Gaps Analysis Regional Meeting Summary: Region 4 – West Central Minnesota

Meeting held on May 15, 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 4, Minnesota’s west central economic development region. The purpose of this summary is to provide a resource for stakeholders in Region 4 and around the state, as well as the Minnesota Department of Human Services (DHS), in their ongoing work to address critical service gaps.

Region 4

Region 4 includes nine counties: Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, and Wilkin.

Region 4 has a population of 227,038 people, representing 4% of the statewide population (U.S. Census Bureau, 2015 Population Estimates). Twenty-eight 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 4 [https://edocs.dhs.state.mn.us/Ifservlet/Public/DHS-7302H-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-one stakeholders participated in the Region 4 meeting on May 15, 2017 in Fergus Falls, Minnesota. Figure 1 describes the self-identified roles of the meeting participants.

<table>
<thead>
<tr>
<th>Role</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/advocate</td>
<td>2</td>
</tr>
<tr>
<td>County lead agency representative</td>
<td>13</td>
</tr>
<tr>
<td>Managed Care Organization representative</td>
<td>4</td>
</tr>
<tr>
<td>Service provider</td>
<td>8</td>
</tr>
<tr>
<td>Role not specified</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</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 4.
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. Each small group was asked to determine the four most important service gaps for their population. Because of small group sizes, the two groups focusing on children with mental health conditions merged into one group. In lieu of service gaps, per se, some groups identified features of the services system that led to service gaps, such as a lack of early diagnosis or treatment and staffing shortages/issues. 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

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adults</td>
<td>Older adults</td>
</tr>
<tr>
<td>a. Mental health/cognitive issues: lack of early diagnosis, [and/or] treatment</td>
<td>a. Caregiver support/respite (in home/out)/adult day</td>
</tr>
<tr>
<td>b. Staffing (including volunteers)</td>
<td>b. Chore services</td>
</tr>
<tr>
<td>c. Transportation (medical)</td>
<td>c. Housing/home modifications</td>
</tr>
<tr>
<td>d. Transportation (non-medical)</td>
<td>d. Personal Care Assistant (PCA)</td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td>Persons with disabilities</td>
</tr>
<tr>
<td>a. Behavioral support</td>
<td>a. Lack of staff – Personal Care Assistant (PCA), foster care, respite care. Low wages, competitive employment</td>
</tr>
<tr>
<td>b. Housing – affordable and safe</td>
<td>b. Placement options for [people] with aggressive behaviors – sexual offenders</td>
</tr>
<tr>
<td>c. Respite care and crisis respite</td>
<td>c. Respite care – in home &amp; out of home, crisis respite</td>
</tr>
<tr>
<td>d. Staffing and staff retention</td>
<td>d. Transportation (medical and nonmedical)</td>
</tr>
<tr>
<td>Children with mental health conditions</td>
<td>Children with mental health conditions</td>
</tr>
<tr>
<td>a. Crisis stabilization</td>
<td>a. --</td>
</tr>
<tr>
<td>b. Inpatient child psychiatry beds</td>
<td>b. --</td>
</tr>
<tr>
<td>c. Specific placements for children with aggressive behaviors</td>
<td>c. --</td>
</tr>
<tr>
<td>d. Specific placements for young children under 13</td>
<td>d. --</td>
</tr>
<tr>
<td>Adults with mental health conditions</td>
<td>Adults with mental health conditions</td>
</tr>
<tr>
<td>a. Aftercare/community support plan (CSP)/community paramedic all-in-one</td>
<td>a. Community prescribers -- &quot;mobile&quot; (go to homes, etc.)</td>
</tr>
<tr>
<td>b. Communication pitfalls with prescribers. Inpatient, outpatient, primary care provider (PCP), non-traditional providers and collateral contact with insurance companies</td>
<td>b. Intensive Residential Treatment Services (IRTS)</td>
</tr>
<tr>
<td>c. Complex needs with multiple diagnoses and chronicity, flexible prescribers</td>
<td>c. Non-medical transportation</td>
</tr>
<tr>
<td>d. Transportation</td>
<td>d. Providers who will take the more complex chemical dependency (CD)-senior-medical-mental health [patients]</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 4. 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>Caregiver support</td>
<td>Housing – all kinds</td>
<td>Crisis stabilization</td>
<td>Community support plan (CSP)/community paramedic/nurse</td>
</tr>
<tr>
<td>Staffing</td>
<td>Respite, crisis and non-crisis</td>
<td>Specific placements for children with aggressive behaviors</td>
<td>Complex needs with multiple diagnoses and chronicity</td>
</tr>
<tr>
<td>Transportation</td>
<td>Staffing/staff retention</td>
<td>Specific placements for young children under 13</td>
<td>Prescribers</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 4, “staffing” and “staffing/staff retention” were combined into a single, overarching “staffing” category.

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

- Complex needs with multiple diagnoses and chronicity
- Crisis stabilization
- Staffing
- Transportation
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 four 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 four 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>
| Complex needs with multiple diagnoses and chronicity  | • [Enhance] preventative services: [for example, have] more trained, flexible staff; rotate Crisis Stabilization Unit (CSU) staff or do “ride alongs” with CSU*  
• [Improve] provider communication (Becker pilot [this approach])*  
• [Increase] technology options*  |
| Crisis stabilization                                   | • Create and implement crisis stabilization model/payment*  
• Increase mobile crisis capacity*  
• Increase funding and incentives to recruit staff (workforce issue)*  
• Create high fidelity respite care model/payment*  
• Serve the whole family, not just the child  
• Engage payers (health plans) to fund and partner on services  
• Develop effective strategies to engage families and kids for solutions  
• Engage schools in crisis stabilization solutions  |
| Staffing                                              | • Professionalize the field, credentialing [and/or] career ladders  
• [Develop] coaching/mentoring opportunities  
• [Develop] internships/partnerships with area colleges and high schools  
• Partner with West Central Initiative (WCI) in the “Live Wide Open” campaign (encourages people to return to lakes area to live and work)  
• Review background checks disqualification rules*  
• Focus on pre-Medicare individuals who work for health insurance benefits/mission driven focus  
• [Create an] umbrella organization for smaller organizations for training purposes  
• [Change] reimbursement* |
Brainstormed solution(s)

- [Replicate] Ready Ride model (West Central Minnesota Community Action Partnership)
- [Replicate] Traverse County model (driver background, given permission to use vehicle to [drive to] medical appointments)
- [Help] Minnesota Department of Transportation (MNDOT) [with] realization of public transit/rural needs*
- [Offer] perks for volunteering; e.g., volunteer X amount of times [and] you get gym membership or meal voucher
- [Employ] county-recruited paid volunteers

### 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 five 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>Complex needs with multiple diagnoses and chronicity</td>
<td>[Increase] provider communication/coordination with all of a person’s providers</td>
</tr>
<tr>
<td>Crisis stabilization</td>
<td>Serve the whole family, not just the child</td>
</tr>
<tr>
<td>Staffing</td>
<td>Diversify recruitment and marketing efforts</td>
</tr>
<tr>
<td>Staffing</td>
<td>Professionalize the field: credentialing, partnership for training, coaching/mentoring, adequate compensation</td>
</tr>
<tr>
<td>Transportation</td>
<td>Craft legislation to address rural transportation needs, removing barriers</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 needs with multiple diagnoses and chronicity | [Increase] provider communication/coordination with all of a person’s providers | 1. Educate clients on the benefits of informing all providers of involved healthcare workers in their care  
2. Educate providers on the importance of communication skills to inform clients of information more effectively  
3. Increase state funding for medical doctor (MD) and collateral contacts to be billable so that providers are able to take the time to communicate between them |
| Crisis stabilization          | Serve the whole family, not just the child                                | 1. Continue multigenerational project  
2. Engage families  
3. [Implement] family case management |
| Staffing                      | Diversify recruitment and marketing efforts                             | 1. Contact West Central Initiative (WCI) to get field added to Live Wide Open campaign  
2. Contact M State [about] opportunities for partnering  
3. Find out Costco’s recruiting plan for pre-retirees  
4. Collect potential social media stories – to have a mission-driving story to advance healthcare/human services field |
| Staffing                      | Professionalize the field: credentialing, partnership for training, coaching/mentoring, adequate compensation | 1. Identify all associations  
2. Meet with Institute on Community Integration (ICI) – they have a presentation  
3. Bring to different associations for their buy-in: (public health (PH), mental health (MH), Minnesota Association of County Social Service Administrators (MACSSA)).  
4. Present to Department of Human Services (DHS) (all associations as united group; includes compensation, 245D, [and] enforcement) |
| Transportation                | Craft legislation to address rural transportation needs, removing barriers | 1. Bring together the Human Services Directors with public transit  
2. Create a legislative strategy  
3. One-to-one visits with legislators  
4. Invite legislators in [to the process]  
5. Complete legislation |

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.