking regulation and the approximate number of members in each in Minnesota. [viii]

Please describe the anticipated or already documented position professional associations of the impacted professions (including opponents) will/have taken regarding the proposal.[ix]

State what actions have been undertaken to minimize or resolve any conflict or disagreement with those opposing/likely to oppose the proposal.[x]

What consumer and advocacy groups support/oppose the proposal and why?

Report to the Legislature

1) Please describe any plans to submit a report to the legislature describing the progress made in the implementation and the subsequent impacts (if measureable) of the scope of practice changes for regulated health professions/occupations. Describe the proposed report's focus and timeline. Any proposed report schedule should provide sufficient time for the change to be implemented and for impacts to appear.

Part 2- Proposal Summary Notes

To be completed by legislators reviewing the proposal. This section serves as a companion to the information provided by authors (Part 1), and is designed for legislators to complete to serve as a guide/facilitate evaluation of proposed statutory changes.

Bill # (if introduced): Title: Author(s): Proposal Summary Notes:

Public Safety and Well Being
Review Notes:

Access, Cost, Quality, Care Transformation Implications
Review Notes:

Regulation
Review Notes:

Education and Professional Supervision
Review Notes:

Finance Issues – Reimbursement, fiscal impacts to state government, etc.
Review Notes:

Fiscal impact of the proposed bill:
☐No ☐YEs

Fund (specify)	FY2017 FY2018	FY2019 FY2020

Expenditure				

If, yes, describe briefly:

Workforce Impacts
Review Notes:

Proposal Supporters and Opponents
Review Notes:

Reporting Requirements, if applicable:
Review Notes:

Other
Does the bill promote health equity?

Does the bill positively impact my constituents?

NOTES:

[i] Minnesota Health Occupation Review Program. Manual of Procedures for use by Occupations submitting proposals to the Minnesota Council of Health Boards. 2002. Available in hard copy upon request. See discussion on Credentialing Policy Guidelines – Part 4.

[ii] Minn Stat 214.002 Subd. 2. (3)

[iii] Federation of State Medical Boards. "Assessing Scope of Practice in Health Care Delivery: Critical Questions in assuring Public Access and Safety." 2005

[iv] Federation of State Medical Boards. "Assessing Scope of Practice in Health Care Delivery: Critical Questions in assuring Public Access and Safety." 2005

[v] Federation of State Medical Boards. "Assessing Scope of Practice in Health Care Delivery: Critical Questions in assuring Public Access and Safety." 2005

[vi] Minnesota Health Occupation Review Program. Manual of Procedures for use by Occupations submitting proposals to the Minnesota Council of Health Boards. 2002. Available in hard copy upon request

[vii] Minnesota Health Occupation Review Program. Manual of Procedures for use by Occupations submitting proposals to the Minnesota Council of Health Boards. 2002. Available in hard copy upon request

[viii] Minnesota Health Occupation Review Program. Manual of Procedures for use by Occupations submitting proposals to the Minnesota Council of Health Boards. 2002. Available in hard copy upon request

Legislative Questionnaire for new or expanded regulation of health occupations. Submitted to the Minnesota Legislature by the Minnesota Advanced Practice Registered Nurse (APRN) in collaboration with the Minnesota Board of Nursing. January 29, 2014. This document includes more questions in addition to those required by Minn. Stat. 214.002. Only the new questions are included in the table.

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TENTATIVE SCOPE OF PRACTICE PROPOSALS FOR THE 2017 LEGISLATIVE SESSION

Submitted Prior to the Developing Tools and Frameworks to Advance Scope of Practice Policies meeting

Purpose: In the registration form for the 2016 National Conference of State Legislators/National Governors Association Minnesota stakeholder meeting , there was a question "Is your organization considering any scope-of- practice proposals during the 2017 legislative session?" Twenty-one out of sixty-two registrants responded "yes". Below are responses grouped by organization and profession. *Please note: this only includes a list of the proposals that were submitted. There may be more proposals by the organizations or health care profession. The organization or professions name by the information submitted does not necessarily mean it is endorsed by the organization.*

Interpreting Stakeholder Group

Setting minimum training and testing standard for spoken language healthcare interpreters in MN to ensure patient safety and access to high quality healthcare.
Legislation to create training and competency standards for spoken language healthcare interpreters

Minnesota Board of Psychology

The Board will be reviewing the definition of the practice of psychology and the Minnesota Psychology Practice Act to identify inconsistencies, outdate language, and to clarify language on who is required to be licensed in the state.

Minnesota Academy of Physician Assistants (MAPA)

Adjustments to the PA advisory board term limits
Changing terminology to reduce physician liability for collaborating with Pas

The Minnesota Advanced Practice Registered Nurses (APRN) Coalition

Global signature authority to sign death certificates

Minnesota Dental Hygienists' Association

The MnDHA has been collaborating with other stakeholders to identify improvements in the Limited Authorization (collaborative practice dental hygiene) model of delivery (Minnesota chapter 150A.10). Changes are needed to make this delivery model more effective and involve more dental hygienists and dentists.
Expanding the collaborative practice dental hygienist Changes to collaborative practice dental hygiene Adjustments to collaborative practice dental hygiene

Minnesota Health Care Safety Net Coalition

Reducing barriers to use and expansion of new health care workforce models such as dental therapists and community health workers and reduce unnecessary scope of practice limitations on existing practitioners such as dental hygienists and nurses. Also, reduce unnecessarily high education requirements or scope of practice requirements that increase the cost of education and create barriers to access for people from underserved communities and those experiencing health disparities. Require Health Equity Impact Assessments of workforce policies to determine whether they are perpetuating or increasing health disparities.

Minnesota Northland Association for Behavior Analysis
We are advancing a bill to license Board Certified Behavior Analysts and Board Certified assistant Behavior Analysts.

Minnesota Senate
Licensing for massage therapists
Licensing for lactation consultants
Proposals will be based on legislative commission and committee hearings.

Minnesota Pharmacists Association
Determined by the Pharmacy Practice Act Joint Task Force. Currently working on priorities.

Normandale Community College/Metropolitan State University - MnSCU
Updates to the collaborative practice dental hygiene statutes to improve access to preventive oral health.

University of Minnesota
Dental Hygiene Collaborative agreements

University of Minnesota College of Pharmacy
Naloxone prescribing