Gaps Analysis Regional Meeting Summary: Region 1 – Northwestern Minnesota

Meeting held on May 9, 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 1, Minnesota’s northwestern economic development region. The purpose of this summary is to provide a resource for stakeholders in Region 1 and around the state, as well as the Minnesota Department of Human Services (DHS), in their ongoing work to address critical service gaps.

Region 1

Region 1 includes seven counties: Kittson, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau.

Region 1 has a population of 86,102 people, representing 2% of the statewide population (U.S. Census Bureau, 2015 Population Estimates). Twenty-six 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, 24 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 1 (https://edocs.dhs.state.mn.us/lsserver/Public/DHS-7302G-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.

Twenty-four stakeholders participated in the Region 1 meeting on May 9, 2017 in Thief River Falls, 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>4</td>
</tr>
<tr>
<td>County lead agency representative</td>
<td>10</td>
</tr>
<tr>
<td>Managed Care Organization representative</td>
<td>2</td>
</tr>
<tr>
<td>Service provider</td>
<td>6</td>
</tr>
<tr>
<td>Role not specified</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>24</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 1.
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. For most regional meetings, there were two small groups working on each population of interest. Because of the small number of participants at this meeting, only one small group worked on each population. 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 features of the services system that led to service gaps, such as workforce issues and complex licensing and regulations. Figure 2 presents the top four gaps determined by each group working on each of the four populations of interest.

2. Prioritization, round one - service gaps

| Older adults | a. Complex licensing and regulations for providers (245D, foster homes, housekeeping) |
|             | b. Early detection/early interventions (lack of medical diagnosis) |
|             | c. Transportation (for clients, for staff to rural areas, accessible transportation) |
|             | d. Workforce issues (low pay, lack of staff, minimal training/improper training) |
| Persons with disabilities | a. Respite both in home & out of home (Polk County says out of home is non-existent) |
|                         | b. Staffing (245D has affected number of [staff]; many service providers not willing to go thru process to become licensed) |
|                         | c. Wage and benefits for direct service providers (certain population available to do the work) |
|                         | d. Workforce/employment [for persons with disabilities] |
| Children with mental health conditions | a. In home and therapy wait lists |
|                                     | b. Inpatient/crisis stabilization |
|                                     | c. Trauma training/support for schools |
|                                     | d. Workforce (a.) respite (b.) psychiatric prescribers |
| Adults with mental health conditions | a. Individual Placement and Support (IPS) |
|                                      | b. Non-medical and medical transportation |
|                                      | c. Non-residential Crisis Services |
|                                      | d. Permanent Supportive Housing |

Note. The service gaps are not listed in rank order.
Prioritization, round two

Next, the small groups worked 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 1. 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>Complex licensing and regulations</td>
<td>Employment [for people with disabilities]</td>
<td>Inpatient/crisis stabilization</td>
<td>Individual Placement and Support (IPS)</td>
</tr>
<tr>
<td>Transportation</td>
<td>Respite</td>
<td>Trauma training/support for schools</td>
<td>Permanent Supportive Housing</td>
</tr>
<tr>
<td>Workforce Issues</td>
<td>Staffing</td>
<td>Workforce</td>
<td>Transportation (medical/non-medical)</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 1, each population group identified a service gap related to workforce and staffing issues – these were combined into a single “workforce issues” category. Additionally, the areas of “transportation (medical/non-medical)” and “transportation” were combined into a single, overarching “transportation” category.

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

- Complex licensing regulations/245D
- Inpatient/crisis stabilization
- Transportation
- Trauma training/support for schools
- Workforce issues
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 five 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 five 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.

<table>
<thead>
<tr>
<th>Service gap</th>
<th>Brainstormed solution(s)</th>
</tr>
</thead>
</table>
| Complex licensing regulations/245D | • Legislators need to visit each of their counties, [and] make a home visit to people that have been impacted by 245D*  
• Revisit why some services have to be 245D licensed. Why do chore services/homemaking have to be licensed for providing indirect services, and Personal Care Assistants (PCAs) do not?*  
• Rules and regulations—[there are] too many regulations; e.g., MnCHOICES assessment, for example, have to use it, is too long, exhausting for person being assessed, what are home and community-based services (HCBS) rules vs. licensing?*  
• Simplify—providers & lead agencies read websites but still have questions. Documentation doesn’t mean quality, have better luck googling information to find information in Department of Human Services (DHS) websites* |
| Inpatient/crisis stabilization-respite care | • Increase community awareness of what crisis services are available and how to access [them] (use of crisis response to prevent hospitalization)  
• Work with providers to increase bed capacity for various levels of need*  
• Recruit and train specialized foster care providers to provide respite for kids with mental health needs |
<table>
<thead>
<tr>
<th>Service gap</th>
<th>Brainstormed solution(s)</th>
</tr>
</thead>
</table>
| Transportation                               | • Lobby to the state to advocate for clients to coordinate transportation through their Prepaid Medical Assistance Programs (PMAPS) (regardless if they have a vehicle or not)*  
|                                              | • Make reimbursement [process] easier for friends and family to help provide transportation  
|                                              | • Increase reimbursement rate, so more family/friends would be willing to drive*     
|                                              | • More access to public transportation, i.e. bus stops at 5pm                           
|                                              | • “State money” for non-medical transportation to each county (kind of like flex funds)  
|                                              | • Recruit/reach out for volunteer drivers (especially in rural areas)             
|                                              | • Use Peer Support Specialist/Senior Companions for transportation                        
|                                              | • State funds for transportation of caregivers, e.g., Personal Care Assistant (PCA) driving 45 minutes there and back for homecare services |
| Trauma training/support for schools          | • Increase collaboration and communication. Money to collaborate between mental health (MH) [professionals] with school staff [as well as] dedicated space, funding, workforce*  
|                                              | • Education about mental health (MH)/trauma*                                         
|                                              | • Offer in-services                                                                     |
| Workforce issues                             | • [Offer] loan forgiveness for those entering [the] healthcare/human services field[s]  
|                                              | • [Develop] specialized tracks for high school students. Partnership with area colleges. Specialized, ongoing training  
|                                              | • Engage new Americans in [the] healthcare/human service fields                       
|                                              | • Focus on individuals age 55-64 (Pre-Medicare) to gain insurance. [As well as] engaging seniors, disabled, mentally ill into workforce  
|                                              | • Partner with larger employers and schools in the area (private sector) to aid in the search. [Emphasis in marketing the] flexibility of work schedules [in the field]  
|                                              | • [Offer] housing incentives to move to the area and work in the health[care] fields  
|                                              | • Increase wages for healthcare fields. [For example,] increase pay for longevity and/or training*  
|                                              | • [Increase] flexibility in licensing/regulation. Grouping services under umbrella organizations*  
|                                              | • Elevate the profession. Market the profession                                      |
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.

<table>
<thead>
<tr>
<th>Service Gap</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex licensing regulations/245D</td>
<td>Amend 245D licensure rule and/or exemption clause</td>
</tr>
<tr>
<td>Inpatient/crisis stabilization, respite care</td>
<td>[Develop] specialized homes for crisis</td>
</tr>
<tr>
<td>Transportation – medical and non-medical</td>
<td>Increase reimbursement rates and flexibility of payment options which will lead to regions being able to increase ability for recruitment of formal and informal supports</td>
</tr>
<tr>
<td>Trauma training/support for schools</td>
<td>Collaborate and communicate with school staff/providers</td>
</tr>
<tr>
<td>Workforce</td>
<td>Partner with community stakeholders, outreach to non-traditional workforce (semi-retired [not ready for Medicare], new Americans, etc.)</td>
</tr>
<tr>
<td>Workforce</td>
<td>[Implement] wage increases, incentives, loan forgiveness, housing incentives for entering healthcare/human services</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>
| Complex licensing regulations/245D | Amend 245D licensure rule and/or exemption clause | 1. Region 1 Directors and providers meet to discuss if this is an issue that can be supported  
2. Gather examples of negative impact on services  
3. Meet with Department of Human Services (DHS) to present/discuss information  
4. Meet with regional legislators to gauge their interest  
5. Write legislation  
6. Present to Minnesota Association of County Social Services (MACSSA) |
| Inpatient/crisis stabilization respite care | Specialized homes for crisis                  | 1. Invite stakeholders in region/counties who want to participate in developing crisis respite response  
2. Determine reimbursement rate for providers  
3. Determine recruiting strategies |
| Transportation—medical & non-medical | Increasing reimbursement rates and flexibility of payment options which will lead to regions being able to increase ability to recruit formal and informal supports | 1. Contact insurance companies to find out reimbursement options/criteria  
2. Brainstorm/identify community group  
3. Advertise/[conduct] outreach |
| Trauma training/support for schools | Collaborate and communicate with school staff/providers | 1. List key players to understand and re-identify partners serving kids  
2. Get on agenda of existing meeting  
3. Bring a topic to educate about what is going on in the agency  
4. Create a local collaborative |
| Workforce                          | Marketing and outreach, partnering with community stakeholders, outreach to non-traditional workforce (semi-retired [not ready for Medicare], new Americans, etc.) | 1. Bring the stakeholders together at a focus group meeting. Identify current stakeholders and start to break down silos/identify leaders moving forward  
2. Set up a meeting [to discuss] marketing, theme, promotion |
| Workforce                          | Wage increases & incentives [such as] loan forgiveness [and] housing incentives for entering healthcare/human services [field]. | 1. [Increase] state reimbursement for wages for Home and Community Based Services (HCBS) workers  
2. [Offer] loan forgiveness  
3. [Offer] relocation incentives, housing [in] rural areas  
4. Elevate status of caregivers |

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.
Attention. If you need free help interpreting this document, call the above number.

For accessible formats of this publication or additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-2600, or use your preferred relay service. (ADA1 [9-15])