Acute Psychiatric and Residential Care

Final Report

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Executive Summary

Much has been said about the ongoing challenges faced in North Dakota with the mental health delivery system. There have also been numerous studies on the system over the past decade. This report attempts to synthesize and prioritize the recommendations made in previous reports and outlines a clear implementation road map of the acute and residential psychiatric beds needed to move North Dakota forward. Policy recommendations will be made throughout each focus area for consideration to strengthen the behavioral healthcare delivery system.

The initial charge in the Request for Proposal (RFP) was as follows:

1. Development of options and recommendations for a long-term plan for acute psychiatric hospitalization and related step-down residential treatment and support needs in the state, including:
    a. The number of acute care beds needed in the state.
    b. Appropriate locations in the state for treatment and support services, considering workforce availability.
    c. Involvement of private providers, including contract requirements, treatment requirements, and outcome measures.
    d. The use of existing public facilities and the need for new public facilities, including options to replace the existing State Hospital facility with one or more treatment facilities focused on forensic psychiatric evaluation and treatment.
2. Development of options and recommendations for a short-term plan for the remainder of the 2021-2023 biennium and the 2023-25 biennium to contract with private acute psychiatric care facilities to provide appropriate treatment services in four or more cities in the state.
3. Development of options and a recommendation for the future use of facilities at the State Hospital, including the LaHaug Building.

Three main reports referenced for this work were completed by Human Service Research Institute (HSRI) in 2018 and 2020. These reports include:

North Dakota Behavioral Health System Study, April 2018
HSRI North Dakota Hospital Study, March 2020
North Dakota Residential Treatment Facility Capacity, Oct 2020

The needs in North Dakota are great. Now is the time to act and implement necessary changes, and not return to study them or shelf them in another report.

The solutions outlined in this report include access to acute psychiatric and residential beds, data management and implementation strategies. One theme throughout the document will coalesce around the need for mental health levels of care being spelled out and defined in code for both public and private providers. A second theme is that after several years and multiple recommendations of consultants, there is a clear need for putting in place a dedicated team focused on implementation and support of the work of the future Department of Health and Human Services to make these recommendations a reality.

Solution #1: Access to acute psychiatric and residential beds

This should not come as a surprise, North Dakota needs a modern state hospital. The deterioration of the existing campus, mounting deferred maintenance, inefficient use of space, shared prison foods and intimidating barbed wire all around are just a few of the many reasons a new hospital is warranted. North Dakota needs a facility dedicated to its citizens that specializes in court-mandated, forensic care and persons with complex needs unable to be cared for in the private sector and their local community.

What might be a surprise is that the state has enough acute hospital beds. Many are in the wrong locations and shared with out-of-state placements. Critical access hospitals across the state must be equipped to assess, stabilize, and transfer mental health and substance use patients to appropriate levels of care according to federal law. The use and reimbursement of telepsychiatry in these hospitals can make it possible promptly. The state hospital should not be providing acute psychiatric stabilization for the Jamestown and Devil's Lake region. These services should be removed from the State Hospital and moved to the local hospitals to fill this gap.

Another surprise may be that the state has an adequate number of residential beds. Changes need to be made in the reporting and definitions of the actual levels of care available. The application process needs to be streamlined to make sure people can access the beds that are available at the right time. The state is already making progress in this area and needs to continue that work.

The state needs to codify the transformed purposes of the state hospital and human service centers. The vision for each has changed, yet the regulations do not reflect it.

In addition, the state has created a huge regulatory mess with the addition of "geropsych" contracts to existing nursing home facilities. The creation of separate regulations for this specialized level of care would provide clarity and ease delivery of this service and not be at odds with the Centers of Medicaid and Medicare Services (CMS) requirements.

Levels of care for mental health need to be codified in the same way as it has been for substance use disorder. A philosophical shift to person centered care is advised. Behavioral healthcare is healthcare. Silos separating addiction treatment from mental healthcare is not best practice or person centered.

Finally, contracts for hospitals and providers must include person centered language of no eject/no reject for patients. All hospitals should be equipped to provide short-term stabilizing behavioral health treatment. This would effectively end the "patient dumping" that is all too common today.

Solution #2 Data Collection and Validity

There is no accurate comprehensive mental health data in North Dakota. Data is not available or understandable, and if able to be obtained, is limited and lacking validity due to missing and/or misidentified fields. There is no way to verify data points as it is often from one source and cannot be verified from any other source, making data meaningless and appearing subjective.

This creates a misunderstanding that fuels debate across the state. Legislators expect data but what is available is siloed, not attached to funding, and not easily accessible. This leads to each department, agency and others creating their own data points that no one can dispute.

What is needed is a comprehensive data collection system that can include private and public providers along with funding. Having a state audit of the state hospital, human service centers, and contracts would be one way to start getting objective information on where monies are being spent, on who and for what levels of care.

One critical piece of improving data collection is that all hospitals and providers, public and private, need to use Medicaid for billing whenever appropriate. This would ensure better data across all dimensions. This requirement needs to be included in all contracts that use public funding. In addition, hospitals, providers, and funders must be required to submit agreed-upon data to the state so that the future Department of Health and Human Services could have accurate meaningful data to report to the federal government.

Solution #3 Implementation

Over the past decade many consultants have been hired, committee meetings held, and reports written about the issues facing the behavioral health system in North Dakota. In some areas, progress has been made. In others, the state looks to many like it is moving backwards. Moving from study and evaluation of a problem to change implementation can be challenging.

Maintaining focus on the needs to support a functioning system and its ability to adapt can be daunting. It is now the time to do the work of implementation. We believe a dedicated team of professionals with one focus will be needed to push the system forward, oversee the integration, and report back success and barriers along the way. It will take a team of 3-5 specialized implementation experts from various disciplines focused solely on this work for the next 3 to 5 years to achieve maximum potential. The fear is if a dedicated team is not put in place with resources to achieve progress, this report will simply become a “Report On A Shelf.”

In addition to building the state hospital and codifying changes to the purpose of the state hospital and human service centers explained above, there are three other critical pieces needed to be implemented: telepsychiatry; communication and collaboration; and practitioner certification, licensing, and workforce.

Maximizing the use of telepsychiatry in all settings is critical for the creation of a seamless system. Full-service telepsychiatry providers can provide services in all critical access hospitals and jails

across the state utilizing North Dakota licensed providers. In addition, the provider can assist in the location of beds and transferring patients to the proper level of care, while collecting much needed data in the process. Examples of the services and costs have been included in the report. State regulations must be changed to fully implement this strategy and to make sure providers are reimbursed in the critical access hospital setting appropriately.

Finally, we offered several regulatory changes in practitioner certification and licensing that would enhance the necessary workforce solutions needed in the state. The first change is to require the state to manage and have oversight of all licensing boards. Licensing boards run by volunteers are not appropriate for this critical piece of workforce development. Second, consideration of state composite boards where more than one license or certification is covered under one board is common across the country and needs consideration. Finally, exploring the use of universal licensing requirements would go a long way in increasing workforce options in behavioral health.

Conclusion

North Dakota needs to implement the following takeaways to create a behavioral health care system for all North Dakotans.

Build a modern and efficient state hospital.

Develop and fund short term/emergency acute psychiatric beds in critical access hospitals.

Clarify Administrative Code 33-07-01 that emergency stabilization of behavioral health can be provided in all emergency departments in all hospitals.

Codify and update the purpose of the state hospital and human service centers.

Create regulations defining behavioral health levels of care.

Improve contracts with hospitals and providers to include the language of

- no eject/no reject.
- requiring the use of Medicaid funding when eligible.
- expecting data when using public funding.

Clarify and maximize the use of telehealth to bolster psychiatric services in all areas.

Dedicate an implementation team to lead this project to completion.

North Dakota does not have time to continue to study this issue. Everyone knows the challenges. It is time to act. The public and private providers must work together to create a behavioral health system of care that every North Dakotan, no matter where they live, their age, gender, or the color of their skin, can access. Now is the time to implement the system changes to prepare you for the century ahead.

Solution #1 Access to acute psychiatric and residential beds

North Dakota needs a new state hospital with specifically defined levels of care requirements. Additional acute psychiatric beds and crisis stabilization beds across the state are also needed to meet demand. The state hospital is necessary as it is the only facility dedicated to serving North Dakotans. The hospital is responsible for caring for those under state jurisdiction including those court-ordered for treatment. And should only specialize in court-mandated treatment and in persons with complex needs.

The International Delphi Method on the optimal number of acute psychiatric beds is 30 per 100K. In the state of North Dakota, this would mean 231 beds. This number would include dedicated state hospital beds and private psychiatric beds. The report continues that anywhere below 15 beds per 100K are considered a severe shortage. At the time of this report considering continued limited capacity, North Dakota exceeds 231 acute psychiatric beds.

If all private beds in North Dakota served North Dakotans, the International Delphi Model shows that the state has an optimal number of beds. But, if up to half of the private sector beds are used by persons from out of state, this puts North Dakota into a mild to moderate shortage of beds assuming 75 acute beds at the state hospital maintaining their current 2021-22 average census. Choices by private providers to maintain beds that serve North Dakotans play a key role in the availability of beds in the state at any given time.

ND actual Adult Acute Psychiatric Beds	**Private ND Beds that are accessible to out of state patients limit ND resident access**
244	160

Excludes contracted out of state Hospital-based DETOX not available in the state
Assumes 75-bed capacity projection at ND State Hospital
Assumes Prairie St John new facility starting capacity projection 10/2022
Assumes other hospitals pandemic related capacity reductions remain in place

There are 3323 total hospital beds across the state of North Dakota, less than 8% are currently capable of treating Acute Behavioral Health Conditions in a resident home community.

The HSRI North Dakota Behavioral Health System Study, in AIM 4 discussed the importance of building an outpatient and community-based service array. The more community-based services and beds are created, the fewer state beds would be required. In addition, AIM 5 of that same study referenced the need to enhance the systems of care of children and youth. Again, as community-based services and supports are built out including crisis services for adolescents and youth, fewer beds would be required.

In addition, residential beds (which are lower acuity levels of care designed for individuals struggling with mental health conditions) need to be accessible statewide. This development can follow the successful adoption of the American Society of Addiction Medicine (ASAM) Criteria which is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions. In addition to this specific mental health levels of care should include crisis stabilization, subacute, intensive residential, and acute levels of care.

An important consideration is that nationwide, mental health and substance use treatment are no longer treated as separate conditions. Research shows that half of the people with a substance use disorder have a comorbid psychiatric condition and vice versa. To build out a behavioral health system faster, we would recommend adding the co-occurring/multi-occurring components to your existing substance use treatment beds. Several successful providers in the state are already doing so.

1.1 State Hospital

North Dakota needs a new state hospital. And it needs additional short-term acute psychiatric beds across the state. The situation in North Dakota at this point is not either-or. Both types of beds are needed across the state.

The condition of the sprawling state hospital campus and the sheer amount of deferred maintenance makes this decision obvious. A new hospital, redesigned specifically for the targeted population recommended here, would be a great step forward in the state. It would also consolidate staff and keep them connected in a more centrally located fashion that would allow them to work across units more safely and efficiently. We agree with the HSRI recommendation that a new hospital is necessary and warranted.

The newest building on the state hospital campus was built in the 1980s. It does not have an industrial kitchen. Patients are served food from the prison brought through the tunnel system. North Dakota psychiatric patients need an all-inclusive facility with amenities including the kitchen, education, and wellness areas such as a gym and pool. Using the existing building and tunnel system to get to needed spaces is not conducive to sharing staff, maintaining patient safety, and creating efficiencies.

Purpose of State Hospital

In the North Dakota Constitution Article IX, (section 12 part 8) states “A state hospital for the insane at the city of Jamestown…” We recommend that the Constitution be changed to more person-centered language here.

In the North Dakota Century Code 25-02, (section 03) the object of the state hospital is spelled out. It says that:

25-02-03. Object of state hospital.

“The state hospital is an institution for mental diseases serving specialized populations of the

mentally ill, including persons suffering from drug addiction or alcoholism. The state hospital is one component of the North Dakota mental health delivery system and serves as a resource to community-based treatment programs. The state hospital shall, pursuant to rules adopted by the department of human services, receive and care for **all** mentally ill persons, including persons suffering from drug addiction or alcoholism, residing within this state in accordance with this title, and shall furnish to those mentally ill persons all needed food, shelter, treatment, and support that may tend to restore their mental health or to alleviate their illness or suffering."

The above definition needs to change to reflect that "all" persons with mental illness are not served. Rather specialized populations including adults with serious and persistent mental illness shall be served in the following categories: forensic including sex offenders, court mandated and those with complex needs. The code needs an additional statement to include a unit for civil commitment of sexually violent predators committed to the custody of the state.

The state hospital has been working toward specialization in serving persons that cannot be served in other settings. This specialization should continue, and the Century Code and regulations need to be changed to reflect this shift. See section 1.4 with language that can be used to further clarify the code. The following table demonstrates those being referred to the state hospital as well as what the study recommends as a referral mix to the state hospital.

State Hospital Referral Data	**10/25/21 referral mix**	**The study recommended referral targets**
Private Hospitals	41%	60%
ED Jamestown/Devils Lake	24%	0%
Residential substance use disorder programs	17%	0%
Jails for psychological evaluation	12%	25%
Forensic referrals for assessment of criminal responsibility and sex offenses	6%	15%

Acute Psychiatric Treatment Committee 10/25/2021 Dr. Rosalie Etherington, Chief Clinics Officer/State Hospital Superintendent, Department of Human Services Testimony

The state hospital should provide only intensive specialty services including forensic, court-ordered treatment, sex offender treatment, and care for complex treatment resistant patients that cannot be cared for in other facilities due to the intensity of their needs. These complex cases may include those patients that cannot be maintained in lower levels of care such as a specialized geropsych unit or those with high levels of behavioral health needs including multi occurring psychiatric substance use who are unable to be treated in other settings or at a lower level of care due to the intensity and complexity of their psychiatric condition.

The state hospital should not be the short-term acute psychiatric hospital for the local region. The critical access hospitals in the area are accountable to provide care to the communities that they are designated and responsible for serving. A robust acute care system starts in local communities with community-based hospitals and support systems. The state hospital is designed to treat only those patients with the highest intensity and complexity of need.

The state hospital should not provide ASAM 3.1 or 3.5 substance use disorder (SUD) levels of care for numerous reasons including those stated above. It is inappropriate clinically, and workforce resources and funding can be more efficiently provided when delivered by private community-based providers across the state that are already licensed to provide these levels of clinical care.

Location of State Hospital

The State Hospital shall reside in Jamestown per the North Dakota state constitution section 12 of Article IX. The consulting team believes it would be easier to find a workforce if the state hospital was moved to the Eastern part of the state where most of the population lives. However, it is up to the people of North Dakota, if they would want to change the constitution, to move it elsewhere. There are benefits to the current location and its centralized location within the state.

Number of State Hospital Beds

In alignment with the updated purpose of the state hospital, the new facility being recommended should maintain its pandemic reduction count which aligns with the 2020 HSRI hospital report which concluded a hospital facility of 75-85 beds would be adequate to meet the needs of the North Dakota population. The flexibility of a new facility to adapt quickly to emerging future trends and specialty care needs would uniquely position the state hospital to meet unmet needs more quickly and efficiently as needed.

Use of Existing State Buildings

Many of the buildings on the state hospital campus have been marked for demolition. Most of the others have been recommended in recent reports to follow as well. The maintenance costs should be saved and repurposed into the new facility.

See attachment Appendix D. Of 28 buildings currently on-site and used by the state hospital nearly half are now identified with supporting documentation from outside reviewers as in need of demolition. The remaining structures are mostly shared with James River Correctional Center and are generally infrastructure-related (sewage lift station, electrical, equipment storage, etc.).

The only building new enough to be considered for renovation is the LaHaug building. In our interviews, the Department of Corrections has expressed interest in looking to see if that building could be used to better serve some of the incarcerated persons in their adjoining facility. However, there would be costs associated with renovating and moving that would need to be considered if it was deemed viable. The use of the LaHaug building is not as simple as moving people over from the prison.

There will be costs associated with demolishing the unused buildings on the campus, relocation and much needed modernizing of steam, water, electrical and other infrastructure.

1.2 Acute Hospital Beds

While building a state hospital, it is imperative to concurrently address system gaps in acute care beds, utilization, and expansion across the state. The Centers for Medicare and Medicaid Services (CMS) created the critical access hospital (CAH) designation in 1997 after a wave of rural hospital closures in the 1980s. The goal was to provide safety net services across rural America. In 2021 an additional provider type was established to support the challenges of rural care, Rural Emergency Hospitals (REH). There are various rural hospital designations and provider types.

Rural hospitals often do not want to care for "those people" as described to us while conducting interviews. It is by the nature of the definition and federal funding of critical access hospitals that they provide service for acute care for all types of conditions with an annual average length of stay of 96 hours or less. Many rural access hospitals across the country have or are in process of increasing capacity in the provision of behavioral healthcare (Gale et al., 2020).

In addition, the federal government enacted the Emergency Medical Treatment And Labor Act (EMTALA) in 1986. This statute imposes obligations for Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) regardless of an individual's ability to pay. They are also required to provide stabilizing treatment for patients with emergency medical conditions. The hospital can transfer the patient if they determine the patient is outside their capability and scope to treat. In North Dakota, there is agreement that the emergency departments are not meeting the needs of emergency behavioral health care in local communities, rural or urban. Even the perception of violating federal law is concerning and should be immediately addressed.

Hospitals under all designations have an obligation to care for patients in emergent healthcare situations. Across the state, countless reports have been provided of hospitals refusing to admit patients in acute psychiatric crises and coercing community-based providers and/or families to "take them back" even when clinically inappropriate, and ill-equipped to manage individuals in need of emergent psychiatric stabilization. This is backwards. The responsibility for emergency care is in the hospital emergency department. Hospital emergency departments must be trained, have transfer

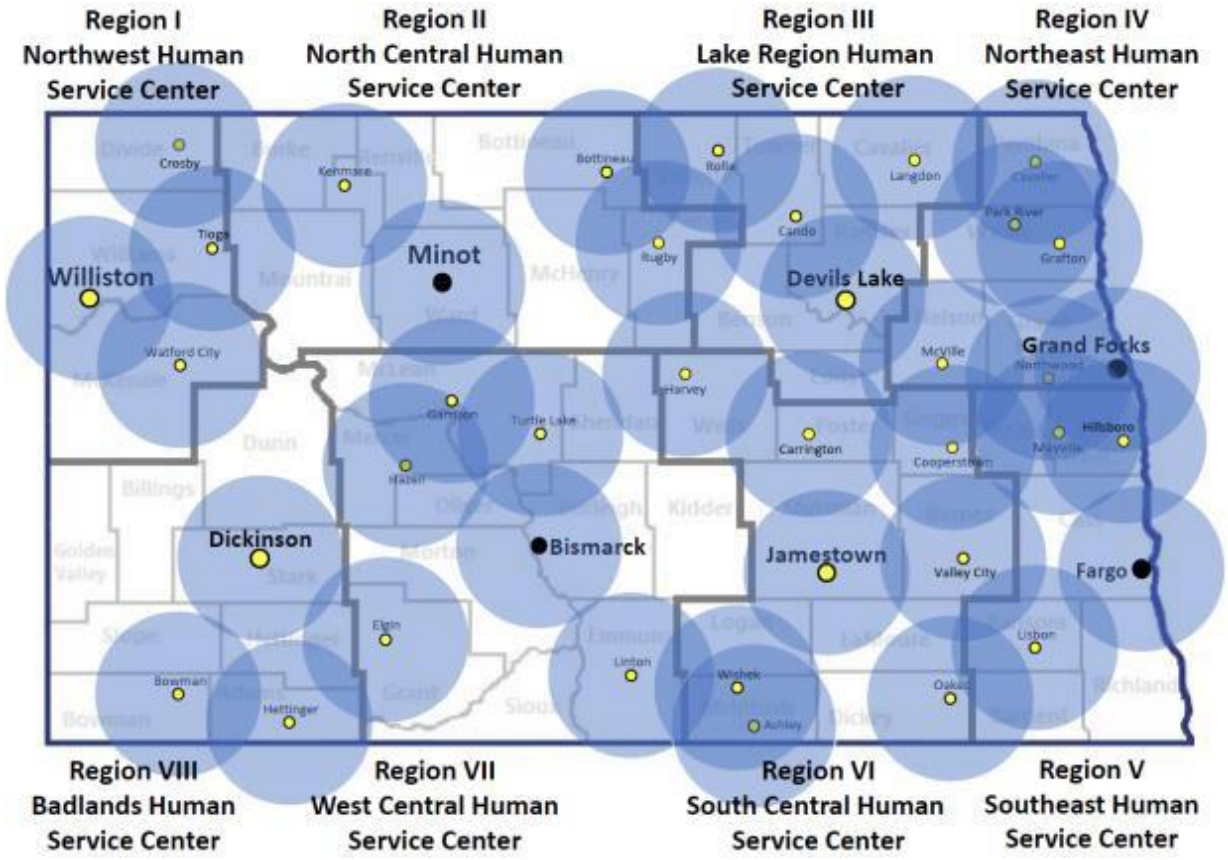
agreements in place and be expected to do what it takes to provide crisis assessments, appropriate behavioral healthcare and stabilization for all patients who have acute needs no matter the diagnosis and/or presenting condition.

Critical Access Hospitals and emergency departments have options: 1) They can accept emergency patients in the emergency departments and provide assessment, stabilization, and transfer. 2) They could designate specific beds for short term behavioral health care. The committee could choose to support either option by 1) providing full service telepsych services for assessment, stabilization and assistance with finding a transfer or 2) creating an incentive program to be administered by DHS to support building out the short term level of care.

In other states, critical access hospitals are on the frontline of delivering rural behavioral health treatment. Many policy briefs and examples of this work can guide this development. This article outlines the challenges facing critical access hospitals and options for the future. It highlights areas of specialty that critical hospitals should focus on including support for elderly populations, populations with psychosocial barriers, populations with behavioral health and addiction (MCG.com).

North Dakota Administrative Code section 33-07-01.1, (subsection 36, numbers 2 and 3, page 48) need to call out that primary care hospitals can provide behavioral health emergency treatment. This section must be updated to address psychiatric treatment needs for emergency stabilization across the state in primary care hospitals. Stabilization must be available in every hospital, regardless of size or location. These are NOT the same as designated units. Crisis stabilization level of care is for a short-term emergency stabilization for behavioral health until an appropriate transfer to another designated inpatient unit or discharge to a lower level of care is possible.

Human Service Centers should have contracts and agreements to co-locate mobile crisis teams and crisis access in rural hospitals. This critical piece must also be required to further support a continuum of defined levels of care across the behavioral healthcare system including rural, tribal, and other underserved areas.



Crisis Services Presentation from Jessica Odermann
Co-located mobile crisis teams in Critical Access Hospitals

Locations of adult acute beds

With the addition of telepsychiatry services and collaboration with mobile crisis intervention at every critical access hospital and/or rural hospital, emergency departments should be equipped to assess and stabilize a person presenting with a mental health crisis or substance use disorder. Short-term acute beds could be established in numerous locations throughout the state, when lower levels of care are indicated mobile crisis teams can facilitate admission to crisis residential units located in each mental health region. The western part of the region is in desperate need of acute care stabilization beds at a minimum in Dickinson, Williston, or both. Jamestown and Devil's Lake need acute psychiatric capabilities and dedicated units in their local hospitals to avoid transporting all acute psychiatric patients to another dedicated hospital unit in another part of the state. Thereby eliminating the need, inconvenience and cost of transport services and facilitating the coordination of discharge planning to local and community supports and follow-up services. This would also provide greater opportunity for family and kinship involvement.

Tribal lands

Significant mental health care disparities continue to exist on tribal lands further exacerbating access to acute psychiatric stabilization, during a crisis. This issue is made worse by the lack of funding resources and the minimal use of Care Coordination Agreements (CCA) between hospitals, community-based provider groups, stakeholder groups and IHS. DHS should continue partnerships that promote engagement to underserved populations including the use of Coordinated Care agreements with Medicaid and IHS to increase Medicaid funding opportunities.

Currently, hospitals continue to struggle to meet the needs of tribal members and other minority populations in the state. There are certain areas that experience greater challenges than others. According to IHS, one area with a particularly critical need for expansion of services is Turtle Mountain. Turtle Mountain has the largest service population of Native Americans in the state at 22,000 and a membership of over 30,000 enrollees. A second area that was repeatedly mentioned as a location for expansion is the area of Minot. This area was noted because the location has a reasonable chance of maintaining a workforce and still be within an hour-plus to the MHA Nation, Turtle Mountain Band of Chippewa, and Spirit Lake Nation.

North Dakota Veterans

Veterans' services in North Dakota are mostly provided by the Fargo Veterans Administration (VA) Health Care Systems and most providers assume that the veteran does not need to rely on state care. For the most part, this is true, however, VA Fargo has nine acute care psychiatric beds. These beds are shared with voluntary Minnesota residents when needed. North Dakota residents can be voluntary or on hold. Additionally, the hospital frequently must care for patients with dementia who are in an acute state, if a locked facility is required for stabilization.

As a result, Fargo VA can often request State Hospital services, when they no longer have capacity in their own facilities. They also transfer veterans regularly to Prairie St John and Sanford hospitals for care. Due to their limited beds, there can be a dependence on other facilities in the area, particularly for long-term psychiatric patients, dementia patients and other patient care requiring locked facilities. They are likely to search for care within the state before considering transfers to VA hospitals in other states, so access and availability at the state hospital becomes a key resource for veteran placements.

Children and Adolescent acute beds

With telepsychiatry services including specialists for children and adolescents, critical access hospitals should be equipped to assess and stabilize children and adolescents with mental health and substance use disorders. In the same way, as it is expanding for adults, children and adolescents should be served across the state where specialized treatment can occur alongside other child/adolescent specialty services. The locations needed for children and adolescent beds include the western part of the state in Williston, Dickinson, and in the Jamestown and Devil's Lake areas. Adding additional beds to the existing Bismarck area makes sense to utilize the workforce and resources.

Presently nearly 80% of child/adolescent beds are located on the state's eastern border. Those beds may be easily utilized by persons from out of state, thus increasing the likelihood of bed shortages for North Dakota children and youth. Choices by private hospital providers to serve North Dakotans play a key role in the availability of beds in the state at any given time.

ND Actual child/adolescent Acute Care Hospital Beds
64

Assumes Prairie St John new facility starting capacity projection 10/2022
Assumes hospitals pandemic related capacity reductions remain in place

The Behavioral Health Division of the Indian Health Services (IHS) operates the Great Plains Youth Regional Treatment Center in Wakpala, South Dakota, which serves all of North Dakota's enrolled adolescents. They currently maintain 16 beds in their SUD facility, 8 for boys and 8 for girls. They have considered the possibility of increasing 2 beds at the center to include children with psychiatric needs.

North Dakota LGBTQ+ communities have significant mental health needs, particularly the youth. The North Dakota *School Climate Report* stated 61% of LGBTQ+ youth in North Dakota have seriously considered suicide and 33% attempted it. Also stated is that the risk of suicidal ideation drops by 40% if a youth feels supported by another person. The North Dakota LGBTQ+ community expressed their strong desire to develop support communities for LGBTQ+ kids to minimize their risk of experiencing suicidal ideation.

Additionally, building a caring culture of awareness, empowering members of the health-care system to identify and break down barriers of misunderstanding and mistrust is critical to this population. Of particular importance is to provide opportunities to the healthcare professional to learn, use and understand current issues of gender and self-identification in the LGBTQ+ youth community.

1.3 Residential Care

North Dakota does not need more adult residential beds. Our team independently verified what was previously stated in the HSRI Residential Treatment Facility Capacity report. The state needs to better define what residential beds are and are not, and clinical treatment expectations at each level of residential care. Existing residential levels of care should be supported to care for complex co-occurring/multi-occurring needs, especially in the western part of the state. Additionally, geropsych beds need to be clearly defined, developed, and funded accordingly.

The state has created regulations for substance use disorder treatment following the ASAM criteria. The spelling out of these regulations has proven successful for the build-out of 16-bed facilities across the state. What is missing is developing co-occurring and complex needs capacity within those existing beds and supporting limited expansion and flexibility in developing capacity for those who do not meet substance use disorder criteria within the ASAM framework. Developing a no

wrong door approach, building capacity within existing residential substance use treatment providers to competently approach co-occurring complex issues including trauma builds on top of existing successful business models, and clinical competence demonstrated in SUD treatment providers statewide. This approach creates co-occurring and stand-alone behavioral health residential beds across the state, with existing vetted providers.

Substance Use Disorder Residential Treatment	**Total Actual Beds**
ASAM Level 3.5 (non hospital based)	143
ASAM Level 3.1 (non hospital based)	119

Unduplicated bed count excluding ASAM level 3.2D which overlaps generally in the same facilities/beds
ASAM 3.1 and 3.5 are generally housed in the same facility and may be fluid
Excludes Corrections facilities licensed for ASAM level 3.1 and 3.5

The beds that are converted and expanded in the co-occurring/multi-occurring space along with any new additional residential beds developed need to be tied into the bed tracking system. Establishing specific length of stay criteria will assist in the throughput of persons moving within the system.

Locations of residential beds

In speaking with private providers, more than one stated they would be interested in participating in expansion to co-occurring capable beds in the western part of the state, in Dickinson and/or Williston. What is needed for that to happen is a designated level of care and a billing code with sustainable funding. There are staffing and clinical oversight differences for best practice when adding in more complex patients. These differences would need to be addressed in daily rates. Additional staff training, support structures and psychiatric oversight must be recognized and supported for services to be provided and supported in a geographically diverse way.

Children/Adolescent Residential Care

The Children's system has implemented significant policy and practice changes throughout the past few years including reductions of out-of-state placements, changes due to the Family First Act, and other juvenile justice system changes. At the writing of this report continued work and requests for proposals are providing a path forward to ensure that Psychiatric Residential Treatment Facilities (PRTF), Qualified Residential Treatment Programs (QRTP) and Shelter Care beds are accessible and being provided to the level expected of current regulations and best practice standards. Provider onboarding has been a challenge as the adoption of best practices has slowed system development.

Children's System	Actual Beds
PRTF	82
QRTP	76
Youth Shelter	45
ASAM level 3.1 Adolescent	57
ASAM level 3.5 Adolescent	16

Unduplicated actual bed count
**DHS is in the process of certification for 6 sites of shelter beds, not included in this number.*

The perception is that there continues to be a great need for PRTF, particularly among tribal children. It is reported that they struggle the most in securing care due to the current referral process. For example, in a system that is already extremely burdensome, IHS referrals that have a medical diagnosis and assessment already completed by a qualified IHS professional, are required to secure an additional assessment, by the state, before being able to receive services. This often causes critical delays in transfer, treatment, and care of the patient, who is often in crisis. This can also contribute to negative feelings thereby jeopardizing the goals of collaboration and trust.

Long-Term Care

The North Dakota plan for geropsych units has caused some regulation complications in the state. Adding the geropsych units to existing nursing homes avoided the IMD exclusion issues. However, it has created large regulatory burdens on the nursing home providers to take care of these persons with complex needs. Nursing home regulations prohibit the use of some of the needed medications and treatments required by complex needs patients. This results in fines, loss of star ratings, and incident tags for doing what is necessary and best practice to care for this psychiatric level of need.

Geropsych (specialty contracted beds)
64

Located in existing Long Term Care facilities

Geropsych facilities should be under a different set of licensing standards and rules to facilitate best practice treatment options for higher needs persons at this level of care. For persons with complex needs, the use of antipsychotics, anti-anxiety medications and others are necessary and prudent. Medications should be able to be dispensed as directed without fear of a tag or notice of a violation under the nursing home CMS statutes. The CMS region guidelines will need to be followed in developing this level of care to standards.

In addition, licensed nursing facilities are not acute levels of care. It is illegal for local hospitals to refuse care to persons from these institutions needing assessment and psychiatric crisis stabilization. Additionally, it is not always appropriate that the patient return to this level of care following stabilization depending on the level of psychiatric need. The critical access hospital if in tune with current behavioral health standards and best practice could transfer to a specialized unit or acute psychiatric bed in a larger hospital for short-term care. In the event the patient meets criteria based upon clinical presentation and difficulty to treat, the state hospital would then be a viable option until which point the patient can be successfully returned to a lower level of care.

Crisis Stabilization Adult

Human Service Centers (HSC) in code is difficult to follow or understand. Some sections have been repealed. HSCs are now within the Clinical Services section of the code which is far from clear. And the services that are provided in HSCs are not even listed in this part of the code, crisis stabilization being one. 50-06 speaks to zones, and does not connect to 75-05-03 and at a minimum need to be consistent in what services are provided and how oversight is conducted.

In 50-06-05.3, the section begins by saying that "the regional human service centers shall provide human services to all eligible individuals and families…" A better practice would be to define which services and types of services will be provided in either code section. The vision as interpreted by 50-06-05.3 our team is that North Dakotans can expect access to a base set of core services no matter where they live. Providers of those services should be expected to demonstrate competencies in serving persons with complex, multi-occurring conditions, providing evidence-based services and providing trauma-informed care which is culturally and linguistically appropriate.

HSCs to date have been seen by community providers as "competition" and not team players. With the state being a payor as well as a provider of services, this line is murky at best. However, the HSCs have been transforming into being the provider for the highest needs clients in the state, serving those with the most complex needs. The HSCs are on the right track narrowing focus and scope. The eligibility for access to services at the HSCs has changed. Regulations should be clarified reflecting this change in purpose.

Human Service Center Crisis Stabilization Beds (facility in each region)
67

In addition, HSCs are an integral part of the creation of residential beds for crisis services. They should continue their transformation to provide crisis residential services throughout each region for adults. Regulations need to be created to address appropriate levels of care in this space, where ASAM level 3.1 is often used incorrectly. Creating a crisis continuum of care adds the level of crisis stabilization and crisis residential that is missing across the state. The HSCs are in a great position to tie this level of care to their crisis outreach and mobile crisis services.

HSCs should provide levels of care to persons with serious mental illness and complex SUD including but not limited to: Assessment and evaluation; case management; mobile crisis; crisis stabilization; and crisis residential.

HSCs need to play a more active role in providing training, support and coordination to all providers including refugee, immigrant, and tribal communities on available services and in navigating the behavioral health system including policy and payment. Tribal leaders continue to note that, despite invitations to participate in community education, county offices do not participate. Part of the HSC mission per administrative rule is for community consultation and education Article 75-05-03 (subsection 06, page 6). Providing much-needed technical assistance would benefit the entire provider network and build needed relationships with all North Dakotans.

Crisis Stabilization Child/Adolescent

The changes in the system with the Federal Family First Prevention Services Act, juvenile detention and the policy of treating children and adolescents out of state have created a new set of challenges for the children's system. The lack of basic and treatment level foster care parents coupled with the increased need for them has exacerbated the issues at hand.

Each policy change is not bad and needs to happen; however, taken together all at once with little understanding by the public on how to access the new system has created a firestorm. Stories of children sleeping in human service zone offices and hotel rooms with zone staff have people rightfully concerned. The recent placement of a child on the state hospital grounds that is staffed by persons trained to work with adults is also worrisome and does not portray the image of a "functioning" system.

Short-term fixes for this include but are not limited to, opening cross-border placements with treatment providers that specialize in children and adolescents, considering specialized children and adolescent facilities within 300 miles of ND borders. Expanding the use of telepsychiatry with board-certified child and adolescent psychiatrists to assist in both direct care and professional consultation similar to the work already being done with Project ECHO at UND.

Once a youth is stabilized at a child and adolescent unit in a hospital there needs to be a direct placement option to an appropriate PRTF level of care. The future department of health and human services should audit the admissions process to determine how transfers from hospitals to residential placements could be handled in a timelier manner.

Expanding youth shelter standards to recognize the need to serve youth in crisis that do not need acute psychiatric inpatient care are needed. Three Affiliated Tribes-Mandan, Hidatsa, and Arikara Nation (MHA) Child Safety Center serve five boys and five girls. This crisis center opened its doors in 2019, survived Covid-19 and currently remains fully operational despite staffing challenges.

MHA Nation is currently considering offering 2 beds to nearby counties. They are actively pursuing licensure, training staff and intend on billing Medicaid in the future. This center is 100% tribally funded. MHA Nation Child Safety Center is a project that can be a model to help other tribal nations and is more than willing to assist others by sharing information.

1.4 Regulatory Changes

Purpose of State Hospital

As stated previously, the purpose of the state hospital should be changed to more clearly reflect the specialization transformation that has been occurring in North Dakota. The areas of Devil's Lake and Jamestown need to have their own acute psychiatric services to not use the state hospital in that capacity. For the most part, substance use treatment should also be done in the private sector unless there are complex needs of comorbidity making that impossible.

The state of Iowa has two mental health institutions that are focused on treating the specialty behavioral health population. The mental health institute's purpose statement would benefit North Dakota. Adding statements like the Iowa code to include specialty areas of focus is important. Below is an example of wording to be built upon.

The purpose of the mental health institutes is to operate as resource center providing one or more of the following:

1. Treatment, training, care, habilitation, and support of persons with mental illness or a substance abuse problem.
2. Facilities, services, and other support to the state to maximize the usefulness of the mental health institutes while minimizing overall costs.
3. A unit for civil commitment of sexually violent predators committed to the custody of the state.

In addition, the mental health institutes are encouraged to act as a training resource for community-based program staff, medical students, and other participants in professional education programs.

The state of North Dakota should consider prioritizing citizens with serious mental illness, forensic challenges and complex service needs only. The purpose statement in the Century Code should reflect this change using a modified version of the example included in this section.

Purpose of Human Service Centers

Clarification of the purpose of Human Service Centers is critical. As noted above, the current definition of the eligibility and services provided at the HSCs is vague and all-encompassing. The administrative rule section, Title 75-05-05, that had defined eligibility and essential client services was repealed in 2020.

In the absence of being able to review North Dakota language, we recommend you use this framework from Nebraska.

An example of clear powers and duties of a regional behavioral health authority can be found in Nebraska. Revised Nebraska statute 71-809 models what a state-run regional authority can do. Specifically, the statute lays out the following:

1. Administration and management of the regional behavioral health authority
2. Integration and coordination of publicly funded services within the region
3. Planning for appropriate service array throughout the region
4. Submission of budgets and annual reports to the state agency
5. Initiation and oversight of contracts for publicly funded services
6. Coordination with the department for conducting financial audits of publicly funded services

In addition, the regions are expected to create financial eligibility expectations for all consumers that are uniform across the state.

One example of how this would improve the system in North Dakota. The Critical Access Hospitals (CAH) are tasked with the creation of mobile crisis services in the state. The HSCs should have agreements or memos of understanding with the various Critical Access Hospitals in each region to make sure these services are in place and gather data on them. The mobile crisis teams would support the CAH in the stabilization of persons needing mental health and substance use treatment.

Long Term Care - Geropsych licensing

Long-term care in North Dakota got complicated with the addition of the "geropsych" level of care. What started as a higher level of care for elderly patients has become a catch-all for higher-level mental health needs across all ages. Challenges lie in the regulations that a long-term care facility must follow in the state while trying to care for this higher need population. What is needed to address these concerns are a separate set of regulations for the higher level "geropsych" level and potentially a corrective name change as well for clarity.

The state of Iowa has a higher level of nursing home care called the Intensive Care Facility for Persons with Mental Illness (ICF-PMI). Like North Dakota, there is a higher level of assessment that qualifies a person to be in the facility. Also, like North Dakota, the facility can be attached to a nursing home facility in a different wing or unit. Two facilities in Iowa can only take age 65 and older due to the facility layout and IMD concerns. One facility can take all ages.

However, different from North Dakota, the ICF-PMI level of care has entirely different regulations. This allows the facility to fully treat the complex needs of the residents. The separate regulations keep the basic and skill level nursing facility from being given consequences for using higher-level medications and behavioral management as needed case by case. The challenges geropsych facilities face in North Dakota could be alleviated by a change in regulations.

We recommend that North Dakota create a separate regulatory structure for this intensive residential level of care for serious mental illness using the regulations referenced from the state of Iowa. And, while creating this new regulatory system, change the name of geropsych to reflect the adults being served in all age categories.

No Eject/No Reject for Providers

Across the state, you can hear countless tales of people being rejected by providers. Or, once a person has an acute episode, the provider refuses to take them back after stabilization. This behavior has occurred from acute providers to long-term care with adults and with youth. One policy that drastically changes this scenario is the no eject no reject policy.

"No reject, no eject" means that an individual who otherwise meets the eligibility criteria for services shall not be denied access to that service or discharged from that service based on the severity or complexity of that individual's mental health and multi-occurring needs.

Adding this definition to provider contracts across the board assures that persons with mental health and substance use issues will be treated and cared for with a person-centered approach. The responsibility to get the support needed is on the provider. No longer will persons be "dumped" at any level of care. By adding this policy, only persons with the highest level of acuity will require state hospital placement.

Examples of no eject/no reject language can be found in multiple sources including this Medicaid letter in the state of New Mexico or this state of Alabama RFP.

Solution #2 Data Collection and Validity

2.1 Data Management

Data collection and usage is a huge topic in North Dakota. Many are requesting data. However, data is not available or understandable, and if able to be obtained, is limited and lacking validity due to missing and/or misidentified fields. There is no way to verify data points as it is often from one source and cannot be verified from any other source, making it meaningless and appearing subjective.

Our team set out to validate and update information in a table provided by HSRI in their 2018 report. HSRI reported that 39% of the behavioral health events in the Human Service Center data excluded info about funding sources. Their data did not include Medicaid Expansion data from Sanford or details from the contracted services. DHS does not have an integrated and standardized data management system that is accountable for all behavioral health data.

In working with federal data, the literature suggests that the SAMHSA data are affected by lack of standardization, administrative burden, lag times, and does not include critical measures such as wait-times and provider shortages.

We are aware of work being done across the HSCs to gather and extract accurate data across all regions by adopting MyAvatar for their electronic health record. The work to be able to extrapolate data from the system has been delayed due to workforce, Covid and aligning of public health and department of human services departments. This data collection is a necessary first step.

However, it is only a first step. Data must be collected across payors to include Medicaid, Medicaid expansion and private insurance and from all providers private and public. Creating such a system could provide "real-time" data for informing immediate capacity and care issues as well as info that can be used for improving care and directing priority spending.

Using data from only certain predetermined parts of the system will never provide an accurate snapshot of the entire system and will not reliably predict need, utilization, or system efficiency.

2.2 Financial Accountability

In looking at data, having access to financial data across all payers is critical for validation. Financial data when gathered and available should be able to verify levels of care being utilized, numbers of beds, and types of services. In addition, the data can be used to verify waitlists, measure no-show rates, and employee time spent and needed. Financial analysis can also provide insight into the value of care.

State Audit of State Hospital and Human Service Centers

One step that can move toward the creation of standardized data collection is an audit of the state hospital and human service centers. An audit would provide baseline information for the current

expenditure and funding source mix. It would also validate levels of care being used and the number of beds being billed across the state. An audit every 5 years would provide stable data for comparison.

ND DHS Reported Expenditures for Adult and Youth Mental Health Services by Human Service Center, 2017-2019 & 2019-2021 Biennial

Human Service Centers	Adult Mental Health Services		Youth Mental Health Services	
	2017-2019 Biennium	2019-2021 Biennium	2017-2019 Biennium	2019-2021 Biennium
Badlands Human Service Center	$6,874,283	$8,416,675	$159,889	$86,348
Lake Region Human Service Center	$5,631,531	$5,790,632	$240,033	$193,680
North Central Human Service Center	$8,330,908	$10,328,639	$1,620,151	$1,685,181
Northeast Human Service Center	$12,772,930	$16,166,013	$4,113,755	$3,849,251
Northwest Human Service Center	$5,057,096	$5,714,178	$144,810	$182,786
South Central Human Service Center	$10,274,418	$11,270,983	$158,509	$165,259
Southeast Human Service Center	$22,626,342	$27,596,766	$2,003,244	$2,237,546
West Central Human Service Center	$12,935,287	$16,670,951	$2,188,085	$1,173,417
Total	$84,502,795	$101,954,837	$10,628,476	$9,573,468

1. Data are from the ND DHS Quarterly Budget Insight Report:

About DHS: Publications: Publications/Research: Department of Human Services: State of North Dakota, Quarterly Budget Insight 2017-2019 Biennium (page 6) and Quarterly Budget Insight 2019--2021 Biennium (page 6)

Utilization data from all providers

There needs to be evidence-based, standardized process measures aligned with the Medicaid division to gather data that could inform the future of the system. Codification of the data collection procedures including requiring any provider that takes state funding including contracted services to participate is a key to improving data management in the state. In addition to collecting the measures SAMHSA requires, they should include but are not limited to wait-times, numbers, and types of licensed providers at each location and others.

2.3 Use of Medicaid across all providers both state and private

Unless the state wants to continue to fund mental health and substance use with primarily state dollars (like the voucher for SUD), a shift to using primarily Medicaid is necessary. For that to happen, a policy change needs to be made that if a provider is going to take a state dollar, they need to provide Medicaid services as appropriate. This must begin with the state billing Medicaid for all eligible services at the HSCs. As for external contracts which seem to be increasingly used, the same standardization and reporting should be required.

There could be challenges for providers to be able to utilize electronic health records (EHR) that could share data with the state. Options to rectify this include potentially making the state EHR available to providers that need one. Another option could be setting up data-sharing agreements such that DHS data management could import data from providers who use another EHR with interoperability agreements. An unused talent pool exists at the universities and should be considered for these types of undertakings. There seems to be very little involvement between DHS and the university systems related to data management science and ongoing research.

As standardization occurs across all providers IHS needs to be included. Having interoperability agreements and compatible EHR data collections and assessments could facilitate patient care and efficiency. In addition, more communication is necessary around the use of Medicaid, especially regarding the Medicaid expansion population as the tribes are not aware of changes being made in this area.

2.4 Provider Contract Changes

Providers who deliver services and receive state funding must be required to enroll in the Medicaid provider system. An expectation of a state Medicaid provider must be to adhere to all Medicaid guidelines and to regularly report data and predetermined outcome measures established in regulations by DHS.

If a client is eligible for Medicaid, there should be a process for expedited enrollment opportunities or presumptive eligibility when individuals are motivated and seeking behavioral health treatment. Once Medicaid eligible, all services which are covered under the state Medicaid program or expansion plan must be billed to Medicaid. Care should not be provided utilizing alternative funding streams as that may be a violation of federal Medicaid rules and regulations.

Contract language should layout payor of last resort and billing expectations for Medicaid and Medicaid expansion enrollees.

Data and outcome measures should be reported out at least quarterly from DHS informing Medicaid providers of system successes and opportunities for shared problem-solving. Engaging provider participation in quarterly quality improvement meetings to ensure continuity can be contractually required.

Solution #3 Implementation

It is now time to do the work of Implementation! Over the past decade many consultants have been hired, committee meetings held, and reports written about the issues facing the behavioral health system in North Dakota. In some areas, progress has been made. In others, the state looks to many like it is moving backward. Moving from study and evaluation of a problem to active implementation can be challenging.

Maintaining focus on the needs to support a functioning system and its ability to adapt and flex can be daunting. It is now the time to do the work of implementation. We believe a dedicated team of professionals with one focus will be needed to push the system forward and develop the system, oversee the integration, and report back success and barriers along the way. We believe it will take a team of 3-5 specialized implementation experts focused solely on this work for the next 3 to 5 years to achieve maximum potential.

3.1 Build a modern and efficient state hospital

As has been recommended in previous reports, the team agrees a modern and efficient state hospital is necessary. The size of the state hospital should be like what was recommended by HSRI with the focus we highlighted above 75-85 beds with the flexibility to shift population focus as needs change moving forward.

The building of a new hospital provides an opportunity to demonstrate investment that promotes diversity, equity and inclusion in design and landscape that encourages every individual to feel seen, heard and valued. This can be achieved by committing to trauma-informed and culturally relevant designs and landscape architecture that promotes healing and engagement to diverse and underserved populations.

3.2 Codifying mental health levels of care including the HSCs and the state hospital

Many states around the country have codified and regulated levels of care for mental health and co-occurring substance use disorders. One of the most comprehensive examples of language for codifying the levels of care can be found in Iowa. The subsequent regulations from this code section including all definitions for care can be found here.

Mental health levels of care need to be developed by administrative rule the same way that substance use disorder levels of care have been in Article 75-09.1 Mental health levels of care should include:

Recommended Levels of Care

Acute Psychiatric inpatient
Hospital-based inpatient medical detox
Geropsych/ICF-PMI
Crisis Residential Stabilization
23-hour crisis observation
Intensive Outpatient Treatment (IOP) MH
Partial Hospitalization Program (PHP) MH
Transitional Living and Supports

Recommended additional best practices supporting levels of care

Strength-Based Case Management
Integrated Treatment for Co-Occurring Disorders
Assertive Community Treatment
Mobile Crisis Response
Jail Diversion-The Stepping Up Initiative
Outpatient Treatment -Evidence-Based Practice preference
Peer Support
Family Support
Crisis Intervention Team (CIT) implementation and training

Human Service Centers Essential Client Services and Eligibility

Regulations regarding the services provided in the HSCs must be clarified to reflect changes and efforts at standardization across the state. Article 75-05-03 explains a former version of the HSCs and the services they were expected to provide. Today, many of these services have changed. Clarifying and offering Medicaid eligible services will be critical in funding the system into the

future and setting an example to private providers on billing Medicaid appropriately.

HSCs are not responsible for providing each level of care "in house". However, they should be responsible for making sure each level of care is available and accessible throughout each region. Every North Dakotan no matter where they live should have equal access to core services, with oversight by the state through HSCs.

At a minimum, HSCs should directly provide levels of care to persons with serious mental illness and complex SUD including: Assessment and evaluation, case management, mobile crisis, crisis stabilization, and crisis residential.

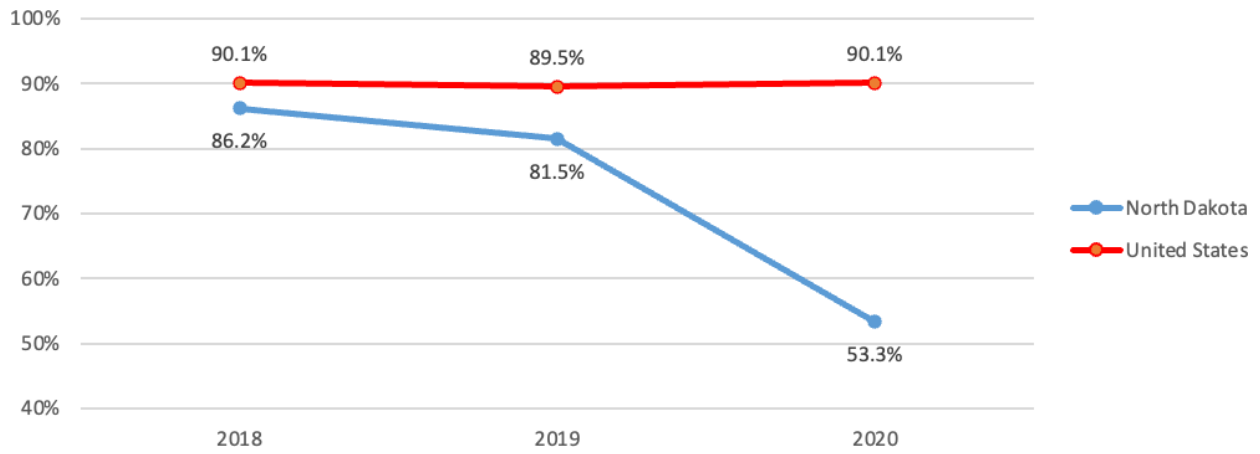
The eligibility requirements for persons seeking treatment at the HSCs have also changed. These changes are not reflected in the rule or Century Code. This does not help with clarification with the public on who can be served or seek help at the HSCs. These changes also need to be updated in the regulations to reflect the Nebraska language provided above.

3.3 Communication and Collaboration

Special population groups, private providers, and educational leaders have emphasized their desire and willingness to collaborate with the state in the areas of technologies, shared spaces, shared resources, and other problem solving to provide appropriate, time-sensitive and quality behavioral health care for its members. During system transitions engagement with all stakeholders is essential. There is a willingness to discuss options and problem solve together to improve services for all. However, communication from the state on changes being made, and in process, has been limited.

Providers are trying to learn and utilize Medicaid but need more than an occasional webinar to fully understand the ins and outs of a new billing system. The changes occurring in Medicaid go beyond simple billing changes, the philosophy of care is also evolving. It is apparent in our conversations with providers, stakeholders, and tribal nations not everyone across the system of care understands or has been provided adequate onboarding to develop, implement and deliver the services now being expected by the Department of Human Services and Medicaid.

Using HSCs as technical assistance centers of excellence to providers and population groups is part of the existing mission of the HSC. This partnership and provider development need to be strengthened in many areas and rebuilt in others to move a modern and redesigned system forward. It is clear from the graph below, that the current mental health system in North Dakota is not meeting the needs of the citizens of this state and from 2018-2020, the most recent data available, is headed in the wrong direction.



SAMHSA 2020: 2018-2020 North Dakota general satisfaction ratings of adult MH consumers & U.S. comparisons.

One specific Tribal recommendation is to have a healthcare "cultural broker" to assist in bridging, linking, and navigating the cultural divide between groups and/or persons of differing cultural backgrounds. The goal would be to promote understanding, encourage cooperation and facilitate positive systemic changes. The cultural broker acts as a go-between and advocate for the individual or group to negotiate with the client and the health care system to produce beneficial, effective, and client-centered health care plans. This can be further accomplished by accepting invitations to join underserved populations' community boards and community groups. This has the potential to build relationships needed to form partnerships and build out a modern and redesigned system that embraces diversity, inclusion, and equity that respects culture and serves all North Dakota residents.

3.4 Telepsychiatry Utilization

For those who were not fully convinced that telehealth was the answer to many workforce issues before, post-pandemic there should be no doubt. Across the country, providers who utilized telehealth during the pandemic had fewer no-show rates and were oftentimes able to facilitate stable and consistent medical care without a patient ever stepping foot into a clinic or facility. For rural states, full use of telehealth can de-escalate crises, refill needed medications and provide guidance to other practitioners to make better diagnostic decisions and referrals.

In North Dakota, organizations that are utilizing telehealth and telepsychiatry do not appear to be embracing the network of experts nationwide that can serve North Dakota residents and provide expert consultation to North Dakota practitioners. Most providers we spoke to were attempting to use local North Dakota providers for services, placing more strain on the already limited workforce within the state. It appears there is hesitance to fully embrace an available workforce that is readily available outside of the state borders. There is certainly additional capacity to be discovered by expanding remote providers and increasing utilization of existing telehealth sites through partnerships, agreements with others in the state including but not limited to: IHS, private hospitals, Veterans Centers, Community Based Outpatient Clinics, rural medical clinics, immigrant refugee centers and tribal facilities.

Telehealth aka telemedicine defined as:

"Telehealth" means the delivery of health care services or consultations through the use of real-time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

Whereas it may make sense to prioritize North Dakota specific providers, there is too much work to be done for local providers to do it all. We have worked with numerous full-service telepsychiatry providers across the country that can bring available services to the state for psychiatry, prescribing, therapy, and crisis stabilization. These service providers bring their own data and tracking of beds to the system that would bring additional value and specialty provider capacity to the state. Licensing boards need to make access a priority by expediting out-of-state provider requests to fill gaps and meet the needs of North Dakotans across the state.

Psychiatric Services in Jails

Based upon direct observation and first-hand interviews the issues around incarcerated persons with psychiatric illness in jails are appalling. The backlog of persons who were held in jail and eventually freed without charges being filed is something to be expected in third world countries, certainly not here. Where is the person's due process? Where is the right to freedom or least restrictive levels of care?

In some counties, jails have attempted partnerships with the HSCs to provide services in jail. However, workforce constraints and the sheer volume of need have made their efforts not enough. Again, an opportunity to engage a full-service telepsychiatry group to provide services to this specialty population - managing psychiatric medications and outpatient treatment needs is important. In addition, they would have access to data to inform decisions and best practices. These contracts could be through the HSCs or with the jails directly.

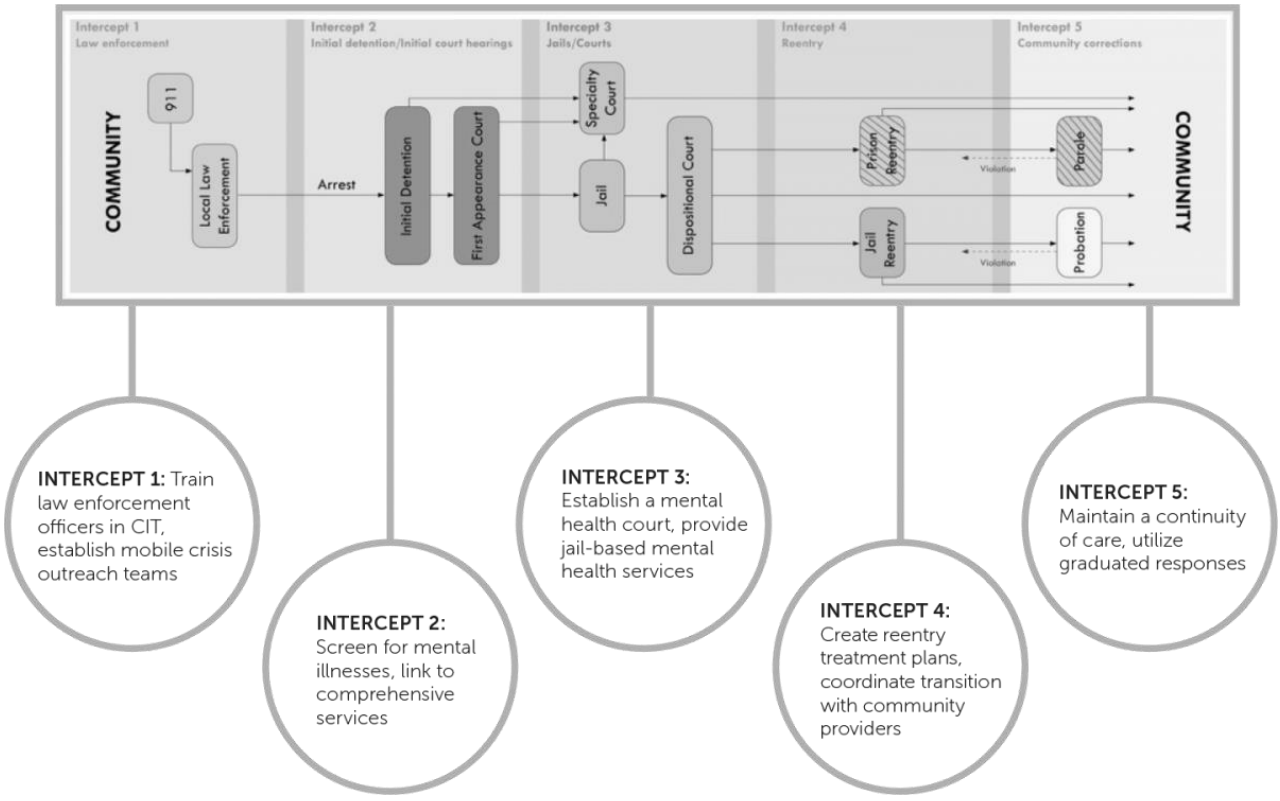
We recommend Sequential Intercept Model implementation and The Stepping Up Initiative: A National Initiative to Reduce the Number of People with Mental Illnesses in Jails–which is sponsored by the National Association of Counties, the American Psychiatric Association Foundation, and The Council of State Governments Justice Center, in partnership with the U.S. Department of Justice's Bureau of Justice Assistance. This initiative calls on counties across the country to reduce the prevalence of people with mental illnesses being held in county jails. (www.stepuptogether.org). At the time of this report, only one North Dakota county has taken the next step and registered with the stepping up initiative.

This is a shared problem; shared problems need shared solutions…

Adopting common language not only ensures that all systems are using the same measure to constantly identify their target population, set a baseline and measure progress but also eases the inherent cultural and professional differences that arise when different professions use different terminology.

www.stepuptogether.org

To reduce the number of people with mental illness in jails, Human Service Centers (HSC) and the Forensic Specialty Services of the State Hospital must take a much more active role in promoting and partnering with county jails on these types of initiatives. It will also be essential that the Human Service Center be held accountable to deliver or ensure the delivery of jail-based care coordination and psychiatry services. HSC must be held accountable to develop protocols and ensure implementation, manage contracts if needed, ensure access, and provide ongoing support to every county jail across the state. The HSC is an integral part of the behavioral health system functioning and this population presently is the most at risk of not being adequately served.



From The Stepping Up Initiative: Reducing Mental Illness in Rural Jails

At least 15 states have passed laws allowing for suspension rather than termination of Medicaid benefits for individuals who are detained or incarcerated in correctional facilities. As a result, jails across the country can keep individuals enrolled or do presumptive eligibility with individuals to get their Medicaid identification card before they are released, making it easier to set up appointments and call-in prescriptions to be ready once they return home. Even when an individual is only detained for a short period, staff can get the process started for enrollment.

Critical Access Hospitals and Crisis Stabilization

As stated above rural Critical Access Hospitals (CAH) must be able to provide a medical screening evaluation and stabilization to all patients regardless of ability to pay. That includes persons with psychiatric or substance use disorders. The use of telepsychiatry services plays an integral role in making this happen and supporting rural emergency room practitioners. Since the CAHs are the planned center for mobile crisis dispatch, telepsychiatry would assist the team on the ground to stabilize and divert people who do not need to be hospitalized.

CAHs could have psychiatric assessments available 24/7 for all ages completed by psychiatric providers. Some providers of telehealth services also assist in patient transfers and placements. Using a telehealth provider to assist with bed tracking would give the state reliable data on the time it takes to find placement. As stated above, all hospitals should be equipped to assess and stabilize a person with any condition including psychiatric conditions.

Example of Telepsychiatry usage for these services

We asked a private telehealth provider to give us a ballpark estimate of what it would cost to fully fund telehealth in all needed areas across the state. This provider is already providing services to private providers in North Dakota. The example document can be found in Appendix E.

1. For Emergency Room (ER) telepsychiatry, all patients presenting with a behavioral health crisis to a hospital ER would be seen by a North Dakota licensed Psychiatrist or Psychiatric Nurse Practitioner within 2 hours of being contacted. This would include a full psychiatric assessment, determining an appropriate level of care and providing medications. This service also includes finding placement for inpatient psychiatric beds, substance use beds or other appropriate levels of care. The cost estimate for all 36 critical access hospitals in the state for 24/7 crisis services is $1.5-$2 million annually.
2. For county jail telepsychiatry, appointments would be available 7 days a week. Urgent appointments would be available within 24 hours of the request. A psychiatric assessment would be completed by a North Dakota licensed Psychiatrist or Psychiatric Nurse Practitioner. Medications would be prescribed as needed to manage symptoms. These medications would come from the jail formulary to control medication costs and avoid medications with abuse potential. The cost estimate for all 24 county jails is $500-$700 thousand a year.

Although we obtained this information from one specific provider, we are aware of several who may be interested in bidding on this work if the state moved forward in this direction.

Regulation Recommendations

The state of Minnesota has a statute they call the "Minnesota Telehealth Act" that would be a great resource for North Dakota. Within the statute several foundational components are defined including:

1. Fully defines telehealth, what is and is not included.
2. Clarifies that all insurance policies sold in the state will cover telehealth the same as an in-person visit.
3. Insists upon parity between in-person and telehealth visits in all locations.
4. Secures equal reimbursement for telehealth as in person for providers.
5. Ensures that health carriers cannot require specific technology to be used but defines parameters for complying with current standards of care.

North Dakota must prioritize simplifying any regulations and billing challenges prohibiting the full usage of telehealth across the state across levels of care from outpatient to inpatient. Making sure that telehealth is defined and billed equally as any other face-to-face service is critical in ramping up usage in a timely fashion.

Another consideration for the legislature is to increase resources to rural and frontier areas that need additional broadband infrastructure and secure technology to be able to deliver quality behavioral health care services. Security for technology systems build trust in the adoption of telehealth service delivery.

3.5 Practitioner Certification, Licensing and Workforce

Reporting on the workforce in North Dakota was not an identified piece of the original RFP. However, without a workforce, the implementation of strategies outlined in this document will be impossible. Numerous works are going on within the state to address this concern. We are highlighting a few areas in this section of the report. For a deeper dive, we have attached a document in Appendix F outlining the systemic changes necessary to grow the behavioral health workforce in North Dakota.

One of the ongoing complaints in North Dakota is the voluntary nature of many of the licensing boards. This fact leads to unnecessary delays in getting applications processed. Please note, it is not that the volunteers are not trying or putting in a good faith effort, it is simply they are volunteers who have other full-time jobs. In addition, there are varying policies and hoops to jump through regarding telehealth depending on the license. North Dakota needs to have every option for quality providers available to them. Streamlining the process for certified and licensed providers to come into the state and removing all barriers to out-of-state providers providing telehealth is critical.

Legislative Actions	Means of Improving Workforce and Behavioral Health Services
Composite licensure boards	Provide consistent regulatory oversight, streamline processes, and remove barriers to interprofessional services
Interstate telehealth compact	Promote the ability to provide services across state lines
Universal licensure recognition	Promote easy relocation of licensed professionals

State-administered licensing boards

One solution that should be implemented is that boards no longer be run by volunteers but by the state. The workforce alone demands state employee time and oversight to make sure all qualified providers can practice in the state and be reimbursed for their work.

State composite board

State composite boards regulate more than one behavioral health profession. A recent review (Beck, Page et al., 2018) showed that almost all states (48) had at least one Behavioral Health Professions composite board overseeing at least 2 behavioral health professions. The most common composite boards (in 27 states) were combinations between Marriage & Family Therapists and Counselors with several also combining with Addiction Counselors. Only North Dakota and Alaska did not have any composite boards. Composite boards provide consistent regulatory oversight while streamlining licensure processes, reducing interprofessional conflict and turf protection. They also encourage interprofessional services and recognition of commonalities between professions.

As one example, composite boards generally facilitate cross-professions supervision where trainees in one profession are permitted to be supervised for licensure by practitioners in other related professions. In 2017, North Dakota legislation was enacted which allowed for up to 50% of required supervision for behavioral health tier 2 professional licensure to be provided by other qualified professionals—with varying conditions and approvals that must be met.

Universal licensure recognition

Universal licensure is when a state recognizes as valid a person's occupational license granted in another state. Six states have enacted universal licensure laws that include all occupations: Idaho, Missouri, Nevada, New Hampshire, New Mexico, and Pennsylvania (Sims, 2020).

In addition to these three recommendations, Nancy Vogeltanz-Holm created a document outlining additional workforce initiatives that would improve behavioral health in North Dakota. Her article is attached in Appendix F. Her investigation outlines the workforce issue in detail as well as additional solutions including incentives and administrative support for students and professionals.

Conclusion

North Dakota needs to implement the following takeaways to create a behavioral health care system for all North Dakotans.

Build a modern and efficient state hospital.

Develop and fund short term/emergency acute psychiatric beds in critical access hospitals.

Clarify Administrative Code 33-07-01 that emergency stabilization of behavioral health can be provided in all emergency departments in all hospitals.

Codify and update the purpose of the state hospital and human service centers.

Create regulations defining behavioral health levels of care.

Improve contracts with hospitals and providers to include the language of

- no eject/no reject.
- requiring the use of Medicaid funding when eligible.
- expecting data when using public funding.

Clarify and maximize the use of telehealth to bolster psychiatric services in all areas.

Dedicate an implementation team to lead this project to completion.

North Dakota does not have time to continue to study this issue. Everyone knows the challenges. It is time to act. The public and private providers must work together to create a behavioral health system of care that every North Dakotan, no matter where they live, their age, gender or the color of their skin, can access. Now is the time to implement the system changes to prepare you for the century ahead.

Appendix A
Common Acronyms

1915i waiver - Medicaid state plan for home and community-based services
AIM - The main aim and questions addressed in the HSRI 2018 report
ASAM - American Society of Addiction Medicine
EMTALA - Emergency Treatment and Labor Act
HSC - Human Service Center
HSRI - Human Services Research Institute
ICF-PMI - Intensive Care Facility for Persons with Mental Illness
IHS - Indian Health Services
IMD - Institutions of Mental Disease
MHA - Mandan, Hidatsa and Arikara Nation, also known as the Three Affiliated Tribes
MSE - Medical Screening Examination
PRTF - Psychiatric Residential Treatment Facilities
QRTP - Qualified Residential Treatment Programs
REH - Rural Emergency Hospitals
SAMHSA - Substance Abuse and Mental Health Services Administration
SUD - Substance Use Disorder
VA - Veterans Administration

Appendix B
Interview Contact List

American Foundation for Suicide Prevention
Bismarck Schools
Cass County Jail
Community Consumers and Advocates
Community Uplift Program - Harbor Health Initiative
Department of Corrections and Rehabilitation, James River Correctional Center
Human Service Centers
Human Services Research Institute
Human Service Zones
Indian Affairs Commission
Indian Health Services Adolescent Treatment Center
Indian Health Services Behavioral Health and Substance Use Treatment Providers
Indian Health Services Great Plains
Mental Health America of North Dakota
Mandan, Hidatsa and Arikara (MHA) Nation including the Child Safety Center
Minot State University
Native, Inc.
North Dakota Behavioral Health Planning Council
North Dakota Department of Commerce
North Dakota Department of Health
North Dakota Department of Human Service Staff
North Dakota District Judge
North Dakota Hospital Association and Members
North Dakota Human Rights Commission
North Dakota Long Term Care Association and Members
North Dakota Medicaid
North Dakota Medical Association and Members
North Dakota State Board of Psychologist Examiners
North Dakota State Hospital, Dr. Rosalee Ethrington
North Dakota State University
North Dakota University System
North Dakota Veterans Administration Community Based Outpatient Clinics
Private Acute Care Hospitals
Private Substance Use Providers
Q-Space Bismarck
Sacred Pipe Resource Center
Sanford Health
Standing Rock Mental Health Providers
Standing Rock Tribal Veterans Service Office
State Refugee Services
State Representatives and Senators
Tribal Veterans Service Offices

Turtle Mountain Child and Family Services
Turtle Mountain Sacred Child Project
University of North Dakota/UNDSMHS
Veterans Affairs and service offices
Youth programs
Youth shelters

In addition, we spoke with 11 Native Americans, representing Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain, Band of Chippewa Indians, and the Mandan, Hidatsa and Arikara Nations, with lived experience receiving inpatient psychiatric health services in North Dakota and/or lived experience as a family member of North Dakota inpatient psychiatric service users.

Appendix C

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Appendix D

Existing State Buildings

NORTH DAKOTA STATE HOSPITAL BUILDINGS AND % OF USE

BUILDING #	BUILDING	USE	YEAR	SQ FT	% USED		FUTURE USE
2708	Electrical Substation	Main electrical substation for campus, houses, back-up generator	1984	1,800	100%	**FULLY USED**	JRCC
2318	Powerhouse	Centralized powerplant and smokestack	1914	39,285	100%		
2320	Sewage Lift Station	Sanitary sewer lift station to link with city water	2012	800	100%		
2534	Grounds Shop	Equipment storage	1956	3,200	100%		
	Vehicle Maintenance Shop	Equipment repair	1949	4,550	100%		
2415	Therapeutic Pool	All hospital therapeutic exercise	1967	6,800	100%		demolish
2605	Lahaug	Inpatient services	1984	143,127	90%	**PARTIALLY USED HOSPITAL SERVICES**	JRCC
2403	Gronewald-Middleton (GM)	Residential sex offender treatment	1956	82,670	60%		demolish
2501	New Horizons (NH)	Residential SUD services and inpatient treatment	1968	75,485	75%		demolish
2206-2308	7 Cottages	Residential services, student housing, storm accommodations	1954	21,000	75%		Retain if not replaced
2509	Learning Resource Center	Patient Services, Staff Offices, Café	1916	75,485	75%		demolish
	Greenhouse	Patient services, treatment space	1997	3,000	25%		move
2511	16 West	Plant Services offices and storage	1930	39,990	50%		demolish
2212	Superintendent Cottage	Storm sleeping rooms, event space	1917	5,552	20%		demolish
	Tunnels – Pedestrian	Pedestrian traffic and dietary delivery		24,832	60%		demolish
	Garages	Storage	1988	1,360	25%	**PARTIALLY USED STORAGE**	JRCC
2536	Grounds Warehouse	Supply storage	1917	2,755	25%		
2426	Warehouse 1	Storage	1929	6,020	10%		

2530	Warehouse 2	Plumbing and electrical storage	1925	23,414	10%		
2532	Grounds Implement Shed	Large equipment storage (garbage truck, etc….)	1926	5,370	20%		
2330	Quonset	Plant equipment storage	1965	3,130	25%		
2316	Administration Building		1916	24,675	0%	**UNUSED**	demolish
1954	Water Tower		-	-	0%		
1958	Water Pressure Pump House		1958	4,802	0%		
2317	Chapel		1961	13,140	0%		
2428	Water treatment (Mason		1958	4,802	0%		
	Employee Building		1952	34,345	0%		

Appendix E
Integrated Telehealth Partners Proposal

ITP Integrated Telehealth Partners

North Dakota Psychiatric Services Support

Executive Summary

Integrated Telehealth Partners (ITP) located in West Des Moines, IA has been providing Telepsychiatry Services since 2013. ITP is composed of a team of board-certified Psychiatrists, Psych Certified Nurse Practitioners, and Licensed Clinical Social Workers. Our team provides psychiatric assessments, medication management and therapy to Emergency Departments, Outpatient Clinics, Inpatient Units, Jails, and other organizations throughout the Upper Midwest including ND, MN, IA, WI, and NE.

Our Vision is to develop and implement a long-term telehealth services model to make timely access to psychiatric healthcare sustainable to underserved areas.

Our Focus is making quality behavioral healthcare available to patients at a reasonable price and at more opportune locations with the use of technology. We want to improve patient care and lower the financial burden on our healthcare system.

ER Telepsychiatry Crisis Service

Patients of all ages presenting with a mental health crisis to a hospital ER will be seen by a North Dakota licensed Psychiatrist or Psychiatric Nurse Practitioner within 2 hours of being contacted. ITP providers will complete a full psychiatric assessment, determine the appropriate level of care for the patient, and provide medications. ITP's Crisis Coordinator team will find placement for Inpatient Psych Beds, Substance Abuse Beds, or other appropriate levels of care for ER patients as deemed necessary by ITP provider.

ER Financial Proposal

ITP estimates an annual investment of $1.5 - $2.0 million dollars for 24 / 7 ER Telepsychiatry Crisis Services in all 36 Critical Access Hospitals in North Dakota.

County Jail Telepsychiatry Services

ITP will have Psychiatric appointments available 7 days a week. Urgent appointments will be available within 24 hours upon request. A psychiatric assessment will be completed by a North Dakota licensed Psychiatrist or Psychiatric Nurse Practitioner. Medications will be prescribed as needed to manage symptoms for inmates with a mental health diagnosis or a screened mental health need. ITP providers prescribe from a restricted jail formulary to control medication costs and avoid medications with abuse potential.

County Jail Financial Proposal

ITP estimates an annual investment of $500 - $750 thousand dollars for Telepsychiatry Services in all 24 County Jails in North Dakota.

Other Telepsychiatry Service Providers

1. **SOC Telemed (SOC)**
2. **Specialist TeleMed (STeM)**

Appendix F
Workforce Report

The North Dakota Behavioral Health Professional Workforce:
Solutions for Reducing Shortages in Rural North Dakota

SUMMARY

This current Behavioral Health (BH) Workforce Report supports our larger Study examining North Dakota's (ND) system-level capacities for providing acute psychiatric hospitalization and step-down residential treatment services. We therefore focus this Workforce Report on the BH professionals most needed for delivering BH services in treatment facilities—and on the ND institutions that educate and train these BH professionals. Solutions for decreasing shortages (and maldistributions) are presented for three areas considered most important by a range of BH stakeholders: (1) Incentives and Administrative Supports; (2) Improving the Clinical Training Environment; and (3) Licensure Issues. Solutions include adjustments to ND's BH Professions Loan Repayment Program; developing well-connected public-private Workforce Administration systems; creating high-performance clinical training sites in rural areas of the state; and modernizing the current BH professional licensing environment.

INTRODUCTION

The federal health agency SAMHSA defines the Behavioral Health (BH) workforce as including most professionals and paraprofessionals whose primary role involves providing care to persons experiencing mental health and addiction disorders and conditions. The ND Department of Human Services' (DHS) has defined the BH workforce as "all licensed and unlicensed staff providing prevention, early intervention, treatment, services, or supports to people with mental health conditions, substance use disorders, or brain injury" (DHS, January 2022: https://www.hsri.org/nd-plan).

BH Professionals who provide assessment, diagnostic, and treatment services—and whose services are typically reimbursable by both Public and Private payers—are the focus of this report. These professionals typically have Doctoral or Master's degrees in a Mental Health (MH) or Addictions field of study and have completed intensive levels of supervised clinical work. Once their degree and clinical practice requirements are completed, they may be licensed to practice as Tier 1 Psychiatrists, Psychologists, Psychiatric-Mental Health Advanced Practice Registered Nurses (APRNs), and Psychiatric Physician Assistants; and as Tier 2 Clinical Social Workers, Marriage & Family Therapists, Clinical Counselors, and Addictions Counselors. "Tiers" for defining the BH Professions was enacted during the 2017 Legislative Session (ND CC 25-01), subsection 01, page 1.

North Dakota's citizens are fortunate to have education and training programs for all BH professions in Tiers 1 and 2 with the exception of Marriage and Family Therapists. Table 1 shows all ND BH Professional Training Programs that lead to licensure in Tier 1 and Tier 2 BH professions. The University of North Dakota (UND) educates about 75% of students graduating from ND's BH professional training programs, as shown in Table 2 (2020 completions) and in Table 3
(Fall 2020 Enrollments).

All of North Dakota's Higher Education institutions provide BH services for enrolled students; and in some Tribal Colleges, students' family members. Only UND and NDSU have BH community clinics—the Northern Prairie Community Clinic at UND and the Community Counseling Services at NDSU. BH graduate students typically provide services under the supervision of BH Program faculty in these community clinics.

Table 1.
Tier 1 & Tier 2 Behavioral Health Professional Titles, North Dakota Degree Programs, & Academic/Licensure Requirements

Professional Title	ND Degree Programs[A]	Minimum Time[B] to Completion and ND Licensure Requirements
Tier 1a		
Psychiatrists[1,2,3,4]	▪ UNDSMHS	Doctoral (MD) 4-years degree followed by a 4-5 years Psychiatry Residency Program and National Board certification by the American Board of Psychiatry & Neurology.
Clinical & Counseling Psychologists[1,3,4]	▪ UND	Doctoral (PhD) 4-5 years degree (includes a 1-year internship) and National Board certification by the Association of State and Provincial Psychology Boards plus a ND-specific examination. Additional post-doctoral supervised training may be required.
Tier 1b		
Advanced Practice Nurses[3,4,5] Psychiatric-Mental Health Family	UND NDSU Univ of Mary	Master's (MSN) 2-3 years degree; Doctorate (DNP) 3-4 years degree; and National Board certification in 1 or more Specialty Areas.
Physician Assistants[1,3,4]	▪ UNDSMHS	Master's (MPAS) 2-years degree in Physician Assistant Studies and National Board certification by the National Commission on Certification of Physician Assistants.
Tier 2a		
Licensed Clinical Social Workers[1,2,3,4]	▪ UND	Master's (MSW) 1-3 years degree plus 3,000 hours of post-graduate supervised clinical work and National Board certification by the Association of Social Work Boards.
Licensed Marriage & Family Therapists[1,2,3,4]	None	Master's 2-3 years degree plus 3,000 hours of post-graduate supervised clinical work and National Board certification by the Association of Marital & Family Therapy Regulatory Boards.
Licensed Professional Clinical Counselors[2,3,4]	UND NDSU Univ of Mary Univ of Jamestown	Master's 2-3 years degree plus 3,700 hours of supervised clinical work of which 3,000 must be post-graduate and National Board certification by the National Board for Certified Counselors.
Tier 2b		
Licensed Addiction Counselors[2,3,4]	Minot State Univ Univ of Jamestown	Bachelor's degree from an accredited Addiction Studies program OR a bachelor's in a related field with a board-approved core curriculum plus 960 hours of supervised clinical work and National Board certification by the National Association for Alcoholism & Drug Abuse Counselors.
Licensed Master Addiction Counselors [2,3,4]	UND NDSU Univ of Mary	Master's 1-3 years degree in Addiction Studies OR a related Mental Health field with a board-approved core curriculum plus 2,000 hours of post-graduate supervised clinical work and National Board certification by the National Association for Alcoholism & Drug Abuse Counselors.
Registered Nurses[3,4]	▪ 10 NDUS Institutions[5] ▪ Univ of Mary ▪ Univ of Jamestown	Complete an Associate's or Bachelor's degree in Nursing approved by the North Dakota Board of Nursing plus supervised clinical work and National Board certification by the National Council on Licensure Examination.

	▪ Rasmussen Univ	

A. UND/SMHS = University of North Dakota/ School of Medicine and Health Sciences. NDSU = North Dakota State University; NDUS = North Dakota University System

B. All master's and doctoral degree programs require a bachelor's degree for entry which typically takes 4 years to complete.

1 = Sixth Biennial Report (2021) – Health Issues for the State of North Dakota, UNDSMHS

2 = Fact Sheets (2018) – Healthcare Workforce Group, UNDSMHS

3 = North Dakota Century Code Title 43 Occupations and Professions

4 = North Dakota Administrative Rules

5 = Valley City State University does not have a Nursing degree program.

Table 2.

ND's Tier 1 & 2 Behavioral Health Professional Degree Programs: Completions—2018-2020[1]

Academic Programs	2018	2019	2020
Minot State Addiction Studies BS	6	10	9
UND Counseling MA	28	33	40
Univ of Mary Counseling MS	0	0	22
NDSU Counseling MS	15	21	8
UND Social Work MSW	73	71	75
UND Physician Assistant Studies MPAS	28	33	28
UND Nurse Practitioner MS (APRN)	85	99	93
Univ of Mary DNP (APRN)	29	25	21
NDSU Nurse Practitioner DNP (APRN)	16	16	13
UND Counseling Psychology PhD	4	9	4
UND Clinical Psychology PhD	5	6	3
Total	287	323	316
UND	221	251	243
UND Percent	77%	78%	77%

1. Completions data from the NCES: Integrated Postsecondary Education Data System (IPEDS) Data for U. Jamestown not available.

Table 3.

ND's Tier 1 & 2 Behavioral Health Professional Degree Programs: 2021 Enrollments[1]

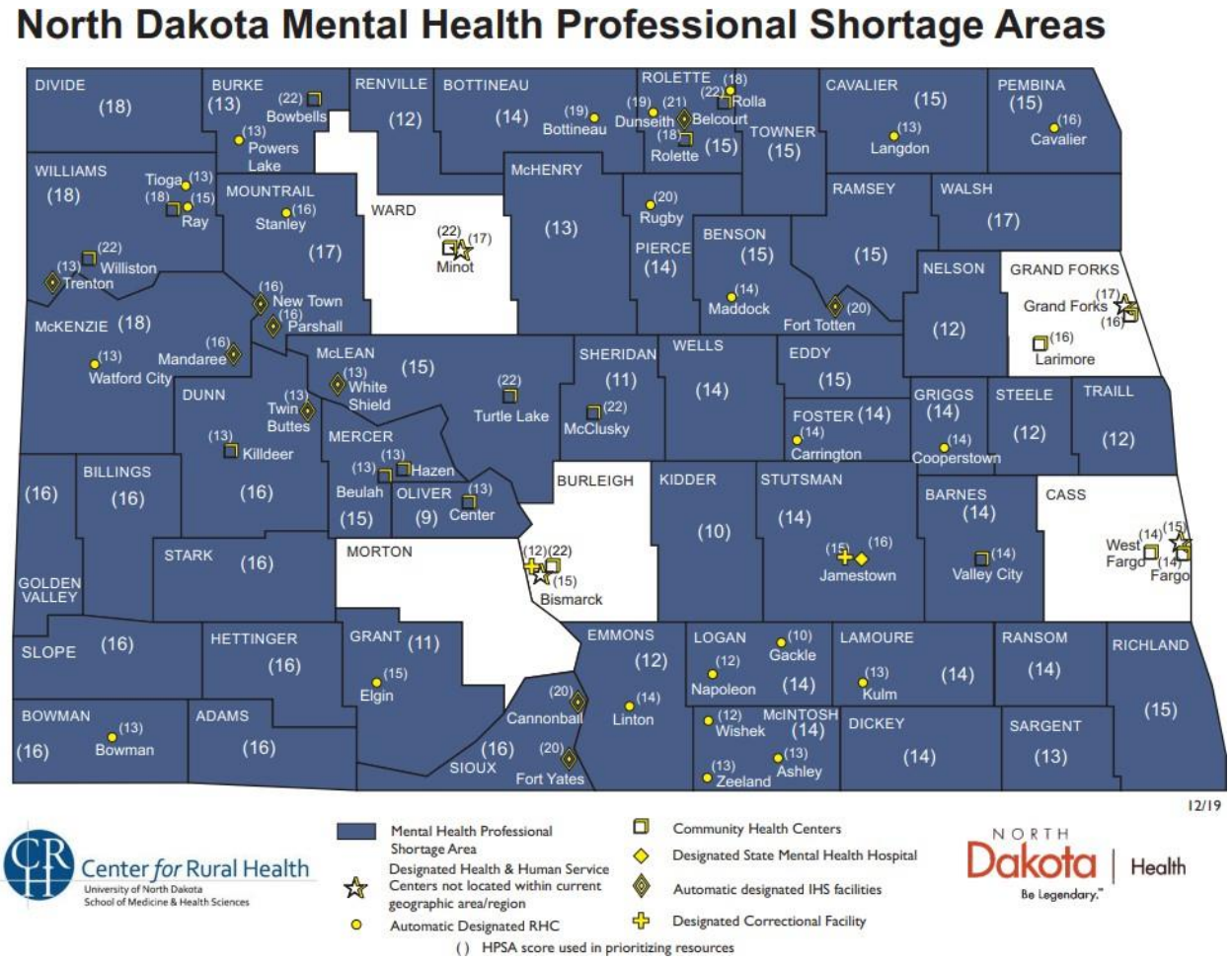
NDUS Academic Programs	Fall 2021
Minot State Addiction Studies	27
UND Counseling	97
NDSU Counseling	58
UND Social Work	160
UND Physician Assistant Studies	69
NDSU Nurse Practitioner: Family	55
UND Nurse Practitioner: Adult Gerontology	37
UND Nurse Practitioner: Family	240
UND Nurse Practitioner: Psychiatric-Mental Health	138
UND Counseling Psychology	33
UND Clinical Psychology	36

Total	950
UND Total	810
UND Percent	85%

1. Enrollment data from the North Dakota State Longitudinal Data Systems plus Heitkamp, T. January 2022 Testimony to the ND Interim Legislative Acute Psychiatric Treatment (APT) Committee Data for ND Private Institutions not available.

THE PROBLEM

ND's shortages of BH professionals is well-documented with 48 of 53 counties designated as being Mental Health Professional Shortage Areas (UNDSMHS Center for Rural Health 2020). Data provided by the CRH show that shortages predominate in rural areas:



Writing in the journal *Health Affairs*, Hope and colleagues (2013) blamed shortages of BH professionals on the chronic underfunding of BH care services—low reimbursement rates by Medicaid and Medicare—resulting in low pay and low resources environments. BH professionals also have high rates of burnout and turnover due to the complexity and demands of providing BH care services. These authors also discuss administrative gaps including a lack of standardized definitions, a lack of data collection and tracking, and

licensing requirements that vary from state to state. Beck et al. (2018) in a review of these issues also concluded that although extensive planning work is needed to improve our BH care delivery systems, there is a "lack of timely and usable data on the behavioral health workforce."

Addressing specifically the serious shortages of BH professionals in rural areas, a 2015 Nebraska survey of BH professionals and administrators reported that low pay, lack of loan repayment options, a lack of clinical supervisors, and complicated processes for Medicaid reimbursement and licensing were main problems in hiring and retaining Tier 1 and Tier 2 BH professionals (Watanabe-Galloway et al., 2015).

Finally, in the majority of states (30), the percentage of college graduates who take their first job in the same state in which they graduate is under 50%. In North Dakota, less than 40% of our college graduates remain in the state for their first post-degree job (EMSI & Wall Street Journal, 2018). Although data specifically for BH graduates in North Dakota are sparse, a study of APRN graduates in 2016 showed that about 50% remained in the state after graduation to work in their profession (UNDSMHS Sixth Biennial Report (2021)).

THE INVESTIGATION

In our current analysis of solutions to BH professional shortages in ND, we used the following Method:

1. Review of existing surveys conducted with ND BH stakeholders
2. Conduct interviews with ND's Program Directors/Leaders of BH Professional Degree Programs*
3. Survey Human Services Centers Leaders about Training Environments
4. Incorporate findings from ND and other states to develop a set of Solutions for ND

*To our knowledge, this is the first systematic review of ND's BH Professional Workforce that includes interview data from Professional Degree Programs Directors/Leaders.

Our review of ND-specific information began by examining several Interim Legislative Committee studies and Legislative actions by the ND Legislature in the past decade. Excluding appropriations bills, there were 25 BH Workforce bills passed during the 2011-2021 Legislative sessions with a substantial percentage passed during the 2015-2019 sessions. A majority of the legislative actions were related to the regulation and defining of BH professionals' titles, scopes of practice, and licensing requirements. For a complete listing of legislative bills and interim studies, see the excellent summary compiled by the North Dakota Legislative Council: *Legislative Bills and Studies Relating to Behavioral Health Workforce* (2022). (North Dakota Legislative Council 2020)

Next, we reviewed two large surveys of BH stakeholders in ND conducted by researchers at the Center for Rural Health (Schroeder & Vanderzanden, 2018) and a ND Department of Human Services (DHS) commissioned study by the consultant group, Health Services Research Institute (HSRI, 2018). The CRH study found that the top three most consistently endorsed solutions for increasing the North Dakota BH workforce were the following:

(1) Adjustments to state licensing and scope of practice regulations;
(2) Practical and effective loan forgiveness programs;
(3) Increasing telebehavioral health.*

*Strategies for increasing telebehavioral health are discussed in another section of the main report.

Incorporating the work of the CRH survey results, the comprehensive BH study from HSRI provided these additional recommendations related to the professional BH workforce:

(4) Raise awareness of student internships/rotations;
(5) Establish a single entity for supporting workforce;
(6) Develop a single database of statewide vacancies for behavioral health positions.

The Interviews

We interviewed Deans, Chairs, and Program Directors of all ND Public BH Tiers 1 and 2 Professional Programs with the exception of undergraduate programs in Nursing. We also interviewed Leaders from Advanced Practice Nursing Programs specializing in Family Practice and for the Physician Assistant Studies Program due to their potential as a pathway for these professionals practicing in BH Care settings. Interviews with Tier 3 Program Leaders are not included in this report.

We interviewed a range of professionals working as BH Workforce Administrators including at the UNDSMHS' Center for Rural Health (CRH), the Department of Health (DoH), the North Dakota University System Office (NDUS), the Department of Commerce, and members of BH Professions Licensing Boards. We received information from HSC Leaders about their training environments. We were unable to interview Area Health Education Centers Leaders.

During the interviews, we asked Program and Administrative Leaders to consider the effectiveness of solutions identified by ND surveys and other regional reports; and to identify any additional solutions they considered important for increasing the numbers of their students practicing in ND's underserved BH settings. Findings are integrated into each of the areas identified as **Solutions for ND.**

SOLUTIONS FOR NORTH DAKOTA

We categorize findings and solutions into three main areas identified by survey and research findings and our interviews with Professional Programs Leaders and Administrators: Incentives and Administrative Supports; Improvements to the Clinical Training Environment; and Licensure Issues.

Incentives and Administrative Supports

State-funded loan repayment programs (LRPs). The Administrative Group responsible for ND's BH Professional Student Loan Repayment Program thought that more funding would be helpful given current applications far exceeded the number of awards available. In 2021, 7 BH professionals were awarded LRP funds out of 32 applications (email correspondence, DoH, December 2021). The legislatively approved total budget for the 2021-2023 Health Professional Loan Repayment Program was $2,120,345 and includes the professions of Medical, Dental, Veterinarians, and BH. BH had the lowest percentage of the budget—18.5% ($392,125). The highest percentage was for Medical (33.4%; $708,220).

Other regional studies of BH recruitment strategies for rural states indicate a top strategy has been to increase options for LRPs. A recent review suggests that targeted scholarships with service requirements are more likely to be effective compared to LRPs; and that efforts directed at undergraduates may be more effective than outreach to middle/high school students (Baum & King, 2020).

One administrator thought that by limiting the LRP awards to already licensed BH professionals, opportunities at influencing practice decisions at earlier stages in the "pipeline" are reduced. An additional observation by our study team is that LRP award conditions may reduce their incentive impact; and may reduce the overall performance of Clinical Training sites' teaching and supervision missions. The language from the Century Code is the following*:*

"…must be employed full-time providing direct patient care in the appropriate settings, no more than 8 hours of a full-time provider's weekly hours will be spent on administrative duties of the aforementioned full-time equivalency, and/or serving as a clinical preceptor; and telehealth providers must live in North Dakota, be physically present and provide services on at least a half-time basis at one entity that meets the site requirements, and provide telehealth services to a second entity meeting the site requirements. Services to both entities combined must meet the full-time requirement defined above." [North Dakota Century Code Chapter 43-12.3] *(pgs. 1-2)*

Program Leaders generally agreed that having more LRP funds available for BH professionals was needed, especially for Tier 2 BH professionals; and generally agreed that more targeted scholarships with service requirements in underserved areas could be an effective strategy.

Single entity for supporting the BH Workforce. Currently, there is a loosely-knit organization of Health Workforce administrators and researchers who provide most of the public support for the recruitment and retention (R&R) of ND's Primary Health (PH) workforce (including Psychiatrists), and since 2015, the BH Workforce. The bulk of activities are conducted at the Center for Rural Health at the UNDSMHS in partnership with the Departments of Health and Human Services and with oversight from the 30-member Governor-appointed Behavioral Health Planning Council.

These Administrative Groups administer loan repayment programs, provide R&R/outreach, and provide vital health workforce data. The UND College of Education houses a federally-financed Behavioral Health Workforce Education & Training (BHWET) program (described in the next section); Area Health Education Centers (AHECs) focus on K-12 outreach; and other state agencies such as NDUS and the Department of Commerce contribute to data collection to some degree. Most private healthcare systems have their own R&R activities. BH professional associations, county and city administrators and others are also often involved in R&R activities.

Interviews with Workforce Administrators suggest that administrative and research/data collection activities have steadily increased over the past few years. To our knowledge, the only ongoing source of publicly available BH workforce data—with interpretation of trends and other issues—comes from the CRH SMHS biennial and supplemental publications (Boards provide licensing information for a fee). Administrators were unsure if a single entity was needed, and if so, where and how that entity would be administratively structured.

Develop a single database of statewide vacancies for behavioral health positions. One health workforce administrator said there are future plans through the Departments of Health and Human Services to establish a modern health workforce tracking system. However, the initial efforts will reportedly focus on the Primary Health (PH) workforce with plans to integrate BH professions data at a later time.

Adoption of a "Minimum Data Set" for tracking and reporting BH professions practice patterns is considered an essential best practice for creating high-performance BH Care delivery systems (Beck, Singer et al., 2018). Minimum data includes BH professionals' demographics, licensure and certification, education and training, occupation, and practice characteristics and settings. For example, currently the ND Licensing Board for Psychologists does not collect ongoing information about types and locations of practices. The most recent testimony on this topic by ND BH Professional Licensing Boards and the ND Attorney General's Office suggests that more consolidation of the multiple Boards' administrative duties could provide more standardization and streamlining of the licensure process (North Dakota Legislative interim APT Committee, 2022) https://www.ndlegis.gov/assembly/67-2021/committees/interim/acute-psychiatric-treatment-committee.

One example of a consolidated BH licensing Board is available here: Nebraska Behavioral Health Workforce Dashboard.

Recommended Actions

▪ Remove LRP restrictions that limit supervisory or admin time for teaching and training.
▪ Consider LRP changes that allow more job flexibility (hours, locations).
▪ Allow pre-licensed students to apply for LRPs and receive decisions, contingent upon licensure. (Applications at the pre-licensed phase provide opportunities for recruitment efforts).
▪ Increase state funded LRPs for non-MD BH professionals to at least 75% of Medical funds; a portion of funds should be dedicated for targeted scholarships with service requirements in priority areas.
▪ Coordinate/reorganize and fund Administrative Workforce supports at appropriate levels.
▪ Develop standardized "minimum data set" processes for collecting PH and BH workforce data.

Improving the Clinical Training Environment

During interviews with BH Professional Programs Leaders at UND and NDSU, we discussed what solutions they thought could increase the number of their graduates who go on to provide BH services in ND and in non-urban areas of the state. The Program Leaders generally agreed that additional financial incentives for students from LRPs to targeted scholarships with service requirements would be helpful. Several Program Leaders identified that a core limitation for graduating more BH professionals is having sufficient numbers of clinical preceptors/supervisors in healthcare sites around the state for students to acquire their pre- and often post-graduate training requirements for licensure. Advanced Practice Nursing and Physician Assistant Studies Leaders were most concerned about the increasingly competitive and finite set of "slots" that meet the training requirements for their students. Advanced Practice Nursing Programs face intense competition from other ND APRN Programs and from Minnesota APRN Programs.

Psychiatry Residency Leaders also viewed the problem from the preceptor side of the equation and said that clinical preceptors for PH and BH trainees are in high demand but often are not allowed compensated time for supervision and teaching activities in hospital settings. Psychiatry Leaders said that payments to preceptors could help sustain and improve training programs for BH professionals. This is consistent with some Model Programs Solutions described below.

Psychiatry Leaders recognized the need for additional Child Psychiatrists in the state and have had discussions for establishing a subspeciality for Child and Adolescent Psychiatry.

The Physician Assistant Studies (PA) Program and the Family DNP Program at NDSU do not offer specialized training in Psychiatry-Mental Health, but both Program Leaders expressed strong interest in "growing" more PAs and APRNs that could provide BH services in underserved areas. There is evidence that increasing the number of Psychiatric APRNs and PAs is an important strategy for increasing the BH Psychiatric Workforce in rural areas if allowed to practice at the "top" of their licenses. In ND, both APRNs and PAs are working at the full scope of their practices. And there is evidence that Psychiatric APRNs and PAs are more likely than Psychiatrists and other PH MDs to practice in rural areas (Pietras & Wishon, 2021).

Program Leaders for UND's Master's level Programs in Social Work and Counseling at UND agreed that providing their ND-based students with clinical training experiences in a diverse range of settings across the state was a challenge. They also endorsed the need for more scholarships and effective outreach efforts for recruiting students into the BH Professions. The Addictions Studies Program Leaders at Minot State felt that their clinical training needs were reliably met due to the existence of a well-established Addictions Counseling Training Consortium.

Clinical and Counseling Doctoral Psychology Program Leaders felt relatively confident that they could continue to maintain sufficient numbers of clinical placement sites for their students. They recognized a need for placing more students and licensed Psychologists in underserved areas of the state and a need for more specializations in Child and Adolescent Psychology. Discussions have been ongoing for establishing an APA-approved internship in Minot as a way to recruit and retain Psychologists in western areas of the state. One Psychology Leader felt that adding 1-2 slots into their training program with funded scholarships tied to service requirements in the state would increase the number of Psychologists who chose to practice in ND.

An excellent example of an innovative BH Training Program is UND's federally-funded Behavioral Health Workforce Education & Training (BHWET) Program. The Program is directed by faculty in UND's Department of Counseling Psychology but supports most Tier 1 and Tier 2 BH Professions Programs at UND. The BHWET Program uses an interdisciplinary, team- and evidence-based model for training. Students receive substantial stipends during their training. The BHWET Program currently lists over 30 clinical training sites including several in underserved areas of ND. While the program is grant-supported and limited to UND students, its successes could serve as a blueprint for creating more high-performance training sites across the state funded by a combination of federal, state, and private funds.

Most HSC Directors reported some level of student training at their facilities including an APA-approved training site for Psychologists at the Southeast HSC. One HSC site said that they were able to recruit BH professionals by employing students in non-professional positions who have not yet received their Master's degree with the agreement that post-graduate supervision will be provided at the HSC in return for providing professional services after licensure (or paying for the supervision).

Both Doctoral Psychology Program Leaders lamented that the ND Human Services Centers no longer provided any paid clinical placements for their Doctoral students and said that in years past, the HSCs were integral to their clinical training programs. The UND College of Education & Human Development Dean, Dr. Cindy Juntunen, felt that the HSCs could be model training sites for high-performing, team-based clinical training that would extend to all Tier 1 and Tier 2 professionals, providing more quality placements for students and services for communities. This is consistent with the HSCs educational and community service missions [North Dakota Century Code: 75-05-03 (subsection 06, page 6); 50-06 (subsection .01, page 1)]. It is recognized that one of the most important factors in deciding to practice in rural areas is having had clinical placement experiences in those settings (UNDSMHS Biennial Report, 2021).

Other States' Solutions for Improving the Clinical Training Environment: Several states are facing similar problems of maintaining sufficient clinical placements and experiences for their BH Professions students. Several states have enacted or have pending legislation for providing funds, typically Medicaid, for services by unlicensed trainees/interns; and/or for providing funds for clinical supervisors and other administrative costs.

Ohio and Indiana currently allow Medicaid reimbursement for trainees/interns providing BH Care services. In Georgia, Community Service Boards can receive direct payments for collaborating with approved Graduate Medical Education programs (Washington State Health Care Authority, Report to the Legislature. 12.1.2020; Ohio Laws & Administrative Rules). In Minnesota, clinical facilities can be paid directly from the Medical Education and Research Costs (MERC) Fund for supervising students in several different health training programs including BH. The MERC fund is from Medical Assistance and Prepaid Medical Assistance Program claims revenue (Minnesota Department of Health).

Recommended Actions

▪ Support integration of HSCs' and BH Professions Degree Programs' Teaching and Training missions. Seek integration with private community health agencies.
▪ Provide a grant fund similar to Minnesota's MERC Program in which BH Care facilities may be reimbursed for preceptors/supervisors teaching and training costs for ND BH Professional Program students.
▪ Provide matching funds for federally- and university-supported high performance BH Training and Professional Service Programs such as BHWET, in underserved areas and for youth. Seek matching contributions from private health organizations.

Licensure Issues

Most BH Professional Programs Leaders felt that licensing practices for their professional disciplines was appropriate and not overly restrictive. However, there continues to be Legislative inquiries to determine if ND's BH Professions Licensing Boards are effective and timely in their support of the BH Professions Workforce. We examined other state's BH Professions Licensing laws as a guide and found at least three strategies for consideration in ND.

Table 4.
Other States' Recent Modifications to BH Professions Licensing Laws

Legislative Actions	Means of Improving Workforce and Behavioral Health Services
Composite Licensure Boards	Provide consistent regulatory oversight, streamline processes, and remove barriers to interprofessional services
Interstate Telehealth Compact	Promote the ability to provide services across state lines
Universal Licensure Recognition	Promote easy relocation of licensed professionals

Composite Licensure Boards: State composite Boards regulate more than one behavioral health profession. A recent review (Beck, Page et al., 2018) showed that almost all states (48) had at least one BH Professions composite board overseeing at least 2 BH professions. The most common composite Boards (in 27 states) were combinations between Marriage & Family Therapists (MFTs) and Counselors with several also combining with Addiction Counselors. Only North Dakota and Alaska did not have any composite boards. Composite boards provide consistent regulatory oversight while streamlining licensure processes, reducing interprofessional conflict and turf protection and encouraging interprofessional services and recognition of

commonalities between professions. As one example, BH composite boards generally facilitate cross-professions supervision where trainees in one profession are permitted to be supervised for licensure by practitioners in other related professions. In 2017, ND legislation was enacted which allowed for up to 50% of required supervision for BH Tier 2 professional licensure to be provided by other qualified professionals—with varying conditions and approvals that must be met.

Interstate Telehealth Compact (PSYPACT) and Temporary in-person, face-to-face practice: Twenty-eight states—Alabama, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin—have adopted an interstate telehealth compact for psychologists, known as PSYPACT. PSYPACT makes it easier for psychologists to practice telepsychology (providing services remotely) and temporary in-person, face-to-face practice across state borders within the compact, reducing burdens of maintaining multiple licenses across states. Legislation is active in another 9 states -- Massachusetts, Michigan, Indiana, Florida, Washington, South Carolina, Connecticut, Idaho, and Rhode Island, plus the commonwealth of the Northern Mariana Islands.

Universal Licensure Recognition: Universal licensure is when a state recognizes as valid a person's occupational license granted in another state. Currently, 12 states have enacted bills that require their occupational boards to allow individuals with out-of-state licenses to obtain a valid occupational license to practice, with some limitations.

Six states have enacted universal licensure laws that include all occupations: Idaho, Missouri, Nevada, New Hampshire, New Mexico, and Pennsylvania (Sims, 2020).

Recommended Actions

▪ Support forming a composite Board for Marriage & Family Therapists, Counselors, and Addiction Counselors; Standardize administrative processes for all BH Professions Boards.
▪ Support PSYPACT agreement for Psychologists.
▪ Consider Universal Licensure Recognition.

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Appendix G

Implementation Plan

Short term plan remainder of 2021-2023 biennium

Action Step	Legislation Required	Priority	Page number
Draft proposal to build a modern hospital with projected costs	None - Direct HHS to pursue	High	8
Draft proposal for LaHaug retrofit for the Department of Corrections	None -Direct DOC to pursue	Medium	10
Develop regulations to fund acute psychiatric services/beds in Critical Access Hospitals	The committee shall recommend a bill draft to address this issue	High	11
Clarify Administrative Code 33-07-01 that emergency behavioral health services can be provided in emergency departments in all hospitals	The committee shall recommend a bill draft to address this issue	High	12
Continue and increase use of Coordinated Care Agreements between IHS and stakeholders	None - Direct HHS and cultural affairs agents to pursue and develop an action plan	High	14
Evaluate the admissions process transfers from hospitals to residential placements for children and adolescents	Department of health and human services shall conduct an functional process audit	High	19
Codify the purpose of the state hospital and human service centers	The committee shall recommend a bill draft to address this issue	High	19
Improve accountability in contracts for hospitals and providers	None - Direct HHS to pursue	High	25
Define mental health levels of care by rule	The committee shall recommend a bill draft to address this issue	High	26

Fund implementation team	The committee shall recommend a bill draft to address this issue	High	26
Improve communications and collaboration between IHS, providers and the state	None - Direct HHS and cultural affairs agents to develop an action plan	High	28
Maximize use of full service telepsychiatry across the state	The committee shall recommend a bill draft to address telehealth language for parity with face-to-face service delivery in all locations.	High	32

Long term plan 2023-2025

Action Step	Legislation Required	Priority	Page number
Break ground on modern hospital facility	Appropriation	High	8
Provide funding for LaHaug retrofit to be utilized by the DOC	Appropriation	Medium	11
Demolish unused state hospital supplemental buildings	Appropriation	Medium	11
Conduct a state fiscal audit on the state hospital and human service centers	Under the oversight of the State Auditor	High	23
Assign a cultural liaison between minority population groups and HSCs, the State and healthcare stakeholders	Appropriation	High	29
Codify state-administered licensing boards	The committee shall recommend a bill draft to address this issue and address telepsych parity throughout	Medium	33
Codify universal licensing	The committee shall recommend a bill draft to address this issue	Medium	33
Codify composite licensing boards	The committee shall recommend a bill draft to address this issue	Medium	33