ADVISORY TASK FORCE ON GOVERNANCE AND FINANCING OF HENNEPIN HEALTHCARE SYSTEM, INC.

What We Are Hearing from Minnesotans

An update on the public consultation: participants, emerging themes, and process for compiling and sharing findings

Task Force Meeting 4

Thursday, November 5, 2026

Prepared by Laurel Health Advisors, LLC

Draft for review by the Chair and the Health Subcabinet

THIS UPDATE

Three questions in 30 minutes

1

Who has been, and will be, consulted

The ten specified categories for consultations and timeline

About 5 minutes

2

What themes are emerging

Nine common themes, with areas of agreement and difference

About 15 minutes

3

How findings will be compiled and shared

Session summaries, numbered public record, Task Force report

About 5 minutes

Where this comes from: Ten anonymized session summaries. Comments are attributed to the group, never to an individual.

Caveat: These are emerging themes, not recommendations for the Task Force.

The law names ten areas of expertise

Area	Who the law names	Status
1	Rural hospitals and rural health systems	Convened in two sessions
2	Urban nonprofit hospitals other than Hennepin County Medical Center	Convened October 23 and 26
3	Physicians in emergency medicine, trauma, critical care or hospital medicine	Convened October 27
4	Registered nurses	Convened October 28
5	Organized labor representing hospital or health care workers	Convened October 22
6	Ambulance services and emergency medical services	Convened October 13
7	Local public health departments and community health boards	Convened October 21
8	Federally qualified health centers and community clinics	Convened October 21
9	Consumer and patient advocates with safety net hospital experience	**Scheduled November 9**
10	State legislators, county commissioners, state agency commissioners	Legislators engaged October 28; additional meetings planned

9 of 10

areas heard at least once by October 28

Additional consultations with Hennepin Healthcare

- Staff
- Leaders
- Board members

Source: Minnesota Laws 2026, Chapter 127, Article 3, Section 18, Subdivision 4(7).

Groups still to be heard

Upcoming

- Consumer and patient advocates with experience receiving care from a safety net hospital
- Former Hennepin Healthcare leaders and board members
- Hennepin Healthcare staff
- State legislators, in a second session

Coverage: once consumer and patient advocates are heard, every one of the ten areas will have had at least one session.

The same core questions, asked of every group

Hennepin Healthcare today

- What it does that no one else does?
- How you depend on it?
- Why its finances are under pressure?
- What the 2026 law settled, and did not?
- What thriving would look like in five years?

The future

- What must stay in public hands?
- What the public should be able to see?
- What conditions must be part of any change?
- How to support financial sustainability and what risks to consider?
- Identify one recommendation you would provide to the Task Force

Questions for each group

Written for each area's vantage point

Examples:

- Why nurses stay or leave?
- What the Legislature needs to do?
- Which hospital services could be absorbed by other providers?

Questions not reached are sent for written answers

Recorded to verify notes, then discarded

Comments attributed to the group, never a person

Summaries shared with each group for review (in process)

Nine themes, and how widely each was heard

Theme	EMS	Clinics, public health	Labor	Urban hospitals	Rural hospitals	Physicians	Nurses	Legislators	Policy observer
A statewide resource no one else could absorb	●	●	●	●	○	●	●	●	○
A training pipeline for the state	●	●	●	●	●	●	●	●	
Beds are full; patients have nowhere to go	●	○	○	●		●	●	●	
Payment does not cover the cost of care	●	●	●	●	●	●	●	●	●
A statewide problem needs statewide funding	●	●	●	●	●		●	●	●
Internal costs and operations need attention	○		●	●	●	○	●	●	
Clearer lines of authority, and a voice	○	●	●	●	●	●	●	●	
Keep it public, and more open		○	●	○			●	○	
Keep the workforce through the uncertainty		○	●	●	○	●	●	○	

● a main point of the session ○ raised in part blank: not raised. Based on the ten anonymized session summaries; urban hospital sittings combined.

A statewide resource, and a training ground for the state

What we heard

- Trauma, burn care, hyperbaric medicine, the poison center and disaster readiness were were named in nearly every session as services Hennepin provides at a scale no other other hospital could take on.
- Other hospitals said they provide some of the same services, but already run at or near capacity and could not absorb Hennepin’s emergency volume, especially without notice.
- Ambulance leaders reported patients arriving by ambulance from 85 of Minnesota's 87 counties since 2024.
- Clinics and public health described a role reaching beyond the county and beyond clinical care: tuberculosis and refugee care, addiction care, and expert advice others rely on.
- Many physicians, nurses, therapists and social workers train at Hennepin, and many stay in Minnesota.

Heard from

Every group, in some form.

Rural hospitals specifically discussed:

- Hennepin is vital to the metropolitan area.
- Rural areas rely on Hennepin mainly for burn care and training.
- Rural hospitals send emergency cases to the nearest hospital able to treat them; some may later be transferred to Hennepin.

For the Task Force: Which services must be retained and how to ensure they are legally protected.

Beds are full, and patients have nowhere to go

What we heard

Ambulance leaders: beds, not trauma capability, are the binding constraint; ambulances wait while hospitals find space.

Providers: patients who no longer need hospital care often stay longer than needed, typically people in a behavioral health crisis or without stable housing.

Hospitals: this affects hospitals across the state and is traced to too few post acute, group home and mental health beds.

Nurses: boarding is heavy, distressing work that adds to turnover; they asked for closer ties with county social services.

Legislators: consider investing in community services that provide a lower level of care once acute care is no longer needed.

Heard from

Ambulance and EMS

Urban and rural hospitals

Physicians

Nurses

Legislators

Clinics, on behavioral health step down care

For the Task Force: Part of the solution lies with the State and county services outside the hospital.

Payment below cost, and a burden one county carries

What we heard

- Every group named public payment below the cost of care, and uncompensated care, as a main cause of the financial pressure.
- Ambulance leaders added the cost of readiness: staffing around the clock, which fee for service payment does not fund.
- Many called Hennepin Healthcare the "canary in the coal mine": urban and rural hospitals face the same forces.
- Nurses, labor, clinics and legislators said a statewide resource is funded largely by one county, while many patients come from elsewhere.
- The remedy offered most often: Medicaid payment that covers the cost of care, for every hospital.

Heard from

Every group

Legislators asked the Task Force to consider:

- The cost of care for patients from outside Hennepin county.
- How costs might be shared.

For the Task Force: Should solutions for sustainable support focus on Hennepin Healthcare alone or for safety net care across the state?

Who decides, and who has a voice

What we heard

- Partners said it is often unclear whether they are dealing with Hennepin County or Hennepin Healthcare and asked for more clarity.
- Hospital and physician groups highlighted barriers related to politics: it would be difficult to partner with Hennepin while decisions are driven by politics.
- Workers and nurses recalled a clearer chain of command under the county and warned against a board that is out of reach.
- Requests for a participation on the board: a labor seat, community health centers and patients, clinical leaders, and financial expertise.
- On the role for the State, views ranged from a State funding, or decisions lifted to the State, to county ownership with State set priorities.

Heard from

Every group except the policy observer

Nurses asked that the County, the board and hospital leaders speak with one consistent message.

For the Task Force: Clarity regarding who holds which powers matters to partners, staff and patients alike.

Keep it public, open, and staffed

What we heard

Public status

- Labor, nurses and clinics asked that Hennepin Healthcare stay public.
- Care for the uninsured and public health should stay public, whatever the structure.

Transparency

- Workers and nurses: open meetings, and budget and staffing data by department (citing Parkland Health in Dallas and Minneapolis Public Schools).
- Hospitals and physicians: board deliberations need some confidentiality to be candid.

Staffing

- Turnover is driven by uncertainty, short staffing and unanswered feedback; the 2026 money steadied cash but not the uncertainty.
- Nearly every group said staff and training should be protected through any change.

Heard from

Labor

Nurses

Clinics and public health

Urban hospitals

Physicians, on keeping clinical leaders

For the Task Force: Transparency into decision making process and staff stability should be conditions for any change, not afterthoughts.

Where the groups do not agree

What drives the losses

Primarily reimbursement: public programs pay below cost, and uncompensated care is high.

Clinics, policy observer, some urban hospitals

Reimbursement and internal staffing, space, supplies, layers management.

Labor, rural and some urban nurses, some legislators

What Hennepin should do

Retain all services: there are too few as it is.

Clinics, physicians, nurses

Retain a core set of services: concentrate on trauma and let others absorb low volume programs.

Some urban hospitals, rural

How open the board should be

Open meetings and published budget and staffing data.

Labor, nurses

Candid closed deliberation, with public accountability for results.

Urban hospitals, physicians

Who should decide

The county, with clearer lines and lines and a board within reach. reach.

Labor, nurses

A State role, clinicians and experts, or a larger partner system.

Clinics, rural and urban hospitals, physicians

Disagreements will be reported to the Task Force as choices, with each position presented fairly.