Recommendations for the Minnesota Health Care Workforce Advisory Council

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Minnesota Department of Health
Office of Rural Health and Primary Care, Workforce Analysis Program
PO Box 64975
St. Paul, MN 55164-0975
651-201-3838
Health.Workforce@state.mn.us
www.health.state.mn.us

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Contents

Executive Summary

The Minnesota Legislature, in 2024 session laws, Chapter 127, Article 66, Section 22, directed the Minnesota Department of Health (MDH), in consultation with the University of Minnesota and the Minnesota State HealthForce Center of Excellence (referred to in this report as the planners or planning committee), to develop recommendations for the creation of a Health Care Workforce Advisory Council.

The Legislative charge was to prepare recommendations for establishing a Health Care Workforce Advisory Council (hereafter, the Council), including recommendations on membership, duties, funding sources, etc. The recommendations were to be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, and higher education finance and policy by February 1, 2025.

The planners acknowledged the need for a centralized workforce advisory body that was guided by credible, objective workforce data and evidence; was positioned to collaborate and coordinate with existing health care workforce entities; could comment on and advise the Legislature on relevant workforce legislation; and was committed to working across all sectors to resolve the persistent and complex health care workforce challenges facing the state.

To execute the charge, the planners consulted with state and national workforce experts as they considered various models to steer and govern the Council, its duties and deliverables, membership, and member term limits. They also notified workforce stakeholders and invited public input on the proposed Council design and structure. The recommendations included in this report reflect the careful thinking of the planners and the input received from the stakeholder engagement process.

Noted below is a high-level summary of the proposed Council and recommendations related to its purpose, membership, duties and deliverables, data needs, etc. A detailed proposal creating the Minnesota's Health Care Workforce Advisory Council can be found in Appendix A.

Establishment: The planners thought it important to describe the purpose of establishing the Council and chose to include language clarifying its objectives. The planners intended for this Council to be a collaborative force; an objective convenor; a coordinator of disparate, decentralized planning efforts; a disseminator of objective data; and above all, a trusted advisor and consultant to the Legislature and all other Minnesota workforce planning entities.

The planners envisioned this Council to be a central and comprehensive source of health care workforce information in the state. Given the cross-sector workforce pressures facing the state, the planners intended for the Council to be broad in its scope, focus, and reach. The Council is directed to address the relevant health care disciplines (such as *pharmacy, nursing, etc.)*, workforce challenges facing different sectors (such as *long-term care)*, as well as current and looming issues (such as *health equity; pipeline efforts to increase participation by those underrepresented in health professions education, workforce shortages and maldistribution, etc.*) facing the workforce.

The planners discussed many models on representation and ways to conduct the work of the Advisory Council. They recommend that the Council establish discipline-specific, profession-specific or issue-specific standing or ad-hoc committees guided by Minnesota workforce experts as way to dive deeper into workforce issues and develop impactful recommendations for the Council to consider.

Membership: The planning committee considered the appropriate depth and breadth of expertise needed to steer and lead this council. They proposed that the Council be steered by a 16-member group of appointees with four members representing the legislative branch, two from state agencies and ten members appointed by the governor, all with demonstrable commitment to the Council's broader charge, experience in addressing health care workforce needs, and subject matter expertise that would benefit the Council's priorities over the next five years. Appointees would have a four-year term on the Council and could be re-appointed. Appendix F suggests potential considerations and qualities of Council appointees.

Staffing and Funding: The planners envisioned the Council to be housed within MDH's Office of Rural Health and Primary Care with staffing support from the MDH commissioner. An ongoing appropriation would be needed to support the Council's research, communication, coordination, and policy duties.

Council Duties: The Legislature in its authorizing charge was comprehensive in the duties and the nature of issues the Council should engage with. The planners added more focus areas to the original charge of the Council, such as: periodic convening of stakeholders and inviting public input; identifying emerging trends in health care profession roles, scopes of practice, education programming, and models of care delivery; workforce retention and burnout factors; efforts to grow faculty, preceptors, and supervisors; career awareness starting in middle schools; and initiatives for credit for prior learning. The planners also included deliverables and reporting responsibilities for the Council.

Given the urgent workforce crises facing the state, the planners also recommended that the commissioner of Health, in consultation with the University of Minnesota and the Minnesota State HealthForce Center of Excellence, lead a stakeholder engagement process to help the Council identify the health care workforce priorities in its first year. The planners proposed that the Council's inaugural appointees possess the expertise that will be needed to steer the Council to address the priorities that emerged through stakeholder engagement.

Deliverables and Reporting: The Council would be required to submit to the Legislature a report that includes information on workforce demand, supply, distribution and labor market projections; workforce spending and funding sources for workforce programs; workforce priorities identified through stakeholder engagement; and an actionable workforce plan along with evaluation and performance metrics. This report is to be delivered every five years. The Council should be committed to implementing and addressing the priorities as laid out in the workforce plan, while acknowledging that some implementation efforts will need to be led by entities other than the Council. Periodically through the five-year plan implementation, the Council should self-review its implementation progress, evaluate its impact, and update the governor.

Data and Access to Information: The planners acknowledged the role other state agencies play in health care workforce development, recruitment, employment, and retention. The Council, while housed at MDH, is expected to be aware of workforce efforts underway in other agencies; should play a lead role in gaining

cooperation and access to data and information from sister agencies in order to execute the Council's priorities as needed; and coordinate enterprise-wide workforce efforts when possible to address the state's workforce challenges.

Existing and New Data Needs: There are multiple state and federal workforce data sources available that can be used to answer questions about supply, demand, geographic and demographic trends, education and training, and other topics pertinent to the work of the Council. An extensive inventory of state and federal level workforce data sources is noted in Appendix E.

Finally, the planners underscored the need for impartiality and commitment to meeting the state's workforce needs as opposed to organizational or professional agendas. The Council will also require thought leadership and adequate resources in order to discharge its duties fully and responsibly. The planners hope for the authorization of this Council so it can work with entities to address workforce challenges and transform Minnesota's health care workforce landscape. The planners stand ready and committed to aid policy makers in these efforts.

Introduction

Health care workforce shortages are a considerable challenge across every part of the care continuum. From direct patient care, to nursing care, to behavioral, oral, and primary health care, and everything in between and beyond, many organizations face extreme hiring difficulties, and many communities and individuals cannot access the care they need within a reasonable distance or time, or care that meets their cultural needs. Shortages plague systems even as many health care organizations have begun to recover from the worst of the pandemic-provoked hiring, burnout, and turnover challenges.

Amidst discussions about the future infrastructure needs for future health care delivery in Minnesota and the financial complexity of academic medicine, workforce issues often took center stage in the deliberations of Governor Walz' 2023-24 Task Force on Academic Health at the University of Minnesota (PDF) The task force was charged with developing recommendations for world-class academic health professions education, research, and care delivery by the University of Minnesota's Health Sciences Programs, and to support the state's public health goals. At its conclusion, the task force recommended:

- a comprehensive health professions workforce plan that aligned with emerging models of care and addressed provider maldistribution (recommendation #11);
- an advisory body for interprofessional training and clinical practice (recommendation #12);
- increased funding for effective strategies to diversify and fill current and future gaps in the health care workforce (recommendation #13); and

the use of workforce data to coordinate and plan future investments (recommendation #14).

The 2024 Legislature, in addressing the work of the task force, further considered the need for ongoing, comprehensive attention to the state's health care workforce needs.

Background

The Charge

The Minnesota Legislature, in 2024 session laws, Chapter 127, Article 66, Section 22, (see Appendix G) directed the Minnesota Department of Health (MDH) in consultation with the University of Minnesota and the Minnesota State HealthForce Center of Excellence to develop recommendations for the creation of a Health Care Workforce Advisory Council. Per the vision of the Legislature, the workforce advisory body would:

- Research and advise the Legislature and the Minnesota Office of Higher Education on the status of the health workforce who are in training and on the need for additional or different training opportunities;
- Provide information and analysis on health workforce needs and trends, upon request, to the Legislature, any state department, or any other entity the Council deems appropriate;
- Review and comment on legislation relevant to Minnesota's health care workforce; and

- Study and provide recommendations regarding a wide range of issues concerning the growth and retention of the health care workforce, such as employment trends, demand and supply, diversity, interprofessional training and clinical practice, increasing access to financing for graduate medical education, etc.

MDH was charged with issuing a report with recommendations on the Health Care Workforce Advisory Council to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, and higher education finance and policy by February 1, 2025. As directed, this report includes the proposed language establishing the Health Care Workforce Advisory Council, a section-by-section review of the language, and recommendations on the following:

- Membership of the Council;
- Funding sources and estimated costs for the Council;
- Existing sources of workforce data for the Council to perform its duties;
- Necessity for and options to obtain new data for the Council to perform its duties;
- Additional duties of the Council;
- Proposed legislation to establish the Council;
- Similar health workforce councils in other states; and
- Council reporting requirements.

Guiding Principles

MDH's staff began the work by reviewing past efforts in Minnesota on health care workforce advisory bodies and meeting with other states with active workforce councils to learn more design elements, governance, membership etc. MDH convened its first meeting with partners from the University of Minnesota and the Minnesota State HealthForce Center of Excellence (hereafter, the planning committee or the planners) in September 2024. At that meeting, the planners took stock of the current health care workforce landscape and shared their concerns with the current state of workforce planning, the difficulty in finding consensus on pressing workforce challenges facing the state, and the need for well-rounded strategies to respond to them. The planners acknowledged the need for a central body that:

- has a comprehensive view of the health care workforce needs of the state;
- has access to and is guided by credible, objective workforce data and evidence;
- collaborates and coordinates with existing health care workforce entities and efforts;
- is empowered to convene and align stakeholder agendas and priorities; and
- stands committed to working across all sectors to promote action to resolve persistent and complex health care workforce challenges.

The planners shared their vision and identified the principles that would be needed to guide the creation of such a centralized workforce advisory body, hereafter, the Minnesota Health Care Workforce Advisory Council or the Council, as well as the ongoing work of this body. Key themes that emerged from these discussions were:

- Commitment to state health care workforce needs vs. profession- or system-specific wants or interests;
- Solution-focused, action orientation driven by objective data and expertise;

- Collaboration and coordination that avoids duplication;
- Neutrality;
- Stakeholder engagement and input along the way; and
- Systems thinking.

The planners committed to adhering to these principles throughout the development of the proposed Council, and designed the Council to help its eventual members hold true to them in their work.

The Planning Process

In response to the legislative charge, the planning committee met from September 2024 through January 2025 to discuss vision, purpose, membership, design and scope for this Council. To that end, the planners:

- Researched, compiled and reviewed profiles of health care workforce councils currently operating in eight other states (see Appendix E);
- Met with representatives from three states—California, Oregon and Utah—who have had similar workforce coordinating and advisory bodies in law, to gather advice, lessons learned, and best practices for designing a state workforce council;
- Consulted with national experts at the National Governors Association Center for Best Practices for design and operational insights related to the Council;
- Reviewed and compiled sources of health care workforce data at the state and federal level that are available to inform the Council's deliberations (see Appendix B);
- Thoughtfully considered various models to steer and govern the Council, its duties and deliverables, membership, and member term limits;
- Drafted a legislative proposal to create an advisory council on health care workforce issues to respond to the state's unique needs, workforce landscape, and players (see Appendix A);
- Notified workforce stakeholders about the proposed Council; sought public input by way of an online survey on the direction, scope and content of the proposed Council; and incorporated, as applicable, feedback from the respondents (see Appendix D); and
- Developed recommendations responsive to the charge in the form of this report.

Stakeholder Input

In addition to input on the design of the Council from partners in other states, the planners were deeply committed to engaging with the public and the state's health care workforce stakeholders, and sought their input on the proposed Council. The planning committee invited individuals representing various sectors of the health care workforce—professional associations, health care facilities, workforce workgroups/centers, education institutions, and state agencies to read the proposed legislative language and provide feedback via an online survey. The request for feedback was sent to a broad list of interested parties via the MDH Office of Rural Health and Primary Care's listserv. MDH also presented the proposed language at two large stakeholder meetings: the governor-appointed Rural Health Advisory Committee, and the Health Care Workforce and Education Committee (formerly the Medical Education and Research Costs [MERC] committee).

The planners sought feedback on the overall proposal language; potential ways in which workforce stakeholders and entities anticipated interacting and engaging with the Council; workforce priorities; and suggestions of individuals or organizations to serve on the Council. The survey also gathered demographic information on respondents. The planning committee carefully reviewed and incorporated this feedback. The final proposed language in this report has benefited from this public input.

Overall, the response to the proposed legislative language was very positive, with 94% of the respondents approving of the proposal to create a health care workforce advisory council, its direction and scope as proposed—53% of the respondents strongly approved of the proposal, 41% somewhat approved, 6% somewhat disapproved and no one strongly disapproved. Additional details on the feedback and responses are summarized in Appendix D.

Recommendations

In response to the legislative charge, the planners developed a legislative proposal to establish an advisory council and its duties, and drafted recommendations for membership, staffing and funding, and sources of workforce data to enable the Council to execute its work. As noted above, the planners engaged with stakeholders and invited input from the public and workforce entities on the proposal. Recommendations included in this report reflect the careful thinking of the planners, insights from other states and national experts, and the input received from the stakeholder engagement process.

Noted below is a section-by-section review of the proposed language related to the Council, including details on membership, duties, reporting requirements, and funding sources. The complete proposed legislation establishing the Council along with workforce data sources and profiles of similar councils in other states are included in the appendices to this report.

Section-by-Section Review of Council Proposal

Establishment

> *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, can advise the legislature on health care workforce issues, is a neutral convenor of competing perspectives; 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 objective health care workforce research and data analysis; (2) collaborate and coordinate with other entities on health care workforce policies; (3) review, comment and advise the legislature and other stakeholders on relevant workforce legislation as it relates to health professions education, training, retention, diversity and 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 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, and certification and educational institutions, in developing their program or legislative recommendations.

The Council shall focus on health care workforce supply, demand, and distribution; health equity; efforts to increase participation by those underrepresented in health professions education; education, training and practice across oral health, behavioral health, pharmacy, nursing, primary and specialty care, allied health care and direct care; and health care workforce data, evaluation, and analysis.

The Council shall establish discipline-, profession-, or issue-specific standing or ad-hoc committees with subject matter experts to advise and support the work of the Council. The Council shall intentionally include perspectives that represent rural needs and workforce diversity in all committees.

As laid out in the legislative charge to MDH and envisioned by the planners, the purpose of the Council is to be a comprehensive, collaborative body that advises the legislature on health care workforce issues, and coordinates public-private health care workforce investments to address the workforce needs of the state.

The planning committee thought it important to describe their vision for how this Council fit within the workforce planning landscape and the role it should play. The planners felt strongly that the Council could and should be a:

- body that would produce and disseminate objective and timely data on state workforce needs to inform priorities;
- space to generate and cross-pollinate workforce policy and program ideas;
- transformative force that could convene and coordinate currently disparate and decentralized workforce planning and investment efforts, and move them forward cohesively and strategically;
- catalyst for futuristic thinking through expert committees that could anticipate emerging health care trends;
- neutral convenor of competing perspectives for entities to have candid discussions and tactfully arrive at common ground when possible to advance goals and legislation;
- dynamic coalition builder to resolve the persistent workforce challenges facing Minnesota; and
- trusted partner, advisor, and consultant to the Legislature and all other Minnesota health care workforce planning entities.

Given the cross-sector workforce pressures facing the state, the planners intended for the Council to be broad in its focus and reach. The planners intentionally called out known and emerging workforce challenges (supply/demand pressures, lack of workforce diversity, unmet rural needs) plaguing many sectors (allied health and direct care providers, primary, oral and behavioral health) to fall within the purview of this Council.

The planners discussed many models of representation and ways to conduct the work of the Council. They recommended that the Council establish discipline-specific, profession-specific, and/or issue-specific standing or ad-hoc committees driven and guided by Minnesota workforce experts as ways to dive deeper into workforce issues and develop impactful recommendations for the Council appointees to consider.

Membership

*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; and

(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. Appointees to 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.

The planning committee considered the appropriate depth and breadth of experts needed to steer and lead this Council. Council membership composition was also a key discussion topic with our state and national partners. Given the many health care disciplines and workforces (nursing, pharmacy, dentistry, etc.), workforce issues (recruitment and retention, faculty development, burnout, workforce diversity, etc.) facing the state, the comprehensive nature of the duties assigned to the Council, and the need to balance impactful representation with realistic governance, the planners proposed that the Council be steered by a 16-member group of appointees with four members representing the legislative branch, two from state agencies, and ten members appointed by the governor with demonstrable commitment to the Council's broader charge, experience addressing health care workforce needs, and subject matter expertise that would benefit the Council's priorities that are set every five years. (For more, see Council Duties.)

Appointees would have a four-year term on the Council and could be re-appointed. For the initial appointments, roughly half would be appointed for two years in order to stagger the terms and allow members to overlap and

provider leadership continuity. The planners' intention was that members would serve and contribute their expertise as needed. As noted above, the planners also proposed that the Council establish discipline-specific, profession-specific or issue-specific standing and ad-hoc committees as mechanisms to bring in subject matter experts and public input.

Staffing

> *Subd 5.* ***Staffing:*** *(a) An Executive Director of the Council shall be hired by the commissioner of health with advice of the Council. The executive director of the Council may offer advice to the governor on applicants seeking appointments to the Council.*
>
> *(b) The commissioner of health shall provide adequate staffing to the Council and the committees 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.*

The planners envisioned the Council to be housed within MDH's Office of Rural Health and Primary Care, with staffing support from the MDH commissioner. An on-going appropriation will be needed to:

- hire an executive director;
- hire research staff to execute research and data analysis responsibilities of the Council;
- staff coordination of activities and communications functions;
- provide professional services for strategic planning, meeting facilitation, goals/priority development; and
- support any data procurement charges, and travel and meeting costs for members.

Council Duties

> *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. The Council may seek public input via town halls, listening sessions, or surveys. Issues may include but are not limited to health care workforce shortages, training and workforce supply needs, demographic and geographic distribution, retention, models 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, educational institutions, the Minnesota Office of Higher Education, relevant state agencies, and other stakeholders on current and proposed health care workforce initiatives, including training and pipeline development, workforce shortages and maldistribution, retention and burnout, evolving roles of health care providers, health equity, and geographic and demographic diversity in the workforce.*

(3) Consider objective, non-partisan 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, behavioral 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 care workers to reflect Minnesota's communities;

(B) addressing the maldistribution of primary care, behavioral health, nursing, oral and other providers in greater Minnesota and in underserved communities;

(C) increasing interprofessional training and clinical practice;

(D) addressing the need for sufficient quality faculty, preceptors, and supervisors to train a growing workforce; and

(E) developing advancement paths or career ladders for health care workers.

(iii) 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 that is responsive to state workforce needs;

(B) changes in practice scopes to address gaps in care;

(C) identifying future models of care delivery and future roles within the care delivery team that impact the workforce;

(D) expanding pathway programs and engaging the current health workforce to increase awareness of health care professions among middle and high school, undergraduate, and community college students, particularly from communities that are underrepresented in the health care workforce;

(E) reducing or eliminating tuition for entry-level health care positions in high-demand settings, expanding other existing financial support programs such as loan forgiveness

and scholarship programs, especially for underrepresented communities, and consider awarding credit for prior and non-credit learning;

(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.

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

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

In its authorizing charge, the Legislature was comprehensive in outlining the duties and the nature of issues the Council should be engaged in, as noted above. The planners added more focus areas to the original charge. These included:

- periodic convening of stakeholders and inviting of public input during priority setting and other Council activities;
- identifying emerging trends in health care profession roles, scopes of practice, education programming and models of care delivery;
- a focus on workforce retention and burnout factors;
- efforts to grow faculty, preceptors and supervisors;
- career awareness starting in middle schools;
- initiatives that award credit for prior learning; and
- additional deliverables and reporting responsibilities for the Council (see the following section for more information).

Given the urgent workforce crises, the comprehensive duties ascribed to the Council as envisioned by the Legislature, and the many interests and perspectives that will likely seek to be named to the Council, the planners strongly recommend that once the Council has been authorized, the commissioner of Health, in consultation with the University of Minnesota and the Minnesota State HealthForce Center of Excellence, lead a stakeholder engagement process to identify the health care workforce priorities for the Council. As this process is underway, the commissioner should work with the governor's office to ensure that the first wave of appointments being considered are informed by the priorities that emerge, and that inaugural appointees possess the expertise that will be needed to steer the Council in addressing these priorities.

The planners proposed charging the Council with developing a practical, measurable, five-year prioritized workplan based on public input and a thorough environmental scan of health care workforce needs. The planners strongly recommend that the Council articulate the priorities for the first five years of its existence. Once the appointments are confirmed, the Council, in consultation with the commissioner of Health, should hire an executive director to lead the Council.

Deliverables and Reporting

> *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 Minnesota Health Care Workforce Advisory Council shall develop health care workforce priorities to meet the workforce needs of the state, and prepare a comprehensive health care workforce plan along with performance and progress metrics.*
>
> *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, and how they are spent; and*
> >
> > *(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, on behalf of the Minnesota Health Care Workforce Advisory Council, shall provide periodic updates to the governor on the performance metrics and the progress made toward achieving the goals as noted in the workplan, and identifying emerging needs.*

As noted above, every five years, the Council shall submit to the Legislature a report that includes information on workforce demand, supply, distribution and labor market projections; workforce spending and funding sources for workforce programs; workforce priorities identified through stakeholder engagement; and an actionable workforce plan along with evaluation and performance metrics.

The Council should be committed to promoting the priorities as laid out in the workforce plan while recognizing that implementation efforts will need to be led by entities other than the Council. To hold itself accountable, the Council should also carefully develop performance and progress metrics as it develops the workforce plan. Part way through the five-year plan implementation, the Council should self-review its implementation progress,

measure itself against the established performance metrics, evaluate its impact, and periodically update the governor.

To summarize, below are some timelines and key proposed milestones for the Council's first few years.

- The Council is authorized with appropriations as requested.
- MDH commissioner along with advisors engages the public and invites input to identify workforce priorities.
- MDH commissioner works with the governor's office to name inaugural appointees to the Council. One half of the initial appointees shall serve a two-year term.
- Within six months of authorization, the Council holds its first meeting.
- Within two years of creation, the Council develops and adopts a prioritized 5-year workforce plan based on public input along with performance metrics and accountability measures. The workforce plan is considered the Council's main deliverable.
- Periodically, during the implementation of the workforce plan, the Council should self-evaluate its progress and consider any course corrections if needed. This process should be repeated every five years when a new workforce plan is developed.

The planning committee expects that in its first year the Council will:

- hire staff and the executive director;
- name its 16 appointed members;
- develop its governance structure, charter, vision and strategic priorities, public engagement plans, deliverables and evaluation criteria that align with 5-year priorities;
- establish standing and ad-hoc committees and name members; and
- outline standard operating procedures regarding meeting frequency and format, decision making, voting, rules for attendance, resignations, mechanisms to mediate conflicts of interest, plans for communications with the public, the executive and legislative branches, and other stakeholders.

The planners stopped short of prescribing these operating frameworks and governance rules, but stand committed to provide any assistance needed to get the Council underway.

Data and Access to Information

> *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 of Health 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 of Health may use data collected and maintained under section 62U.04 to carry out the duties required under this section.*

The planners acknowledged the role other state agencies play in health care workforce development, recruitment, employment and retention. The planners expect the Council housed at MDH to be aware of workforce efforts underway in other state agencies; play a lead role in gaining cooperation, and access to data and information from sister agencies to execute the Council's priorities as needed. The Council should also coordinate enterprise-wide workforce efforts when possible to maximize the impact to address workforce challenges.

Existing Sources of Workforce Data and New Data Needs

Minnesota is fortunate to have a wide variety of data sources that can shed light on the various issues the Council will be expected to study. There are both state and federal workforce data sources that can be used to answer questions about supply, demand, geographic and demographic trends, education and training, and other topics pertinent to the work of the Council. An extensive inventory of state and federal level workforce data sources is noted in the Appendix B. The datasets described in Appendix B will form the foundation of the Council's research work, but additional datasets may be required depending on the needs of subcommittees, members, and stakeholders.

The Council's funding proposal will include legal, IT, and staff costs to procure additional data as needed from other state agencies (such as labor market data), professional associations (such as the American Medical Association Physician Masterfile) or enhancing MDH's licensed workforce survey for additional data collection efforts. The funding proposal also includes costs to undertake ad-hoc data collection efforts (qualitative or quantitative) or to conduct research or evaluations of workforce policies.

Final Thoughts

The planners acknowledged the Legislature's foresight in requesting an in-depth study on the design, scope, and structure of a central workforce advisory body to address the health care workforce needs of the state. The planners underscored the need for impartial thought leadership and commitment to meeting the state's workforce needs as opposed to organizational or professional agendas, and adequate resources so that the Council can discharge its duties fully and responsibly. The planners hope for the authorization of this Council so it can work with entities to address workforce challenges and transform Minnesota's health care workforce landscape. The planners stand ready and committed to aid policy makers in these efforts.

Appendix A: Minnesota Health Care Workforce Advisory Council – Proposed Legislation

[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, can advise the Legislature on health care workforce issues, is a neutral convenor of competing perspectives, 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 objective health care workforce research and data analysis; (2) collaborate and coordinate with other entities on health care workforce policies; (3) review, comment and advise the legislature and other stakeholders on relevant workforce legislation as it relates to health professions education, training, retention, diversity and 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 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, and certification and educational institutions, in developing their program or legislative recommendations.

The Council shall focus on health care workforce supply, demand, and distribution; health equity; efforts to increase participation by those underrepresented in health professions education; education, training and practice across oral health, behavioral 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 establish discipline-, profession- or issue-specific standing or ad-hoc committees with subject matter experts to advise and support the work of the Council. The Council shall intentionally include perspectives that represent rural needs and workforce diversity in all committees.

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; and

(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. Appointees to 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 of health with advice of the Council. The executive director of the Council may offer advice to the governor on applicants seeking appointments to the Council.

(b) The commissioner of health shall provide adequate staffing to the Council and the committees 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. The Council may seek public input via town halls, listening sessions, or surveys. Issues may include but are not limited to health care workforce shortages, training and workforce supply needs, demographic and geographic distribution, retention, models 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, educational institutions, the Minnesota Office of Higher Education, relevant state agencies, and other stakeholders on current and proposed health care workforce initiatives, including training and pipeline development, workforce shortages and maldistribution, retention and burnout, evolving roles of health care providers, health equity, and geographic and demographic diversity in the workforce.

(3) Consider objective, non-partisan 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, behavioral 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 care workers to reflect Minnesota's communities;

(B) addressing the maldistribution of primary care, behavioral health, nursing, oral and other providers in greater Minnesota and in underserved communities;

(C) increasing interprofessional training and clinical practice;

(D) addressing the need for sufficient quality faculty, preceptors, and supervisors to train a growing workforce; and

(E) developing advancement paths or career ladders for health care workers.

(iii) 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 that is responsive to state workforce needs;

(B) changes in practice scopes to address gaps in care;

(C) identifying future models of care delivery and future roles within the care delivery team that impact the workforce;

(D) expanding pathway programs and engaging the current health workforce to increase awareness of health care professions among middle and high school, undergraduate, and community college students, particularly from communities that are underrepresented in the health care workforce;

(E) reducing or eliminating tuition for entry-level health care positions in high-demand settings, expanding other existing financial support programs such as loan forgiveness and scholarship programs, especially for underrepresented communities, and consider awarding credit for prior and non-credit learning;

(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.

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

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

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 Minnesota Health Care Workforce Advisory Council shall develop health care workforce priorities to meet the workforce needs of the state, and prepare a comprehensive health care workforce plan along with performance and progress metrics.

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, and how they are spent; and

(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, on behalf of the Minnesota Health Care Workforce Advisory Council, shall provide periodic updates to the governor on the performance metrics and the progress made toward achieving the goals as noted in the workplan, and identifying 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.

Appendix B: State and Federal Workforce Data Sources

Below is a summary of the readily available state and federal data sources (state data is denoted as "MN"; otherwise the source is federal).

Tables 1 and 2 below include comprehensive workforce data sources that can be used to examine both "supply" and "demand" side questions about the health care workforce. A brief description of each of these datasets is also noted below.

Table B1. Data Sources Related to Workforce Supply

K-12	Post-secondary completion	Incumbent workforce
MN Statewide Longitudinal Education Dataset (SLEDS)	MN Statewide Longitudinal Education Dataset (SLEDS) Integrated Postsecondary Education Database (IPEDS)	MN health professional licensing data MN health care workforce surveys MN Occupational Employment Statistics MN Staffing Patterns Current Population Survey / American Community Survey

- The **Minnesota Statewide Longitudinal Education Dataset (SLEDS)** is a powerful longitudinal dataset administered by the Minnesota Office of Higher Education, that matches student data from pre-kindergarten through completion of postsecondary education and into the workforce. This dataset can help shed light on the career trajectories of healthcare providers, their demographics and can answer questions such as "what individual-level factors are associated with obtaining licensure and/or employment in a health care profession?" which can help the Council design and/or promote targeted interventions for building the health care workforce supply.

- The **Integrated Postsecondary Education Database**, administered by the U.S. Department of Education, provides summary statistics on the number of postsecondary program completers by state, educational program, major, and degree type, as well as demographic characteristics. This data will permit the Council to track enrollment and graduation trends in postsecondary health care programs. It can also help to answer questions about the demographics of program enrollees and completers—important information to help with questions about health equity.

- The **Minnesota health professional license data** (collected and administered by the licensing boards themselves) and the **Minnesota health care workforce survey** (administered by the Minnesota Department of Health at the time of license renewal) are both powerful and comprehensive sources of data for studying a wide variety of aspects of Minnesota's licensed health care professional workforce, including its geographic distribution, its demographic characteristics, career satisfaction and burnout, future plans, hours worked, telehealth usage, and many other pressing and policy-related concerns.

- The **Minnesota Occupational Employment Statistics** (a program administered by the Minnesota Department of Employment and Economic Development, with a federal counterpart) provides a wealth of information on the entire health care workforce, including both licensed and unlicensed professions. The dataset includes current employment counts and wages, which can help answer crucial questions

about hiring and wage trends. Observing wage trends over time helps us to understand whether and how the industry may be responding to increased hiring demand.

- **Minnesota Staffing Patterns**, also administered by the Minnesota Department of Employment and Economic Development, are a matrix of employment patterns by industry and occupation in Minnesota. This is very useful for understanding the distribution of workers by profession and industry to answer questions about employment trends (e.g., "in what types of establishments do the majority of Certified Nursing Assistants work?").

- The **Current Population Survey** and **American Community Survey** are both national surveys administered by the Census (with both national and state-based estimates) that can help us understand both the health care workforce itself and, more broadly, understand the demographic and economic characteristics of Minnesota's population. Both datasets can provide insights on population need based on demographic characteristics such as age, race, poverty levels, and other descriptors.

Table B2. Data Sources Related to Workforce Demand

Current labor market demand	Projected employment demand/need
MN Job Vacancy Survey MN Occupations in Demand Tool Help Wanted Online – "real time" job openings data	MN Occupational and Industry Employment Projections Current Population Survey/American Community Survey

- The **Minnesota Job Vacancy Survey** is an annual survey conducted by the Minnesota Department of Employment and Economic Development, covering all 800+ occupations in the state of Minnesota. Job vacancies are a leading indicator of workforce shortages, and this survey has been ongoing for approximately 20 years, making this a very rich source of data for understanding health care workforce shortages over time, by occupation, and by region of the state.

- The **Minnesota Occupations in Demand** tool is developed by the Minnesota Department of Employment and Economic Development to provide a measure of hiring demand that accounts for occupation size and turnover. This is a robust way to rank occupations by their level of hiring demand (by region), which may help the council make decisions about where to focus its efforts given modest state resources.

- The **Help Wanted Online** data, administered by a national, private non-profit company called the Conference Board, is a unique data source that makes use of current online job postings, coded to the national Standard Occupational Classification coding structure, which allows analysts to track a wide variety of up-to-the minute hiring trends, including in-demand skills, current tools and technology used on the job, etc.

- The **Minnesota Occupational Employment Projections** program is administered by the Minnesota Department of Employment and Economic Development. It is unique among these datasets because it allows us to monitor *future* job growth, both by occupation (what people do) and by industry (the types of establishments in which they do it).

- Apart from these state and national workforce data sources, many **professional associations also collect their own workforce data** (e.g., the MN Hospital Association's workforce survey; Leading Age Minnesota's workforce data etc.) that may be leveraged to better understand sector-specific workforce demand and supply issues.

- In addition to these datasets that will form the foundation of the Council's research work, additional datasets may be required depending on the needs of subcommittees, members, and stakeholders. For example:

    - It may prove necessary to conduct one-time **qualitative** studies (such as focus groups or in-depth interviews) to learn more about the experiences or motivations of segments of the health care workforce.

    - There may be the need to conduct **one-time evaluations (process or outcome)** of various interventions, incentives, and approaches (for example, the council may wish to develop a clear understanding of the specific effects of loan forgiveness on growing the supply of rural providers, or on the effect of opening a rural training program on retention of workers in rural areas). This may require designing studies and collecting data on an ad hoc basis.

    - There may be the need to request **specialized and/or disaggregated data** from partners; in particular, the Department of Employment and Economic Development, the University of Minnesota, the Office of Higher Education, or other agencies, depending on the needs of the Council.

Appendix C: Council Planning Committee Members

Minnesota State Colleges and Universities Representative
Valarie DeFor
Executive Director, Minnesota State HealthForce Center of Excellence
Winona State University
vdefor@winona.edu

University of Minnesota Representatives
Shailendra Prasad, MD MPH FAAFP
Associate Vice President of Global & Rural Health
Executive Director & Carlson Chair of Global Health, Center for Global Health and Social Responsibility
University of Minnesota
shailey@umn.edu

Tricia Todd, MPH
Director, Pre-Health Student Resource Center
Office of the Associate Vice President for Academic Health Sciences
University of Minnesota
todd0002@umn.edu

Minnesota Department of Health Representative
Zora Radosevich, MPH
Director, Office of Rural Health and Primary Care
Minnesota Department of Health
zora.radosevich@state.mn.us

Appendix D: Summary of Public Feedback on the Proposed Council

As described above, the planning committee shared a draft of the proposed legislative language creating the Workforce Advisory Council and requested public feedback from stakeholders and the public via an online survey. The survey consisted of 11 optional questions. Topics included the proposal language; future anticipated engagement with the Council; suggestions for individuals or organizations to serve on the Council; and priorities for workforce issues. The survey also requested that people share their gender, race, geography, and organization type.

The total number of people who answered one or more of the demographic questions ranged from 29 to 34 individuals. Missing data were excluded from the analysis.

Survey Questions

Please provide your contact information:

- First name; Last name
- Email address
- Organization (if applicable)

Which of the following best describes your organization?

- Advocacy or lobbying organization
- Educational institution or program
- Health care facility or system
- Media
- Minnesota state agency
- Professional association
- Union or labor organization
- Workgroup or council
- I am responding as an individual and not representing an organization
- I am responding as a student and not representing an organization
- Other (please specify)

How much do you approve of the following sections of the proposed workforce council?
Strongly approve; Somewhat approve; Neutral; Somewhat disapprove; Strongly disapprove; Unsure

- Membership
- Appointments
- Terms of Public Members
- Staffing
- Duties
- Deliverables and Reporting

- Data and Access to Information
- The proposal as a whole

Please provide any additional feedback you have for the planning committee. (For example: are there other functions not already noted that you would like to see this council do? Any particular concerns you have about this council?)
How do you see yourself or your organization interacting with a future health care workforce council?

- Seeking advice/consultation on workforce ideas
- Requesting data
- Legislative/lobbying assistance
- Share information or data with the council
- Other (please specify)

What are the most important workforce issues that you would like to see this council prioritize?

- Employment trends and demand
- Strategies to address health workforce shortages, recruitment, and retention
- Future investments to increase the supply of health care professionals
- Increasing the diversity of health professions workers to reflect Minnesota's communities
- Addressing the maldistribution of providers in greater Minnesota and in underserved communities in metropolitan areas
- Increasing interprofessional training and clinical practice
- Addressing the need for faculty to train a growing workforce
- Developing advancement paths or career ladders for health care workers
- Increasing access to financing for graduate medical education
- Changes in practice scope to address gaps in care
- Identifying future models of care delivery that impact the workforce
- Expanding pathway programs to increase awareness of health care professions
- Reducing or eliminating tuition for entry-level health care positions
- Incentivizing recruitment into the health care field from greater Minnesota and underrepresented communities
- Expanding existing programs, or investing in new programs, that provide wraparound support services to the existing health care workforce
- Other (Please specify.)

Would you like to suggest a person or organization to serve on this council? (If so, please share the person's name and/or organization below).

Which racial/ethnic categories apply to you? (Optional.)

- African
- Black/African American
- American Indian or Alaska Native
- Asian - South Asian
- Asian - Southeast Asian

- Asian - Other
- Hispanic/Latin
- Middle Eastern/North African (MENA)
- White
- Another race or ethnicity (please specify):

What is your gender? (Optional.)

- Male
- Female
- Non-binary or third gender

Which of the following best describes the region of your organization? (Optional.)

- Central MN
- Northeast MN
- Northwest MN
- Southeast MN
- Southwest MN
- Twin Cities area

Which of the following best describes the location of your organization? (Optional.)

- Large metro area or surrounding
- Small metro area
- Small town or isolated rural area

Survey Results

Nearly all respondents (94%) approved of the proposed deliverables and reporting; 91% approved of the duties assigned to the council; and 91% approved of the data access provisions. There was moderate approval (ranging from 82% to 85%) of the appointee terms and staffing proposed for the Council. Respondents registered a bit more disapproval on two sections of the proposal— *membership* and a*ppointments.* While 62% generally approved of the proposed membership composition and criteria, 18% somewhat disapproved of it, and 3% strongly disapproved of it. Similarly, while 70% approved of appointment considerations, 3% somewhat disapproved of it, and another 3% strongly disapproved of it. Most of the written comments received were related to these two sections. When asked how respondents anticipated interacting with the Council, s*haring information or data* (85%), followed by seeking *advice or consultation* (64%) were the two most common choices. Nearly 4 out of 5 respondents indicated they anticipated interacting with the council in more than one way.

Regarding respondent characteristics, just under 30% of the respondents were affiliated with an educational institution, 26% chose to respond as individuals, 14% represented health care facilities/systems and another 14% were from professional associations. About 80% of the respondents identified as white and 80% identified

as female. There was more regional variation with 53% of the respondents from the Twin cities area, 30% from central Minnesota, 10% from the southwest and 7% from the northeast part of the state.

Table D1. Race or ethnicity of survey respondents (n=32)

Race or ethnicity	Percent
African	0%
African American or Black	3%
American Indian or Alaska Native	3%
Asian - South Asian	0%
Asian - Southeast Asian	0%
Asian - Other	0%
Hispanic or Latin	3%
Middle Eastern or North African	3%
White	81%
Another race or ethnicity	6%

Note: Respondents could select more than one race or ethnicity.

Table D2. Gender of survey respondents (n=29)

Gender	Percent
Female	79%
Male	21%
Non-binary	0%

Table D3. Region of survey respondents (n=30)

Region	Percent
Central MN	30%
Northeast MN	7%
Northwest MN	0%
Southwest MN	10%
Southeast MN	0%
Twin Cities area	53%

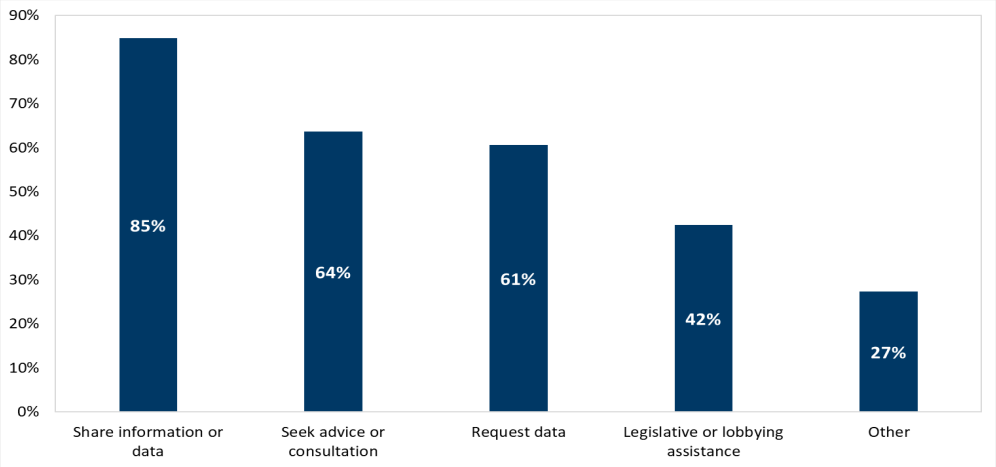
Table D4. Geography of survey respondents (n=28)

Geography	Percent
Large metro area or surrounding	54%
Small metro area	14%
Small town or isolated rural area	32%

Table D5. Organization type of survey respondents (n=35)

Organization type	Percent
Advocacy or lobbying organization	0%
Educational institution or program	29%
Health care facility or system	14%
Media	0%
Minnesota state agency	9%
Professional association	14%
Union or labor organization	0%
Workgroup or council	0%
Responding as an individual	26%
Responding as a student	0%
Other	9%

Figure D1. Ways respondents anticipate interacting with the proposed council (n=33)



Note: Respondents could select more than one option.

Figure D2. Combined ways respondents anticipate interacting with the proposed council (n=33)

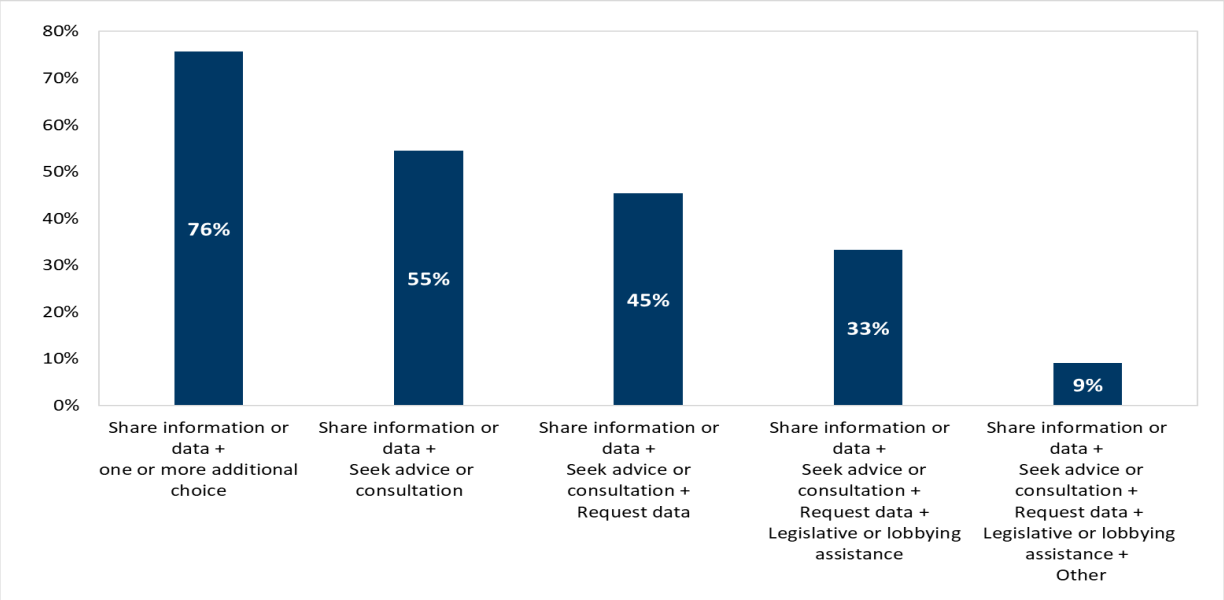
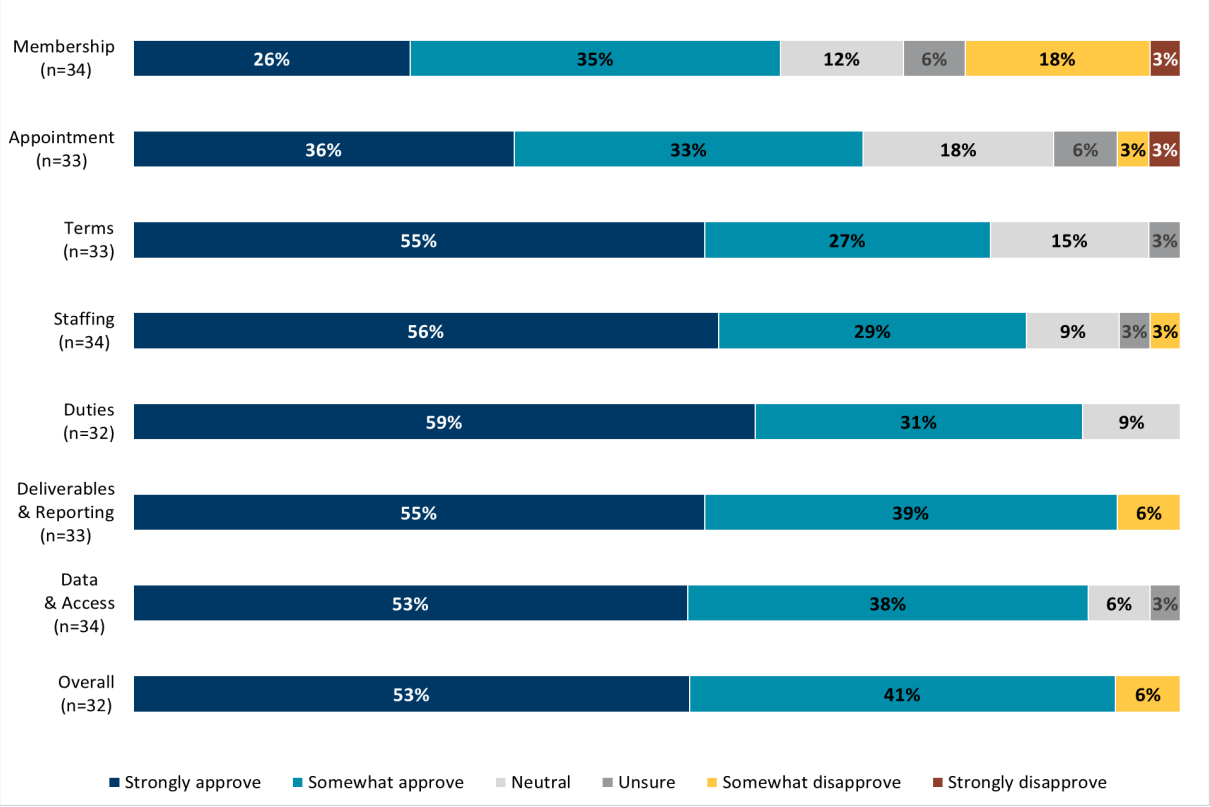


Figure D3. Percent approval rating overall and for each of the seven sections of the proposal



Survey respondents were asked to provide open-ended feedback about the proposal. A total of 32 individuals provided written comments. The planners received additional written feedback from three stakeholders via email. Some respondents commented on more than one section. The most feedback (n=23) was provided about the *Membership* and *Appointments* sections of the proposal. Comments were aggregated and summarized for this report. Suggestions included:

- Make the membership less bureaucratic
- Specify member expertise
- Specify membership representation of rural, tribal, and diverse communities
- Specify membership representation of the nursing workforce center, DHS-direct care services, K-12, University of Minnesota Health Sciences, community colleges, hospitals, health systems, Critical Access Hospitals, state Medicaid, health licensing bodies, health care providers, health care consumers
- Specify membership representation of health professions including oral health, nursing, physicians, behavioral health, community health workers, and acupuncturists
- A few comments were specific to the council member *Terms* and *Staffing* sections (n=4):
    - Reduce term lengths from four years to two or three years
    - Clarify how this work will be different from the current workforce efforts of MDH's Office of Rural Health and Primary Care
    - Spend state staff time on projects to address the shortage rather than management of the Council
    - Locating the Council within MDH is important to preserve neutrality

Duties was the second most commented-on section (n=10):

- Include preceptors from the community in addition to faculty preceptors
- Limit tuition relief to underrepresented populations
- Include middle school in pathway programs
- Add contemporary needs as a priority to convene stakeholders
- Add funding strategies to address debt-to-income ratios
- Add a specific focus on retaining physicians and nurses in rural areas
- Add a specific focus on workplace safety and burnout
- Include funding strategies for rural psychologist training
- Reduce the scope of duties
- Expand the need for diversity to also include diversity of training, skills/education development, generations, and years of experience
- Specify that underserved communities are not always defined by geography such as 'individuals with disabilities'
- Add a duty to educate students on providing equitable health services to individuals with disabilities
- Examine financing across all types of health care education
- Rather than focus on 'models of care delivery,' focus on the people and the roles within a care team
- Add 'people with disabilities' when listing underrepresented/underserved communities and underrepresented identities
- Limit analysis efforts to health care workforce trends and priorities

Some respondents provided feedback on the *Deliverables and Reporting* section of the proposal (n=5):

- Reduce the frequency of the comprehensive plan from every 5 years to every 3 years
- Include self-assessment of the council, such as progress reports, external evaluation, and a sunset review, to ensure council accountability and to track effectiveness

- Add a requirement for detailing how state-controlled funding for health professions training and education is being spent

One comment each was received pertaining to the two sections *Data and Access* and *Funding*:

- Implement stronger provisions around data sharing, data standards, and data privacy
- Specify funding and resource allocation

Additional feedback was received that was either not specific to a proposal section or was in reference to more than one section (n=10). This general feedback included:

- Replace the word *'pipeline'* with an alternative such as '*pathway*'
- Use the terminology *'health professionals'* instead of *'Allied Health*'
- Specify which professions are included in '*health professions*'
- Specify a process for stakeholder engagement
- Implement leadership training
- Collaborate with specific organizations or groups
- Specify that direct care pertains to healthcare
- Remove the word 'care' from the title of the council

Appendix E: Select State Workforce Advisory Councils

California

Title: Health Workforce Education and Training Council

Year: 2022

Statute: California Health and Safety Code, Sec 128250

Membership: 18 members in statute[1]; among the 12 appointed positions, members serve a two-year appointment for the first year of the council and a four-year appointed term after that. Members include: six members appointed by the governor, three each appointed by the Speaker of the Assembly and the Chairperson of the Senate Committee, one member each of the following or a designee Department of Health Care Access and Information, Secretary of Labor and Workforce Development, President of the University of California, the Chancellor of the California State University, and the Chancellor of the California Community Colleges.

Funding: Information not available

Charge: "Responsible for helping coordinate California's health workforce education and training to develop a health workforce that meets California's health care needs." The Council's charge includes extensive GME responsibilities including development of GME and workforce training and development priorities, standards for residency and health professional education and training programs, and review and recommendation of health professions career pathways.[2]

Recent projects:
March 2024 HWET Council Meeting Minutes (PDF)

Contact: HealthWorkforce@hcai.ca.gov, **(916) 326-3726**

Link: California Health Workforce Education and Training Council

[1] California Health Workforce Education and Training Council. Cal. Health & Saf. Code § 128250. Link last accessed 8/23/24

[2] California Health Workforce Education and Training Council – Power and authority of Council. Cal. Health & Saf. Code § 128252. Link last accessed 8/23/24

New Mexico

Title: New Mexico Health Care Workforce Committee

Year: 2012

Statute: NM Stat § 24-14C-2 (2021)

Membership: Includes representatives of health care consumers; health care providers; organized groups representing physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists and pharmacists; health care work force training institutions; the Department of Health; the public education department; the higher education department; and the licensing boards.

Funding: Annual Report, 2024: Recommendation #1 to the legislature asks for $600,000 in recurring funding for staffing and data modeling.

Charge: "Analyze and make recommendations to the legislature regarding incentives to attract qualified individuals, develop a short-term plan and a five-year plan to improve health care access, analyze the collected data and make recommendations to the legislature for building healthier communities and improving health outcomes, and devise an electronic survey for Boards to provide to applicants for licensure or renewal of licensure…"

Recent projects:
New Mexico Health Care Workforce Committee 2024 Annual Report (unm.edu)

Contact: Hengameh Raissy - Chair, New Mexico Health Care Workforce Committee (hraissy@salud.unm.edu)

Link: New Mexico Health Care Workforce Committee (2013-ongoing) University of New Mexico (https://digitalrepository.unm.edu/nmhc_workforce/)

North Carolina

Title: North Carolina Health Professions Data System (HPDS)

Year: 1973

Statute: No specific statute created the HPDS. Please see the links below for historical information. § 143-613(d) directs the UNC Board of Governors to report on the number of medical graduates each year to the legislature. The Sheps Center does the analysis for this reporting.

Membership: Housed within the Program on Health Workforce Research and Policy at the Cecil G. Sheps Center for Health Services at UNC Chapel Hill.

Funding: The HPDS is funded by the NC AHEC Program Office at the University of North Carolina at Chapel Hill. Contracts and grants with other funders support project-related work that uses the HPDS data.

Charge: Collect and disseminate descriptive data on 21 categories of licensed health professionals in North Carolina

Recent projects:
Interactive Visualizations – NC Health Workforce

Reports – NC Health Workforce

Contact: nchealthworkforce@unc.edu; Catherine Moore (cmoor@unc.edu)

Link: NC Health Workforce (https://nchealthworkforce.unc.edu/)

History of HPDS:
History of the Health Professions Data System

About NC Health Workforce

Oregon

Title: Health Care Workforce Committee [Committee of the Oregon Health Policy Board/Oregon Health Authority]

Year: 2009

Statute: Oregon Revised Statutes (ORS) 413.017(3), House Bill 2009, Section 7 (3)(a)[3]

Membership: Broad flexibility in statute

Funding: Staffing provided under agency funding

Charge: "To coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation and an increasingly diverse population. The Committee will advise and develop recommendations and action plans to the Oregon Health Policy Board for implementing the necessary changes to train, recruit and retain a dynamic health care work force that is scaled to meet the needs of new systems of care."

Recent projects:
Health Care Workforce Committee Strategy Papers on Workforce Diversity, Wellness & Resilience, and Development and Retention, Jan 2024 (PDF)

Evaluation of Effectiveness of Health Care Provide Incentive Program, Feb 2023 (PDF)

Contact: Leslie Clement, Oregon Health Authority, leslie.m.clement@state.or.us

Link: Oregon Health Authority: Health Care Workforce Committee (https://www.oregon.gov/oha/hpa/hp-hcw/pages/index.aspx)

[3] Oregon Health Care Workforce Committee – Charter & Committee Operations, 2024-2025 (PDF) (https://www.oregon.gov/oha/HPA/HP-HCW/Documents/Charter.pdf) Link last accessed 8/23/24

South Carolina

Title: South Carolina Office for Healthcare Workforce (SCOHW)

Year: 2016

Statute: AHEC state agency established in 1972. No specific authorizing state statute.

Membership: SCOHW has a staff of 6 and is a division of the South Carolina AHEC Program Office. South Carolina AHEC is a state agency that is administratively housed at the Medical University of South Carolina.

Funding: Initial funding in 2009 from The Duke Endowment. Recurring state funds beginning in 2016 through South Carolina AHEC. Additional recurring state funds were awarded beginning in 2023 to support dedicated nursing workforce research.

Charge: "SCOHW studies issues that affect the balance of supply and demand for different types of healthcare professionals across South Carolina. Its primary mission is to develop accurate, reliable information about the healthcare workforce in South Carolina and to make that information widely available to support planning and policy decisions. SCOHW strives to be neutral in its approach to workforce analysis, providing accurate, timely information that is grounded in evidence and free from bias or agenda." SCOHW analyzes and disseminates descriptive data on 20 licensed health professions and will hopefully be adding three more behavioral health professions in the coming year.

Recent projects:
2024 SCOHW Report Details

Visualizations SCOHW

Contact: Katie Gaul (gaulk@musc.edu; (843) 792-5943)

Link: SC Office for Healthcare Workforce | SC AHEC (https://www.scahec.net/scohw.html)

Utah

Title: Utah Health Workforce Advisory Council

Year: 2022

Statute: HB 176 Utah Health Workforce Act

Membership: Specified in statute; 14-19 members along with terms;

Funding: Re-purposing/Transfer of historical appropriations[4]

Charge: Created the Utah Health Workforce Information Center to collect workforce data and conduct research. The Utah council grants oversight of the Utah Medical Education Council and requires the Utah Department of Commerce to work with the council and the information center to collect data regarding Utah's health workforce.[5] The charge also includes studies on health workforce supply, employment trends and demand, options for training and educating the workforce, recommendations on issues related to workforce shortages, recruitment, retention, and other Utah health workforce priorities.[6] Standing subcommittees include subcommittee on legislative review, data review, and the Utah Medical Education Council.

Recent projects:
Utah Behavioral Health Workforce Survey – Proposed profession-specific survey tool for behavioral health license renewals, March 2024 (PDF)

Utah State Workforce Data Report, 2023 (PDF)

Contact: Kendyl Brockman, Health Workforce Policy Analyst, kbrockman@utah.gov

Link: About Health Workforce Advisory Council | PCRH (https://ruralhealth.utah.gov/about-hwac/)

[4] Veritas Health Solution – NGA HCW Governance Models_Final slide deck. Available upon request.

[5] Utah Health Workforce Act. (https://le.utah.gov/~2022/bills/static/HB0176.html) Link last accessed 8/23/24

[6]. Utah Health Workforce Advisory Council -- Creation and membership (https://le.utah.gov/xcode/Title26B/Chapter1/26B-1-S425.html) Link last accessed 8/23/24

Virginia

Title: Virginia Health Workforce Development Authority (VHWDA)

Year: 2010

Statute: § 32.1-122.7. Virginia Health Workforce Development Authority; purpose

Membership: Governed by a Board of Directors. The Board has 19 members: three legislative members, the Chairperson of Senate Finance and Appropriations (or designee), the Chairperson of House Appropriations (or designee), nine non-legislative citizen members appointed by the Governor, and five ex officio members: the Commissioner of Health or their designee, the Chancellor of the Virginia Community College System or their designee, and the Director of the Department of Health Professions or their designee, the Director of the Department of Workforce Development and Advancement or their designee, the Director of the State Council of Higher Education for Virginia or their designee.

Funding: The Authority receives general state funding, federal grants, and revenue generation. The Commonwealth of Virginia currently provides $1.6M annually for operational expenses, which is matched by a federal $1.3M Area Health Education Center grant from the Health Resources and Services Administration (HRSA). The Authority also administers a Community Health Worker training program that generates about $80,000 in revenue annually.

Charge: The mission of the Authority is to facilitate the development of a statewide health professions pipeline that identifies, educates, recruits, and retains a diverse and appropriately geographically distributed, and culturally competent quality workforce. The Authority is sanctioned to act as the main consortium for Virginia's medical schools to qualify for Area Health Education Centers programs and manage related federal, state, and local programs, operating independently for public benefit. It can gather and analyze data on health care delivery, training, and education where such efforts are lacking; it has the capacity to evaluate policies and make related recommendations; and it can apply for and accept federal, state, and local public and private grants, loans, appropriations, and donations.

Recent projects:
Virginia Statewide Area Health Education Centers (AHEC) Progam Annual Report 2021 (PDF)

Health Workforce Study | Virginia Health Workforce Development Authority

Contact: Harrison Hayes, VHWDA Executive Director; HHayes@VHWDA.org

Link: About Virginia Health Workforce Development Authority (https://www.vhwda.org/about/vhwda)

Washington

Title: Health Workforce Council

Year: 2003

Statute: Under Engrossed Senate House Bill (ESHB) 1852 (PDF)

Membership: Composed of leaders from a range of health care stakeholders, including education and training institutions; healthcare organizations; community health services; labor and professional associations; state agencies, and employer representatives. The Council has flexibility to add members from additional sectors or organizations as needed. It currently has 22 members plus a chair and co-chair.

Funding: (2019) Legislative funding to staff the Council along with increased administrative support.

Charge: "Provide updates to policymakers on health workforce program educational output along with employer needs, tracking progress on implementation of new programs, and bringing together key stakeholders to develop and advocate for sustainable solutions. The Council identifies policy and funding priorities to bring to the Governor, Legislature, and other policymakers and stakeholders."

Recent projects:
Health Workforce Council Annual Report 2023 (PDF)

Outcomes/impact: Recommendations to policy makers in annual reports. Annual Report, 2022, recommendations informed the House Bill 1503 that authorizes collection of health workforce data (effective January 2025). Annual Report, 2023 recommendations focus on educational debt burden and community resource needs for the health care workforce.

Contact: Bianca Laxton bianca.laxton@wtb.wa.gov

Link: Health Workforce Council | Washington Workforce Training & Education Coordinating Board (https://wtb.wa.gov/planning-programs/health-workforce-council/)

Appendix F: Proposed Appointee Attributes and Traits

The planners proposed several traits and characteristics for appointee considerations to the Council.

Committed

- **Committed/Available**—Committed to the work of the Council, available to engage in the work.
- **Neutral**—Independent thinking; actions are not solely driven by affiliated organizational interests/needs.

Perspective

- **Futuristic**—Visionary; anticipates emerging trends/innovations and can communicate them to the Council.
- **Historic**—Holds historical context and can prevent the Council from "reinventing the wheel."
- **Current state**—Informed about the current state and ably communicates this context.
- **Creative**—Poses new ideas, or makes new connections between existing ideas.
- **Systems thinking—**Understands the interrelated nature of health care and the health care workforce.
- **Rural**—Lived experience in a rural setting and can represent the rural viewpoint.
- **Underserved community**—Lived experience as a member of an underserved community and can represent this viewpoint.
- **Consumer—**Lived experience as a consumer of healthcare and can represent the consumer viewpoint.
- **Legislative**—Member of the legislature.

Relational

- **Influential**—Ability to win others over. Communicate council positions and sway key audiences/stakeholders.
- **Partnerships**—Proven experience building and maintaining diverse partnerships and alliances.
- **Tolerant**—Tolerance for ambiguity, differing viewpoints, possible tensions that may arise when discussing challenging topics.
- **Negotiation**—Tactfully reconcile differing perspectives and move work forward.
- **Collaborative**—Works well with others toward the common goals of the committee.

Action Oriented

- **Critical Thinking**— Analytical thinker, driven by data, logic, rigor in discussions.
- **Solution Focused**—Driven to identifying solutions, compromises.

Expertise

- **Workforce Subject Matter Expertise in Priority Area**—SME in priority areas.
- **Data and Policymaking Expertise**—Expertise in workforce data and policy making insights.

Other

- **Other**—TBD

Appendix G: The Charge to MDH

Minnesota Session Laws 20204, Chapter 127, Article 66, Section 22

DIRECTION TO COMMISSIONER OF HEALTH; HEALTH PROFESSIONS WORKFORCE ADVISORY COUNCIL.
Subdivision 1. Health professions workforce advisory council. The commissioner of health, in consultation with the University of Minnesota and the Minnesota State HealthForce Center of Excellence, shall provide recommendations to the legislature for the creation of a health professions workforce advisory council to:

(1) research and advise the legislature and the Minnesota Office of Higher Education on the status of the health workforce who are in training and on the need for additional or different training opportunities;

(2) provide information and analysis on health workforce needs and trends, upon request, to the legislature, any state department, or any other entity the advisory council deems appropriate;

(3) review and comment on legislation relevant to Minnesota's health workforce; and

(4) study and provide recommendations regarding the following:

(i) health workforce supply, including:

(A) employment trends and demand;

(B) strategies that entities in Minnesota 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 workforce, including:

(A) increasing the diversity of health professions workers to reflect Minnesota's communities;

(B) addressing the maldistribution of primary, mental health, nursing, and dental providers in greater Minnesota and in underserved communities in metropolitan areas;

(C) increasing interprofessional training and clinical practice;

(D) addressing the need for increased quality faculty to train an increased workforce; and

(E) developing advancement paths or career ladders for health care professionals;

(iii) increasing funding for strategies to diversify and address gaps in the health workforce, including:

(A) increasing access to financing for graduate medical education;

(B) expanding pathway programs to increase awareness of the health care professions among high school, undergraduate, and community college students and engaging the current health workforce in those programs;

(C) 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;

(D) incentivizing recruitment from greater Minnesota and recruitment and retention for providers practicing in greater Minnesota and in underserved communities in metropolitan areas; and

(E) 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.

Subd. 2. Report to the legislature. On or before February 1, 2025, the commissioner of health shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and higher education finance and policy with recommendations for the creation of a health professions workforce advisory council as described in subdivision 1. The report must include recommendations regarding:

(1) membership of the advisory council;

(2) funding sources and estimated costs for the advisory council;
(3) existing sources of workforce data for the advisory council to perform its duties;
(4) necessity for and options to obtain new data for the advisory council to perform its duties;
(5) additional duties of the advisory council;
(6) proposed legislation to establish the advisory council;
(7) similar health workforce advisory councils in other states; and
(8) advisory council reporting requirements.

References

Minnesota Legislature, in 2024 session laws, Chapter 127, Article 66, Section 22 (https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/)

Deliberations of Governor Walz' 2023-24 Task Force on Academic Health at the University of Minnesota (PDF) (https://www.health.state.mn.us/facilities/academichealth/recommendations.pdf)

62U.04 (https://www.revisor.mn.gov/statutes/cite/62U.04)

California Health and Safety Code, Sec 128250 (https://casetext.com/statute/california-codes/california-health-and-safety-code/division-107-health-care-access-and-information/part-3-health-professions-development/chapter-4-health-care-workforce-training-programs/article-2-california-health-workforce-education-and-training-council/section-128250-california-health-workforce-education-and-training-council)

March 2024 HWET Council Meeting Minutes (PDF) (https://hcai.ca.gov/wp-content/uploads/2024/05/March-2024-HWET-Council-Meeting-Minutes.pdf)

California Health Workforce Education and Training Council (https://hcai.ca.gov/workforce/health-workforce/council/)

California Health Workforce Education and Training Council. Cal. Health & Saf. Code § 128250 (https://casetext.com/statute/california-codes/california-health-and-safety-code/division-107-health-care-access-and-information/part-3-health-professions-development/chapter-4-health-care-workforce-training-programs/article-2-california-health-workforce-education-and-training-council/section-128250-california-health-workforce-education-and-training-council)

California Health Workforce Education and Training Council – Power and authority of Council. Cal. Health & Saf. Code § 128252 (https://casetext.com/statute/california-codes/california-health-and-safety-code/division-107-health-care-access-and-information/part-3-health-professions-development/chapter-4-health-care-workforce-training-programs/article-2-california-health-workforce-education-and-training-council/section-128252-powers-and-authority-of-council)

NM Stat § 24-14C-2 (2021) (https://law.justia.com/codes/new-mexico/2021/chapter-24/article-14c/section-24-14c-2/)

New Mexico Health Care Workforce Committee 2024 Annual Report (unm.edu) (https://digitalrepository.unm.edu/nmhc_workforce/13)

New Mexico Health Care Workforce Committee (2013-ongoing) University of New Mexico (https://digitalrepository.unm.edu/nmhc_workforce/)

Interactive Visualizations – NC Health Workforce (https://nchealthworkforce.unc.edu/interactive/)

Reports – NC Health Workforce (https://nchealthworkforce.unc.edu/reports/)

History of the Health Professions Data System (https://nchealthworkforce.unc.edu/hpds-history/)

About NC Health Workforce (https://nchealthworkforce.unc.edu/about/)

Health Care Workforce Committee Strategy Papers on Workforce Diversity, Wellness & Resilience, and Development and Retention, Jan 2024 (PDF) (https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2023-Evaluation-of-Health-Care-Provider-Incentives-Report.pdf)

Evaluation of Effectiveness of Health Care Provide Incentive Program, Feb 2023 (PDF) (https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2023-Evaluation-of-Health-Care-Provider-Incentives-Report.pdf)

Oregon Health Authority: Health Care Workforce Committee (https://www.oregon.gov/oha/hpa/hp-hcw/pages/index.aspx)

Oregon Health Care Workforce Committee Charter and Operations 2024-25 (PDF) (https://www.oregon.gov/oha/HPA/HP-HCW/Documents/Charter.pdf)

2024 SCOHW Report Details | SC AHEC (https://www.scahec.net/scohw/reports/139);

Visualizations SCOHW (https://www.scahec.net/scohw/visualizations.html)

HB 176 Utah Health Workforce Act (https://le.utah.gov/~2022/bills/static/HB0176.html)

14-19 members (https://le.utah.gov/xcode/Title26B/Chapter1/26B-1-S425.html)

Utah Health Workforce Information Center (https://le.utah.gov/xcode/Title26B/Chapter4/26B-4-S705.html)

Utah Behavioral Health Workforce Survey – Proposed profession-specific survey tool for behavioral health license renewals, March 2024 (PDF) (https://ruralhealth.utah.gov/wp-content/uploads/2024-Behavioral-Health-Survey-Final-1.pdf)

Utah State Workforce Data Report, 2023 (PDF) (https://ruralhealth.utah.gov/wp-content/uploads/HWAC-Utah-state-health-workforce-data-2023-report.docx-2-1.pdf)

About Health Workforce Advisory Council PCRH (https://ruralhealth.utah.gov/about-hwac/)

Utah Health Workforce Act (https://le.utah.gov/~2022/bills/static/HB0176.html)

Utah Health Workforce Advisory Council -- Creation and membership. (https://le.utah.gov/xcode/Title26B/Chapter1/26B-1-S425.html)

§ 32.1-122.7. Virginia Health Workforce Development Authority; purpose (https://law.lis.virginia.gov/vacode/title32.1/chapter4/section32.1-122.7/)

Virginia Statewide Area Health Education Centers (AHEC) Progam Annual Report 2021 (PDF) (https://www.vhwda.org/pdf/2021AnnualReport.pdf)

Health Workforce Study Virginia Health Workforce Development Authority (https://www.vhwda.org/initiatives/health-workforce-study)

About Virginia Health Workforce Development Authority (https://www.vhwda.org/about/vhwda)

under Engrossed Senate House Bill (ESHB) 1852 (PDF) (https://apps.leg.wa.gov/documents/billdocs/2003-04/Pdf/Bills/Session%20Laws/House/1852-S.sl.pdf)

Health-Workforce-Council-Annual-Report-2023 (PDF) (https://wtb.wa.gov/wp-content/uploads/2024/01/Health-Workforce-Council-Annual-Report-2023.pdf)

Health Workforce Council | Washington Workforce Training & Education Coordinating Board (https://wtb.wa.gov/planning-programs/health-workforce-council/)