Gaps Analysis Regional Meeting Summary: Region 7 – East Central Minnesota

Meeting held on May 3, 2017

Convened by Wilder Research for the 2015-16 Department of Human Services Gaps Analysis study

July 2017

The information, views, opinions, and conclusions included in this summary are those of the regional meeting participants and do not represent the official position or policy of the Minnesota Department of Human Services.
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Introduction

Gaps Analysis

The Gaps Analysis gathers local information about the capacity and gaps in Minnesota’s publicly funded home and community-based services (HCBS) system and continuum of mental health (MH) services and supports to meet the needs of all persons who need services. The Gaps Analysis is conducted every other year. Previously, the Gaps Analysis was conducted through a survey process that primarily asked county lead agencies to provide their perceptions about the availability of HCBS and MH services and supports. For the 2015-16 analysis, the process was revised to provide an opportunity for regional stakeholders to review and use data from the past Gaps Analysis with a focus on solutions. The 2015-16 Gaps Analysis was conducted through 11 regional meetings, each attended by approximately 40 stakeholders including representatives of lead agencies, service providers, and consumers/advocates. The regional meetings provided an opportunity for participants to discuss and prioritize top service gaps, identify solutions to service gaps, and develop action plans to implement the solutions.

This report provides a summary of the meeting for Region 7, Minnesota’s east central economic development region. The purpose of this summary is to provide a resource for stakeholders in Region 7 and around the state, as well as the Minnesota Department of Human Services (DHS), in their ongoing work to address critical service gaps.

Region 7

Region 7 includes nine counties: Benton, Chisago, Isanti, Kanabec, Mille Lacs, Pine, Sherburne, Stearns, and Wright.

Region 7 has a population of 580,850 people, representing 11% of the statewide population (U.S. Census Bureau, 2015 Population Estimates). Twenty-five percent of the region’s population is enrolled in Minnesota Health Care Programs (MHCPs), including: Medical Assistance (MA), MinnesotaCare, Minnesota Family Planning Program, Home and Community-based waiver programs, and Medicare Savings Programs. Of those enrolled in MHCPs, 21 percent used one or more HCBS or MH services and supports. Additional data about current and potential service users and data from the previous Gaps Analysis (covering 2013-14) can be found in the 2015-16 Gaps Regional Data Profile for Region 7 (https://edocs.dhs.state.mn.us/Iserver/Public/DHS-7302E-ENG).
Regional meeting participants

Approximately 40 stakeholders were invited to each regional meeting. These stakeholders included representatives from counties, tribes, and managed care organizations with administrative or contract authority to provide assessment and support planning (i.e., lead agencies); providers of HCBS and MH services and supports; and advocates for current and potential service users.

Thirty-seven stakeholders participated in the Region 7 meeting on May 3, 2017 in St. Cloud, Minnesota. Figure 1 describes the self-identified roles of the meeting participants.

1. Roles of regional meeting participants

<table>
<thead>
<tr>
<th>Role</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/advocate</td>
<td>5</td>
</tr>
<tr>
<td>County lead agency representative</td>
<td>20</td>
</tr>
<tr>
<td>Managed Care Organization</td>
<td>5</td>
</tr>
<tr>
<td>Service provider</td>
<td>5</td>
</tr>
<tr>
<td>Role not specified</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>

DHS representatives and staff from Wilder Research also attended this and the other regional meetings to present data, facilitate activities, answer questions, and take notes during table discussions. This process is described in more detail in the next section of this report.

Regional meeting process

Wilder Research staff facilitated and managed the logistics for each of the regional meetings with support from representatives from DHS. Each meeting began with an overview of the Gaps Analysis process and purpose by DHS division leadership and a brief presentation of data on demographic characteristics of the region’s population, service utilization by the region’s residents, and the 2013-14 Gaps Analysis by Wilder Research. The remainder of the meeting consisted of three facilitated activities that helped participants to:

- Prioritize what they identified as service gaps for all persons who need services in the region
- Brainstorm solutions to service gaps identified as a priority
- Develop action plans to implement the most promising solutions

This report highlights key findings from each of the three facilitated activities in Region 7.
### Prioritized service gaps

The goal of the first facilitated activity was to identify a prioritized set of service gaps that stakeholders wanted to address in the region. This activity was broken into three rounds of prioritization described below.

### Prioritization, round one

In round one, participants worked in small groups with a focus on one of the following four populations: older adults, persons with disabilities, children with mental health conditions, or adults with mental health conditions. Two small groups discussed each population, for a total of eight small groups. Because of small group sizes, the two groups focusing on children with mental health conditions merged into one group. Each small group was asked to determine the four most important service gaps for their population. In lieu of service gaps, per se, some groups identified broader issues that may have led to service gaps, such as shortages in affordable housing with affordable services. Figure 2 presents the top four gaps determined by each group working on each of the four populations of interest.

<table>
<thead>
<tr>
<th>2. Prioritization, round one - service gaps</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adults</td>
<td></td>
</tr>
<tr>
<td>a. Affordable housing</td>
<td>a. Affordable housing with affordable services (e.g., homemaker)</td>
</tr>
<tr>
<td>b. Chore services</td>
<td>b. Geriatric mental/behavioral health, including medication management</td>
</tr>
<tr>
<td>c. Non-medical transportation</td>
<td>c. Non-medical transportation</td>
</tr>
<tr>
<td>d. Shrinking labor force and volunteer force</td>
<td>d. Respite</td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td></td>
</tr>
<tr>
<td>a. Affordable housing</td>
<td>a. Assistive technology and environmental accessibility</td>
</tr>
<tr>
<td>b. Direct support staff shortage/provider respite</td>
<td>b. Staffing shortage</td>
</tr>
<tr>
<td>c. Transportation</td>
<td>c. Subacute level of care/staffing shortage</td>
</tr>
<tr>
<td>d. Two-way communication/Accessing people in the community</td>
<td>d. Transportation</td>
</tr>
<tr>
<td>Children with mental health conditions</td>
<td></td>
</tr>
<tr>
<td>a. Placement for youth with aggressive behaviors with strong family component</td>
<td>a. --</td>
</tr>
<tr>
<td>b. Psychiatric prescribers locally [lack of availability] and [insufficient reimbursement] rates</td>
<td>b. --</td>
</tr>
<tr>
<td>c. Respite care for children with serious emotional disturbance (SED)</td>
<td>c. --</td>
</tr>
<tr>
<td>d. Transportation to medical services</td>
<td>d. --</td>
</tr>
<tr>
<td>Adults with mental health conditions</td>
<td></td>
</tr>
<tr>
<td>a. Housing</td>
<td>a. Housing continuum</td>
</tr>
<tr>
<td>b. Psychiatric prescribers</td>
<td>b. Inpatient beds</td>
</tr>
<tr>
<td>c. Recovery support services</td>
<td>c. Psychiatric prescribers</td>
</tr>
<tr>
<td>d. Transportation</td>
<td>d. Workforce (all levels)</td>
</tr>
</tbody>
</table>

Note. The service gaps are not listed in rank order. Because of small group sizes, the two groups focusing on children with mental health conditions merged into one group.
Prioritization, round two

Next, the two small groups working on the same population merged together to further narrow the service gaps identified as a priority for that population. To aid in this, the group members completed a grid ranking activity in which they ranked each service gap in terms of its ease to address and level of impact. Figure 3 presents several example photos of the grid ranking exercise conducted in Region 7. Each participant was instructed to place one sticker into the appropriate quadrant of the grid based on whether they thought it would be relatively easy or hard to address (e.g., How many resources would be required? How much time would it take?) and the level of impact addressing the gap would have (e.g., How many people would this help? Would this help individuals with a high level of need?). For example, if a participant thought a service gap would be difficult to address but doing so would have a high impact on the population in their region, they placed a sticker in the lower right quadrant.

3. Ease and impact grid ranking activity examples

The grid ranking exercise helped participants prioritize the three service gaps for their target population that they would recommend during the solution development stage of the meeting. Figure 4 presents the resulting three service gaps identified as a priority for each population.
4. Prioritization round two – top three service gaps for each population

<table>
<thead>
<tr>
<th>Older adults</th>
<th>People with disabilities</th>
<th>Children with mental health conditions</th>
<th>Adults with mental health conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric mental and behavioral health</td>
<td>Affordable/accessible Supportive Housing</td>
<td>Local psychiatric prescribers and reimbursement rates</td>
<td>Housing continuum</td>
</tr>
<tr>
<td>Lack of workforce</td>
<td>Lack of subacute level of care</td>
<td>Placement for youth with aggressive behaviors with strong family component</td>
<td>Recovery support</td>
</tr>
<tr>
<td>Non-medical transportation</td>
<td>Provider/staff shortage</td>
<td>Respite</td>
<td>Workforce continuum</td>
</tr>
</tbody>
</table>

Note. The service gaps are not listed in rank order.

Prioritization, round three

Finally, each participant reviewed all the prioritized gaps across the four populations, and voted for the one(s) that they felt should advance into the solution development stage of the meeting. Each participant was allowed four votes that could be distributed in any manner across any service gap(s) in any population. Prior to the voting, the facilitators engaged the participants in a conversation about potentially combining service gaps that were similar or overlapping across populations. In Region 7, the meeting participants coalesced around the desire to combine “housing continuum” and “affordable/accessible supportive housing” into an overarching “housing” category. Participants also combined “lack of workforce,” “workforce continuum,” and “provider/staff shortage” into a single overarching category of “lack of workforce.”

Six service gaps received the largest number of votes and advanced into the solution development phase:

- Geriatric mental/behavioral health
- Housing
- Lack of workforce
- Psychiatric prescribers
- Recovery support
- Subacute (not hospital) level of care
Potential solutions

The goal of the second facilitated activity was to identify a set of solutions to the prioritized service gaps. The facilitated activity was separated into three stages during which participants: 1) brainstormed solutions to the prioritized service gaps, 2) evaluated potential solutions by discussing considerations such as feasibility and barriers to implementation, and 3) voted on a set of solutions for which action plans would be developed during the final part of the meeting. It is important to note that complete “solutions” to the service gaps may not be available, but instead participants discussed strategies to help shrink the service gap. All kinds of solutions and strategies that were identified by participants are simply referred to as solutions throughout this report.

Brainstorming solutions

During the brainstorming activity, participants formed small groups focused on identifying possible solutions for one of the six gaps listed above. They also worked within their groups to determine the level at which each possible solution would need to be implemented (e.g., regional, statewide). Participants were encouraged to focus on solutions that could be implemented regionally, but were given space to document solutions that would need to be implemented at a state level (e.g., reforming legislation, increasing reimbursement rates for service provision). Figure 5 lists the solutions that were brainstormed for each of the top six service gaps. Solutions marked with a “*” were noted as being state-level, statewide, state and regional, or legislative solutions on the participants’ note sheets. It is important to note that some solutions may require state-level action but were not indicated as such by the participants and are not starred below.

5. Brainstormed solutions for service gaps identified as a priority

<table>
<thead>
<tr>
<th>Service gap</th>
<th>Brainstormed solution(s)</th>
</tr>
</thead>
</table>
| Geriatric mental/behavioral health       | • [Include] mental health screening in primary care – include in annual check-ups  
• Educate older adults – address stigma, it is not just “normal aging”  
• Increase proportion of health professionals’ training in geriatric behavioral health, mental health in particular (physicians in particular)  
• Increase preventive efforts in nursing homes – submit application for skilled nursing facility (SNF) quality improvement opportunity  
• Leverage Medicare codes for cognitive screening and partner with medical providers and associates to increase rates of screening and build on this to include mental health screening  
• Identify resources to refer people to after assessing for need through MN Choices*  
• Address transfer trauma that occurs with move to assisted living or nursing home |
| Housing                                  | • Group Residential Housing (GRH) funding to unlicensed setting – scattered site*  
• Shared supportive options – roommate matching  
• Develop more housing with supports  
• Allow exceptions to $40,000 limit for modifications*  
• Increase voucher funds  
• [Provide landlords with] rental guarantee to cover rent/expenses – incentives to landlords |
<table>
<thead>
<tr>
<th>Service gap</th>
<th>Brainstormed solution(s)</th>
</tr>
</thead>
</table>
| Lack of workforce | • Increase and simplify enrollment processes for providers*  
| | • [Provide] specific training – high school programs, colleges/technical schools, volunteerism, career days/fairs  
| | • [Work with] Public Employees Retirement Association of Minnesota (PERA). [Consider] tuition reduction, scholarships, monetary incentives, loan forgiveness, stay/retention bonus to enter workforce for these populations. Focus on recruitment of adults 49-65 who still want to work  
| | • [Change] licensing process – professional individual (too complex/too expensive)*  
| Psychiatric prescribers | • Increase payment rate to sustain providers*  
| | • [Identify] regional dollars or grant[s] to pay for travel to get providers to rural area  
| | • [Develop] contract and share costs to co-located service models  
| | • Increase telehealth access and education to persons*  
| Recovery support (strengths-based, pro-active, flexible, preventive) | • Seek coverage for these activities, especially Wellness Recovery Action Plans (WRAP)*  
| | • Education (formal)  
| | • Empowerment education/training to potential advocates  
| | • Mandate and normalize WRAP  
| | • Increase the role of the Certified Peer Supports (CPS)*  
| | • [Provide] peer respite  
| | • [Implement] decision making, voting. Mandate Adult Mental Health Initiative (AMHI) representation with pay - not token (equivalent bodies; mandate inclusion of persons with lived experience)*  
| Subacute (not hospital) level of care | • Design programs that advocate for long-term staff – raise reimbursements*  
| | • Combine mental health with health services (do not segment): integrate human services delivery. Share data among regional counties to define needed care that, in turn, demonstrates funding levels needed  
| | • Expand existing inpatient rehabilitation facilities (IRF) – Rule 36s and state hospitals do not exist (do not need hospital level of care). [Include] onsite psychiatric, security, resources, and behavioral health services*  
| | • [Implement] central intake and coordination. Partner with community resources (preventative, non-profit) so that all continuum of care providers are involved  

DHS Gaps Analysis Regional Meeting Summary, Region 7
Solutions selected for action planning

Each small group was asked to select approximately three of their solutions to review and discuss. They were asked to discuss considerations related to the feasibility of these solutions as well as the barriers to implementing them. Following this evaluation, each small group presented their two most preferred solutions to the broader group for consideration. Then, using a “walking caucus” approach, participants were asked to line up in front of the solution they most wanted to work on. This process was used to identify six solutions for the region around which action plans for implementation would be developed. Figure 6 displays the selected solutions.

6. Preferred solutions to service gaps identified as a priority

<table>
<thead>
<tr>
<th>Service gap</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric behavioral and cognitive health</td>
<td>Increase use of screening tools for mental health and cognition at annual exam in primary care</td>
</tr>
<tr>
<td>Housing</td>
<td>[Implement] shared supportive options such as roommate matching</td>
</tr>
<tr>
<td>Lack of workforce</td>
<td>Focus on recruitment and retention through incentivizing</td>
</tr>
<tr>
<td>Lack of workforce</td>
<td>[Increase] rates and [reduce] enrollment processes for providers</td>
</tr>
<tr>
<td>Psychiatric prescribers</td>
<td>[Increase use of] telehealth</td>
</tr>
<tr>
<td>Recovery support</td>
<td>Mandate decision-making groups to significantly include those with a lived experience and for pay</td>
</tr>
</tbody>
</table>

Action plans

For the final activity of the meeting, small groups of participants developed detailed implementation plans for their preferred solution to a given service gap. Each group was instructed to complete an action plan that included the following:

- A list of action steps and the goal of each step
- Names and/or roles of people leading and supporting each action step
- Resources required to implement each action step
- Barriers that might impede each action step
- A communication plan around each action step
- A target completion date for each step

The action plans varied widely in their length and types of steps needed to move them forward. Some of the action planning groups were able to incorporate more detail regarding the points above than others. Figure 7 displays the steps associated with each action plan.
### 7. Action steps

<table>
<thead>
<tr>
<th>Service gap:</th>
<th>Solution:</th>
<th>Action steps:</th>
</tr>
</thead>
</table>
| Geriatric behavioral and cognitive health | Increase use of screening tools for mental health and cognition at annual exam in primary care | 1. Educate providers on Medicare reimbursement for cognitive exams  
2. Identify tool for mental health screening  
3. Explore possibility of screening for cognitive/behavioral health as a supplemental benefit for Minnesota Senior Health Options (MSHO) or performance improvement plan (PIP)/quality improvement plan (QIP) topic  
4. [Implement an] educational campaign [targeted at] providers to increase use of these two tools  
5. [Implement an] educational campaign [targeted at] consumers regarding these tools |
| Housing | Shared supportive options such as roommate matching | 1. Create a regional taskforce  
2. Find county staff for taskforce/team |
| Lack of workforce | Focus on recruitment and retention through incentivizing | 1. Identify data sources  
2. Review data specific to county and region  
3. Prioritize compelling needs  
4. Engage local employers and providers in the process  
5. Identify potential incentives for job retention  
6. Engage Minnesota State Colleges and Universities (MNSCU), other educational institutions, and other stakeholders |
| Lack of workforce | Increase rates for providers and downsize enrollment processes | 1. [Provide] support and training on enrollment, 245D, etc.  
2. Identify case examples of lack of services. [Identify] questions providers have  
3. [Provide] education about enrollment standards, not limited to contracts  
4. [Work to increase] inadequate rates |
| Psychiatric prescribers | [Increase] telehealth | 1. Increase access to psychiatric providers. Educate region 7 counties and providers about accessing medications to stabilize mental health diagnoses  
2. Contract Prepaid Medical Assistance Programs (PMAP) |
| Recovery support | Mandate decision-making groups to significantly include those with a lived experience and for pay | 1. DHS identify contracts with counties  
2. Of those, determine which would be appropriate to have this requirement  
3. Implement representation and the open [meeting] law  
4. Implement statewide |

The action plans were meant to serve as a resource for meeting participants, and potentially other stakeholders in the region, to help guide their work to solve critical service gaps. Transcribed action plans were provided back to the meeting participants so that they could be modified or added to as the work progressed. Detailed action plans and participant lists are included in Appendix A for the Regional Gaps Analysis Meeting Summaries and can be obtained by contacting DHS at 651-431-2600.
Next steps

An overall statewide report will be available on the DHS Gaps Analysis website in fall 2017 (http://mn.gov/dhs/gaps-analysis).

DHS identified the following next steps:

- DHS plans to hold additional meetings with stakeholders, specifically persons who use services, their families, and advocates. The Department has also consulted with tribal health directors about how best to gather input from tribes and they have recommended holding two separate meetings, one with the Ojibwe tribal nations and one with the Dakota tribal nations.
- DHS is committed to continuing to work with action planning groups to process the information collected through the Gaps Analysis study and to identify ways to support their actions steps. In the past, for example, the Gaps Analysis study results were used to guide grant funding and the development of specific training efforts. The results from these regional meetings will likely be used in a similar way.
- The Department will check in with the action planning groups as well as various stakeholder groups (such as the County State Work Group, one or more Managed Care Organization workgroups, Tribal Health directors, and the HCBS Partners Panel) when the final report is completed this fall and again in 2018 as planning begins for the next Gaps Analysis study.

ABOUT THIS REPORT:
This summary was developed by Wilder Research in collaboration with the Minnesota Department of Human Services Aging and Adult Services, Disability Services, and Mental Health Divisions.

July 2017
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