Minnesota Department of Health – Health Care Workforce Advisory Council Proposal Request for Feedback

NOVEMBER 1, 2024

[144.xxx] HEALTH CARE WORKFORCE ADVISORY COUNCIL

Subd. 1. **Establishment.** The legislature has recognized the need for a body that has a comprehensive view of the health care workforce needs of the state and is committed to working across all sectors to promote action towards resolving persistent health care workforce challenges. The Minnesota Health Care Workforce Advisory Council is established to: (1) provide ongoing health care workforce research and data analysis; (2) provide health care workforce policy and program monitoring and coordination; (3) advise and comment on relevant workforce legislation as it relates to health professions education, training, retention, demographics, changes in health care delivery, practice, and financing; and (4) recommend appropriate public and private sector policies, programs and other efforts to address identified health care workforce needs. The council shall focus on health care workforce supply, demand, and distribution; health equity; pipeline efforts to increase participation by those underrepresented in health professions education; oral health, mental health, pharmacy, nursing, primary and specialty care training and practice, allied health care, direct care; and health care workforce data, evaluation and analysis.

The council shall consult and collaborate with other health care workforce planning entities including but not limited to the Governor's Workforce Development Board, area councils on graduate medical education, advisory committees that support health care workforce education and clinical training, health professional associations, licensing bodies, certification and educational institutions, in developing their program or legislative recommendations. The council may establish standing or ad-hoc subcommittees to support the work of the council.

Subd. 2. **Membership.** (a) The Minnesota Health Care Workforce Advisory Council shall consist of sixteen members appointed as follows:

(1) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(2) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(3) the commissioner of Employment and Economic Development or a designee;

(4) the commissioner of the Office of Higher Education or designee;

(5) ten members appointed by the governor who have expertise regarding the council's priorities.

Subd. 3.**Appointments.** In making appointments to the council, the governor shall ensure geographic and demographic representation. Appointees should demonstrate commitment to the council's broader charge, proven experience in addressing health care workforce needs, and subject matter expertise that might benefit the council's priorities.

Subd. 4. **Terms of public members.** (a) The terms of the members appointed under subdivision 2 shall be four years except for the initial appointment where the appointing authority shall appoint as nearly as possible one-half of the members to a two-year term. Members may serve until their successors are appointed.

(b) Initial appointments should be made by October 30, 2025. The commissioner of health shall convene the first meeting no later than January 5, 2026. Members of the council shall elect a chair and participate in hiring an Executive Director.

(c) Except for section 15.059, subdivisions 2 and 3, section 15.059 shall apply to the council and to all council member appointments, except those members who are commissioners or their designees. The members of the council shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

Subd 5. **Staffing**: (a) An Executive Director of the council shall be hired by the commissioner with advice of the council. The executive director of the council may offer advice to the governor on applicants seeking appointment.

(b) The commissioner of health shall provide adequate staffing to the council to carry out its responsibilities. This includes administrative, research, planning and strategy facilitation services. The commissioner shall provide comprehensive, non-partisan, and methodologically rigorous data, research and recommendations on health care workforce issues as requested by the council.

Subd. 6. **Duties.** (a) The council, with staffing support from the commissioner of health, shall:

(1) Regularly convene stakeholders from various groups across the state to identify and prioritize the pressing needs related to the health care workforce. Issues may include but are not limited to health care workforce shortages, training/pipeline needs, demographic and geographic distribution, retention, modes of care that relate to health care access and equity, emerging health care professions and roles, emerging health professional education programs and institutions.

(2) Advise the legislature and relevant stakeholders, educational institutions, the Minnesota Office of Higher Education and other relevant state agencies on current and proposed health care workforce initiatives, including training and pipeline development, initiatives related to workforce shortages and maldistribution, evolving roles of health care providers, and initiatives aimed to increase geographic and demographic diversity in the workforce.

(3) Conduct research and develop actionable recommendations regarding the following:

(i) health workforce supply and demand, including:

(A) employment trends and demand across all professions, including but not limited to primary care, mental health, and oral health;
(B) strategies that entities in Minnesota or other states are using or may use to address health workforce shortages, recruitment, and retention; and
(C) future investments to increase the supply of health care professionals, with particular focus on critical areas of need within Minnesota;

(ii) options for training and educating the health care workforce, including:

(A) increasing the diversity of health professions workers to reflect Minnesota's communities;
(B) addressing the maldistribution of primary, mental health, nursing, dental and other providers in greater Minnesota and in underserved communities in metropolitan areas;
(C) increasing interprofessional training and clinical practice;
(D) addressing the need for sufficient quality faculty to train a growing workforce; and
(E) developing advancement paths or career ladders for health care workers;

(iii) increasing funding for strategies to diversify and address gaps in the health care workforce, including but not limited to:

(A) increasing access to financing for graduate medical education;
(B) changes in practice scopes to address gaps in care;
(C) identifying future models of care delivery that impact the workforce;
(D) expanding pathway programs to increase awareness of the health care professions among high school, undergraduate, and community college students, particularly from those communities that are underrepresented in the health care workforce, and engaging the current health workforce in those programs;
(E) reducing or eliminating tuition for entry-level health care positions that offer opportunities for future advancement in high-demand settings and expanding other existing financial support programs such as loan forgiveness and scholarship programs;
(F) incentivizing recruitment into the health care field from greater Minnesota and underrepresented communities,
(G) incentivizing recruitment and retention for providers practicing in greater Minnesota and in underserved communities; and
(H) expanding existing programs, or investing in new programs, that provide wraparound support services to the existing health care workforce, especially people of color and professionals from other underrepresented identities, to acquire training and advance within the health care workforce; and

(iv) other Minnesota health workforce priorities as determined by the advisory council.

(4) Submit a comprehensive five-year workforce plan to the legislature as defined in subdivision 7, and provide information and analysis on health care workforce needs and trends to the legislature, any state department, or any other workforce planning entity as requested.

Subd. 7. **Deliverables and reporting.** (a) The council shall duly execute its responsibilities as noted in subdivision 1 and subdivision 6. In addition, every five years, the commissioner of health, in consultation with the Minnesota Health Care Workforce Advisory Council, shall develop health care workforce priorities to meet the needs of the state, and prepare a comprehensive health care workforce plan. The first plan must be submitted to the legislature by January 15, 2027, and an updated plan must be submitted every five years thereafter. The comprehensive health care workforce plan must include, but is not limited to the following:

(1) an assessment of the current supply and distribution of health care providers in the state, trends in health care delivery and reform, and the effects of such trends on workforce needs;

(2) five-year projections of the demand and supply of health care workers to meet the needs of health care within the state;

(3) identification of all funding sources for which the state has administrative control that are available for health professions training and education;

(4) recommendations and action plans to meet the projected demand for health care workers over the five years of the plan.

(b) In the interim between the publication of comprehensive health care workforce plans, the commissioner of health, in consultation with the Minnesota Health Care Workforce Advisory Council, shall provide periodic updates to the governor on the progress made toward achieving the projected goals, addressing workforce needs of the state, and identify emerging needs.

Subd. 8. **Data and Access to Information**. (a) The commissioner may request that a state agency provide data in a usable format as requested by the commissioner at no cost to the commissioner.

(b) The commissioner may also request from a state agency unique or custom data sets. That agency may charge the commissioner for providing the data at the same rate the agency would charge any other public or private entity.

(c) Notwithstanding any provisions to the contrary, the commissioner may use data collected and maintained under section 62U.04 to carry out the duties required under this section.

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