I. **Welcome and Introductions**

Elizabeth Biel welcomed the committee, led introductions, and presented the meeting agenda.

II. Review Fall 2015 Activity (PP slide #3)

TCCP added a new region: Fargo, ND. The process of bringing them on board went very well. Biel answered their questions/concerns about losing placements, costs, etc. TCCP expects to add Montana as new partner soon, and Fargo will be good practice for them as their state has similar small autonomous regions.

III. Review TCCP Student Passport Developments (PP slide #4-7)

The web software development is going very well. Working drafts of a number of sections are complete. The programmer is currently working on the student status information section. He and Biel are also working on the process for how schools will approve users

a. Next Phases

Student Passport is different from the StudentLink scheduling program; it follows each student instead of each clinical experience. This will help with our work on the Advanced Practice system, because it is also student-oriented.

There will be different views for schools, programs, and health systems.

Student Passport is being developed as a modular system, so it will have great flexibility and high customization ability. This is the base structure of the software, so it won't need to be modified frequently.

Working on:

- What the management views will be like: how to look at a group of students to see what still needs to be done
- Information verification options, and how schools will assign students to placements
- Roster reports. These will be exportable to excel. TCCP already collects a lot of the roster information, so this will make it easier for the sites. Users can choose which order they want the data in.

<u>Q&A:</u>

Question: Currently the schools send a message to the clinical sites saying that all of the students are ready for their clinical sites. Will it now be the responsibility of the clinical site to go looking for the data?

Answer: No, the schools will still be in communication with the clinical sites.

Question: Will Education Partners (EPs) decide who has access to the student information?

Answer: EPs will have control over the maintenance of the student data; Clinical Partners (CPs) will only be able to view. Schools can set up multiple users to enter the data.

Question: How does the student data get into the system? Can it be downloaded from the background check people? Will there be a duplication of effort?

EP response: They will still have to keep the student information in their own database because they are using the databases for multiple programs that are not a part of TCCP.

Biel: The schools will be able to choose to store all their student data in this system as well, even if the other programs aren't part of TCCP.

CP response: It may mean extra steps for the EPs in the beginning, but it will save time later because the clinical sites can get the information directly from the system instead of having to get it from the EPs.

CP comment: The developer is willing to work with every different individual system to find out how to make it work and to make it as streamlined as possible.

Repeat of earlier question: Whose responsibility is it to confirm that everything is "ready?"

Answer: The schools. They will make sure everything is "green" – ready to go.

b. Timeline (PP slide #7)

June: Have "first draft" of the Student Passport software ready.

Summer: TCCP staff will be working with Duluth partners and testing the software with fictional data. Will make fictional students and test how it works for everyone. Hope to get it to 95% readiness.

September: Will be piloting with Duluth actual students. Biel will go to Duluth to instruct students during this first testing time and to find out how it works for them. There will be an intro page explaining why the information is collected and who will have access to it.

One part of the training will be regarding the students' pictures: There will be a message with guidelines like: "making sure your picture is something you'd want your boss to see."

If the Duluth pilot goes well, Student Passport will be released to everyone for Spring 2016; otherwise, will take another semester to get it working right.

<u>Q&A:</u>

Comment: Could the Advisory Committee also test the fictional student data along with TCCP staff; search for glitches?

Answer: That's a good idea; will be arranged.

Question: Regarding documentation in Student Passport, will it be the school's decision about how the documents are entered and/or stored? i.e.: Whether students can upload copies of their official documents, or if they will submit the originals to the schools and have staff verify and upload?

Answer: Yes, the schools can individually make those decisions for themselves.

Question: How will TCCP members access Student Passport? Will it be within the StudentLink system?

Answer: it will be a separate database from StudentLink, and will also be linked to on the TCCP website.

Question: Currently students go to the TCCP informational site for their onboarding/orientation information; could we also include access to Student Passport on the site?

Answer: Yes, we could do that. The students will receive notification emails directly from the Student Passport which will include links the system, but we could have backup links on the TCCP website in case they lost their email, etc. That way they would know where to go for access at any time without having to contact their schools. (Note from Biel: We will have to make sure that providing those links on the TCCP site will not affect the system's security.)

IV. Review Budget

The main change in the budget is that TCCP will be paying for more of Judith Mitchell's time. It's increasing from a 50% to 75% appointment.

Payment for our programmer is hourly, so we contract for a certain amount of time per contract year. We still have time left on the current contract.

The 'New Initiatives' funding will probably go to Student Passport again for next year.

Question: Will there be recurring operating costs for Student Passport?

Answer: Yes, $13,500 per year.

Question: What is the 'Coordinator' position?

Answer: That is the staffing position we've had open for the past year and are hoping to fill soon.

Question: What will be done with the fees Montana pays?

Answer: We will wait to discuss that until we have 100% confirmation that they will be working with us: don't want to count on the money until the contract is signed.

V. Review and Discuss TCCP & MMCGME Fiscal Sponsorship Opportunity Research

*Reconnect TCCP Mission

How the mission has worked out in real life – staff always working on making the process as easy as possible for both sides. If we can make it easier for clinical sites to get the info, it's easier for them to say "yes."

*Fiscal Sponsorship Opportunity

After discussing the proposal, we can decide on next steps – do we want to proceed? If so, how?

*Background

It's still just a draft that we're working on – haven't made a final agreement.

One on one meetings were talking to partners about the draft

This is the procedure we've used for other TCCP decisions.

NOTE: 1/15/15 WAS DATE OF FIRST MEETING WITH MMCGME – NOT MAY 15TH!!!!

The draft is being constantly refined as we get feedback.

*Who has contributed?

List of who it's been presented to.

(Add Advanced Practice Committee to list in PowerPoint.)

*Lessons learned – ways the process could have been done differently.

Didn't make it clear that HealthForce didn't ask us to leave.

Different groups had different priorities, the message should have been tailored.

We gave the wrong idea about the administrative problems – that it was Winona's fault, or that the staffing was the number one part of the merger – that was just intended to be an example of one issue that might be helped.

*Feedback from Stakeholder Groups

Took early draft of presentation to the stakeholder groups

Note: Liz would love to go to ADPN meeting, but the timing was wrong. Their next full meeting isn't until September. There will be a break in their meeting at the end of this month, so Liz could be there to answer questions, informally.

From Val: Maybe we start with informal touching base, but we may need further steps – do we talk to people one-on-one, or have some small meetings?

There could be another meeting convened in the summer to talk about this, since it didn't affect all members of the big group.

They can figure out what works for their group, and then Liz can do what they need.

Refining data collection:

HealthForce MN first meeting. Presentation, ask for feedback, decision about moving forward?

Came up with list of what you look for in a new partnership. Leading Age had a similar relationship with MHA. They have an umbrella group that does salaries, pensions, etc.

They suggested the "back door policy" in case it doesn't work.

Schools were concerned this wouldn't lead to their being charged for placements.

Added annual review clause. Began development of guideline about making sure neither organization affects how clinicals are granted.

Question: Was it only Fairview and Allina who "approved?" Answer: No, the others were just offering feedback – weren't really in a position to approve or not, since they don't work as closely with TCCP.

MMCGME

Liz put together an explanation of TCCP. They were impressed with the amount of work we do. Some of these people didn't know what we do, so it was good for them to learn.

They talked a lot about how this could work with interdisciplinary efforts – track current workforce, to help project how the future should go.

Impressed with efficiencies.

Asked a lot of point blank questions, like "how much would it take today to track everything in our systems." Answer: We could do it, but haven't considered it yet. Would take software, staff, etc.

Discussed that TCCP does not try to find clinical placements, and neither does MMCGME. TCCP is not responsible for finding placements. Not responsible if a match isn't found.

Comment from Val: Even in a "hit by a bus" scenario, HealthForce would keep things going.

MMCGME would be there to help us with our mission.

They developed a sub-committee to discuss the sponsorship.

They introduced Liz to the medical school. The med school thought we were going to try to sell them our software, but Liz was there to find out what they need. Again, their placements are tied to the students, similar to APP.

Next meeting:

Scope of practice issue raised for first time.

Were concerned about governance – that TCCP remain autonomous.

Developed better language about "parent organization" to "fiscal sponsorship opportunity."

Letter was submitted from MACN yesterday that maybe we need to look at things a bit more.

From MACN on behalf of Jeanine Gangeness:

Should there be an RFP?

Conflict of interest with medical education?

Not sure there is an urgent need for this partnership.

There should be more time for consideration.

All member schools signed on to this letter.

From Christina: This is a misunderstanding – MMCGME does NOT work with med students, or with scheduling.

There are questions about who are our chairs, what are our bylaws, etc.

Comment: As Val said, HealthForce "has our back." Would MMCGME feel the same?

2 big issues, is TCCP going to continue to work on behalf of nursing?

Will it make things worse for APRNs?

From Val: As far as the medicine/aprn conflict, we're trying to figure out how that influences our partners, whether it's emotional, professional perspective? Can you separate the bigger issues from what we're doing?

From Ann: She shares their concerns about aprns vs. med. There is a lack of trust. Are they going to take over and push us out? Or let us in? Statistics: By 2020 we're going to be 1000 primary care providers short. The medical education numbers are not increasing. There won't be an increase in medical students, residents, doctors. The APRNs /PAs are the only option?

Ann: Our TCCP voice is very strong. Now we have something the med people want, so puts us in a new position, more influence. She doesn't believe any of this will change through this alliance. There is

already the competition. TCCP has never influenced any of this. This won't change with this partnership. From clinical partners perspective, they would have it "all in a similar package."

There's always going to be the issue of competition.

She appreciates the fears, but doesn't know if they're reality.

Response from MACN: Would it be in the terms of the agreement? Answer: absolutely!

Question: What is the Advisory Committee? What is the fiduciary responsibility?

From Liz: We have membership policies, fee structure, appeal structure.

Do we have bylaws? Yes, we have them written down. Liz can put them together and share them with people.

We need to decide how we're going to make this decision.

Tanya: We do have structure, bylaws, etc. This will all stay the same no matter what.

We're looking to combine the information for interprofessional development, trying to manage the chaos. MERC, Cevisa??? Nothing is going away with this agreement, it's a way for us to collaborate together. This is about addressing workforce needs. We're not talking about scope of practice at all. This is about having information in a database.

Comment: The focus of TCCP has always been about the process. Not about the larger issues. TCCP is about the practical aspects of coordinating clinicals.

As a newer member – she doesn't have the bylaws – could they be sent out?

MACN had a retreat to revise their bylaws, maybe we could do the same?

Comment: Maybe as we move forward with more important decisions, should the Advisory Committee be elected?

Response from Liz: The individual groups decide who their representatives are. The 2-year programs decide who to send, etc.

Comment: Also, all partners don't have equal financial stake, so does that affect it?

Comment: Could the bylaws, etc. be on the website?

Comment from Val: In another group, people introduce themselves as "representative of" to remind themselves they're representing others who aren't at the table. Make the representation more formal.

Troy Taubenheim presenting.

Re-introduce people.

Most people at the meeting have probably already been introduced to what MMCGME does.

Voting members are the health systems, U of M med school. Has been focused on med grad education for decades. Meet monthly.

Affiliated hospitals are the sites that train residents and fellows. They get reporting. Only certain hospitals have "GME provider" status – reimbursable by federal government.

7 employees provide services to teaching hospitals for state and federal reimbursement. Provide software to track 1350 students with 115 programs, driven by specialty usually.

Question: How much does it cost to be a member? Based on number of FTEs each hospital has. The budget for the office is around 1 million, divided by FTEs and billed.

(Med students are counted by FTEs instead of by number of hours like nurses. It's a federal gov't definition. One person = one FTE. 1350 per academic year. Fiscal years are different for hospitals.)

Fairview has about 350-375, HCMC 300, Regions/VA 150, Allina 70, HealthEast 50…

Proportionately paid for according to who's getting the service.

Their staff works for the hospitals.

The money actually comes from state/federal funding for medical education.

Even though some hospitals aren't on the board, they are still very actively involved in what the office does. They may participate in committees. The committees are the ones who really do the work, and the board votes on what they produce.

The board members are concerned about all parts of the system. They can't separate out just med students – it's all part of a big system. TCCP and MMCGME are as much a part of hospital operations as the OR, for example. It's all part of the big picture.

The reason Troy is here today is because what he works on is what the hospitals want him to work on. They work with Pharmacy, adding Dieticians for VA, bringing other programs in.

Question: Can the affiliated members become voting members?

Answer: Started as association of medical education sites. In the beginning, was just a small number of hospitals. MN Association of Public Teaching Hospitals. Hennepin, Ramsey Cty, U of M.

In 2004, request from Allina and Children's to have a seat at the board. They wrote a resolution that any health system with at least 40 FTEs could request to be a board member. The other health systems haven't been as interested in board membership. Their main concern is that they're getting what they

need in terms of support. They don't have a need so far, because the board is working on what they want.

Question: What do they do for the Pharmacy program?

Answer: MERC is part of it.

Question was raised at board meeting about what tracking is done for APRNs? VA said "I want every trainee that steps on our site to be tracked."

So, part of it is community benefit reporting.

They aren't going to track lab techs in their systems, so what should they do?

They wanted to go to advanced practice folks to have them participate. They said "We have that – it's TCCP."

Troy said that what TCCP has accomplished is really good. We're ahead of the rest of the country.

Next thing is where do we go from here?

VA wasn't interested in TCCP, but MMCGME said we should all be working together to keep this system going. Support it.

Everyone around the country is talking about interdisciplinary training.

Voting is done by system – Fairview will vote one way as an organization.

Children's new member – when she does rounds, she has people from all programs there. PAs are not part of that, so she was uncomfortable evaluating them. So MMCGME said "how can we help with this." They don't only do Medical education.

Politics/lobbying. It's very valuable for Troy to know what's going on with everyone.

Commissioners on workforce effort, talking about medical education, if they are talking to them about med students only, they don't care. They need to know what's going on with everyone. Advanced Practice in particular. Loan forgiveness, as an issue, will affect all of them. Preceptor grants, etc. 2 members ranked more money for advanced practice people above more money for med students.

Ultimately, the reason why everyone does this, is to have good people to hire. That is the goal for everyone. They have enormous hiring needs and should be doing everything they can to train people.

Question: What do you do with regards to MERC?

MERC is designed to go to the teaching site. Medicare money for GME also goes to the teaching site. (Not the school.) This is limiting. Each hospital has a limit on how many FTEs they get money for. This meant that they couldn't have students at smaller teaching sites that weren't included. So they're trying to get the money to go to the trainee program. So the students will be funded wherever they go.

People are going to apply for grants to get this money. (Schools) (Note from Val: This is proposed, hasn't gone through yet.)

Went to legislators and said schools aren't going to train more people unless they're getting more clinical sites to train them at. They need to be able to expand that.

Troy is buffer between program directors and clinical sites. How the funding goes back and forth. The goal is not to make more money for one or the other, the goal is to ensure we continue to train the same or more numbers of well-qualified physicians. Public entities are in this to provide clinicians to Minnesotans. In their articles of incorporation, that is their mission.

Questions: April 30th was when Troy learned about TCCP. That meeting was exploratory about advanced practice tracking. Invited deans of nursing. When this first came up, about how we might work together.

When Interdisciplinary talk comes up, we're going to be able to say that we DID something, not that we just talked about it in theory.

Question: What about Mayo Rochester who is not in MMCGME but is in TCCP? Will they have to join? Answer: No. In Minnesota there are two main tracking systems. The 1350 with MMC, and the Mayo group, which is completely separate in terms of graduate medical education. They do have participation in coordinator conference, programs may have interaction. They may have specific rotations with each other.

We are not looking to merge the two. They have about 1400 trainees, and their system works really well.

The relationship with sites they're not involved with will be handled by TCCP.

Question: That is what we're wondering – what is shared? What is separate? This is a good example – TCCP's membership will not be affected by MMC's.

TCCP will not have anything to do with graduate medical education. But at the high levels, the hospitals are interested in both and how they fill their needs.

Comment: We are very different organizations.

Troy: Their database is way more complicated/advanced because it's federal money and has to be tracked very precisely. Have to have complete accountability.

They have a quality committee – the accrediting committee says that they are accountable for stuff like quality improvement, safety initiatives, etc. If a reviewer from ACGME came out and asked a random person what their hospital's policies are, they would have no idea. Their committee is working to fix that issue. Residents and Fellows need to be in the driver's seat of working on these initiatives. Why wouldn't you get advanced practice people involved in this effort as well? (Comment: They already are on top of that.) Would it be good for the doctors and nurses to be working together on this stuff?

This is all theory at this point. What we're talking about doing is providing back office support for TCCP. This is the initial step. Collaborating with hiring, tax ID number stuff, etc. This is a transition. TCCP will go on either way, but this is an opportunity to get people more involved with the big ideas. Troy can go to their VA member and say "you need to work with TCCP." Liz went to their board January 23rd. Their board members were very impressed with what we're accomplishing. If you're getting all this done with just a couple of employees, you must have a really good committee behind them. They are impressed with what we're doing.

Comment: At HealthEast, the stuff done with clinical education goes on "in the shadows," not a big focus. Someone at HealthEast came to her and said "we need to get involved with TCCP and she said "we already are! I'm on the board!" This effort will contribute to making us more visible.

Question: Why are the people in their group doing this? Because they need more staff. The limiting factor is not a supply of students. The schools also have a limitation in terms of faculty. Comes back to limitations in clinical training folks. With MMC, they can discuss in the group: "We need to train more of xxx people. If I'm at my limit, can you take them? How do we get more trained people into the work force?"

Example: The VA is limited as far as GME because of their types of patients, but maybe they could take a lot more of the nursing students.

Troy can't guarantee there will be more opportunities, but he can say that no one on the board has ever dictated to a program how or where they train their students. This is not what they do. They don't dictate placements.

If there's one thing the hospitals want Troy to do, it's track the medical students.

Troy couldn't contribute to changing the competition even if he wanted to.

Question: Who tracks the students?

Answer: pretty much nobody. It's all piecemeal. Tanya is beginning to try to track them for Fairview. Has a spreadsheet tracking, because she asked for it.

Med school does track some for MERC reporting.

Board is looking for a solution. It would be overkill to put the med students in their resident/fellow tracking. But it could happen. A better approach would be to work with the medical school to find a good solution. Again, this will have nothing to do with whether or not they get the clinicals. Just with tracking. They don't carry out the initiatives, they facilitate them.

From Val: wants to reinforce that the reason Troy can't affect clinical placements is because it isn't in his bailiwick.

From Troy about med students: It would be nice to work together with them. But if we contracted out software to them, it would take away from TCCP's mission. One of his board members said that working with us might dilute what they do. Have to remind them of the "big picture."

If MMC doesn't do the back office support, we should still work together collaboratively. Troy can push his members to work towards these big goals together with us.

Val: It's about collaboration and partnership, to work together for the good of the state. They exist to help Minnesota get the best healthcare they can. This seems to be the same for Troy/MMC. We all serve the state.

MNSCU/UofM competition for funding is another huge competition, but they're still working together.

Their hospitals come together even though they are competitors.

Val – are there questions?

Some people have to leave, will talk about where we go from here.

From Troy: They have a group to do due diligence investigating the TCCP agreement. He told their board they need to go to their people who work with TCCP and ask them why we should have a partnership.

He hopes we will continue to work together whether or not we have this formal agreement. Either side could decide not to move forward.

Their board knows this isn't going to happen tomorrow. There will be more discussion, figuring things out. He doesn't want to do this deal if TCCP's members aren't on board.

Val: Troy & Liz and Val have been communicating about this. People in the committee can contact Troy to ask questions if they like.

A bunch of people had to leave, Troy left.

Liz took back over.

Question: What would be the benefits if we moved forward?

Collaboration,interprofessional, manage work better for clinical sites so they can track people better.

Allina: Big benefit is in reporting. Everyone is struggling with the same thing. They are losing MERC money because they can't prove what they're doing. If they lose money, they will be less likely to take the students. Even though there is a system need to train people.

Our only hope to meet the needs is in the mid-level providers, PAs/NPs so we can care for Minnesotans, and they need to find a way to be able to do that.

Having to do more with less, things have to be made easier.

Doesn't understand what the fears are – they aren't based in reality.

It's all about the fear of doctors vs. advanced practice nurses.

They need to make the pipeline to bringing APRNs on board so easy that they can add more providers!

Question: Where did this big fear come from?

Answer from MACN: Anything that feels like it might hurt getting clinicals scares people.

Ann: What exactly makes people so afraid?

Answer: A lot has to do with the recent legislative battle.

Ann: If we are not at the table, the med students are going to get the money from the legislature.

When we started TCCP, people blamed us if they didn't get clinicals.

It isn't reality-based, it's fear driven, and based on historical things that have gone wrong.

There will be uncertainty, of course, in the beginning. But we should stand toe-to-toe with them and be treated as equals.

They want the "voice at the capital." They have a lobbyist.

If we have an official relationship, the executives will pay attention to APRN. Need to get people behind us.

This has already affected Children's. They thought they were limited by their budget, so they were cutting back on their placements. The MMC board member said "not a problem."

Also, VA wants to come on board.

Where do we go next?

We need to keep on talking, get bylaws out, etc.

VI. **Hear Member Updates**

VII. **Next Meeting Date: July 15, 2015**

VIII. **Adjourn**