DEPARTMENT OF HUMAN SERVICES

Adult Mental Health Initiatives Funding Formula Workgroup Meeting

Details

When: October 27, 2021, 1:00-3:00p

WebEx Only, meeting access code: 1465 10 9457, meeting password: AMHI. **This is not an in person meeting.**

Agenda

- Housekeeping, reminder of shared goals and group norms – 5 minutes
- Review of Social Determinants of Health (SDOH) and Medical Risk survey results, questions and discussion – 15 minutes
- Complete SDHO and Medical Risk Priority Matrix – 15 minutes
- Review of Area Deprivation Index (ADI), questions and discussion – 15 minutes
- Complete ADI Priority Matrix – 15 minutes
- Review definition of "Rural," questions and discussion – 15 minutes
- Complete "Rural" Priority Matrix – 15 minutes
- Next steps – 25 minutes
    - Follow-up actions from this meeting
    - Plan for final meeting, questions and discussion

The next meeting scheduled for 11/10 from 1-3pm is the final meeting of this workgroup. We want to thank everyone for the difficult and collaborative work happening for AMHI Reform.

Meeting Summary

Review
- Reviewed standing housekeeping items around meeting participation.
- Brief review of workgroup's norms and shared outcomes
- Clarified some points around the data:
    - There is no risk of too many variables interacting with each other in a negative way in the model as it is built. That was addressed during the build.
    - Values/weights placed on formula variables are being recommended by this group.
    - All variables could have some weight assigned, some could have none, and some could have very high weight assigned.

Prioritizing social determinants of health
- Brief review of the priority matrix and methodology we previously used during September meetings.

- Reviewed a drafted priority matrix for the 5 social determinants of health and medical risk variables. This matrix was compiled based on survey responses from the workgroup that were completed between the 10/13 and 10/27 meetings.
  - There were 12 responses to the homework assignment survey.
  - Looks like SMI/SPMI is both highly relevant and highly responsive based on the responses we received.
  - SUD, felt it was high relevance and highly responsive. Deep poverty is in this area as well, more in the middle.
  - Perhaps still relevant and still responsive but perhaps less so was medical risk and homelessness.
  - On the other spectrum is past incarnation. That was plotted as low relevance and low responsiveness.
  - Keep in mind – not everyone responded or submitted a response. Opportunity now for the group to weigh in.
- Any thoughts on where some of these variables should land?
  - Shauna: why is medical risk a different color?
  - Ashley: I separated that out because it's a different kind of data, done through ACG scores not SDOH data. Also, would like to orient the group to why there's light and dark green for the SDOH variables. I looked at both where respondents plotted the variables and also responses to the question "should it be included." The darker colors had the highest scores. The lighter colors had lower scores. And then none of the variables were noted as not being included. All were recommended to be included, but to varying degrees.
  - Elisabeth: And that includes past incarceration?
  - Ashley: Yes. Respond to still include it, but it was rated as being low relevance, low responsiveness. However, the group still has the option to decide among that. The group has a couple of options for how we could approach the social determinants of health in terms of how to prioritize them.
  - Shauna: Past incarceration, on its own does make sense there, but it does impact homelessness for example. So it's not one that stands alone, but it definitely connects with some of those others.
  - Shauna: I'm curious about the SUD not being a darker green, just knowing the high percentage of co-occurring. Seeing it here on the matrix, I would've thought that would've been a darker green given the impact that SUD has.
  - Ashley: that was one was kind of in the middle in terms of inclusion, and I think that speaks to the challenge of co-occurring and the funds being adult mental health.
  - Amy: I looked at it through a county lens, and to me, it's 2 pots of money, so I'm taking it as, this is AMHI funding, so SUD isn't going to be front and center.
  - Tim: I would say we view it pretty similar.
  - Elisabeth: is there general consensus then that this is where you would keep SUD on the matrix?
    - Support to keep it where drafted (based on thumbs up entered into WebEx)
  - Elisabeth: I know another issue that had come up in past discussions has to do with past incarceration. What are the thoughts around where it landed on the matrix?
  - Tim: Are we still clear that this is the prison population and not the jail population?
  - Abbie: this is reported to MA as having been incarcerated in the prison system in the past. Not current, but in the past.
  - Tim: from that perspective, I think looking at local jail population would be more telling than past prison incarcerations.
  - Kesha: I agree with Tim, and that's why I rated it lower. In the comment box I said that I think incarceration is relevant, but with the data source we're using that's why I rated it lower. If we're looking at jail, I would have maybe placed this differently, but with the data,

- you know, as we determined last time that the data points are set if you will. So, for me, that's why I placed it where it was because it was that prison focus.
- Shauna: Quick question. So the data source that we looked at is about past prison incarcerations, right? As we look at setting the weight of social determinants of health. Is it the combined score weight, or is each one weighted on its own?
- Ashley: They each get their own percentage assigned to them, but those do get blended together to a degree.
- Shauna: Ok, so if we set the weight higher, knowing that the jail population is more significant, even though it's not factored in this number, would that kind of extrapolate a little bit toward a jail population?
- Ashley: so using it like a proxy?
- Shauna: Yes, so if we used it as a proxy and weighted it more, could it be used, to meet the needs we're talking about? I agree that jail would be more significant.
- Abbie: you could consider this a proxy for jail, it's not a 1:1 obviously. But people do enter the prison system by entering the jail system first. So that is an option.
- Ashley: Just to know some options, when Mike built the model, he put in all the social determinants of health on their own, but he also built in pre-created blends: total social determinants of health combined together, and one that is 'any' which is slightly different. The idea being that if the group felt that all are important and equally so, you could use the total measure and set one weight. If you felt that all are important but at different levels, we could look at them this way and set weights for each individual one. If you feel that only certain ones should be called out, for example the two in dark green because they have the highest score for inclusion, you could say just those 2. So you can think about that as we're looking at this too. To conceptualize it, showed an example of what a total score would look like on the matrix.
- Elisabeth: Should we maintain past incarceration in this section of the matrix?
    - Agreement via thumbs up in WebEx
- Elisabeth: Great. Just to go back, don't want to overlook medical risk and homelessness and where they were plotted on the matrix from those who responded. Does anyone want to speak to that?
- Shauna: I think that I put it there as relevant to the mission and from a community perspective, looked at it from access. Many times, if an individual can't get access to MH services, they might be seeking their primary care provider for medications. And then knowing the somatic impact that mental health has on overall physical health that people are experiencing is pretty high and just looking at where these funds, in helping support people with their mental health and helping them get connected with medical care, could help potentially decrease other costs in the system across the state. That social determinant factor of access to medical is pretty important and high. Probably not as high as SMI/SPMI but definitely in that same quadrant because of that interconnectedness to overall health care.
- Elisabeth: other thoughts or points of view?
- Abbie: Just a reminder, the data for homelessness is self-reported to medical assistance. It is not the point in time count. This is what is reported to MA as far as a person's housing status.
- Elisabeth: Is everyone in agreement that medical risk and/or homelessness are relevant to the mission and very relevant to the community issues, and so should be plotted there? Or are there other perspectives or concerns? If looks good to you, let us know, gives us a thumbs up.
    - Agreement from the group
- Shauna: So if folks were looking at homelessness as a point in time instead of as a social determinant of health, would people keep homelessness still at that lower end of that

quadrant? I'm curious because I would personally like to see it higher. I think it belongs in a dark green category just given the impact that it has. So I'll be an outlier and I'm not a thumbs up on that.

- o Elisabeth: that's a great question. If you don't think about the data. The data for us is an administrative expectation or requirement, because we have to have something to input into the formula to make some determinations. But if you just look at it in terms of a social determinant of health, where would you plot it on this matrix? Would it be higher as Shauna said, or would you put it somewhere different?
- o Chuck: I think it's the same argument you have for the incarceration one. Given the data sources available, you do have to factor that in. I don't know if DHS has a real good way or anybody has a real good way on a lot of these, and we've talked over and over about getting good data. And I think the data, while an administrative necessity, is a challenge to moving anything on here. I think the group did a good job identifying the 2 probably most significant or top 3. And then the whole thing with the chemical and mental health divisions not using the money for the other when they both impact people, at least equally if not significantly. This is a good representation of where the group's at.
- o Elisabeth: Any other thoughts?
  - ▪ None.
- o Elisabeth: Are we ready to move onto the next page?
- o Ashley: I think I just want to get confirmation from the group. Is your recommendation that we use all of these at these priorities? So, all are in the formula, but with their own weights so to speak?
  - ▪ Thumbs up from the group.

Area deprivation index and rural allocation discussion

- Something that we looked into because we're trying to find something that would get to those nuances of service access and delivery, the differences that really impact access for someone experiencing mental illness.
- The Area Deprivation Index is a measure of the neighborhood socio-economic disadvantage, and it's a vetted and reliable updated source. It is currently managed by the University of Wisconsin.
- It uses census data as well as the American Community Survey data. It drills down to that 9-digit [zip code] neighborhood level. So that can show that even within a town, there are multiple different neighborhoods that have different access scores. It allows us to account for those nuances that are present in certain parts of the state that population and social determinants of health alone could not get at. How the actuarial built this into the formula, he averaged out the scores for each community and applied a weighted ADI score that reflects the relative level of socio-economic disadvantage with that region.
  - o It's not saying that if one neighborhood within a region has a particular score, then the entire region has that score. It's a blend of the scores across that region to get a final score.
- Any questions about ADI or the resources shared?
  - o None.
- Showed the map of the ADI scores across the state and oriented the group to the color and scoring key for the map.
- Any questions or concerns about incorporating this into the formula? Like we said, it looks at the income, education, employment, and housing quality within that neighborhood unit. It's a source the team found that we were hopeful could be a way to try to get to all those other factors that we can't always find a way to capture or measure.
  - o Shauna: It's interesting that going from the metro area heading toward Fargo, in those lighter colors, that's I-94 corridor. So when you've got major interstates and larger cities that have higher economic impact. I think, where the major thoroughfares within the state are.

- - Ashley: and even within areas you can see variation. So you know, even within those large population centers (highlighted Hennepin and Ramsey Counties), you get some variation at the neighborhood level.
  - Chuck: I just want to make sure – so for the purposes of the formula, a red area would get preferential funding over a blue area?
    - Abbie: if you pace the value on ADI in the formula, yes. More funding would go to those regions that have more red areas than blue areas, based on how you weight this on the formula.
    - Chuck: when you look at development and state resources, this map kind of represents that. When you look at the Duluth area with the ACT teams and other areas with state hospitals and facilities, or CBHH, when you look at other things, it's kind of representative of that. This could get to some of the issues that I have with that not being considered a factor.
  - Tim: are you weighting this off the population of those areas, or number of those neighborhoods identified versus the number of people in those neighborhoods?
    - Shauna: I thought it was looking at economic and housing and resources, which could have an impact based on population. If you don't have as much population, you're going to have less economy, right? And you're going to have to have, you know, some of those pieces. But my understanding is that population is its own factor, and this is about the infrastructure pieces within that area.
    - Tim: seeking clarification on how it's weighted. How is that being considered within the formula?
    - Ashley: It's a score, so a blended score for a region so to speak. The formula does the math to connect the blended score with the other variables and how they're set up.
    - Abbie: Like Ashley said, it's a weighted score. So it averages the ADI scores across the region and provide an averaged score for that region. It's not about the number of people living there, it's about all of those factors that go into that score.
- Other questions related to ADI? If not, we can go on to prioritizing this on the matrix.
- [viewing priority matrix] Any other questions or concerns, or are you ready to put some ideas down? How useful do you think ADI will be in the formula?
  - Kesha: I think it's important in there. I think it should be a factor included in there. It goes hand in hand with the rural allocation piece, because as you can see metro is heavier on the low end, the blues, and outstate was more red. It associates to the rural and also looks at some of the other components with accessibility. I think we should use it as a factor.
  - Elisabeth: where would you plot it?
  - Kesha: I think it's responsive to the community, so I would plot it high there. I think the relevance to the mission could go either way. So for me, it would be high responsiveness to the community and then either direction for relevance to the mission. Because it wasn't necessarily mental health base but we know some of the factors influence that. So yeah, middle I guess.
  - Elisabeth: any other thoughts on ADI? Did something jump out at you when you first looked at it that might influence where you'd plot it on this matrix?
  - Amy: This is Amy from Region 2, and there isn't a blue spot in my region. So it's very relevant and if I were to put it anywhere, it probably would be high relevance, high responsiveness because it would fuel everything.
  - Shauna: I would agree with Amy as well, but looking from the mission and just looking at the factors that may not be directly mental health related, but they're all factors that get to access and in terms of someone being able to have the ability to get what they need within that region.
  - Chuck: I agree with Amy, it's right on.

- o Kim: I agree as well.
- o Tami: Yeah, I think it's a nice way to look at a region and be able to determine, like Amy mentioned where she doesn't have any blue, I feel like it's making sure to look at the whole area and not just a specific county.
- o Marty: I noticed when you zoom in to the metro area, there are pockets that are all red. I didn't ask this earlier and I went to the website, but this doesn't really address the impact of race and ethnicity on population, but you can glean from the maps the concentration of poverty. It's certainly a valid measure. I don't know if the population measures get weighted along with the poverty measure, but it's certainly going to impact people's access to services.
- o Elisabeth: it sounds like there is high agreement that there is high relevance and high responsiveness. Am I reading that right from this discussion? Give a thumbs up.
  - ▪ Multiple thumbs up responses.
- o Abbie: Thank you everyone and we'll be sure to look again very closely at the formula so that we're best able to explain it in our final wrap up meeting. Just so that everyone is in agreement and understanding of how that is calculated into the formula, so more homework for AMHI team to do, and we'll hopefully be able to explain that even more clearly next time. So thank you and Marty, you bring up some very good points about not really measuring the demographics, the regional demographics. Unfortunately, we have not found a good data source on that at all. So some of these things are proxies, and kind of getting to that in a roundabout way. But it's definitely something that we want to make sure that we are recognizing within the formula and we hear those concerns very loud and clear.

Rural factor
- As you know, defining rural is very difficult to do because there is not one true definition used across the board for everything. What we did find is that the Minnesota State Demographic Center, Minnesota Department of Health, and Minnesota Department of Agriculture, along with HRSA, the Health Research Services Administration, federally, use the rural-urban commuting codes to define rural and urban.
- There was a lot of information included, especially that report from the demographic center, it was a very long detailed report. So the RUCA class of codes say 1-10 delineate the metropolitan, micropolitan, small town, and rural community areas and the direction of their primary commuting flows. Are people commuting into them? Are people commuting away for things like work, education, service access? This also is getting at that access to service, those needs that ADI is getting at, but in a more population focused way. MDH uses codes 4-10 to issue rural health grants in the state of Minnesota. So anything that is 4-10 gets counted as rural. For purposes of the formula and in general, these codes allow us to account for the rural pockets that might occur in an urban county.
  - o For example, Dakota County is a large geographic county. It's also a very diverse county that includes all kinds of communities within its boundaries. For the formula, we could average the RUCA scores for Dakota County and get a combined score. So counties with higher rural pockets would have higher weight on the rural factor, but counties that have more of a combination of rural and urban would still have rural accounted for, but it would be a lower weight.
- This is something that is updated. It uses census data and it also uses the American Community Survey data, so it uses every 5 years of information.
- [showing MN map of RUCA scores] Oriented to the map and explained how the scores land across the state. Of all of MN, there are only 14 counties that are considered rural. There are only 13 counties that are considered urban. All the rest are a mix.

- So the question we have, how do we define rural for our formula? Should these codes be used for that purpose?
  - Amy: When you look at the regions, you're going to have a mixed bag, I don't think you're going to have 100% rural. The way they're divided up into small, medium towns. This map depicts community, not county. When I look at the northern tier, those aren't county lines.
  - Abbie: No, it measures again at the census tract. So that neighborhood level, and you're right, some regions are going to have a large mix. What I'm seeing here is that if you look at the legend, the 4 through 10, some regions are going to have a predominantly rural factor and others will have a predominantly urban factor. So if you average that out and blend it, it won't be all or nothing. It won't say, Sorry Dakota County because you touch St. Paul you don't get anything even though we know that there are parts of Dakota County that don't have cell service.
  - Shauna: No, I think the blending, if you took this map and plotted the regions on top of this and did some kind of average or blend of those scores end up looking like for that region, might make sense. I like that it is going to be sensitive enough, for those counties that have all 3. And then from a weighting perspective, I'm wondering if there's a way to take the 1-10 and break it up. 1-3, 4-6, 7-10, or something like that to weight or group. Groupings could equal some weight. Thinking out loud.
  - Chuck: For me, you almost have to do the regional thing and see how they come out. I'm trying to wrap my head around this. Like you said, it'll account for the variation. So I think you need to do the AMHIs first.
  - Abbie: We have confirmed that it can be done within the formula model, as it functions right now. Hopefully we'll have that built in by the next meeting. We wanted to make sure this was a definition that people were in agreement on, and then take the time to build that into the model. I'm hearing people are in agreement with using the RUCA codes as our definition for rural.
    - Thumbs up from the group.
- Let's go ahead and do preliminary plotting. We can of course revisit it after seeing how the codes apply within the model.
  - Tim: which year is this data based on? Last one I think I saw was 2017. Is this newer than that?
  - Abbie: It was based on the American Community Survey from 2010-2015. So it averages the data from 2010-2015. New information should be coming out soon I would think.
  - Ashley: And we'd be able to update the data going into the formula once we have it.
  - Chuck: Again, this goes back to the issue that we have no perfect data to measure anything so far. And this is just another example of it.
  - Abbie: Perfect data doesn't exist. We do our very best.
  - Chuck: I'm not faulting you. It just doesn't exist.
- Prioritizing rural factor/allocation in the matrix – where does it fit within the matrix? Is there relevance to the mission and how responsive is it to community?
  - Amy: this is a tough one because the relevance, it's relevant to me and to region 2 and other regions, but is it relevant to other regions? And how do you address that as the facilitators of this group? Say its high relevance to 50% of this group and the rest say no, it's not relevant to me.
  - Kesha: Well, that and I kind of hear this again where we weight population, this is the other side of population. If we give population high or lower, you know there's extra barriers and cost to accessibility and all that stuff that we kind of talked about. So I go back and forth in my head, but I feel that I would agree with Amy that it's relevant.
  - Elisabeth: when you say relevant, to the mission? I assume you mean it's very responsive to the local community issues or concerns. Where would you then plot it on the matrix as a whole?

- o Amy: I would say high middle. You know, in the last 18 months we've had lots of conversations about equity and access. Here's the thing that I'm growing tired of hearing. We have to improve access for rural communities. But no one throws money at it to solve the problem. We have a lot of meetings. I attend a lot of meetings to discuss access. But there is never a solution that comes on board. If you were to allocate extra money to rural AMHIs and you gave those AMHIs flexibility to improve access without us having to put it in a box that was determined 20 years ago, I could solve a problem in my county. You could throw money at a problem and you could solve it. This group, we could solve some problems.
- o Shauna: And I think that's where I struggle with it even being in the middle there. I go back to access, in a rural area how relevant that is to the mission, of providing services and resources to people within our community. I would like to see it further over to the right. From a population perspective, I would say if population is high, then it would kind of wash it out a little bit, from that fear of a perception factor. So, you know when you're looking, using rural factor is important. I'd be remiss if I didn't channel my human service director, Kathy Johnson from Kittson County, to say rural is one thing, frontier is another. Frontier is another even more, there's even less people than rural factor.
- o Chuck: I- just want to throw in, one of the challenges faces, is that the feds want to see equal access to services across the state. DHS does a great job of getting waivers and programs and stuff, and then in rural areas there isn't a population to serve them. The AMHIs fill that gap and give some equal access to individuals across the state, which I would think would look good to the feds. I just want to put a plug in for Amy and solving local county or region issues. This is a funding stream that can help mediate some of the differences and access to providers again.
- o Abbie: And a reminder, we don't have to worry about the federal funding piece. 100% of AMHI funds are state dollars. So yes, we in theory should be able to provide based on the needs of the communities, the differences between rural and metro. Other thoughts on how to prioritize rural?
- o Marty: You know, I'm ok with how it's positioned. Maybe it's the corrective needed to balance out some of the urban areas. Some of them will look pretty need in other categories, like population and social determinants, and if this mitigates some of this, then it makes sense. My only concern is that if you have extra dollars, it's still a workforce issue if you're going to hire to expand the service and we're, statewide certainly, I imagine it's not just an issue for Hennepin County, we're having trouble hiring case managers, ILS workers, you name it. I put an article in the chat (Rural-urban mental health disparities in the US during COVID-19). I know there's a lot of workforce work done, and I don't know if that's available to look at per region or county. What's the percentage of people or disciplines, I don't think it's gotten any better.
- o Elisabeth: so, it's sounding like the rural allocation, rural factor, has a high importance high relevance and is an important factor for being responsive to the community issues. It looks like that everyone's in agreement. Can I get some confirmation?
  - ▪ Thumbs up from the group.

What comes next?
- Thank you everyone. And Marty, that article is very interesting.
- Next meeting is scheduled for November 10. At that meeting, our intent is to review the priority matrix to date, reviewing all the variables and looking at it from the big picture perspective. We'll hope to finalize the recommendations and priorities from this group.
- Then we'll run some scenarios with the model. So we'll pull the model back up, which should be updated by then too, and we'll start assigning weights based on these priorities. You as a group can

decide if they're the final or we're just trying out different combinations. We'll see how those priorities play out on the allocations as a group in real time.

- The goal for that meeting is to come away with some decisions, setting those final recommendations based on the priorities. If we're able to set some of the specific weights, that's a bonus in addition. And then, looking back over the recommendations the group has made for the legislative report, and if there are other recommendations that the group would like to discuss or include. So Chuck, if you recall at the last meeting, we talked about that, if there are other things outside of this funding formula, that can be a discussion point. That probably requires an additional meeting to do that, so if the group decides to commit time to that, we'll do it, it would just have to be before November 30th, so keep that in mind.
- And then we hope to also celebrate all the work that has gone into this. This has been a lot of work, a long process, and we're not done yet. But we're getting to a funding formula with priorities, so it's still a pretty big deal.
- We'll send things to the group ahead of time, so the group can see how it's all coming together before then.
- Any questions with next steps?
  - Kesha: I just have quick question. You said we'll develop the priorities on it if you will. Is that saying we won't, I thought it said if we have time we'll set the percentages on it? Is it correct that this group is responsible for the percentages as well?
  - Ashley: We're kind of leaving it to how the discussion goes and if we're able to come to that point. It kind of depends on once we see it all together and in the model. So if the group feels comfortable saying, ok we're going to put 25% on population, then we'll write that down.
  - Kesha: So this group doesn't decide that then it would go back internally to the smaller behavioral health division group to decide that.
  - Abbie: Yes and no. The recommendations from this workgroup, no matter what, are going into the report to the legislature. DHS will take into consideration all of the recommendations that are coming out of this group for determining that. Ideally, this group comes to agreement about the percentages that would be placed on the variables. What Ashley was saying is that if this group can't come to agreement on those exact numbers, that's ok. We will still have the agreement of this is a high value, high weight, this is a medium value, medium weight. It's really how you all determine the final product that you're comfortable with sharing. If that makes sense.
  - Kesha: Yeah, it does. And I would just really advocate for this group, I think we can come to some consensus because I think how we've kind of placed those boxes, we've kind of figured out things out. I think it's important that this group gets to set the percentages too.
  - Ashley: Absolutely, that's our hope for this group too. It's just recognizing too that these can be complicated conversations. When we first talked about getting to percentages in our first meeting, that seemed like a really daunting task. We're flexible with where we land, we'll have your recommendations either way. But I think we can get there too.

Wrap up and review of the meeting
- Reviewed what we had covered throughout the meeting.
- Reviewed what worked well this time around:
  - Survey ahead of time
  - Large group discussions