

# **HEALTH SERVICES COMMITTEE**

The Health Services Committee was assigned the following responsibilities:

- Study state and federal laws and regulations relating to the care and treatment of individuals with developmental disabilities or behavioral health needs pursuant to Section 33 of House Bill No. 1012 (2017).
- Study the state's early intervention system for children from birth to age 3 with developmental disabilities pursuant to Section 2 of Senate Bill No. 2325 (2017).
- Receive a report on the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes pursuant to of North Dakota Century Code (NDCC) Section 18-13-02(6).
- Receive a report from the Department of Human Services (DHS), State Department of Health, Indian Affairs Commission, and Public Employees Retirement System (PERS) on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes pursuant to NDCC Section 23-01-40.
- Receive a report by the State Department of Health regarding progress made toward the recommendations relating to the quality of care for individuals with stroke pursuant to NDCC Section 23-43-04.
- Contract with a private entity, after receiving recommendations from the Insurance Commissioner, to provide a cost-benefit analysis of every legislative measure mandating health insurance coverage of services or payment for specified providers of services, or an amendment that mandates such coverage or payment pursuant to NDCC Section 54-03-28.
- Receive a report from DHS regarding the status of the children's prevention and early intervention behavioral health services pilot project pursuant to Section 3 of House Bill No. 1040 (2017).
- Receive a report from the State Department of Health on the results of the independent review of the tobacco prevention and control plan's effectiveness and implementation pursuant to Section 16 of Senate Bill No. 2004 (2017).
- Receive a report during the 2017-18 interim from the North Dakota Board of Social Work Examiners, Board of Addiction Counseling Examiners, Board of Counselor Examiners, and North Dakota Marriage and Family Therapy Licensure Board on the status of implementation of supervision and training requirements pursuant to Section 5 of Senate Bill No. 2033 (2017).
- Receive a report from the Task Force on Children's Behavioral Health regarding the task force's efforts and on its findings and recommendations and any proposed legislation necessary to implement the recommendations pursuant to Sections 4 and 5 of Senate Bill No. 2038 (2017).

Committee members were Senators Judy Lee (Chairman), Tom Campbell, Robert Erbele, Tim Mathern, and Nicole Poolman and Representatives Bert Anderson, Pamela Anderson, Gretchen Dobervich, Karla Rose Hanson, Karen Karls, Aaron McWilliams, Karen M. Rohr, Mary Schneider, and Kathy Skroch.

The committee submitted this report to the Legislative Management at the biennial meeting of the Legislative Management in November 2018. The Legislative Management accepted the report for submission to the 66<sup>th</sup> Legislative Assembly.

## **STUDY OF DEVELOPMENTAL DISABILITIES AND BEHAVIORAL HEALTH NEEDS**

Section 33 of House Bill No. 1012 (2017) directed a study of state and federal laws and regulations relating to the care and treatment of individuals with developmental disabilities or behavioral health needs. The study follows previous legislative studies from the 2013-14 interim and 2015-16 interim Human Services Committees' studies of behavioral health needs. The study must include the state's services and delivery systems, including whether changes are necessary to maintain compliance with state and federal laws and regulations; efforts by other states to comply with the 1999 *Olmstead v. L.C.* case, including the planning and implementation process for any new programs; community- and non-community-based services, including the costs and effectiveness of services; noncompliance with state and federal laws and regulations, including a review of the fees and penalties for noncompliance; a comparison of voluntary and involuntary compliance with state and federal laws and regulations, including a review of long-term costs and effectiveness; the impact of implementation and expansion of selected programs that were added to address unmet needs, including the impact on costs and effectiveness of new programs; needed changes to address noncompliance and a timeline for completing changes; data on the number

of individuals who would be impacted by voluntary compliance efforts, and data on the type of services that may need changing, including housing, peer counseling, outpatient treatment, crisis line access, and transportation services; and an evaluation of the funding, mission, and caseload at the Life Skills and Transition Center, including the center's transition plan and number of clients eligible for community placement.

## **Background**

### **2013-14 Interim Human Services Committee - Study of Behavioral Health Needs**

During the 2013-14 interim, the Human Services Committee was assigned a study of behavioral health needs pursuant to Section 1 of Senate Bill No. 2243 (2013). The study included consideration of behavioral health needs of youth and adults and consideration of access, availability, and delivery of services. The committee contracted with Schulte Consulting, LLC, to assist with the behavioral health needs study. The consultant's report identified six primary opportunities to better address behavioral health needs of youth and adults in North Dakota, which included service shortages, workforce expansion, insurance coverage changes, changes to the structure and responsibilities of DHS, communication improvement, and data collection and research expansion.

### **2015-16 Interim Human Services Committee - Study of Behavioral Health**

During the 2015-16 interim, the Human Services Committee continued with a study of behavioral health needs pursuant to Section 7 of Senate Bill No. 2048 (2015). The study included consideration of behavioral health needs of youth and adults and access, availability, and delivery of services. As part of its study, the committee also reviewed key legal obligations related to behavioral health services.

## **Overview**

### **Statutory References**

North Dakota Century Code Section 50-06-01 defines "behavioral health" as the planning and implementation of preventative, consultative, diagnostic, treatment, crisis intervention, and rehabilitative services for individuals with mental, emotional, or substance use disorders, and psychiatric conditions.

North Dakota Century Code Section 25-01.2-01 defines "developmental disability" as a severe, chronic disability of an individual which is attributed to a mental or physical impairment, or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more areas of major life activities; and reflects the individual's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

North Dakota Century Code Section 50-06-01.4 requires the structure of DHS to include the State Hospital, the regional human service centers, a vocational rehabilitation unit, and other units or offices and administrative and fiscal support services as the Executive Director determines necessary. The department must be structured to promote efficient and effective operations and consistent with fulfilling its prescribed statutory duties, shall act as the official agency of the state in the discharge of functions not otherwise by law made the responsibility of another state agency, including among others administration of programs for individuals with developmental disabilities, including licensure of facilities and services, and the design and implementation of a community-based service system for persons in need of habilitation; and administration of behavioral health programs. To administer behavioral health programs, the section requires the department to establish a policy division responsible for reviewing and identifying service needs and activities in the state's behavioral health system in an effort to ensure health and safety, access to services, and quality of services; establishing quality assurance standards for the licensure of substance use disorder program services and facilities; and providing policy leadership in partnership with public and private entities. The department also must establish a service delivery division responsible for providing chronic disease management, regional intervention services, and 24-hour crisis services for individuals with behavioral health disorders.

North Dakota Century Code Section 25-04-01 provides for DHS to administer and control the Life Skills and Transition Center in Grafton for individuals with developmental disabilities. The purpose of the center is to maintain the relief, instruction, care, and custody of individuals with developmental disabilities or other individuals who may benefit from the services offered at the center; and to provide onsite and offsite additional services and effectuate its powers and duties to best serve individuals with developmental disabilities and other individuals who may benefit from those activities.

## **Department of Human Services - Organizational Structure**

The mission of DHS is to provide quality, efficient, and effective human services, which improves the lives of people. The department is updating its vision, values, and how it measures success. The department anticipates

using a concept called *the social determinants of health* for its foundation for developing its vision and priorities. The concept is about the health and well-being of all, and includes:

- Economic stability - Including employment, level of income, expenses, debt, medical bills, and support.
- Neighborhood and physical environment - Including housing, transportation, safety, parks, playgrounds, and walkability.
- Education - Including literacy, language, early childhood education, vocational training, and higher education.
- Food - Including addressing hunger and providing access to healthy options.
- Community and social context - Including social integration, support system, community engagement, and preventing discrimination.
- Health care system - Including health coverage, provider availability, provider linguistic and cultural competency, and quality of care.

### **Behavioral Health Division**

The committee received information from the Behavioral Health Division regarding its responsibilities and current initiatives. The Behavioral Health Division is responsible for reviewing and identifying service needs and activities in the state's behavioral health system in an effort to ensure health and safety, access to services, and quality of services; establishing quality assurance standards for the licensure of substance use disorder program services and facilities; and providing policy leadership in partnership with public and private entities. The division provides functions including regulation, administrative, workforce development, prevention and promotion, and partnerships. The regulation function includes licensing of various entities, including substance abuse treatment programs, opioid treatment programs, human service centers, psychiatric residential treatment facilities, driving under the influence seminar programs, and updating administrative rules. The administration function includes administering the mental health block grant, the substance abuse block grant, community and tribal prevention grants, the substance use disorder voucher, the problem gambling program, brain injury programs, and 2-1-1 services. The workforce development function includes providing training and technical assistance relating to best practices, program licensing, prevention, data collection, and evaluation; training through behavioral health conferences; training for mental health first aid, and establishing partnerships with various institutions and consortia. The prevention and promotion function includes creating resources, including the Parent's Listen, Educate, Ask, Discuss program, the Speaks Volume program, the prescription drug take back program, prevention and media center resources, and tribal and community prevention programs. The partnerships function includes providing support to other groups, including the Behavioral Health Planning Council, the children's behavioral health task force, the Governor's Prevention Advisory Council, the State Epidemiological Outcome Workgroup, the Brain Injury Advisory Council, and ND Cares Task Force.

### **Substance Use Disorder Voucher Program**

The committee received an update regarding the substance use disorder voucher program which was implemented pursuant to Senate Bill No. 2048 (2015) and began in July 2016. The program was implemented to address barriers to treatment and increase the ability of people to access treatment and services for substance use disorders. The committee was informed 12 private substance abuse treatment providers were participating in the program as of July 2018. Of the 946 individuals who applied to receive a voucher, 913 were approved during the period of July 2017 to April 2018.

### **Justice Reinvestment Initiative - Free Through Recovery Program Update**

The committee received updates regarding the Justice Reinvestment Initiative pursuant to Senate Bill No. 2015 (2017). The program is a partnership between the Department of Corrections and Rehabilitation and DHS. The behavioral health component of the Justice Reinvestment Initiative is called the free through recovery program. The mission of the free through recovery program is to improve health care outcomes and reduce recidivism by delivering high-quality community-based behavioral health services, linked with effective community supervision. The free through recovery program is a performance-based program, and providers of the program are reimbursed based on outcomes. The four outcomes being measured include stable housing, stable employment, recovery, and reduced criminal justice involvement. The payment includes a monthly base rate and a 20 percent incentive if the individual participants meet three of the four identified outcomes.

The reports stated services began on February 1, 2018, and the program serves individuals with a serious and persistent mental illness or a moderate or severe substance use disorder. Through April 2018, 328 referrals have been made and 289 participants have entered the program. The program has a capacity to serve up to 670 individuals. Sixty-eight percent of the participants had co-occurring disorders. Ninety percent of the participants

had a substance use need. Ninety-seven percent of the participants were at a moderate, moderate-high, or high risk for future crime. After 1 month of data, the committee was informed 78 percent of participants met three of the four outcomes.

### **University of North Dakota - School of Medicine and Health Sciences Center for Rural Health**

The Behavioral Health Division contracted with the University of North Dakota - School of Medicine and Health Sciences Center for Rural Health to develop a report of available telehealth services for behavioral health. Testimony indicated telehealth services are being provided and are reimbursable for selected addiction services.

The division also contracted with the center to create a comprehensive behavioral health workforce development plan to increase the number of behavioral health providers and to facilitate the development of a peer support specialist certification. Recommendations included:

- Establish the infrastructure available to support and coordinate workforce development efforts;
- Develop and provide ongoing support for the paraprofessional behavioral health workforce; and
- Support the development and adoption of mechanisms to enhance the capacity of the existing workforce.

According to testimony, 43 states have established Medicaid reimbursable programs to train and certify peer specialists. The department is reviewing the possibility of developing a federal 1915(i) Medicaid state plan amendment. The department has provided four scheduled trainings throughout the state for peer support specialists and almost 100 individuals have been trained as peer support specialists. Eight individuals also have completed a Train the Trainer program, which allows individuals to provide peer support training.

### **Human Services Research Institute**

The Behavioral Health Division contracted with the Human Services Research Institute for \$160,000 to conduct a review of the state's behavioral health systems. The committee received the institute's report entitled *North Dakota Behavioral Health Systems Study - Final Report*. The report provided 65 specific recommendations in 13 areas. The 13 areas include developing a comprehensive implementation plan; investing in prevention and early intervention; ensuring individuals have timely access to appropriate behavioral health services; expanding the types of outpatient and community-based services; enhancing and streamlining the system of care for children and youth with complex needs; continuing to implement and refine the criminal justice system strategy; engaging in targeted efforts to recruit and retain a qualified and competent behavioral health workforce; continuing to expand the use of telebehavioral health interventions; ensuring the system reflects its values of person-centered, cultural competency, and trauma-informed approaches; encouraging and supporting communities to share responsibility with the state for promoting high-quality behavioral health services; partnering with tribal nations to increase health equity for American Indian populations; diversifying and enhancing funding for behavioral health; and conducting ongoing, statewide, data-driven monitoring of need and access.

The department has also contracted with the institute for \$178,000 to develop an implementation plan for the study. The department reported it will begin the first phase of implementation between September and October 2018. The first phase will include planning and organizing recommendations into categories to determine which recommendations require legislative involvement and which can be addressed by agency policies, licensing boards, providers, or advocacy groups. The second phase will include prioritization and refinement of the recommendations and will occur between November and December 2018. The third phase will include implementing the recommendations and will occur between January and March 2019. The fourth phase will include monitoring and sustaining implementation and will occur between April and June 2019.

### **State Hospital and Regional Human Service Centers**

The committee received information from the State Hospital regarding its responsibilities and initiatives. Services at the State Hospital include traditional behavioral health hospital services, residential sex offender treatment, and residential substance use disorder treatment services under contract with the Department of Corrections and Rehabilitation. The committee was informed individuals must meet medical necessity to be admitted in a hospital setting. Individuals are committed to the State Hospital by voluntarily admitting themselves, by a guardian, or by a court order. The number of individuals served at the State Hospital has been consistent over the last 3 years.

The committee received information from the regional human service centers regarding their responsibilities and initiatives. Sixty percent of the staff at the regional human service centers are involved with providing behavioral health-related services. The remaining 40 percent are involved with a combination of developmental disabilities, child welfare, adult protection, and vocational rehabilitation services. Developmental disabilities services include eligibility determination, individualized service planning, and quality monitoring of community providers. Regional

supervision includes the supervision of child protection investigations, foster care licensing, foster care placement, and child care licensing. Adult protection services include adult protection investigations, education and training, and the coordination of services for individuals identified as vulnerable adults. Vocational rehabilitation services include a combination of assessment, counseling, and assistance for the purpose of attainment, and retraining for employment services. Behavioral health services at the regional human service centers are a combination of emergency, regional intervention, specialized assessment, and chronic disease management services. Emergency services include an open access model for the clinics, 24-hour crisis line, mobile crisis, social detoxification, crisis residential, and emergency services to jails. Regional intervention services are used for the purpose of identifying the least restrictive services necessary for an individual's care and providing the services in the local community whenever possible. Regional human service centers provide a combination of chronic disease management services, including self-management support, rehabilitation and recovery services, targeted case management, medication management services, psychotherapy services, hospital and residential services, skills training and skills integration, transitional living services, supported living arrangements, specialized homeless case management, supported employment services, and regional recovery centers. The reports revealed the unduplicated client count of individuals receiving public behavioral health services at the regional human service centers was 18,837 in state fiscal year 2017.

#### **Open Access Clinical Model and Other Initiatives**

The committee reviewed the effectiveness of the open access clinical model at the human service centers. The Department of Human Services began the open access clinical model initiative in September 2015. The model has been adopted by all the regional human service centers as of July 2017. The purpose of the open access model is to eliminate waiting lists. The committee was informed research has shown individuals are more likely to follow through and stay in care if care is available at the time of need. An average of 1,186 individuals are being assessed each month. One out of five individuals is referred to a private partner in the community. From the time of entry into the human service center to assessment averages 1 hour. From the assessment to the first treatment session is approximately 9 days.

The committee reviewed other initiatives at the regional human service centers. The Department of Human Services began evaluating and planning for the redesign and expansion of emergency services across the state in January 2018. The redesign will include crisis residential services. The department is adopting an interdisciplinary team model with clinical and psychosocial interventions that are integrated, individualized, long-term, and transitional. The model will be integral for recovery management and psychosocial rehabilitation services. The department is developing crisis services to recognize the different needs based on populations served, including adult mental health, adult substance abuse, children and family, and individuals with intellectual disabilities.

#### **Developmental Disabilities Division**

The committee received information from the Developmental Disabilities Division regarding its responsibilities and initiatives. The developmental disabilities services system provides services to individuals with an intellectual or developmental disability and children from birth to age 3 with developmental delays. Services include residential and day habilitation, employment, family support, self-directed, corporate guardianship, infant development, and right track. These services are paid with federal funds received through the Medicaid state plan, Medicaid 1915(c) Home and Community-Based waiver, and Part C of Individuals with Disabilities Education Act, and from the general fund. The following schedule provides information regarding the total unduplicated number of individuals who received developmental disabilities program management services:

	State Fiscal Year						
	2010	2011	2012	2013	2014	2015	2016
Unduplicated count of individuals receiving developmental disabilities program management	5,611	5,785	5,834	5,981	6,331	6,767	7,168

The testimony indicated the Medicaid 1915 (c) Home and Community-Based waiver is approved for a 3-year period and may be renewed for 5 additional years. The current waiver was approved in 2009 and the 5-year renewal period expires March 2019. The renewal must be submitted to the federal Centers for Medicare and Medicaid Services by January 1, 2019. The department is considering creating a children's waiver, changing eligibility requirements, and adding to the existing waiver.

#### **Developmental Disabilities New Payment System**

The committee received information regarding the new developmental disabilities payment system. The new payment system was implemented on April 1, 2018. The new system is based on a needs assessment for each individual served and rates standardized across all providers. A steering committee was created to review the new

payment system. The committee was informed some providers have expressed concerns regarding administrative time required to provide the monthly billing data, and the department is considering options to simplify the process.

### **Life Skills and Transition Center**

The committee received information from the Life Skills and Transition Center regarding its responsibilities and initiatives. The Life Skills and Transition Center is a service provider included in the continuum of services for individuals with intellectual disabilities and serves as the "safety net." The center serves individuals who typically need the highest level of care and have unique and complex medical or behavioral health needs. Programs at the Life Skills and Transition Center include residential, vocational, and outreach services. Residential services include 24-hour comprehensive services and supports, including medical and clinical programming, services for adults with sexual offending behaviors, services for individuals needing skilled nursing or behavioral health services, and services for youth transitioning from the center to a community setting. Vocational services includes the Work Activity Program, which provides services for individuals at vocational work on-campus or at off-campus sites within the Grafton area. Outreach services include independent supported living arrangements; clinical assistance, resources, and evaluation clinic; and developmental disabilities behavioral health services. The report indicated the Life Skills and Transition Center is focusing on providing more outreach services. The Transition to the Community Task Force met in June 2018 and suggested changes to the mission and goals of the center, which involve community capacity building and better aligning the center with community providers.

The budget for the center is \$58,860,913 for the 2017-19 biennium, of which \$28,478,830 is from the general fund. The average number of clients per day was 74 in 2017. The center also served 234 individuals in other regions of the state in fiscal year 2016. Twenty-six individuals are on a priority planning list for community placement. The daily cost of serving an individual at the center is \$981.77 per day. The daily cost of serving an individual at a community-based intermediate care facility ranges from \$377.70 per day to \$724.69 per day for adults, from \$404.34 per day to \$1,003.93 per day for children, and from \$400.07 per day to \$763.40 per day for physically handicapped adults. The rates for serving an individual at a community-based intermediate care facility do not include certain costs included in the Life Skills and Transition Center rates, such as dental and medical services.

### **Governor's Office - Office of Recovery Reinvented**

The committee received information regarding a newly created Office of Recovery Reinvented. The office was created on January 9, 2018, pursuant to an executive order. The mission of the office is to promote strategic and innovative efforts to eliminate the shame and stigma associated with the disease of addiction. The office is funded through in-kind donations and grants from nonprofit organizations. An advisory council was created to provide insight and feedback to shape new and existing efforts. The office partnered with the DHS Behavioral Health Division to host a recovery reinvented event in September 2018. The office also is partnering with the First Lady to increase awareness and eliminate shame and stigma of addiction.

### **Olmstead and Mental Health Parity - Updates**

The committee received information regarding the 1999 United States Supreme Court case *Olmstead v. L.C.* 527 U.S. 581 (1999) (Olmstead), and updates regarding mental health parity.

#### ***Olmstead v. L.C. and the Olmstead Commission***

Olmstead is a United States Supreme Court case regarding discrimination against people with mental disabilities. In Olmstead, the Court found mental illness is a form of disability and unjustified isolation of a person with a disability is a form of discrimination under Title II of the Americans with Disabilities Act (ADA). The Court held community placement is required and appropriate only if "[a] the State's treatment professionals have determined that community placement is appropriate, [b] the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and [c] the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." Since this 1999 decision, there has been litigation in each of the 12 United States Circuit Courts of Appeal. In addition to enforcement of the Olmstead decision through the court system or through agreements, the United States Attorney General published regulations for implementing the requirements of the ADA, including requirements from Olmstead, such as Title II, regarding state and local government services, and Title III, regarding public accommodations and commercial facilities.

The state is required to have a plan to address the Olmstead decision. The North Dakota Olmstead Commission met in November 2017 and March 2018 and adopted recommendations for restructuring the commission. The Governor signed an executive order in September 2018 to restructure the commission. The new governance includes a citizen member and a representative from the Governor's office as co-chairmen. Voting and nonvoting membership of the commission was changed from 13 voting members to 10 voting members. The commission also

is authorized to create subgroups as needed and to seek expertise for guidance and counsel regarding issues that may arise. The new structure will allow for a more statewide focus and allow for more input from all stakeholders.

The committee was informed the Protection and Advocacy Project will be the lead contact for the commission for individuals, providers, businesses, other government entities, and concerned citizens. As part of its 2019-21 biennium budget request, the Protection and Advocacy Project will request one Attorney II full-time equivalent (FTE) position for the Olmstead commission. The proposal will include total funding of \$238,929, of which \$164,314 is from the general fund, for the new position and related operating costs.

### **Mental Health Parity - Updates**

The committee received information regarding the federal Mental Health Parity and Addiction Equality Act of 2008. The purpose of the Act is to prevent health insurance companies from placing more treatment limitations or financial requirements on services related to mental health or substance abuse than on surgical or medical services. The Act prohibits a health insurance policy from imposing nonquantitative treatment limitations on services related to mental health or substance abuse unless the limitations are comparable to and are not applied more stringently than factors used to apply limitations on surgical or medical services. The Insurance Commissioner issued Bulletin No. 2018-1 in July 2018, relating to insurance coverage of treatments for the autism spectrum disorder. Treatments for autism generally are considered a mental health service or benefit. The bulletin stated if an insurance company chooses to cover the autism spectrum disorder and seeks to place qualitative or nonqualitative treatment limitations on autism spectrum disorder treatments or benefits, the company must identify a similar limitation exists for the insurance coverage of surgical or medical services treatments and benefits. The bulletin also addressed coverage of applied behavior analysis therapies for autism. Applied behavior analysis therapies previously were considered an experimental or investigative therapy. Insurance companies no longer are allowed to classify applied behavior analysis therapies to treat children with autism spectrum disorder as an experimental or investigative therapy.

### **Other Information, Reports, and Testimony**

The committee conducted a tour of the Life Skills and Transition Center. The committee received additional information and testimony relating to the developmental disabilities and behavioral health needs study, including the costs and effectiveness of community- and noncommunity-based services from representatives of the Anne Carlsen Center, Development Homes, Inc., Red River Human Services Foundation, Hit, Inc., Heartview Foundation, Vocational Training Center, Cass County Sheriff's office, Praxis Strategy Group, Upper Valley Special Education Unit, Self-Advocacy Solutions, Protection and Advocacy Project, The Arc of North Dakota, North Dakota Disabilities Advocacy Consortium, Mental Health America of North Dakota, Community Options, Grand Forks Housing Authority Board of Directors, Grand Forks Housing Authority, PATH North Dakota, Inc., Consumer and Family Network, North Dakota University Extension Service, North Dakota Association of Counties, Family Voices of North Dakota, and other stakeholders. The information and testimony received included:

- Recent developments in the related federal laws and rules and recent case law relating to the Olmstead decision;
- State plans to comply with the Olmstead decision;
- A survey of agency alcohol, drug, and risk-associated behavior prevention, treatment, and enforcement programs.
- Reviews of children's mental health services resources;
- Analysis of state institutions for individuals with an intellectual or developmental disability;
- A conference of State Court Administrators report entitled *2016-2017 Policy Paper - Decriminalization of Mental Illness: Fixing a Broken System*;
- Summaries of behavioral health-related awareness and prevention activities, and other educational and referral supports;
- Background regarding a new internship program called the Career, Readiness, Education, And Training, Experience for individuals with disabilities who want to work;
- Review of services for individuals on the autism spectrum;
- Background regarding a new behavioral health program to assist incarcerated individuals;
- Analysis of the impact of allowing more individuals with higher behavioral needs to be served in the community;
- Concerns regarding children with mental illness being excluded from Medicaid coverage;

- Concerns regarding a lack of services available for individuals with developmental disabilities and behavioral health needs;
- Consideration of all forms of evidence-based treatment and recovery services for the full continuum of care and for reimbursement of behavioral health services;
- Support for expanding the free through recovery program;
- Support for addressing gaps in adolescent services, recovery support services, medication-assisted treatment, dual-diagnosis treatment, and withdrawal management;
- Support for peer-to-peer support models;
- Support for the Human Services Research Institute *North Dakota Behavioral Health Systems Study*;
- Support for increasing community services for individuals with developmental disabilities;
- Support for continued "safety net" programs for dually diagnosed individuals with behavioral health concerns;
- Support for programs for students with intellectual disabilities who transition to the Life Skills and Transition Center;
- Support for increasing clinical assistance, resources, and evaluation services throughout the state;
- Personal experiences of individuals who are at, or who were at, the Life Skills and Transition Center; and
- Background regarding efforts to redevelop underutilized buildings at the Life Skills and Transition Center.

### **Recommendations**

The committee recommends [Senate Bill No. 2026](#) to establish a voucher system for mental health services. The bill draft:

- Appropriates \$1,050,000 from the general fund and authorizes 1.50 FTE positions to the Department of Human Services for the system;
- Requires DHS to ensure private providers accepting vouchers collect and report process and outcome measures;
- Requires DHS to develop requirements and provide training and technical assistance to private providers accepting vouchers;
- Requires private providers accepting vouchers to provide evidence-based services; and
- Requires DHS to provide a report to the Legislative Management regarding the rules adopted to establish and administer the voucher system.

## **STUDY OF EARLY INTERVENTION SYSTEM FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES**

The committee was assigned a study of the state's early intervention system for children from birth to age 3 with developmental disabilities pursuant to Section 2 of Senate Bill No. 2325 (2017). The study was to include a historical overview of the system; funding mechanisms, including Medicaid; the broader implications of how the state's system interfaces with other early childhood systems; and responsibilities for implementing federal law directing states participating in Part C of the federal Individuals with Disabilities Education Act to locate and evaluate children from birth to age 3.

### **Overview**

North Dakota Century Code Section 25-01.2-01 defines "developmental disability" as a severe, chronic disability of an individual which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more areas of major life activity, which include self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic sufficiency; and reflects the individual's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

North Dakota Administrative Code (NDAC) Section 75-04-06-04 provides service eligibility for children from birth through age 2 is based on distinct and separate criteria designed to enable preventive services to be delivered. Young children may have conditions which could result in substantial functional limitations if early and appropriate

intervention is not provided. If a child, from birth through age 2, is either at high risk or developmentally delayed, the child may be included on the caseload of an intellectual disabilities-developmental disabilities case manager and considered for those services designed to meet specific needs. Eligibility for continued service inclusion through intellectual disabilities-developmental disabilities case management must be redetermined by age 3 using criteria specified in NDAC Section 75-04-06-02.1. For purposes of NDAC Section 75-04-06-04, "developmentally delayed" means a child, from birth through age 2 who is performing 25 percent below age norms in two or more areas, which include cognitive development; gross motor development; fine motor development; sensory processing; communication development; social or emotional development; or adaptive development; or who is performing at 50 percent below age norms in areas, which include cognitive development; physical development; communication development; social or emotional development; or adaptive development. "High risk" means a child, from birth through age 2, who based on a diagnosed physical or mental condition, has a high probability of becoming developmentally delayed; or based on informed clinical opinion documented by qualitative and quantitative evaluation information, has a high probability of becoming developmentally delayed.

### **Developmental Disabilities Division - Program Administration**

The Department of Human Services' Developmental Disabilities Division administers the delivery of services for eligible individuals with an intellectual or developmental disability, and children birth through age 2 with developmental delays. Services administered by the division include residential and day supports, employment, family support, self-directed, corporate guardianship, infant development, and right track. Part C of the Individuals with Disabilities Education Act is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through 2 years of age and their families. States are not required to provide Part C services; however, if a state chooses to apply and accept the federal grant, services must be provided in compliance with federal requirements. Any state that accepts federal Part C funds is responsible for the costs of all Part C services regardless of whether federal funds are sufficient. Required Part C program activities include administrative activities, the child find system, service coordination, direct services, technical assistance, and interagency coordinating council. Activities the state supports, but are not required to support, include audiology and experienced parent services.

The Department of Human Services has hired a Part C Coordinator, which has increased the number of FTE positions, from 0.50 to 1.5, dedicated to the administration of the early intervention system for individuals with developmental disabilities.

### **Developmental Disabilities Division - Child Find Activities**

The committee was informed regulations for the Part C program require each state to have a comprehensive child find system. The system must include identifying, locating, and screening all infants and toddlers with disabilities birth through age 2 as early as possible. The majority of individuals receiving early intervention services in the state are identified through child find activities, which include the birth review program and the use of birth review postcards and right track program screenings. The use of birth review postcards is a joint effort with DHS, the State Department of Health, and all birthing hospitals. Brochures for the right track screenings are given to families when a child is at the hospital. Right track providers conduct development screenings and observations to assist families in determining if a referral to the early intervention program is desired and appropriate. The right track program is a collaboration with the regional human service centers and private providers located throughout the state. The committee learned 48 percent of referrals for Part C services are from the right track program, 20 percent are from physicians and birthing hospitals, and 20 percent are from family members.

### **Eligibility Determination**

County social service staff determine eligibility for economic assistance programs, including Medicaid. Eligibility determination must be completed if a family decides to receive early intervention services. Under the federal Part C program, families are not required to apply for Medicaid to receive infant development services. According to testimony, a number of families may be eligible for Medicaid, but choose not to apply. These family's early intervention services then generally are paid from federal Part C program funds which are limited. The Department of Human Services reported it has identified 37 children who may be Medicaid eligible but whose families have not applied for Medicaid services.

The committee received the following suggestions for improving access to the developmental disabilities Medicaid waivered services:

- Reconsider the application form or adopt a screening form that better identifies the type and scope of services being requested;

- Enhance training for both case managers and county eligibility staff on roles, programs, timelines, and other factors that may influence eligibility and services;
- Improve public awareness, including identifying the home- and community-based services program as a Medicaid program, and improving information available on the website and information in parent handbooks;
- Improve communication between DHS, county services, medical communities, and other key stakeholders; and
- Consider specialty units for determining eligibility for early intervention economic assistance applications.

### **Other Early Childhood Systems**

The committee reviewed other early childhood systems. The committee received information from the Nurse-Family Partnership program. The Nurse-Family Partnership is a volunteer-based program that provides regular home visits to first-time, low-income mothers, beginning early in pregnancy and continuing through a child's 2<sup>nd</sup> year. The program is free and voluntary. The program began in Cass County in 2004 and is administered by the Fargo Cass Public Health Department. Approximately 160 families are served in Cass County. Funding for the program is provided by Cass County, the City of Fargo, Cass Clay United Way, and the Dakota Medical Foundation.

The healthy families program is a voluntary home visitation program. The program began in the city of Grand Forks and Nelson County in 2000 and expanded to Burleigh and Morton Counties in 2008. The program is designed to support families. In-home visits begin prenatally or after birth and continue until a child is 3 years of age. The program is free and serves all income levels.

### **Transition Services**

The committee reviewed the process of children reaching 3 years of age and transitioning out of the early intervention system. The Department of Public Instruction partners with DHS to transition children from federal Part C early intervention programs to federal Part B special education services. Federal Part B eligibility requirements are different from requirements for the federal Part C early intervention programs. A child must be assessed by educational professionals to determine eligibility for the federal Part B special education services based on 1 of 12 disabilities categories. The 12 categories include autistic, deaf-blind, hearing impaired, other health impaired, orthopedically impaired, speech-language impaired, visually impaired, traumatic brain injured, intellectual disability, emotional disturbance, specific learning disability, and noncategorical delay. According to the testimony, over the past 5 years 30 to 39 percent of children being referred from the federal Part C early intervention programs have entered the educational system without a need for special education services. Each state education agency and school district must implement policies and procedures to ensure all children ages 3 and older with disabilities are identified and evaluated. There are 32 special education units in the state that typically hold preschool screenings several times throughout the year. The committee was informed DHS and the Department of Public Instruction will collaborate to identify child find activities across the state to determine if any activities can be combined.

### **Early Intervention System Task Force**

The committee suggested DHS coordinate the formation of a task force comprised of representatives of DHS, providers of the early intervention system, and other stakeholders to review concerns with the early intervention system, and develop possible solutions for the committee's consideration. The task force was created and, in addition to holding numerous meetings, the task force held a summit on November 29, 2017, and prepared a report entitled *ND Early Intervention Solutions Summit Report* for the interim Health Services Committee. The summit focused its efforts in six areas of the early intervention system--child find activities, service coordination, delivery of early intervention services, administration and performance monitoring, family engagement, and professional development and technical assistance.

The task force identified the following number of children served in the state's early intervention system from fiscal years 2012 through 2016:

<b>Early Intervention System</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Unduplicated number of children served in the early intervention system	1,743	1,933	2,298	2,565	2,694

Based on its review, the task force recommended the following:

- Identify opportunities to utilize Medicaid funds for direct services prior to the use of Part C funds or funds from the general fund;

- Develop a separate Medicaid application for families accessing the Medicaid waiver for their children only when their family income exceeds eligibility guidelines;
- Continue improving efforts between the county social services and the human service centers;
- Consider an ongoing study to review the feasibility of other funding options for the state's Part C early intervention system, including the use of private insurance through a direct billing arrangement or an insurance trust fund, the use of funds from the common schools trust fund, or other state funds;
- Establish a longitudinal data system and identify unique state identifiers for the data;
- Create efficient developmental screening and early childhood supports; and
- Consider adding a representative of the Department of Corrections and Rehabilitation to the Interagency Coordinating Council.

### **North Dakota Interagency Coordinating Council**

The committee received information from the North Dakota Interagency Coordinating Council. The federal government requires the Governor to appoint a group of stakeholders to advise and assist the lead agency of the federal Part C program and the operation of those services. The council is to provide leadership for a coordinated statewide interagency system of comprehensive early intervention services and prevention awareness for children with disabilities and at-risk children. The council recommended:

- Supporting ongoing efforts and collaboration with the DHS Medical Services Division;
- Exploring alternative funding sources; and
- Continuing to seek opportunities for involvement with the North Dakota Interagency Coordinating Council for future changes to the state's Part C services.

### **Other Information and Testimony**

The committee received additional information and testimony relating to the early intervention system for individuals with developmental disabilities study from other agencies and organizations, including representatives of Designer Genes of North Dakota, Anne Carlsen Center, Hit, Inc., North Dakota County Director's Association, Family Voices of North Dakota, and other stakeholders. The information and testimony included:

- A review of the allowable uses of the common schools trust fund;
- Concerns regarding a lack of adequate coordination of the federal Part C early intervention system program;
- Concerns regarding the financial sustainability of the early intervention system;
- Support for simplifying the Medicaid eligibility application process;
- Support for conducting eligibility testing every year for individuals in the early intervention system;
- A review of a flow chart of the early intervention system from a providers' point of view;
- Support for improving the payment system to allow services for more individuals in the state;
- A review of a flow chart of the Medicaid application process for eligibility determination; and
- A summary regarding the Family Voices of North Dakota Project Carson, which is an early intervention program that connects families with a child who receives a prenatal or adverse diagnosis to other families who have gone through the same experience.

### **Recommendations**

The committee makes no recommendations regarding its study of the early intervention system for individuals with developmental disabilities.

## **REPORT ON IGNITION PROPENSITY STANDARDS**

The Legislative Assembly approved House Bill No. 1368 (2009), which created NDCC Chapter 18-13 related to reducing ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. This chapter provides for the enforcement of ignition propensity standards for cigarettes by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. Fees collected for testing cigarettes are to be used by the State Fire Marshal for the

purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial \$250 fee for certification, which is deposited in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund. In addition, NDCC Section 18-13-02(6) requires the State Fire Marshal to review the effectiveness of test methods and performance standards and report each interim to the Legislative Management the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. The committee was assigned the responsibility to receive this report.

The committee received a report from the State Fire Marshal, which included a summary of test methods, performance standards, and certification results. According to the data collected from North Dakota's National Fire Incident Reporting System, there was an increase in fires caused by cigarettes from 2010 to 2017, but a decrease in the fire injuries and deaths related to smoking. Annual statistics indicate the increase in cigarette fires is related to the increase in total fires. The percentage of fires caused by smoking in the state remains stable. The number of cigarettes certified since the program's inception in 2010 is 1,305. The number of cigarettes currently certified is 1,001. The committee received two recommendations from the State Fire Marshal to improve effectiveness of the law on reduced ignition propensity standards for cigarettes:

- Amend NDCC Section 18-13-02 to provide clearer direction regarding the standard to use and allow the State Fire Marshal's office to enforce the most recent and safest standards; and
- Amend NDCC Section 18-13-02 to include "any product to be rolled for smoking," which will help maintain commercial competition requirements for similar products and ensure fire safety standards continue to be met in the future.

## **REPORT ON PLANS TO REDUCE THE INCIDENCE OF DIABETES IN THE STATE**

The Legislative Assembly approved House Bill No. 1443 (2013), which amended NDCC Section 23-01-40 to require DHS, the State Department of Health, the Indian Affairs Commission, and PERS to collaborate to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. The agencies are to report on the plans to the Legislative Management. The committee was assigned the responsibility to receive this report.

The committee received a report entitled *Diabetes in North Dakota 2018*. The goals identified in the report include expanding the national diabetes program pilot project to 7 cities in the state--Bismarck, Mandan, Jamestown, Minot, Fargo, Grand Forks, and Dickinson in the 2019-21 biennium; evaluating the efficacy of the pilot project to determine whether the program should be added to the PERS health plan; implementing a statewide diabetes prevention action plan; increasing awareness of pre-diabetes and the National Diabetes Prevention Program; identifying the availability of the National Diabetes Prevention Program in underserved regions of the state; increasing the rate of screening, testing, and referral of individuals with pre-diabetes to the national diabetes prevention program; increasing insurance coverage of the National Diabetes Prevention Program by state health plans; and continuing to support and expand diabetes care in education programming in underserved areas of the state.

The committee was informed benchmarks were established to monitor the effectiveness of strategy implementation. Diabetes prevalence in the state has remained stable at 8.6 percent. Pre-diabetes is estimated to affect approximately 34 percent of the state's population. The report included the following recommendations:

- Support coverage of the National Diabetes Prevention Program for the PERS health plan beneficiaries;
- Support healthy, vibrant communities; and
- Support policies that improve outcomes for individuals with or at risk for diabetes and other chronic diseases.

## **REPORT ON IMPROVEMENTS TO CARE FOR INDIVIDUALS WITH STROKE**

The Legislative Assembly approved House Bill No. 1323 (2015), which amended NDCC Section 23-43-04 to require the State Department of Health to establish and implement a plan for achieving continuous improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment, establish a data oversight process, and implement a plan for achieving continuous improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment. The committee was assigned the responsibility to receive this report.

The committee received a report from the State Department of Health which stated the state's stroke system was created in 2009 to establish a comprehensive, coordinated, efficient system for the continuum of health care for individuals suffering a stroke. The system is administered by the State Department of Health and stroke partners, including the American Heart Association, critical access hospitals, tertiary hospitals, and the North Dakota

Emergency Medical Services Association. The stroke system of care has developed statewide stroke guidelines for the care and transport of stroke patients that arrive at critical access hospitals. Two Fargo hospitals are designated as comprehensive stroke centers, four tertiary hospitals in the state are designated as primary stroke centers, and 30 critical access hospitals in the state are designated as acute stroke-ready hospitals. Thirty-three percent of stroke patients are 18 to 65 years of age and 49 percent are 66 to 85 years of age. The report indicated a goal is to identify stroke patients quickly and provide appropriate treatment. An average stroke patient loses 1.9 million brain cells for each minute treatment of stroke is delayed. Hospitals that do not have computed tomography scanners are encouraged to immediately transport the stroke patient. The State Department of Health made no recommendation regarding future legislation.

### **Testimony from Interested Persons**

The committee received information from interested persons regarding the comprehensive stroke system. Key items expressed include concerns regarding sufficient state funding for core system components, and concerns regarding the state's definition of brain injury and how the definition is impacting access to work for some stroke survivors.

The federal Traumatic Brain Injury Act of 1996 defined brain injury as an injury based on an external force. Many states including North Dakota adopted this definition, but have since expanded the definition to include an acquired brain injury model. North Dakota recently expanded its definition, but added exclusionary provisions. Nontraumatic encephalopathy, nontraumatic aneurysm, and stroke were excluded from the definition. The committee was informed the state's statutory definition for brain injury has become very clinical, whereas, other statutory definitions, including serious mental illness and developmental disability are more broad. According to testimony 19 individuals from the North Dakota Brain Injury Network and 4 individuals from the Community Options program were denied services during the state fiscal years 2015 through 2017 because of the definition. Benefits of including post-stroke patients in the brain injury definition include avoiding the need to develop a duplicate support process; providing medical providers and the health care community one source of information regarding available next steps; providing post-stroke patients with access to agency specialists able to review the patients' coverage options; and providing data for further evaluation of post-stroke brain injury inquiries, disability level, and unmet needs.

### **Committee Recommendations**

The committee recommends [Senate Bill No. 2027](#) to broaden the statutory definition of brain injury.

## **HEALTH INSURANCE MANDATES - COST-BENEFIT ANALYSIS**

North Dakota Century Code Section 54-03-28 provides a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The committee was assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2019 legislative session. The Insurance Commissioner must pay the costs of the contracted services, and each cost-benefit analysis must include:

1. The extent to which the proposed mandate would increase or decrease the cost of services.
2. The extent to which the proposed mandate would increase the use of services.
3. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of the insured.
4. The impact of the proposed mandate on the total cost of health care.

North Dakota Century Code Section 54-03-28 also provides any legislative measure mandating health insurance coverage may only be effective for the next biennium and is limited to the public employees health insurance program. For the subsequent Legislative Assembly, PERS must prepare and request introduction of a bill to repeal the expiration date and expand the mandated coverage to all accident and health insurance policies. In addition, PERS is required to prepare a report, to attach to the bill, regarding the effect of the mandated coverage or payment on the system's health insurance program. The Public Employees Retirement System must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue.

### **Health Insurance Mandate Analysis Costs**

The committee received information regarding recent costs incurred by the Insurance Department for health mandate-related cost-benefit analyses. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. During the 2009 legislative session, the Insurance Department paid a total of \$28,070 to Milliman USA for analyses of three bills. During the 2011 legislative session, the Insurance Department paid a total

of \$14,982 to Milliman USA for analysis of one bill. During the 2013 legislative session, there were no health insurance mandates referred for cost-benefit analysis. During the 2015 legislative session, the Insurance Department paid a total of \$26,564 to Milliman USA for analyses conducted on three bills. During the 2017 legislative session, the Insurance Department paid a total of \$17,200 to Acumen Actuarial LLC for analysis of one bill.

### **Insurance Commissioner Recommendation**

The Insurance Commissioner received proposals from NovaRest, Inc., Arthur J. Gallagher & Co., Milliman, Inc., and Acumen Actuarial LLC, which were evaluated 60 percent on bidder qualifications and 40 percent on cost. NovaRest, Inc., scored 10 points, Arthur J. Gallagher & Co., scored 6.7 points, Milliman, Inc., scored 6.4 points, and Acumen Actuarial LLC, scored 7.9 points. The Insurance Commissioner recommended, based on the proposals received, the Legislative Council contract with NovaRest to perform cost-benefit analysis during the 66<sup>th</sup> Legislative Assembly.

### **Recommendation**

The committee recommends the Legislative Council contract with NovaRest, Inc., for cost-benefit analyses of legislative measures considered by the 66<sup>th</sup> Legislative Assembly mandating health insurance coverage pursuant to NDCC Section 54-03-28.

## **REPORT ON CHILDREN'S PREVENTION AND EARLY INTERVENTION BEHAVIORAL HEALTH SERVICES PILOT PROJECT**

Section 3 of House Bill No. 1040 (2017) appropriates \$150,000 from the general fund to DHS for the purpose of establishing a children's prevention and early intervention behavioral health services pilot project in the school system of the department's choice, including services relating to children suffering from the effects of behavioral health issues. The bill also requires DHS to provide a report to the Legislative Management before September 1, 2018, regarding the status of the children's prevention and early intervention behavioral health services pilot project. The committee was assigned to receive this report.

The committee was informed an informal group of stakeholders met during the 2017-18 interim to identify solutions for addressing mental health and substance use issues in schools. The group included representatives of school administrators, special education, higher education, Department of Public Instruction, rural and urban schools, Department of Corrections and Rehabilitation, DHS, and the Council of Educational Leaders. The committee learned the group identified gaps between the behavioral health system and the educational system that had to be addressed before a pilot project could begin. The group reviewed the system and identified the following needs:

- Improve training and resources for schools and behavioral health professionals;
- Increase utilization of screening and early intervention services;
- Improve access to clinical services when needed both within the school and externally; and
- Provide recovery support during transitions from out of home services to school.

The department indicated it planned to open an invitation for elementary and middle schools to apply for the pilot project in August 2018. After the committee completed its work, DHS issued a public notice on October 3, 2018, stating the Behavioral Health Division awarded funding for a behavioral health school pilot project to Simle Middle School in Bismarck.

## **TOBACCO PREVENTION AND CONTROL PLAN**

Section 16 of Senate Bill No. 2004 (2017) requires the State Department of Health to provide a report to the Legislative Management regarding the development of a statewide tobacco prevention and control plan that is consistent with the five components of the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*. The committee was assigned to receive this report.

The state's comprehensive tobacco prevention and control plan is based on the federal Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*. The state's plan has four goals:

- Preventing initiation of tobacco use among youth and young adults;
- Eliminating exposure to secondhand smoke;
- Promoting quitting tobacco use; and

- Building capacity and infrastructure to implement a comprehensive evidence-based tobacco prevention and control program.

The state plan was finalized in October 2017 and the department is working with Professional Data Analysts Inc., to provide an independent review and overall evaluation of the effectiveness and implementation of the state plan. According to the reports, the data for the 2017 and 2018 state fiscal years is being compiled and analyzed and a report will be issued later in the 2017-19 biennium. Professional Data Analysts, Inc. provided preliminary evaluation results for the fiscal year ending June 30, 2018, and does not anticipate major changes to the state plan. The committee was informed key focus areas that continue from the previous plan include:

- Educating the public and policymakers of the need to increase the price of tobacco products to decrease youth and adult smoking rates;
- Protecting the statewide smoke-free indoor air law;
- Working with health systems to implement cessation protocols and referrals to the statewide telephone cessation program called NDQuits;
- Delivering health communication messages relating to changing social norms relating to tobacco;
- Utilizing surveillance and evaluation to assess tobacco use in the state and determine the effectiveness of the program;
- Engaging youth in tobacco advocacy efforts at the local level;
- Increasing collaboration with DHS regarding tobacco retailer compliance checks and cessation; and
- Implementing bidirectional referrals to NDQuits through electronic health records and send updates to primary care providers.

### **Testimony from Interested Persons**

The committee received testimony relating to increasing the tax rates on tobacco products.

## **REPORT FROM BEHAVIORAL HEALTH PROFESSIONAL BOARDS**

Senate Bill No. 2033 (2017) provided that a portion of the supervised experience to qualify for licensure as a clinical social worker, counselor, or marriage and family therapist may be provided by a licensed behavioral health professional other than the profession being licensed. The bill allowed an applicant for licensure as a clinical social worker to meet the supervised experience requirement through experience in the practice of clinical social work, and allowed the Board of Social Work Examiners additional flexibility in accepting licensure from other jurisdictions. Section 5 of the bill required the North Dakota Board of Social Work Examiners, Board of Addiction Counseling Examiners, Board of Counselor Examiners, and North Dakota Marriage and Family Therapy Licensure Board to provide a report to the Legislative Management regarding the status of implementing these changes. The committee was assigned the responsibility to receive this report.

### **North Dakota Board of Social Work Examiners**

The committee received information from the Board of Social Work Examiners. Senate Bill No. 2033 modified the standard under which applicants for clinical social work obtain the necessary 3,000 hours of supervised experience. The second 1,500 hours of the 3,000 hours now can be obtained under the supervision of licensed professionals other than a licensed independent clinical social worker if geographic or other factors make the modification reasonable. The bill also created an alternative way of receiving licensure by reciprocity. The board may grant a license even if the laws of the two states are not substantially similar if the applicant is licensed in good standing under the laws of another jurisdiction and possesses qualifications or experience in the practice of social work which are substantially similar to the minimum requirements for licensure in this state. The testimony indicated the board streamlined licensing procedures. A license may be issued in 2 to 4 weeks if an applicant submits all required information and meets all of the criteria. The board also authorized two of its board members to approve initial licenses and master of social work supervision plans if no further issues need to be discussed. Issues may include background checks, mental health history, whether applicant is in good standing, or if clinical work does not meet criteria. The committee was informed the challenge with social work licensure is that states use different social worker titles and each title has different licensing requirements.

### **Board of Addiction Counseling Examiners**

The committee received information from the Board of Addiction Counseling Examiners. The board collaborated with the Board of Counseling Examiners and the North Dakota Board of Social Work Examiners to review and encourage dual licensure. The board proposed Administrative Code changes to allow a National Association of

Addiction Professionals National Certified Addiction Counselor Level II certification or a Master Addiction Counselor certification to become licensed and accepted immediately without an academic or clinical training review. Any applicant with a verifiable license or certification in good standing from another jurisdiction may be accepted immediately as an intern until the academic and clinical training reviews or any other outstanding items are complete. The committee was informed any advanced practice professionals established in Senate Bill No. 2042 (2017), including medical doctors, psychologists, advanced practice registered nurses, and physician assistants, will not have the academic requirements, but may have minimal clinical training requirements to become licensed. Other advanced practice professionals, including licensed independent clinical workers, licensed professional clinical counselors, and licensed marriage and family counselors may be licensed with minimal training requirements.

### **Board of Counseling Examiners**

The committee received information from the Board of Counseling Examiners which indicated the board was reviewing its process and anticipated proposing Administrative Code changes.

### **Marriage and Family Therapy Licensure Board**

The committee received information from the Marriage and Family Therapy Licensure Board which indicated the state's licensure standards for marriage and family therapists are similar to the licensure standards of other states; therefore, there are no impediments preventing individuals licensed in other states from becoming licensed in North Dakota nor preventing individuals receiving an education in a different state from becoming licensed in North Dakota.

### **Board of Psychologist Examiners**

The committee received information from the Board of Psychologist Examiners. The board proposed the following administrative changes:

- Adding operational data to expedite licensure permitting the board to allow qualified applicants licensed or certified outside the state to practice while waiting for completion of licensure in this state;
- Allowing the Professional Responsibility Examinations to be administered in written form;
- Easing the process to obtain approval for continuing education sponsors;
- Clarifying the relationship with the Educational Standards and Practices Board regarding school psychologists;
- Clarifying board membership requirements for nonpractitioner members and allowing applied behavior analysts to be eligible for serving on the board; and
- Adding supervision changes that align qualifications of those receiving training with the work credentials of the mentor.

### **Other Information and Testimony**

The committee received additional information and testimony relating to board licensure from representatives of the Department of Corrections and Rehabilitation, North Dakota County Social Service Director's Association, the North Dakota University System, and other stakeholders. The information and testimony included:

- Comments regarding professional and occupational licensure restrictions;
- Background regarding behavioral health-related board statutory provisions, including statutory requirements for appointment to behavioral health-related occupational boards;
- A summary of a National Conference of State Legislatures' report entitled *The State of Occupational Licensing - Research, State Policies and Trends*;
- A summary of recent legislation passed by the state of Nebraska relating to licensing board rules;
- Discussion of commonalities of educational curriculum for various counseling-related professions;
- Concerns of disciplinary actions relating to adequate training and supervision;
- Concerns relating to supervision requirements of social workers and the expansion of the board's regulatory responsibilities;
- Concerns relating to the oral examination process for becoming a licensed psychologist and other challenges of becoming licensed as a psychologist or counselor in the state; and

- Concerns regarding challenges for international students applying for licensure to practice as a psychologist in the state.

At the committee's request the North Dakota Board of Social Work Examiners, North Dakota County Social Service Director's Association, and other licensed social workers met to discuss concerns expressed during the 2017-18 interim. A representative of the North Dakota Board of Social Work Examiners stated the board anticipates introducing a bill in the 2019 legislative session to address licensure concerns.

## **REPORT FROM TASK FORCE ON CHILDREN'S BEHAVIORAL HEALTH**

Sections 4 and 5 of Senate Bill No. 2038 (2017) created the Task Force on Children's Behavioral Health for the purpose of assessing and guiding efforts within the children's behavioral health system to ensure a full continuum of care is available in the state. The task force includes the Superintendent of Public Instruction, the Executive Director of DHS, the State Health Officer, the Executive Director of the Indian Affairs Commission, and the Director of the Committee on Protection and Advocacy. The task force is required to assess and guide efforts within the children's behavioral health system to ensure a full behavioral health continuum of care is available in the state; make recommendations to ensure the children's behavioral health services are seamless, effective, and not duplicative; identify recommendations and strategies to address gaps or needs in the children's behavioral health system; engage stakeholders from across the continuum to assess and develop strategies to address gaps or needs in areas including education, juvenile justice, child welfare, community, and health; and provide a report to the Legislative Management every 6 months regarding the task force's efforts. The committee was assigned the responsibility to receive these reports.

The committee was informed the task force also includes members from the Department of Juvenile Services and tribal areas. The report indicated the task force is focusing efforts to develop strategies to address gaps or needs in education, juvenile justice, child welfare, community, and health. The Department of Human Services has contracted with the Consensus Council to manage and facilitate task force meetings. The council is developing a matrix of services, including service providers and who qualifies for services. The task force strategies include interagency agreements, statutory changes, and proposed funding. The task force developed recommendations in areas including adoption of school seclusion and restraint policy and practices guidelines, formation of a state-level children's services committee and regional children's services committees, suicide prevention, bullying prevention and intervention, sufficient and sustainable funding, expanded emergency care resources, juvenile court rules for maltreatment, state and tribal service collaboration, early intervention, and substance exposed newborn services.

## **OTHER INFORMATION**

The committee received information from the State Department of Health regarding the members appointed by the Governor to serve as the advisory committee to the State Health Officer pursuant to NDCC Section 23-01-05, information regarding changes to the structure of the department and grant opportunities; and information regarding the department's newborn screening program and metabolic foods program.