

HUMAN SERVICES COMMITTEE

The Human Services Committee was assigned the following responsibilities:

- A study of family caregiver supports and services pursuant to Section 1 of 2015 House Bill No. 1279.
- A study of behavioral health needs pursuant to Section 7 of 2015 House Bill No. 2048.
- Receive the annual status report from the Autism Spectrum Disorder Task Force pursuant to North Dakota Century Code (NDCC) Section 50-06-32.
- Receive the annual report from the Department of Human Services (DHS) describing enrollment statistics and costs associated with the children's health insurance program (CHIP) state plan pursuant to NDCC Section 50-29-02.
- Receive a report from DHS regarding the autism spectrum disorder voucher program pilot project pursuant to NDCC Section 50-06-32.1.
- Receive a report from DHS regarding the outcomes of the Medicaid and Medicaid Expansion cost-sharing provisions study and the associated legislative recommendations and related draft legislation pursuant to Section 1 of 2015 House Bill No. 1037.
- Receive a report from DHS relating to life skill services, including evidence-based return-to-work model provided for individuals with a traumatic brain injury pursuant to Section 1 of 2015 House Bill No. 1046.
- Receive a report from DHS regarding development activities of the developmental disabilities system reimbursement project pursuant to Section 14 of 2015 Senate Bill No. 2012.
- Receive a report from a statewide family controlled parent-to-parent support organization receiving a grant under Section 19 of the 2015 Senate Bill No. 2012, regarding the use of grant funds pursuant to that section.
- Receive a report from a statewide family-to-family health information and education organization receiving a grant under Section 20 of 2015 Senate Bill No. 2012, regarding the use of grant funds pursuant to that section.
- Receive a report from DHS regarding the adult protective services program, including the effectiveness of the program, information on services and outcomes, and funding by human service region and in total pursuant to Section 23 of 2015 Senate Bill No. 2012.
- Receive a report from DHS regarding its quarterly behavioral health services reports pursuant to Section 26 of 2015 Senate Bill No. 2012.
- Receive a report from DHS regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs pursuant to Section 4 of 2015 Senate Bill No. 2048.
- Receive a report from the Department of Public Instruction (DPI) regarding mental health training provided by school districts pursuant to Section 5 of 2015 Senate Bill No. 2048.
- Receive a report from DHS regarding the outcomes of the study of statutory references to mental health professionals to determine whether changes in the law may help to more fully utilize these professionals within their scope of practice, as it relates to the responsibilities of DHS to provide services or license facilities together with any recommendations pursuant to Section 1 of 2015 Senate Bill No. 2049.
- Receive a report from DHS regarding eligibility for developmental disability waivers pursuant to Section 1 of 2015 Senate Bill No. 2234.

Committee members were Representatives Kathy Hogan (Chairman), Bert Anderson, Dick Anderson, Chuck Damschen, Alan Fehr, Dwight Kiefert, Gail Mooney, Naomi Muscha, Kylie Oversen, Jay Seibel, Peter F. Silbernagel, and Greg Westlind and Senators Tyler Axness, Dick Dever, Oley Larsen, Judy Lee, and Tim Mathern. Representative Curt Hofstad was a member of the committee until his death in June 2016.

STUDY OF FAMILY CAREGIVER SUPPORTS AND SERVICES

The committee was assigned a study of family caregiver supports and services pursuant to Section 1 of 2015 House Bill No. 1279. The study was to:

- Identify policies, resources, and programs available for family caregivers and encourage additional innovative and creative means to support family caregivers so they are able to continue to provide in-home support for older adults;
- Include input from stakeholders, including representatives of hospitals, social and clinical providers, advocacy organizations, tribal governments, state and local agencies and institutions, and caregivers;
- Receive testimony on the needs of family caregivers, including designation of caregivers, training, respite services, medical leave policies, and delegation of tasks to nonmedical aides;
- Include an inventory of the resources available to family caregivers; and
- Make any recommendations for administrative actions to support family caregivers.

Current Services

The Department of Human Services Division of Aging Services receives federal funds under the federal Older Americans Act to provide support and services to caregivers in the state. The North Dakota Family Caregiver Support Program is designed to:

- Provide training, supportive services, and respite care to caregivers who provide unpaid care on a 24-hour basis to enable an older adult to remain in their own home;
- Assist grandparents or relative caregivers who are caring for a child age 18 or younger or an adult child with a disability;
- Provide a system of support services to unpaid caregivers including individuals who are caring for an adult age 60 or older, grandparents or other relative caregivers who are 55 years of age or older and who are caring for a child age 18 or younger, grandparents or other relative caregivers who are 55 years of age or older caring for an adult child with a disability between ages 19 and 59, and individuals who are caring for a person with Alzheimer's or a related dementia regardless of their age;
- Enable caregivers to continue to provide care in their homes and community for as long as they choose;
- Provide support and services that safeguard the caregiver's own health and emotional well-being, including information about local services and supports in the community;
- Provide assistance from a trained caregiver coordinator from a human service center to help caregivers assess needs and access support services;
- Provide counseling, support groups, and training services to meet caregiver individual needs for assistance;
- Provide respite care for temporary relief to caregivers who provide 24-hour care; and
- Provide supplemental services to assist with the cost of incontinence supplies and assistive devices such as a shower bench or safety rails.

During fiscal year 2013, 285 unpaid caregivers received 24,856 respite care hours of service. A survey conducted during the fall of 2014 revealed that the respite care program helps keep older adults at home an average of 24 months longer than they could have without the support. In addition, caregivers report that the program assists a caregiver with coping with the challenges of providing 24-hour care in their homes. The 2015 Legislative Assembly provided funding of \$1,836,000,000, of which \$274,072 is from the general fund, for programs and services relating to family caregiver and support service.

The Department of Human Services dementia care services program is a state-funded program that provides care consultation and training to caregivers to address the unique and individual needs that arise throughout the various stages of dementia. Eligibility is not based on diagnosis, age, or income and anyone may participate in educational sessions on dementia. The program includes identifying available services within the region; providing information to medical professionals, law enforcement, and the public regarding the symptoms of dementia, the benefits of early detection and treatment, and the services available to individuals with dementia and their caregivers; assessing the needs of individuals with dementia and their caregivers; training care providers to manage and provide for the care of individuals with dementia; providing consultation services to individuals with dementia and their caregivers; and facilitating the referral of individuals with dementia and their caregivers to appropriate care and support services. The 2015 Legislative Assembly provided funding of \$1.2 million from the general fund for dementia care services.

Consultant Services

The committee requested and received approval from the Chairman of the Legislative Management to contract with a consultant to assist with the study of family caregiver supports and services. The specific tasks to be addressed by the consultant included:

1. Identify current public and private resources/services/supports for family caregivers, both public and private, and by region and/or county.
2. Identify barriers/challenges family caregivers experience, which includes the need for training, respite services, medical leave policies, and delegation of tasks to family members and nonmedical aides.
3. Identify best practice models for family caregiver support programs from other states.
4. Identify emerging practices and technology that can enhance caregiver and patient home supports.
5. Provide recommendations to the interim committee.

The committee received proposals from three entities interested in providing consultant services--North Dakota State University (NDSU) Extension Service; Health Management Associates; and Dr. Karin L. Becker. The committee contracted with the NDSU Extension Service. The contract cost was \$24,999. The consultant's proposal included:

- Creating a database of current systems for caregiving in North Dakota, including informal, private, and governmental community supports for information and referral, education, advocacy, respite care, case management, and direct service provisions;
- Gathering feedback from stakeholders to identify barriers and challenges from the perspective of family caregivers;
- Reviewing scientific literature and websites to identify successful models across the nation and internationally. In addition, conduct analysis of the key themes of success for caregiving models;
- Reviewing scientific literature and websites to identify emerging practices and technology, including identifying practices and technology that may be particularly relevant to North Dakota with an emphasis on rural needs; and
- Developing recommendations, including best practices for community supports and technology opportunities, policy needs, and top priorities for family caregiver supports and services.

The NDSU Extension Service conducted its study from November 2015 to May 2016 and provided periodic updates to the committee. The final report was presented to the committee in May 2016. The report included information on current resources for family caregivers in North Dakota, barriers and challenges of family caregiving, best practices for family caregiver support programs, emerging practices and technology to enhance caregiver supports, and conclusions and recommendations. The final report identified services and resources for caregivers including the following:

- **Managing caregiving logistics** - Including advocacy services, assistive technology and equipment, care management, and information and referral services;
- **Direct support in providing care** - Including adult day care, dementia care, home health care, homemaker and chore, hospice, and personal care services;
- **Improving caregivers' ability to provide care** - Including meal services, training and education, transportation, and volunteer services; and
- **Fostering caregivers' well-being** - Including emotional support and respite services.

Challenges of caregiving, as identified in the report, include the lack of sufficient respite services, the need for help finding available services and resources, the lack of knowledge and training relating to providing care, caregiver stress and burdens, and financial burdens of caregiving. The best practices for family caregiver support programs include the following:

- **Availability of help and support** - Including telephone-based psycho-educational interventions, virtual care, and community nurses;
- **Financial cost of care and funding** - Including sliding fee scales and vouchers, increasing access to paid family medical leave, and long-term care planning;
- **Knowledge and ability to provide needed care** - Including interactive training, comprehensive discharge planning, long-term educational programming, and preventive care; and
- **Respite and well-being of caregiver** - Including in-home care, and health education programs.

Emerging practices and technology to enhance caregiver supports include the following:

- **Availability of help and support** - Including person-centered care, mobile adult day care, working with college students, technology, socially assistive robots, and smart wear;
- **Financial cost of care and funding** - Including telemedicine reduced hospitalization, co-op models, and tax credits for caregiving;
- **Knowledge and ability to provide needed care** - Including home visits upon discharge, virtual learning modules in hospital waiting rooms, use of social media to increase awareness, training for employers about eldercare, and mobile apps for long-distance care; and
- **Respite and well-being of caregiver** - Including online emotional support groups and the Behavioral Risk Factor Surveillance System's caregiver module to detect caregiver burden.

The study concluded that:

- High costs of care and lack of funding for services to support caregiving provides challenges for caregivers;
- Both caregivers and stakeholders have identified insufficient access to respite care as a major gap of service;
- Caregivers have identified difficulty with finding, connecting to, and navigating available services and resources;
- Family caregivers lack training relating to logistics and management of caregiving, including a provision of support in activities of daily living; and
- Both caregivers and stakeholders have identified challenges with a lack of available and appropriate services, especially in rural regions of the state.

The final report included the following recommendations:

Overarching Recommendations

- Develop a family caregiving task force that includes caregivers, service providers, and community leaders to develop recommendations to address service gaps, distance, population density of those needing service, culture, and other caregiving challenges; including a review of current, best, and emerging practices; and recommendations to close service gaps in selected areas; and to address unique concerns relating to rural caregiving;
- Encourage marketing and outreach efforts to increase awareness of current programs and services available;
- Consider changes to eligibility criteria, or increase use of funding for individuals not currently financially eligible;
- Increase service availability, including respite care, care management, training and education, emotional support, volunteer programs, and various direct care supports, including adult day care, homemaker/chore, dementia care, and personal care;
- Increase resources to address caregiver well-being, including preventative, screening, and intervention care; and
- Develop supports and guidelines to streamline the integration of state-sponsored services and specialized programs for veterans and Indian tribes.

Improving Avenues for Sustainable Funding for Family Caregivers and Programs That Support Them

- Consider legislation that provides tax credits to employers in the private sector for providing a 12-week paid family medical leave, including employees that take leave from work to care for a spouse, child, or parent with a serious health condition;
- Expand the minimum requirements of the federal Family and Medical Leave Act to increase the number of individuals that may access benefits by adjusting eligibility requirements, expanding the range of family caregiving relationships, or increasing the amount of unpaid leave that may be taken;
- Review budget reductions, including homemaker services;
- Consider reimbursement options for telemedicine and other technologies that have reduced repeated hospitalizations and allow long-distance caregivers to be included with health care visits;
- Consider adjusting the sliding fee scale for state-funded service payments for the elderly and disabled (SPED) programs that provide services to help older adults or physically disabled persons with difficulty completing tasks, so that they are able to live at home independently. In addition, consider adjustments that account for cost of living and inflation, and eases the financial burden of lower-income older adults;

- Educate employers regarding the needs of family caregivers, including the importance of developing policies and strategies that support, retain, and reduce the burdens and stress of employees that are engaged in caregiving; and
- Develop a plan to expand long-term care insurance coverage across the state, including educating citizens of the benefits for long-term care insurance, expanding tax credits to individuals that purchase coverage and employers that provide a level of benefit toward the insurance, and providing state employees with a subsidized long-term care insurance plan.

Increasing Access to Respite Care

- Review the feasibility of applying for federal grants from the Lifespan Respite Care Program to advance objectives, including expanding and enhancing respite services in the state, improve coordination and dissemination of respite services, streamline access to programs, fill gaps in service where necessary, and improve the overall quality of the respite services currently available;
- Expand the availability of respite care by training college students and other volunteers to allow relief for family caregivers;
- Evaluate best-practice training tools, including respite education and support tools for family caregivers. Evaluation should include identifying tools that are original and professionally designed to train individuals seeking to become a respite volunteer. In addition, the evaluation should include identifying tools that are appropriate for use within many settings, including schools, veterans' organizations, hospitals, senior centers, and faith communities;
- Promote awareness of the Family Caregiver Support Program to ensure it is fully utilized across the state;
- Create a directory of local respite care available to family caregivers. This directory should be easy to navigate and available online and in print. Moreover, it should be updated on a regular basis; and
- Assess the utilization of facility-based respite care to determine awareness and acceptance by family caregivers.

Improving Resources to Help Family Caregivers Find, Connect to, and Navigate Available Services

- Identify marketing and communication strategies that will promote awareness and benefit the Aging and Disability Resource-LINK and the statewide options counseling system. Strategies should be developed to increase referrals and connect family caregivers with needed services;
- Develop a caregiver resource center website within the Aging and Disability Resource-LINK, or any appropriate organization, to increase access to existing programs and services for caregivers. The website may include relevant online resources, training, support, respite, and planning tools for family caregiver needs. In addition, the website may be a caregiver portal that hospitals, clinics, and other caregiver stakeholders promote;
- Develop a comprehensive guide of caregiving for North Dakota caregivers similar to publications created in other states, including the United Way Caregivers Coalition's Pathways for Caregivers from United Way of Northern New Jersey;
- Explore current care coordination improvement efforts within the state to determine if there are ways to better support the needs of family caregivers that are assisting care recipients transition from hospital to home, rehabilitation, or hospice. In addition, encourage public and private care coordination to use evidence-based care coordination programs that include caregiver assessments;
- Identify ways to increase communication, awareness of services, and collaboration between organizations, including health care, social services, and aging services; and including county and regional organizations, to identify local family caregiver resources, and increase referrals; and
- Provide public awareness to increase involvement with caregiving beyond the primary caregiver and to enhance greater understanding of family caregiving issues.

Increasing Training and Education for Informal and Professional Caregivers

- Provide in-person instruction for medical and nursing tasks that a caregiver will need to provide at home, including medication management, injections, and wound care and transfers. In addition, require instructions to be inclusive of both care recipients discharged from a facility and individuals that have not been discharged from a facility, but may need this type of instruction;
- Ensure training is available in-person and online to meet various family caregiver training needs, including caregiving basics, managing care of others, financial caregiving, legal issues, medical and mental health support, communication, physical tasks of caregiving, caregiver self-care, and end-of-life issues;

- Identify partnerships, including universities and health care systems, that may collaborate to develop and deliver family caregiver track training;
- Increase the availability of the Powerful Tools for Caregivers Program statewide, and other evidence-based training programs that are effective;
- Ensure information, including schedules for a training program, are aggregated and accessible to family caregivers;
- Develop opportunities for family caregiver peer supports, including a mentoring program with former caregivers, training events, and outings for both caregiver and care recipients;
- Provide for the development of in-person and online support groups for caregivers of older family members; and
- Identify the feasibility of developing a professional training track for employees that deliver care. The training may include a small fee to help cover the costs of sustaining and updating a training program.

Closing Gaps in Caregiver Support Services in Rural Areas

- Support a statewide direct care workforce initiative to increase the number of individuals that are interested in caregiving professions, specifically in rural areas;
- Identify ways telehealth may address the needs of rural family caregivers and their care recipients, including plans for sustainable funding;
- Consider developing a pilot project for a mobile adult day care model in rural communities;
- Develop volunteer networks to support the needs of rural caregivers, including identification of available funding and administrative hosting that may be needed to recruit, orient, train, supervise, and coordinate the volunteers;
- Provide programs that help family caregivers organize caregiving tasks through platforms, including Lotsa Helping Hands, a social media website which allows caregivers to calendar a care recipients task needs and family/friends to sign up for performing specific tasks. Share the Care is a similar publication that can be adopted by caregivers and friends, health professionals, faith communities, and businesses;
- When county social services are the only provider of a key service (such as respite or personal care), determine ways to provide assistance so that they can continue to provide services to eligible clients and to expand services, if possible, to private-pay clients;
- Provide funding for a pilot project that will include careful evaluation studies, including best practices for caregiver services targeting rural areas and may lead to effective and cost-efficient solutions; and
- Provide funding for innovative technologies that allow older adults to live independently for longer periods of time, including developing technologies that support virtual caregiving from longer distances to allow seniors living in rural areas to communicate with a caregiver living in urban regions or out of state.

Hospital Discharge Policies

The committee also reviewed hospital discharge policies. The committee received information from AARP regarding draft model legislation which is referred to as the Caregiver Advise, Record, Enable (CARE) Act to address supports for family caregivers during a patient's transition from a hospital. The committee learned 30 states, the District of Columbia, and two territories have passed legislation similar to the CARE Act. Other rural states include Wyoming, Alaska, Utah, and Nebraska. The 2015 Legislative Assembly considered similar legislation in House Bill No. 1279; however, the bill was not approved. The committee compared the provisions of the bill to provisions in similar bills approved in Nevada, Oregon, and Utah. The committee learned a survey conducted by AARP in October 2015 identified family caregiver respondents expressed the need for family caregivers to receive more specific information and directions from a hospital when a patient is released, more hospital awareness regarding the level of care a patient needs after being discharged, and more information regarding who to call or ask when a family caregiver needs assistance. The CARE Act model recommends the following:

- **Designation of the Caregiver in the Medical Record** - Allows a patient or legal guardian the ability to designate a caregiver when being admitted to the hospital.
- **Notification to the Caregiver of Discharge** - Provides for a hospital to notify a family caregiver if a patient is being discharged or transferred to a different facility.
- **Instruction of Aftercare Tasks** - Creates a framework for a family caregiver to receive instructions for tasks the family caregiver will perform once a patient is discharged from the hospital.

The committee received information from hospital providers regarding current regulatory requirements for hospital discharge planning, including information relating to the current discharge planning process. The committee learned hospitals already have discharge policies that are governed by internal policies and the State Department of Health. In addition, hospitals are required to follow rules and standards for discharge planning, which are established by the federal Centers for Medicare and Medicaid Services (CMS) and the federal Joint Commission.

When a patient is ready for discharge, the hospital provides the patient and family a written copy of discharge instructions. A nurse reviews the instructions and the medications prescribed. The patient is also encouraged to allow the hospital to inform and include a family member or caregiver when discussing instructions and other information. The patient does have the right to request that a family member or caregiver not be notified. The committee learned CMS, through its Conditions of Participation rule, require the following to be documented in a patient's medical record:

- Patients have a written discharge plan developed;
- Patients have specific discharge instructions provided in writing;
- Patient's goals and preferences for their discharge plan are taken into account;
- Patient's caregivers and support persons are active partners in the discharge plan and care;
- Hospitals consider the availability and capability of the caregiver to provide home care;
- Discharge planning begins within 24 hours of admission;
- Discharge planning process is completed prior to discharge; and
- Discharge instructions are presented in a way that the patient and the caregiver can understand.

Other Information

The committee reviewed other information relating to the study of family caregiver supports and services from other agencies and organizations, including DHS, the Department of Labor and Human Rights, AARP, and hospital providers. The information related to:

- Family caregiver supports and services in the United States and in North Dakota, including information of a study conducted by the National Alliance for Caregiving and AARP, tasks performed by caregivers in North Dakota, and policy solutions to address family caregiver supports and services; and family support and health care discharge planning;
- Family caregiver services provided by DHS, including information on the Family Caregiver Support Program, dementia care services program, family home care, family personal care; and the Aging and Disability Resource Center service process and number of clients served;
- State and federal employment-related laws that support and protect family caregivers;
- Hospitals using accountable care organizations; and
- Funding for North Dakota's long-term care continuum services, and information regarding the SPED sliding fee schedule.

Testimony from Interested Persons

The committee received information from interested persons, including providers, organizations, and individuals relating to the study of family caregiver supports and services. Concerns and recommendations provided to the committee include:

- The need for a sustained commitment to improving the system of caregiving in North Dakota;
- Concern regarding the lack of understanding by patients and their caregivers of hospital discharge instructions;
- The need for better communication between hospital staff and patients relating to discharges;
- Concerns regarding general fund budget allotment changes to DHS for reimbursements of homemaker services and Child Care Aware of North Dakota grants and the negative effect the reductions will have on services;
- Concerns regarding qualified service provider payment levels for homemaker services provided to assist individuals to remain in their homes and avoid more expensive levels of care;
- Improve public awareness of services available through the aging and disability resource center, including providing sufficient funding for the services;

- Improve the system of caregiving by creating policy initiatives that allow individuals to care for an aging parent without leaving the workforce, creating system changes within the health care and health and human services systems to promote coordination and focus in transition homes, and supporting an environment that allows for creativity to meet the demands for caregiving;
- Review the benefits of assistive technology for family caregiver supports and services; and
- Provide assistance that will help a family or caregiver manage patient care and promote communication between medical professionals and caregivers relating to family support and health care discharge planning.

Prioritizations

The committee received information from the NDSU Extension Service, DHS, and AARP regarding suggested prioritization of recommendations for the study of family caregiver supports and services. The committee learned that many recommendations may need to be implemented over several years. The following recommendations were identified as priorities:

- Create a statewide family caregiver task force that will focus on service gaps in rural areas, including funding for pilot projects developed by the task force;
- Support training programs, including caregiver basics, managing care of others, financial and legal issues, caregiver well-being, physical tasks, and end-of-life issues;
- Restore funding for homemaker services reduced as a result of 2015-17 biennium budget reductions and update the sliding fee schedule for the SPED program to include inflationary increases;
- Promote awareness of the Family Caregiver Support Program and other services that provide respite options for family caregivers to ensure it is fully utilized across the state;
- Review the feasibility of applying for the federal Lifespan Respite Care Program grant to address gaps in respite services;
- Support the statewide direct care workforce initiative to increase the number of individuals seeking a caregiving profession, including rural areas;
- Increase available respite care services by training college students and volunteers;
- Improve services that assist caregivers with navigating available resources, including marketing and communication strategies to promote the Aging and Disability Resource-LINK and statewide options counseling system, create a caregiver resource center within the Aging and Disability Resource-LINK to increase access to existing programs and services, and create a comprehensive guide to caregiving, including resources, training, supports, respite, and planning tools;
- Approve the CARE Act to address supports for family caregivers during a patient's transition from a hospital.

Committee Recommendations

The committee recommends a bill [\[17.0227.02000\]](#) relating to family caregiver supports and services. The bill provides appropriations, including one-time funding of \$197,580 from the general fund to the NDSU Extension Service for establishing a pilot project to expand local training programs to include family caregiver training, \$200,000 of federal funds to DHS to administer the Lifespan Respite Care Program, and \$1,535,000 from the general fund to DHS to provide an inflationary adjustment to the SPED sliding fee schedule. The bill also directs DHS to establish and promote a caregiver resource center website, to review long-term care services, and to provide recommendations to the Legislative Management of options to increase the number and level of services and funding provided for home- and community-based services.

The committee recommends a bill [\[17.0124.02000\]](#) to require hospitals to establish and maintain written discharge policies.

STUDY OF BEHAVIORAL HEALTH NEEDS

The committee was assigned a study of behavioral health needs pursuant to Section 7 of 2015 Senate Bill No. 2048. The study was to include consideration of behavioral health needs of youth and adults and access, availability, and delivery of services. The study was to include a review of services related to autism spectrum disorder. The study was to include input from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions. The study was to also include the monitoring and reviewing of strategies to improve behavioral health services implemented pursuant to legislation enacted by the

64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.

In addition, Section 5 of 2015 Senate Bill No. 2048 requires DPI to provide a report to the Legislative Management regarding mental health training provided to school districts. The committee was assigned to receive this report.

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 2013 Senate Bill No. 2243. The study included consideration of behavioral health needs of youth and adults and consideration of access, availability, and delivery of services. The study included input from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions. 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.

Department of Human Services

The Department of Human Services provides behavioral health services through its Behavioral Health Services Division, the State Hospital, and the eight human service centers located throughout the state. The Behavioral Health Services Division is responsible for overseeing a statewide network of substance abuse and mental health treatment, recovery support services, mental health promotion, and substance abuse prevention services. During the 2013-15 biennium, the division licensed 81 substance abuse treatment programs, 43 driving under the influence education programs, 8 regional human service centers, and 6 psychiatric residential treatment facilities for children and adolescents. The State Hospital, located in Jamestown, provides traditional and secure services to adult patients. Traditional services include short-term acute inpatient psychiatric and substance abuse treatment, intermediate psychosocial rehabilitation services, forensic services, and safety net services for the adult patients. Secure services include inpatient evaluation and treatment services for sexually dangerous individuals. The State Hospital has available 304 beds, including 105 beds for addiction services at the Tompkins Rehabilitation and Corrections Center; 123 beds for acute inpatient and intermediate psychosocial rehabilitation services; and 76 beds in the secure services unit (sex offender program). The department operates eight regional human service centers in Williston, Minot, Devils Lake, Grand Forks, Fargo, Jamestown, Bismarck, and Dickinson. The human service centers core services include aging services, developmental disabilities, vocational rehabilitation, child welfare services, children's mental health, serious mental illness, acute clinical services, substance abuse services, low-intensity sex offender treatment, and crisis/emergency response services. The human service centers served 11,686 clients in the first quarter of fiscal year 2016.

Department of Corrections and Rehabilitation

The Department of Corrections and Rehabilitation (DOCR) provides behavioral health services through its Division of Adult Services and Division of Juvenile Services. The Division of Adult Services provides for the development of personal growth and rehabilitation programs for inmates. Mental health programs are provided to assist inmates with mental health concerns through counseling, psychological services, and psychiatric services. In addition, the State Penitentiary is a licensed addiction treatment center which staffs licensed addiction counselors, licensed social workers, and paraprofessionals to assist inmates in overcoming addictions and personal problems. The State Penitentiary has allocated eight beds to serve inmates with special mental health and vulnerability concerns who cannot reside in general housing. The James River Correctional Center has a 26-bed mental health unit that allocates additional staff resources to managing the behavior and treatment of offenders with serious mental illness, chronic suicidal tendencies, or vulnerability concerns who cannot reside in general housing. The Division of Juvenile Services includes the Youth Correctional Center and eight regional community-based services offices located throughout the state. The division provides comprehensive case management, treatment, and supervision programs for troubled adolescents. Treatment programs for juveniles include group counseling, individual counseling, substance abuse education, cognitive-behavioral classes, recovery and relapse prevention counseling, grief/loss counseling, victim impact programming, security intervention (gang) classes, physical fitness, spirituality and health services, and work.

Funding

The 2015 Legislative Assembly provided funding as follows for programs and services relating to behavioral health needs for the 2015-17 biennium:

	General Fund (In Millions)	Other Funds (In Millions)	Total (In Millions)
Department of Human Services			
Behavioral Health Services Division	\$9.2	\$11.0	\$20.2
State Hospital - Traditional services	50.0	21.5	71.5
State Hospital - Secured services	13.5		13.5
Human service centers	117.4	81.3	198.7
Total Department of Human Services	\$190.1	\$113.8	\$303.9
Department of Corrections and Rehabilitation			
Division of Adult Services	\$8.6		\$8.6
Division of Juvenile Services	4.0	\$2.1	6.1
Total Department of Corrections and Rehabilitation	\$12.6	\$2.1	\$14.7

Behavioral Health-Related Information

The committee reviewed behavioral health-related information including an overview of behavioral health, an overview of a behavioral health system of care, key legal obligations related to behavioral health services, the DHS behavioral health services delivery system, including information on the substance abuse disorder system, regional interventional and emergency services continuum, adult behavioral health services, children's behavioral health services, and a report on mental health training for school districts, and other committee reports.

Behavioral Health - Overview

The committee learned mental illness and substance abuse disorders are considered interrelated brain-based diseases. Deinstitutionalization; availability of drugs and alcohol; and the lessening of traditional family, community, and social supports have increased behavioral health issues in North Dakota. The state is lacking a consistent system to ensure people with mental health and substance abuse disorders receive effective medical and psychosocial interventions. In addition, mental health and substance abuse treatment systems may have competing philosophies relating to the use of medicines, the role of self-help supports, and the role of various health professionals. Each system identifies the disease it treats as primary and any symptoms from the other disease as secondary, and as a result, each system focuses only on one disease. Dually diagnosed patients may respond poorly to treatments because conditions from the other disorder may not be recognized or managed appropriately. The use of medications, psychosocial interventions including therapy and community supports, the level and duration of services, and the setting of service delivery needs should be specific for each individual's needs. Evidence-based medication treatment and psychosocial interventions exist, but are not available for routine clinical care of mental health and substance abuse disorders. Needs include access, training, insurance coverage, quality measurement, and consistent care. Federal, state, and local systems are now changing treatment of behavioral health conditions from integrated funding streams, research, and administration of treatment into blended systems which consider relationships and overlap between conditions and its impact on other medical conditions.

Behavioral Health System of Care - Overview

The committee learned behavioral health disorders are common, treatable, and often not accessible because of stigma and culture, shortages of providers and maldistribution, low payment rates, and a lack of integration across the care system. Behavioral health service settings include specialty behavioral health clinics and hospitals, outpatient independent providers, health clinics, hospitals, long-term care centers, mutual support groups and peer-run organizations, schools and educational settings, jails and prisons, other community settings, and home-based services. Treatment services include assessment and diagnosis, counseling and psychotherapy, medications, and supportive services, including care management and coordination. Behavioral health service providers include specialty behavioral health providers, including psychiatrists, psychologists, specialty nurses and social workers, addiction counselors, and other master-level licensed behavioral health therapist services; primary care physicians, including family medicine, pediatrics, internal medicine, obstetrics and gynecology, and emergency services; social and human services, including school counselors, criminal justice professionals, and aging and disability services; and informal volunteers, including support groups and peer counselors.

The committee learned a 2009 report by the Congressional Research Service provided actions that are needed for improving behavioral health services, including routine and systematic use of evidence-based practices, resolving the workforce shortage issues, ensuring access to care by removing financial barriers, coordinating mental health care with general health care and social services, and developing a way to systematically measure and improve the quality of care delivered. Measuring the quality of mental health care requires collection of data for many measures over a sustained period of time. The measures need to reflect patterns, which include the process of obtaining care and the outcome of the care received.

Key Legal Obligations Related to Behavioral Health Services

The committee received information from the Bazelon Center for Mental Health Law, Washington D.C., regarding legal obligations related to behavioral health services. The committee learned the legal framework for behavioral health services includes the United States Supreme Court ruling in the 1999 *Olmstead v. L.C.* case; Medicaid and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; the federal Mental Health Parity and Addiction Equity Act of 2008; and the federal Affordable Care Act of 2010. The 1999 Supreme Court ruling determined that the Americans with Disabilities Act requires states to provide community-based treatment for persons with mental disabilities when a state's treatment professionals determine that such placement is appropriate; affected persons do not oppose such treatment; and placement can be reasonably accommodated, considering resources available in the state and the needs of others with mental disabilities. The ruling included protecting at-risk people with disabilities that live in the community but have under-treated behavioral health conditions that place them at serious risk of institutionalization. In addition to state institutions, the ruling also applies to privately owned and operated facilities in the state's service delivery system. States must provide EPSDT services to Medicaid-eligible children and youth under age 21. States must also provide necessary health care, diagnostic services, treatment, and other measures to correct physical and mental illnesses and conditions regardless of whether services are specifically covered in the state's Medicaid plan. Early and Periodic Screening, Diagnostic, and Treatment also requires states to provide intensive home-based services to Medicaid-eligible children with a disability that affects behavior. The federal Substance Abuse and Mental Health Services Administration determined these services include intensive care coordination, peer services, intensive in-home services, respite care services, mobile crisis response and stabilization services, flex funds, trauma-informed treatments, mentoring, supported employment, and consultative services. The federal Mental Health Parity and Addiction Equity Act of 2008 provides that private health insurance plans that cover services for individuals with mental health or substance abuse disorders must be equitable with coverage for other health conditions; limits on coverage for these plans are not allowed to be stricter for behavioral health services than for other services; copayments and deductibles are not allowed to be higher for behavioral health services than for other services; and a plan that includes out-of-network coverage for physical health care, must include out-of-network coverage for behavioral health care.

Department of Human Services - Behavioral Health Services Delivery System

The committee learned DHS provides behavioral health services through its policy division, which is the Behavioral Health Services Division, and a services division, which includes the State Hospital, and the eight regional human service centers. The department's behavioral health system is based on the following values:

- **Recovery-oriented systems** - Includes systems of health and human services that affirm hope for recovery, exemplify a strength-based orientation, and offer a wide spectrum of services and supports aimed at engaging individuals with mental health and substance abuse conditions into care and promoting their resilience and long-term recovery from which they and their families may choose.
- **Person-centered care** - Based on the individual's self-identified hopes, aspirations, and goals, builds on the individual's own assets, interests, and strengths, and is carried out collaboratively with a broadly defined recovery management team which includes formal care providers and others who support the individual's own recovery efforts and process, such as employers, landlords, teachers, and neighbors.
- **Integrated care** - The collaboration between behavioral health and primary care providers to ensure the most effective and informative care for the consumer. Integrated care focuses on consumers and family members as partners in the health care process.
- **Trauma-informed** - An approach to the delivery of behavioral health services including an understanding of trauma and an awareness of the impact it can have across settings, services, and populations.

The Behavioral Health Services Division is responsible for overseeing a statewide network of substance abuse and mental health treatment, recovery support services, mental health promotion, and substance abuse prevention services. The committee learned the Behavioral Health Services Division provides leadership for the planning, development, and oversight of the state's behavioral health system by improving access to services, addressing behavioral health workforce needs, developing policy, and ensuring quality services are available for those with behavioral health needs. The policy roles of the Behavioral Health Services Division include:

- **Health and safety** - Licensing, certification, administrative rule updates, contracts, law and policy changes, training and technical assistance, data-driven planning, partners, and compliance requirements.
- **Access to services** - Priority status, partnerships, grant funding and request for proposals, policy and law changes, payments and partnership with payers including Medicaid, and training and technical assistance.
- **Quality** - Outcome-based contracts, best practice requirements, training and technical assistance, evaluation and data collection, process and outcome measures, prevention resource and media center, analysis of system changes, and fidelity.

The core functions of the Behavioral Health Services Division include:

- **Regulation** - Substance abuse licensing, opioid treatment program licensing, human service center licensing, psychiatric residential treatment facility licensing, Driving Under the Influence seminar program licensing, and administrative rules.
- **Administration** - Mental health block grants, substance abuse block grants, community and tribal prevention, problem gambling, brain injury, FirstLink 2-1-1 services, and the Robinson Recovery Center.
- **Workforce development** - Training and technical assistance, behavioral health conferences, mental health first aid, and partnerships with institutions and consortiums.
- **Prevention and promotion** - Parents Listen, Educate, Ask, Discuss program, prevention resource and media center, Speaks Volumes program, tribal prevention programs, community prevention programs, and prescription drug take back.
- **Partnership** - Mental Health and Substance Abuse Planning Council, Governor's Prevention Advisory Council, State Epidemiological Outcomes Workgroup, Brain Injury Advisory Committee, Problems Gambling Advisory Council, and ND Cares.

The state's delivery system provides, directly or through contracts, a full continuum of integrated behavioral health services, including:

- **Substance abuse disorder services** - An integrated and full continuum of psychotherapeutic and rehabilitation services with priority given to Schedule IV drug users, pregnant females, and uninsured individuals.
- **Extended care services** - Integrated and full continuum of medically necessary treatment and rehabilitative services for individuals with severe and persistent mental illness to enhance opportunity for:
 - **Productive community living** - 24-hour emergency care and access to hospitalization, assertive community treatment, and intensive case management;
 - **Active chronic disease management** - Medication management and therapy services including addiction therapy; and
 - **Other services** - Psychosocial rehabilitation and day treatment, peer and family support services, supported employment, supported housing, and various levels of residential environments.
- **Specialized children's services** - An integrated and full continuum of treatment and support services for severely emotionally disturbed children including mental health, substance abuse, social, educational, and juvenile services.

Substance Abuse Disorder System

The committee learned the goal of the substance abuse disorder system is to provide a full range of high-quality services to meet the needs of North Dakotans. In addition, the system should have prevention, intervention, treatment, and recovery support services; include activities and services that go beyond traditional interventions; and coordinate, communicate, and link with primary care because of the prevalence of co-morbid health, mental illness, and substance abuse disorders. The primary goals of the DHS Behavioral Health Division's substance abuse prevention system are to support local-level effective substance abuse prevention, develop and promote a substance abuse prevention system, and to develop an integration of the behavioral health system. Priorities include preventing underage drinking, adult binge drinking, and prescription drug abuse. The priorities are determined through ongoing data compilations provided by the state epidemiological outcomes workgroup. Factors that contribute to the development of substance abuse include retail availability, social availability, economic availability, enforcement, promotion, community norms, and individual factors.

The committee learned an addiction is a primary, chronic disease of the brain's reward, motivation, memory, and related circuitry. Dysfunction in the circuits may lead to characteristics of biological, psychological, social, and spiritual manifestations. This dysfunction may cause an individual to pursue substance abuse or other behaviors as a pathological reward or relief. Addiction may involve cycles of relapse and remission, and without treatment and recovery activities, addiction is progressive and may result in disability or premature death. Treatment is the use of any planned, intentional intervention in the health, behavior, and personal or family life of an individual suffering from alcoholism or from another drug dependency designed to enable the affected individual to achieve and maintain sobriety, physical and mental health, and a maximum functional ability. Components of treatment include physical and psychiatric evaluations, detoxification, counseling, self-help, treatment for co-morbid physical or behavioral complications, and medication-assisted therapy. A chronic disease management program may include a treatment plan with regular monitoring,

coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools.

The committee learned there are 57 licensed private adult substance abuse treatment programs in the state. The public service delivery for chronic disease management includes medication for withdrawal and to prevent relapse and diminish cravings, outpatient counseling, residential treatment, care coordination and case management, supported employment, home- and community-based services, and social supports. All eight regional human service centers provide substance abuse disorder treatment services, and contract for multiple residential levels of care. The level of services vary at each location for other substance abuse disorder services, including social detoxification, medical detoxification, residential treatment, adolescent-supported housing, adolescent residential treatment, and population-specific residential treatment. Each regional human service center and the State Hospital determine the services to provide based on identified needs and the number of individuals seeking services at that location, and by reviewing services private providers may be offering in the region. Each region has regional advisory councils that discuss services that may be lacking. In addition, the level of funding determines availability of services at each location. The committee learned a lack of access to community-based services, including residential treatment, is contributing to increasing incarceration rates. The committee learned 75 percent of individuals incarcerated in the state meet criteria for an active substance abuse disorder diagnosis. The committee learned DOCR created a correctional behavioral health workgroup that includes DOCR, DHS, probation and parole officers, and jail administrators. The goal of the workgroup is to make recommendations to the 65th Legislative Assembly regarding the improvement of access to behavioral health care for individuals involved with the state's criminal justice system.

Regional Intervention and Emergency Services Continuum

The committee learned Section 1913(c)(1) of the federal Public Health Service Act requires community mental health centers to provide 24-hour crisis services and screening for potential admission to a state mental health facility. North Dakota Century Code Section 25-03.1-04 requires screening and admission of an individual to the State Hospital to be performed by a regional human service center, and if appropriate, treated locally. This "gatekeeper" function ensures services are provided in the least restrictive and community-based environment. The emergency services continuum requires the capacity to prevent, respond, de-escalate, and followup from a crisis across a continuum of services. Emergency services include:

- **Rapid assessment and triage** - Which includes a continuum of regional intervention services, including an open-access model of care. Regional human service centers are implementing open-access models of care. An open-access model of care is an immediate assessment of an individual when they enter a regional human service center so that the level of care may be determined. The level of care may include emergent, urgent, or routine care.
- **Crisis line** - Which includes a 24-hour crisis line that provides immediate telephone support for the resolution of a behavioral health crisis. There were 1,400 crisis calls in the second quarter of fiscal year 2016.
- **Crisis services** - Which includes immediate, short-term help to individuals experiencing a crisis. There were 10,981 documented crisis and emergency services in the second quarter of fiscal year 2016.
- **Mobile crisis services** - Which includes behavioral health emergency responses of prompt and effective support to resolve a crisis and defer hospitalization. Mobile crisis services are provided in the Southeast region of the state. There were 105 interventions that averaged 113 minutes each in the second quarter of fiscal year 2016. Of the 105 interventions, 103 resulted in crisis resolutions and 2 required hospitalization.
- **Crisis stabilization** - Which includes crisis residential units and respite or safe bed services. A crisis residential unit is a residential service that provides emergency treatment as an alternative to hospitalization. A respite or safe bed service is a residential service that provides a safe bed to individuals in crisis that do not require admission to a treatment facility. There were 1,918 individual services in a crisis residential unit or respite care unit in the second quarter of fiscal year 2016. Crisis stabilization units are provided in seven regions of the state. The North Central region does not have a crisis stabilization unit.
- **Emergency room collaboration** - Which includes human service center contracts with local community hospitals to provide emergency psychiatric services. Local community hospital contracts are active in five regions of the state. There were 116 individual services in the second quarter of fiscal year 2016. The majority of State Hospital admissions result from individuals that do not stabilize at a local community hospital.

North Dakota Century Code Section 25-03.1-20 provides a person may be committed for involuntary treatment of mental illness only if a district court finds the individual is a person requiring treatment. A person requiring treatment includes a person that is mentally ill or chemically dependent, and if not treated, would be at serious risk of harm to self or others. There were 330 admissions to the State Hospital in the second quarter of fiscal year 2016. In addition, there were 219 petitions for court-ordered treatment and 27 petitions for court-ordered medication.

Adult Behavioral Health Services

The committee reviewed adult behavioral health treatment services. Adult behavioral health treatment services address health, home, and community issues. Treatment services relating to restoring health issues include medication management services, intensive case management, psychotherapy services, integrated dual disorders treatment, and restoration to competency. Treatment services relating to restoring home issues include skills training and case aide services, residential and transitional living services, supported living arrangements, specialized homeless case management, and supported employment services. Treatment services relating to restoring community issues include regional recovery centers, peer support services, sex offender treatment, and family therapy. Adult behavioral health services provided by the human service centers include specialized recovery and rehabilitation services and specialized residential and transitional treatment. Services provided by the State Hospital include specialized inpatient rehabilitation treatment, specialized transitional treatment, and specialized residential treatment for sex offenders. The committee reviewed adult behavioral health services for the second quarter of fiscal year 2016. The committee learned 11,613 adult mental health individuals received services in an identified program of care, which included 5,284 individuals that received contracted residential services, and 1,702 individuals with severe mental illness that received 16,471 services. There were 11,358 episodes of psychotherapy from clients that received residential services and 69,384 case management services documented. There were 2,918 adult mental health individuals that received contracted transitional living services.

Children's Behavioral Health Services

The committee received information from various organizations regarding children's behavioral health. The early childhood period for an individual involves development that is greater than any other stage of human development. Development includes gross motor skills, fine motor skills, speech, and social emotional development. Delays in development can occur for various reasons, which include genes, genetic syndromes, trauma in utero, trauma during delivery, and trauma during childhood. Trauma may include vascular trauma, physical trauma, neglect, and toxic exposures. Mental health issues for children ages 0 through 5 is determined by a child's ability to master core developmental tasks including how a child may regulate emotions, how they form relationships, or if they develop the ability to learn and explore their environment. A lack of screening consistency among providers may cause problems with coordination and continuity of treatment for a child. The goal of the state's EPSDT, also referred to as Health Tracks, is early detection, prevention, and treatment of problems for all children and youth enrolled in Medicaid. Components of Health Tracks screening include health history, physical examination, identification of all medical conditions and needs, immunizations, age-appropriate laboratory tests, development assessment, nutritional assessment, mental health screening, vision screening, hearing screening, oral inspection, and treatment and referrals for any necessary services.

The committee received information regarding behavioral health issues involving students in schools. Identifying behavioral health issues in children is more common once a child begins school. The goal of addressing student behavioral health issues is to promote wellness among students in schools. A comprehensive plan should include public schools, community health services, mental health services, juvenile services, and criminal justice systems to interact as a solution to address mental health issues for students. Children who experience trauma are more likely to have lower grade point averages, a higher rate of school absences, a higher probability of dropping out of school, more suspensions and expulsions, a decreased IQ score and lower reading ability, deficits in attention, deficits in abstract reasoning, deficits in long-term memory for verbal information, and more special education services. Risk factors among students in middle and high school include depression, family structures, first interaction with law enforcement, addiction, and physical and sexual abuse. Behavioral health services are needed for students from various demographics, not only for "at-risk" students.

The committee reviewed behavioral health challenges of adolescents. Child neglect is the primary cause of juvenile justice and criminal justice involvement. The committee learned that it is important to identify youth early, assess them accurately, and provide diversionary options when possible. Youth in the custody of DOCR are an increasingly challenging group to service. Complex and often interrelated issues require intensive and sometimes lengthy interventions to allow a youth to successfully return to their home, school, and community. Policies and strategies should keep at-risk youth connected to their homes, schools, and communities. In addition, policies should be developed to strengthen families, and strengthen intervention in families to support, encourage, and promote positive child development.

The committee learned 47 licensed private and public adolescent substance abuse treatment programs are operating in the state. In addition, the DHS Behavioral Health Division administers the voluntary treatment program that provides out-of-home treatment services for a Medicaid-eligible child with a serious disorder.

The committee learned youth services provided through regional human service centers include specialized rehabilitation services and specialized clinical services. Specialized rehabilitation services include the partnership program, the transition to independence program, and supported employment. Youth residential services include

psychiatric residential therapeutic services through the Ruth Meiers Adolescent Treatment Center in Grand Forks, residential child care services for females in foster care through Kay's Place in Minot, youth residential services through a residential treatment center in Bismarck, and treatment for youth with substance abuse disorder through PATH, Inc., in Fargo. The substance use disorder mothers and children program provide services for a child while the child's mother is receiving addiction treatment. In-home and community skills training are services for parent-child education, parenting skills, and daily living skills training. Court-ordered services include parental capacity evaluation, sex offender risk assessment, and adolescent drug court. The committee also reviewed other services for children including family focused services, inpatient treatment services, and residential treatment services. In the first quarter of fiscal year 2016, there were 557 youth in a partnership program, 595 youth receiving federal Title IV-E foster care services, 245 youth in substance abuse disorder services, 695 youth receiving individual psychotherapy, and 1,292 youth receiving case management services. The average age of a child receiving services was 12 years old.

Mental Health Training - School Districts

Section 5 of 2015 Senate Bill No. 2048 requires DPI to provide a report to the Legislative Management regarding mental health training provided by school districts. The department developed a *Youth Mental Health Training* fact sheet, which provides background of the state's mental health data and provides suggestions for ways to implement the youth mental health training. School districts are required to provide 8 hours of youth mental health training once every 2 years to all elementary, middle, and high school teachers and administrators. In addition, 2015 Senate Bill No. 2209 requires each school district to provide 2 hours of professional development each year relating to youth suicide risk indicators, appropriate responses, and referral sources to middle and high school instructional staff, teachers, and administrators. The committee learned 10 training sessions have been held in the state with 290 participants since July 2015.

The Department of Public Instruction received input from superintendents and educators throughout the state, and provided the following recommendations:

- Require each school district to provide a minimum of 8 hours of professional development on youth mental health each biennium to pre-kindergarten, elementary, middle, and high school teachers, paraprofessionals, administrators, and encourage ancillary and support staff to participate;
- Require at least 2 of the 8 hours to be used to address a school district's needs assessment results, which includes social and emotional learning, including resiliency, suicide prevention, bullying, and trauma; and
- Require each school district to report professional development hours to DPI.

Involuntary Treatment Laws

The committee reviewed information regarding involuntary treatment laws and issues. The information reviewed related to prior mental health and substance abuse legislation in the state, voluntary and involuntary treatment laws in other states, recent involuntary commitment case law, state holding period for emergency involuntary commitments, and states comparison of quality and use of outpatient commitment laws. The committee also received information from organizations regarding commitment laws, issues, and options.

Future Role of Human Service Centers and the State Hospital

The committee received information from DHS regarding the future role of the regional human service centers and the State Hospital for meeting the state's behavioral health needs. The department anticipates regional human service centers will provide the following services:

- **Emergency services** - 24-hour services manage and resolve crises in the least restrictive setting necessary, with referral to community services, in lieu of the State Hospital, whenever appropriate. Services will include open access assessment, 24-hour crisis line, mobile crisis services, social detoxification services, crisis residential services, and emergency services to jail.
- **Regional intervention services** - Regional intervention services refer to appropriate community services in lieu of State Hospital admission. Services will include assessment and screening services, community hospital services, and resource management.
- **Chronic disease management** - An integrated, multidisciplinary continuum of services for chronically mentally ill individuals to be provided in the least restrictive setting. Human service centers have an addiction program that meets requirements of North Dakota Administrative Code Articles 75-05 and 70-9.1. Services will include self-management support, rehabilitation and recovery services, targeted case management, medication management services, and residential services.

The regional advisory councils will be expected to evaluate the availability and effectiveness of care for planning and enhancing services. The Department of Human Services anticipates making changes at the State Hospital in areas

including clinical director assignment, quality management development, accreditation preparation, electronic health record development, professional training partnerships, and telehealth expansion.

Behavioral Health Needs Assessment

The committee received information from DHS regarding a report on the behavioral health needs assessment. The purpose of the assessment was to identify priority recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting children, adults, families, and communities in health and wellness, to reach their full potential. The assessment included a review of epidemiological data, a review of the full continuum of care, and a review of global systems and infrastructure. Epidemiological data includes a review of the youth risk behavior survey, the behavioral risk surveillance system, and the national survey on drug use and health. The goal of the continuum of care model is to ensure access is available to a full range of high-quality services to meet the various needs of an individual. Funding and reimbursements, infrastructure, and best practices were considered for each area of the continuum of care model. The continuum of care includes:

- **Promotion and prevention** - Prevention is a cost-effective way to avoid issues relating to behavioral health disorders. Identified service gaps include limited resources for mental health promotion and mental illness prevention efforts, workforce issues, lack of credentialing for prevention-related professionals, and a lack of understanding of the value of promotion and prevention efforts.
- **Intervention** - Research has identified that early intervention services may contribute to reduced health care costs and assist with improved health and well-being of individuals. In addition, early intervention strategies assist individuals to recognize if they are at-risk for behavioral health disorders and may need assistance to identify and change high-risk behaviors into healthy patterns. Identified service gaps include lack of integrated education systems, workforce limitations, inconsistent universal screenings, lack of funding for screenings, inefficient process for conducting assessments and referring for further assessment and treatment services.
- **Treatment** - Treatment is the use of any planned, intentional intervention in the health, behavioral, and personal life of an individual suffering from a behavioral health disorder designed to enable the affected individual to achieve and maintain physical and mental health, and maximum functional ability. Identified service gaps include criminalization of behavioral health disorders, limited community-based services available to allow individuals choice of services in the least restrictive environment, lack of integrated services and data exchange, limited communication of available services, workforce limitations, and the need for clarification of the role of public and private systems.
- **Recovery** - Recovery is the process of change for individuals to improve their health and wellness, live a self-directed life, and strive to reach their full potential. Identified service gaps include workforce limitations, limited evidence-based services, lack of infrastructure to support available services in the state, and limited payments to support evidence-based recovery services.

The committee reviewed the following suggested changes identified in the behavioral health needs assessment:

- Increase the use of data collection and analysis of behavioral health systems;
- Support substance abuse disorder early intervention services;
- Establish a children's behavioral health leadership group;
- Promote mental health and early identification of mental illness;
- Continue to support public service delivery system changes relating to core services and population; and
- Recognize behavioral health conditions as a chronic disease.

Other Committee Information and Reports

The committee conducted a tour of the State Hospital, the James River Correctional Center, the Northeast Human Service Center, and behavioral health-related provider facilities in Grand Forks. The committee received other information from providers, organizations, and individuals related to the study of behavioral health needs, including:

- Behavioral health definitions;
- Role and challenges of residential treatment services;
- Substance abuse treatment needs;
- A summary of information provided by the Council of State Governments relating to behavioral health and the criminal justice system;

- Federal Mental Health Parity and Addiction Equity Act, including the legal framework of the Act, the implications of the Act for the state, and requirements of the Act;
- Current behavioral health issues under consideration at the federal level;
- The need for more programs and services that address the unmet needs of consumers and families in the state, including consumer-centered support programs and a formal one-on-one peer support program;
- The need to address the addiction counselor workforce shortage, including supporting professional development for workers and assisting treatment providers with offering additional services;
- The definition of addiction counseling pursuant to NDCC Section 43-45-01;
- The need for a continuum of care model for mental health-related services that would be similar to those of the state's developmental disability system; and
- The need for additional behavioral health services.

Recommendations Received by the Committee

The committee received the following recommendations from agencies, organizations, and individuals categorized by major topic areas:

Alternatives to Incarceration

- Address structure for local and state alternatives to incarceration;
- Allow prosecution deferred upon condition of successful completion of treatment and a period of crime-free conduct for first-time drug offenders;
- Allow offenders with low-level drug crimes or nonviolent crimes due to substance abuse have their convictions reduced to a misdemeanor or removed from their record upon successful completion of treatment and a period of successful probation;
- Add more pretrial services that provide timely evaluations that consider criminogenic risk factors and behavioral health needs to assist the judicial system in determining alternatives to felony convictions and incarceration;
- Expand the use of Rule 32.2 of the North Dakota Rules of Criminal Procedures, relating to pretrial diversion, to help address mental health commitment issues; and provide additional awareness of the services;
- Add more juvenile and adult drug courts, and additional funding for existing drug courts to help address the needs of individuals with a dual diagnosis;
- Ensure individuals can maintain psychotropic medications while incarcerated;
- Expand the use of electronic monitoring for individuals to reduce overcrowding in prison facilities;
- Divert individuals that are incarcerated because of an addiction into a long-term treatment program; and
- Allow DOCR flexibility to release certain offenders convicted of drug crimes to probation upon successful completion of DOCR treatment, similar to the authority DOCR has with felony driving under the influence offenders.

Behavioral Health Services/Programs

- Collaborate with the Behavioral Health Planning Council for advocacy;
- Determine whether programs are effective in achieving desired outcomes and prioritize funding for the programs that are working;
- Create incentives and provide statewide efforts to educate physicians about medication-assisted treatment;
- Enhance reimbursements for certain services, including telemedicine and levels of care;
- Address significant gaps in detoxification and intoxication management to reduce placements in jail for detoxification, including funding to ensure social detoxification services are sufficient and available in all regions of the state, and funding to major cities for operating their own detoxification centers;
- Address the limited funding and resources available for chemical dependency patients, including additional services similar to the Robinson Recovery Center program in Fargo;
- Require a standard minor in possession education course similar to the Prime for Life Driving Under the Influence program;

- Provide funding to establish and maintain adolescent treatment programs in local facilities or the State Hospital;
- Provide more partial outpatient treatment services, provide financial assistance for individuals participating in long-term aftercare at existing facilities, and include more aftercare programs for outpatients as part of the comprehensive treatment plan;
- Add funding to address recovery supports including housing, social, and peer support; increase use of peer support specialists; and provide reimbursements for recovery coaching;
- Provide additional services and options for long-term placement of individuals with severe mental illness;
- Increase use of vouchers to cover gaps in recovery supports; ensure ease of access, and allow more consumer choices for services through a voucher system;
- Review use of home- and community-based services waivers; and
- Create a zero-reject model.

Case Management

- Consider use of private case management options;
- Address the lack of available case management services at human service centers; and
- Address comprehensive case management services for individuals, including persons with serious emotional disability, homelessness, or incarcerated.

Children's Behavioral Health

- Provide a full continuum of care that is well-defined and integrated and support a continuum that would be similar to those of the state's developmental disability system;
- Provide additional community-based supports for mental health needs;
- Address public health approach to management;
- Develop a person-centered care model similar to the model developed at Washington State University;
- Provide funding to implement evidence-based practices to reduce risks;
- Provide an adequate grievance and appeals process;
- Improve collaboration among other special education professionals, social service offices, and local agencies;
- Provide oversight by DPI, the State Department of Health, and DHS;
- Develop and refine a shared services model that can be replicated and scaled up in both rural and urban school districts throughout the state;
- Support a school-based mental health system with funding and policy;
- Address the lack of collaboration among supports and providers, including preschool special education and child care;
- Adjust child care assistance rates for providers that care for a child with special needs;
- Support efforts to reduce toxic stress, build executive function and self-regulation, create active skill building including coaching and training, and develop human capital to improve outcomes;
- Improve access to mental health experts in schools for both the students and staff;
- Provide more programs for students with behavioral health issues including appropriate staffing levels for the programs;
- Address the need in schools for mental health assistance that includes a long-term teaching approach for students and families;
- Provide teachers with more professional resources to work with behaviorally challenging students in their classroom;
- Improve behavioral health-related discussions in schools;
- Create pilot project grants to create partnerships between school districts and state agencies to develop and coordinate resources in communities to allow students and families to receive needed support;

- Create a network that meets quarterly to discuss scope of project, share best practices, and review outcomes and program evaluation;
- Establish children's assessment networks to identify prevalence and service needs;
- Provide incentives for providers to add services where gaps exist;
- Review children's waiver options;
- Increase funding for child care inclusion services;
- Increase peer support services;
- Provide funding for a permanent supportive housing program for youth at risk of homelessness, human trafficking, suicide, or incarceration;
- Implement an evidence-based model that provides educational programming to students;
- Provide professional development and capacity-building to staff;
- Establish protocols and relationships with community care providers to facilitate acquisition of time sensitive and appropriate interventions and treatment;
- Provide early intervention, assessment, and referrals to support students before crisis occurs, including referrals and persistent facilitation with mental health care providers;
- Provide intervention, support, and follow through for students and families;
- Increase the number of inpatient psychiatric beds at community hospitals or the State Hospital;
- Address concerns regarding lack of community psychiatric facilities and inefficient use of medical transportation;
- Develop short-term community-based crisis beds that specialize in providing behavioral and psychiatric services;
- Increase use of critical access hospitals; and
- Establish a training center to assist individuals with finding a job and recovery skills training.

Database

- Develop and maintain a statewide behavioral health database, including a directory of behavioral health providers and specialties; one that will measure effectiveness, cost savings, and review data over a period of time; and determine if successful programs can be replicated;
- Expand the use of 2-1-1 services or develop a central call center for data collection and research for substance abuse, add funding and assist with a marketing campaign to provide awareness, and require organizations to provide updated information;
- Provide state funding to assist FirstLink with the National Suicide Prevention Lifeline service;
- Develop an online treatment locator that will include availability, waiting time, and service type; and
- Develop a bed management system.

Definition

- Develop a definition regarding who is served under behavioral health services;
- Define core services;
- Define emergency care;
- Review defining partial hospitalization as outpatient; and
- Add tobacco and nicotine to the addiction counseling services definition in NDCC Section 43-45-01.

Emergency Services

- Develop community-based crisis teams that are available to respond immediately to a behavioral or psychiatric crisis including mobile crisis teams;
- Ensure universal access across the system for all levels of crisis services, including assessment, inpatient, short-term housing, and in-home crisis response; and

- Provide additional financial and nonfinancial support for behavioral-related care, including training, equipment, and legal services for emergency medical services providers, including local emergency medical responders, volunteer and professional emergency medical technicians, paramedics, and community paramedics.

Evaluation

- Standardize screening and assessments, and provide a system of reimbursement;
- Require providers to use the same screening tools to ensure accuracy of results, increase ease of communication between provider agencies, and to promote the ability to measure change and a child's progress;
- Address underutilization of EPSDT services as an entry point for services and source of payments;
- Allow child care providers to be trained to provide early childhood screenings;
- Require child care providers to be included in the development of individualized education plans to help address challenging behaviors;
- Consider reviewing NDCC Section 25-03.1-04 to allow for individuals to be screened via interactive television; to establish a statewide screening system that would allow any regional human service provider to provide prescreening services, rather than limiting prescreening to only the local regional human service center; and to allow a qualified medical professional to conduct a screening for admission to the State Hospital;
- Maintain doctor-patient relationships by providing for an independent examiner to assess a patient, collect required data, and represent a county during hearings;
- Require human service centers to provide temporary onsite services to accommodate the needs of individuals in permanent supportive housing; and
- Support suicide prevention, including supporting mental health questions on health screenings.

Housing

- Continue the North Dakota housing incentive fund; and authorize a one-time contribution to a landlord risk mitigation fund to provide an incentive for landlords to rent to households struggling with challenges that include poor credit, criminal history, and eviction history;
- Continue the North Dakota Homeless Grant;
- Authorize one-time funding for development of a regional coalition relating to homelessness, hunger, and poverty;
- Authorize a homeless prevention program;
- Provide funding to implement a mental health group home model in the state;
- Add more transitional and residential facilities;
- Increase substance abuse services and services for individuals diverted from the prison or probation system, including halfway houses, transitional housing, and peer support advocates;
- Provide funding for establishing and maintaining halfway houses in each region of the state that can provide onsite support and structure for individuals, which includes additional funding for case managers and onsite house managers;
- Review residency laws relating to vulnerable adults;
- Expand funding to increase permanent supportive housing units and provide permanent housing services throughout the state similar to the services provided by the Cooper House in Fargo; and
- Increase access to mental health and other related services that improve educational outcomes for transitional youth, including implementation of services that identify and connect with transitional youth, increase awareness of local resources, and connect transitional youth to services and supports.

Involuntary Commitment

- Extend the state's holding period for emergency involuntary commitments from 24 hours to 72 hours;
- Allow the hospital conducting a mental health commitment evaluation to have jurisdiction;
- Impose financial penalties on noncriminal traffic offenses, including speeding offenses, to generate funds that would provide additional grants through DHS to provide more beds for involuntary commitments; and
- Allow an individual to be placed into a treatment center during the emergency review process.

Labor Shortage

- Support professional development of workers and provide incentives for training offered by agencies;
- Add incentives, including loan forgiveness loan repayments or stipends for counselors and students training to become addiction counselors, and nursing staff in the behavioral health field;
- Create efforts to recruit psychiatrists, psychiatric nurse practitioners, physician assistants, and behavioral health professionals throughout the state;
- Create a media campaign for recruiting addiction counselors as a career choice;
- Partner with colleges and universities to align curriculum with tribal and national efforts, which includes tribal addiction workers, peer support specialists, and behavioral health technicians;
- Provide incentives for clinical supervisors training new trainees and support treatment providers that are willing to train new addiction counselors through the consortium system;
- Create dual licensure with other professions with agreements from other behavioral health-related boards;
- Increase use of telemedicine by expanding types of professionals using telemedicine, including counselors;
- Address the shortage of workers at human service centers, including psychiatry, therapy, and case management services; and
- Establish a minimum wage for individuals answering suicide calls in the state.

Licensing

- Adopt the National Association for Alcoholism and Drug Abuse Counselors uniform licensing recommendations for all 50 states;
- Authorize the Board of Addiction Counseling Examiners, or a related board, to include assessments of persons for use or abuse of gambling as part of a licensee's scope of practice;
- Allow licensed associate professional counselors to be considered a licensed mental health professional;
- Improve the reciprocity process for licensed addiction counselors, add funding for internship hours, and engage other master's- and doctoral-level practitioners with specific experience in the diagnoses and treatment of substance abuse disorders;
- Review reciprocity requirements and create "portability" contracts with surrounding states; and
- Allow Minnesota social workers to practice in North Dakota without a license for the purpose of providing services to Minnesota clients.

Medicaid/Insurance Coverage

- Maximize the use of federal funds that are available for behavioral health services, including the federal Medicaid Emergency Psychiatric Demonstration program;
- Consider requesting waivers through CMS for permanent supportive housing services, including the 1915(c) Home and Community-Based Services Waiver, the 1915(i) state plan option, and the 1115 waiver through demonstration projects provided by Medicaid;
- Add reimbursement requirements by third-party payers for telehealth, which currently exists for physicians;
- Require insurance companies to offer coverage for treatment services that are covered in neighboring states and to cover codependency and family treatment services provided by licensed addiction counselors;
- Allow Medicaid to provide reimbursement for services including recovery coaching, music therapy, mental health crisis intervention and stabilization, and review Medicaid rehabilitation service options;
- Review the federal Mental Health Parity and Addiction Equity Act of 2008;
- Change policy that requires an individual to expend \$15,000 before Medicaid coverage is provided for family focused services; and
- Encourage support for continuing Medicaid Expansion and of the federal Affordable Care Act.

Patient Transitions

- Continue addressing youth issues, including foster care transitional living situations and youth runaways;

- Support families with a child that has a challenging behavior to ensure the continuity of supports between the child's school and home;
- Add incentives for physicians to work with treatment providers to expand medication-assisted treatments;
- Add additional services for individuals transitioning from the sex offender treatment program to the community;
- Support individuals transitioning from treatment facilities back into the community;
- Provide for coordination and communication between behavioral health services and primary care;
- Address patient transitions from specialization, primary care, and peer support;
- Increase utilization of health information network and health information exchange; and
- Improve care through record sharing.

Prevention

- Develop public awareness and an education campaign for the general public regarding behavioral health needs;
- Add more resources for educating individuals on the importance of mental health-related issues; and
- Increase efforts for public awareness of crisis services.

State Hospital

- Address the delay of transferring patients to the State Hospital after they are approved for admission; and
- Provide for the State Hospital to designate more beds for involuntary commitment patients.

Training

- Allow acceptable mental health training to focus on specific areas, including behavioral disorders, social and emotional needs of students, suicide prevention, behavioral and mental health, bullying, depression, eating disorders, drug abuse, stress, and trauma;
- Allow proven evidence-based training strategies that reduce risk factors for students and address specific needs of a school or district;
- Deliver statewide professional development to school district staff regarding mental health issues, including mental health first aid;
- Require all teachers, law enforcement, social service providers, and foster parents to receive training, including trauma-informed care;
- Address the issue of a lack of providers in the state that receive specialized training or have knowledge with children from birth to age 5;
- Provide a total of \$3 million, including \$1 million to rural school districts, \$1 million to urban school districts, and \$1 million to regional education associations for school-based mental health programming;
- Support education and training programs that address trauma-focused care and treatment that includes all disciplines and placement settings;
- Expand training opportunities and internship slots for providers and prescribers;
- Address the lack of providers with specialized training in mental health issues for youth and in evidence-based models of therapy;
- Provide funding for specialized training of adolescent and young adult substance abuse and mental health professionals;
- Assure training for primary care providers in evidence-based models;
- Review the current level of training hour requirements prior to licensure and allow for training to occur while an individual is employed;
- Implement common curriculum for consistency of training; and
- Provide adequate staffing levels and quality training for employees of DHS.

Transportation

- Consider changes to reduce the need for transporting individuals to other communities for hospitalization and subsequently to the original community for a hearing;
- Provide funding for more access services to transportation;
- Reimburse counties for the costs of transporting an individual outside of a county; and
- Provide funding and assistance with transportation and other costs to allow family members to participate in programs not in their area.

Committee Recommendations

The committee recommends a bill [[17.0182.05000](#)] relating to policy changes that do not require additional funding to:

- Extend the holding period from 24 hours to 72 hours for emergency involuntary commitments for individuals with a serious physical condition or illness;
- Change youth mental health training requirements to require each school district to provide a minimum of 8 hours of professional development on youth mental health each biennium for teachers, paraprofessionals, administrators, and encourage ancillary and support staff to participate; to require at least 2 of the 8 hours to be used to address a school district's needs assessment results, which may include social and emotional learning; and to require each school district to report professional development hours to DPI;
- Require behavioral health training for early childhood service providers; and
- Create a children's behavioral health task force.

The committee recommends a bill [[17.0183.04000](#)] relating to program expansion with additional funding requirements to:

- Appropriate one-time funding of \$10,000 from the general fund and require DHS to adopt rules for an evidence-based alcohol and drug education program for individuals under 21 years old in violation of NDCC Section 5-01-08;
- Appropriate \$1,956,000 from the general fund to DHS for children's prevention and early intervention behavioral health services;
- Appropriate \$70,000 from the general fund to DHS for a behavioral health database;
- Appropriate \$1,920,000 from the general fund to DHS for peer-to-peer and family-to-family support services;
- Appropriate \$24,393,668, of which \$12,196,834 is from the general fund, and authorize 1 full-time equivalent position for DHS for targeted case management services for individuals with severe mental illness and severe emotional disturbance.

The committee recommends a bill [[17.0204.03000](#)] relating to the role and function of DHS to:

- Change behavioral health definitions;
- Change administration of behavioral health programs to define the roles for policy and service delivery divisions;
- Change the licensure process for regional human service centers to require accreditation from a national accrediting body and licensing by DHS;
- Add crisis services to the continuum of services for individuals with serious and persistent mental illness;
- Change membership and role of advisory groups for human services centers;
- Allow designated behavioral health providers to furnish preventive diagnostic, therapeutic, rehabilitative, or palliative services to individuals eligible for medical assistance; and
- Remove the designated location of a second state hospital for the mentally ill.

The committee recommends a bill [[17.0289.02000](#)] to change the definition of addiction counseling to include gambling, tobacco, nicotine, or other harmful substance or behavior, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, 5th edition, text revision (2013), or a future edition adopted by the board.

The committee recommends a concurrent resolution [[17.3010.01000](#)] to amend and reenact subsection 8 of Section 12 of Article IX of the Constitution of North Dakota to remove provisions requiring a state hospital to be located in Jamestown.

OTHER COMMITTEE RESPONSIBILITIES

In addition to the study of family caregiver supports and services and the study of behavioral health needs, the committee also received information relating to other committee responsibilities, including the Autism Spectrum Disorder Task Force, autism spectrum disorder voucher program pilot project, CHIP, Medicaid Expansion, brain injury life skill services, developmental disabilities, developmental disability waiver eligibility, family control parent-to-parent support, family-to-family health information and education, adult protective services, quarterly behavioral health services reports, addiction treatment services voucher, and statutory references to mental health professionals.

Autism Spectrum Disorder Task Force

North Dakota Century Code Section 50-06-32 establishes an Autism Spectrum Disorder Task Force. The task force examines early intervention services, family support services that would enable an individual with autism spectrum disorder to remain in the least restrictive home-based or community setting, programs transitioning an individual with autism spectrum disorder from a school-based setting to adult day programs and workforce development programs, the cost of providing services, and the nature and extent of federal resources that can be directed to the provision of services for individuals with autism spectrum disorder.

The task force includes 14 members appointed by the Governor. The task force recommended adding two additional members to the task force, including an adult with autism and a tribal representative. The task force meets four times per year. The task force developed a state plan in 2014, and within the next year, the task force anticipates merging the goals provided in the state plan by integrating a collective impact design. Collective impact is a collaborative effort model to share ideas, costs, and information to improve services and supports statewide, regionally, and nationally. The new approach will allow the state to maximize the efficiency and effectiveness of autism services.

Autism Spectrum Disorder Voucher Program Pilot Project

North Dakota Century Code Section 50-06-32.1 required DHS to establish a voucher program pilot project beginning July 1, 2014, to assist in funding equipment and general educational needs related to autism spectrum disorder for individuals below 200 percent of the federal poverty level from age 3 to under age 18 who have been diagnosed with autism spectrum disorder. In addition, DHS is required to adopt rules addressing management of the voucher program pilot project and to establish eligibility requirements and exclusions for the voucher program pilot project. Section 13 of 2015 Senate Bill No. 2012 provides for the continuation of the autism spectrum disorder voucher program pilot project and to report to the Legislative Management regarding the autism spectrum disorder voucher program pilot project.

The committee learned 55 voucher applications have been received since July 1, 2015, and of the 55 voucher applicants, 43 families have met the income criteria and 41 families are actively being served. Each qualifying child is eligible for up to \$12,500 per year. Voucher funds may be used for a one-time item purchase, for ongoing services, or for both a single-item purchase and ongoing services. Funds are used for various purposes including autism-specific camps, tutoring, monitoring devices, sensory processing equipment, communication devices, and respite care. Any funds that are not utilized by a family will be released into a voucher pool for other families to access.

Children's Health Insurance Program

North Dakota Century Code Section 50-29-02 requires DHS to prepare, submit, and implement a CHIP state plan and report annually to the Legislative Management and describe enrollment statistics and costs associated with the plan. The Legislative Assembly appropriated \$20.5 million, of which \$2.8 million is from the general fund, for the 2015-17 biennium.

The state reached the federal medical assistance percentage (FMAP) minimum for CHIP of 65 percent on October 1, 2013. The 65 percent FMAP continued until September 30, 2015. Provisions in the federal Affordable Care Act allowed the state to be eligible for an additional 23 percent federal match increase; therefore, the FMAP for CHIP is now 88 percent through September 30, 2016. The committee learned, as of December 2015, there were 2,523 premiums paid for children enrolled in CHIP.

Medicaid Expansion

Section 1 of 2015 House Bill No. 1037 requires DHS to study options for implementing income-based cost-sharing provisions for the Medicaid and Medicaid Expansion programs and to provide a report to the Legislative Management regarding the outcome of the study and the associated legislative recommendations and related draft legislation. Medicaid cost-sharing provisions may include copayments and premiums; may be imposed on outpatient services, inpatient services, nonemergency use of emergency room services, and prescription drugs; may be imposed on

individuals in eligibility groups that include single adults, parents, aged, blind, and disabled. The department reduces the provider payment by the amount of the copayment obligation, regardless of whether the copayment is collected by the provider. Services that are exempt from cost-sharing include emergency services, family planning services, preventative services provided to children, pregnancy-related services, and services resulting from provider preventable services. Individuals that are exempt from cost-sharing include children under 18 years old, pregnant women, individuals living in an institution that are required to contribute most of their income to the cost of care, and individuals receiving hospice services. Medicaid premiums and copayments are limited to an aggregate of 5 percent of a household income, and DHS must monitor a beneficiary's premiums and copayments. Premiums under a state plan may not be imposed on individuals with incomes below 150 percent of the federal poverty level. The committee received additional information regarding various examples of premium waivers approved by CMS; the CMS training provided to state Medicaid agencies; reports and studies on Medicaid cost sharing; and Montana's efforts to include premiums for its Medicaid Expansion population.

The committee considered, but did not recommend a bill draft to eliminate Medicaid copayment requirements.

Brain Injury Life Skill Services

Section 1 of 2015 House Bill No. 1046 requires DHS to provide a report to the Legislative Management on the use funds appropriated to DHS for the purpose of providing life skill services for individuals with brain injury. The department contracted with Community Options, Inc., to provide a minimum of 6 hours of service to 50 individuals per month through June 30, 2017. The prevocational skills program is designed to improve "soft" skills through community integration and volunteer experience to prepare individuals for employment. "Soft" skills include memory training, navigating public transit, communicating with others, and time management. The committee learned 40 individuals were involved in the prevocational skills program during June 2016. The average length of time an individual is in the program before entering the return to work program is 85 days. The return to work program is based on an evidence-based return to work model that seeks to achieve competitive employment through placement and long-term followup services in the community. The committee learned 25 individuals were involved in the return to work program during June 2016. Hours of employment are based on an individual's ability, needs, and impact of the brain injury. The brain injury program targets individuals that have a brain injury, including traumatic brain injury, aneurism, stroke, and trauma during birth. The committee learned the program is contracted with the North Dakota Brain Injury Network.

Developmental Disabilities

House Bill No. 1556 (2009) provided for DHS to contract for a study of the methodology and calculation for a ratesetting structure used by DHS to reimburse all developmental disabilities service providers. The independent contractor recommended changing to a prospective reimbursement process using an independent ratesetting and resource allocation model for the entire developmental disabilities client base. The 2011 Legislative Assembly directed DHS to establish a steering committee and develop a developmental disability payment system with an independent rate model utilizing the support intensity scale. During the 2013-15 biennium, it was determined the steering committee should address selected items prior to implementation of a new system, including reviewing concerns with ratesetting; identifying audit requirements and cost-related reporting; finalizing North Dakota Administrative Code, service descriptions, and related policies and procedures; submitting waiver and Medicaid state plan changes to CMS; and implementing the billing module within the case management system to accommodate making payments under the new payment system. Section 14 of 2015 Senate Bill No. 2012 requires DHS to provide a report to the Legislative Management regarding the activities of the developmental disabilities system reimbursement project.

The committee learned the current retrospective system does not relate the needs of the consumers to funding. Under the current system, an audit is required to be completed which is time consuming. The audit and cost settlement process can take up to 2 years to complete, which causes financial issues for some providers. The current system is labor intensive for providers and the state, and the new prospective system will allow funding to follow the consumer. The new system will allow the level of staffing to be based on the needs of the consumer. The new system will not require a cost settlement and there will be a statewide standard rate. The committee learned other tasks that need to be finalized to implement the new system include finalizing North Dakota Administrative Code changes, service descriptions, and related policies and procedures; submitting waiver and Medicaid state plan changes to CMS; and implementing a billing module within the case management system.

Testimony from Interested Persons

The committee received information from interested persons, including providers, organizations, and individuals. Key items expressed relating to the developmental disabilities system reimbursement project include:

- Concerns regarding the proposed new system for the developmental disability reimbursement project not differentiating a payment rate for community- and facility-based vocational services.
- Concerns regarding issues relating to the developmental disability reimbursement project not being addressed, including property costs, night staff, transition period, rates, outliers, and statement of costs.

The Department of Human Services addressed the issues and concerns provided to the committee as summarized in the following schedule:

Provider Issues	Current Status of Provider Issues
Development of a multiplier method	The development of a multiplier methodology for adults and children has been completed. The steering committee and stakeholder group recently met and have agreed on the children multiplier methodology. The department is currently preparing the budget estimates for the 2017-19 biennium, for the new multiplier methodology.
Development of an outlier process for consumers with exceptional medical or behavioral needs	Specific diagnosis conditions have been identified for an outlier process that will allow a provider to request enhanced funding if the support intensity scale does not provide enough hours and it is determined the lack of additional hours will pose a health or safety risk for that consumer. The department is including 2.5 percent of the project's budget to address potential consumer needs that may be included in this category.
Inclusion of a transition period	Consultants for the project determined there was no need for a transition period. The department does not anticipate a transition period. Additional funding will not be included for a transition period.
Determination of audit requirements and cost reports for providers	Providers with an intermediate care facility will need to submit cost reports pursuant to a CMS requirement of paying the upper payment limit. Providers that do not have an intermediate care facility will not be required to submit cost reports.
Development of community- and facility-based rates for day services	A review of rates and services provided by facility- and non-facility-based providers identified that non-facility providers have more costs; therefore, only one rate will be allowed for day services.

In addition, the committee learned DHS resubmitted its waiver amendment to CMS due to 2015-17 biennium budget reductions. The committee learned resubmitting the waiver amendment to CMS will delay implementation of the new system until January 2017.

After the committee completed its work, DHS issued a public notice on September 22, 2016, stating that the new ratesetting system for providers of developmental disability services will not be implemented on January 1, 2017. The department stated a new rate system may provide a different reimbursement rate to providers, and more time is needed to evaluate the number of clients who may be impacted if a provider chooses to provide less support.

Developmental Disability Waivers Eligibility

In March 2014, a new CMS rule established requirements for the qualities of settings that are eligible for reimbursement for Medicaid home- and community-based services, which are provided by the federal 1915(c) Home and Community-Based Services Waivers. The Department of Human Services completed a review of current services, which included site visits and work with CMS, consumers, and providers to assure compliance with new rules. Section 1 of 2015 Senate Bill No. 2234 required DHS to study eligibility for developmental disability waivers and to provide a report to the Legislative Management regarding the eligibility for developmental disability waivers.

The committee learned DHS created an internal eligibility workgroup in October 2014 to review the new *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, 5th edition, text revision (2013), and its impact on developmental disability eligibility. Initial recommendations provided by the workgroup include:

- If cognitive testing has been completed and is still valid, it will be considered in eligibility determination, but will not hold as much weight in the eligibility formula as it currently does.
- If cognitive testing has not been completed or it is no longer valid, it will not be required, but cognitive screening will be required.
- Adaptive functioning testing will be required and will hold more weight in the eligibility formula than intellectual functioning.
- Individuals with related conditions must have an intellectual disability or adaptive functioning disability.

The Department of Human Services distributed a survey to a group of stakeholders and a meeting was held in September 2015 to discuss results of the survey. The stakeholder groups identified various eligibility criteria for waivers. Some stakeholders also identified concerns with current eligibility criteria, including a requirement relating to intellectual disability or related condition. The committee learned that any suggestions or changes relating to eligibility for developmental disabilities waivers will be considered when DHS prepares its budget request for the 2017-19 biennium.

The committee received information from interested persons, including providers, organizations, and individuals. Concern was expressed regarding how DHS defines the term "related conditions" when determining eligibility of

developmental disabilities services, and a suggestion was made that individuals with a diagnosis of Down syndrome be automatically eligible for developmental disabilities services without additional cognitive and functional testing.

The committee learned DHS requested guidance from CMS regarding eligibility of developmental disabilities case management services. An individual must qualify as needing an institutional level of care to be eligible for the developmental disabilities waiver. Even though an individual may meet certain criteria to be eligible for services, that individual may not qualify for any services because the individual does not meet the institutional level of care requirement. A state may choose its own level of care for determining eligibility for developmental disabilities waivers, which includes hospitalization, intermediate care facility, or nursing facility. Various tools are available to help states make a determination and a state must receive approval from CMS for its level of care. North Dakota chose an institutional level of care.

Committee Recommendations

The committee recommends a bill [[17.0049.01000](#)] to add Down syndrome to the definition of developmental disability for determining eligibility assistance.

Family-Controlled Parent-to-Parent Support

Section 19 of 2015 Senate Bill No. 2012 requires grant recipients of a family-controlled parent-to-parent support grant to provide a report to the Legislative Management regarding the use of grant funds. The North Dakota Federation of Families for Children's Mental Health is a parent-run advocacy organization that focuses on the needs of children and youth with emotional, behavioral, and mental disorders and their families, from birth through transition to adulthood. The committee learned the organization received a grant of \$75,000 for the 2015-17 biennium and for the quarter ending September 30, 2015, the North Dakota Federation of Families for Children's Mental Health has provided support and education for over 121 families. In addition, the staff has had 5,796 parent contacts and 43 new referrals during the quarter.

Family-to-Family Health Information and Education

Section 20 of 2015 Senate Bill No. 2012 requires grant recipients of a family-to-family health information and education grant to provide a report to the Legislative Management regarding the use of grant funds. Family Voices of North Dakota is a health information and education center for families and professionals, that provides information and resources relating to health care, disability, and chronic health illnesses and issues for affected children with special health care needs. The organization received a grant of \$75,000 for the 2015-17 biennium. Use of the grant funds includes adding a part-time consultant in the Dickinson area, increasing and maintaining hours of existing staff, and increasing travel for outreach services and to meet with families in areas without staff including Minot and Devils Lake.

Adult Protective Services Program

Section 23 of 2015 Senate Bill No. 2012 requires DHS to provide a report to the Legislative Management regarding the adult protective services program, including the effectiveness of the program, information on services and outcomes, and funding by human service region and in total. The program addresses the safety of vulnerable adults at risk of harm because of the presence or threat of abuse, neglect, or exploitation. Adults are considered vulnerable, or "at-risk," if a mental or physical impairment affects the ability of taking care of themselves or making good decisions. The program is offered statewide through the regional human service centers or local partner agencies. The Aging Services Division administers a statewide toll-free number that includes accepting adult protective services program reports. Since July 2015, 1,041 reports have been received by telephone or other communications and an online web intake form called Harmony for Adult Protective Services has reduced the amount of time adult protective services program workers spend receiving reports. The committee learned DHS is also standardizing the screening process to develop appropriate screening questions that will ensure worker safety during home or in-person visits. Adult protective services program workers are responsible for providing community training and education. The department has received a federal grant to provide for statewide training and education to law enforcement and victim service workers that will focus on addressing issues of abuse in later life. The committee learned, after 2015-17 biennium budget reductions, funding provided for the 2015-17 biennium totals \$2,271,920, which includes \$178,350 for the Badlands Human Service Center, \$324,899 for the West Central Human Service Center, \$200,984 for the South Central Human Service Center, \$425,550 for the Southeast Human Service Center, \$324,936 for the Northeast Human Service Center, \$190,282 for the Lake Region Human Service Center, \$303,261 for the Northwest and North Central Human Service Centers, and \$323,658 for other statewide services.

Quarterly Behavioral Health Services Reports

Section 24 of 2015 Senate Bill No. 2012 requires DHS to provide a report to the Legislative Management regarding its quarterly behavioral health services. The new report has been designed to be consistent with other reports provided in DHS's *Quarterly Budget Insight* report. The report includes information on behavioral health services funding and on the number of individuals served in each program for the quarter.

Addiction Treatment Services Voucher

Section 4 of 2015 Senate Bill No. 2048 requires DHS to provide a report to the Legislative Management regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs. The substance abuse disorder voucher program was implemented and guidance provided to all treatment providers in July 2016. The voucher will cover screenings, assessments, individual therapy, group therapy, family therapy, room and board, recovery coaching, urine analysis, and transportation.

The committee learned the program has two active providers in the state--Heartview Foundation and ShareHouse, Inc. The Department of Human Services is encouraging rural providers to also participate in the program.

Statutory References to Mental Health Professionals

Section 1 of 2015 Senate Bill No. 2049 requires DHS to provide a report to the Legislative Management regarding the outcomes of the study of statutory references to mental health professionals to determine whether changes in the law may help to more fully utilize these professionals within their scope of practice, as it relates to the responsibilities of DHS to provide services or license facilities. Stakeholders that participated with the project included the State Department of Health, DHS, the Board of Counselor Examiners, the Board of Addiction Counseling Examiners, the Marriage and Family Therapy Licensure Board, the State Board of Medicine, the State Board of Nursing, the State Board of Psychologist Examiners, the North Dakota Hospital Association, the Long Term Care Association, the North Dakota Life and Health Insurance Guaranty Association, the North Dakota Protection and Advocacy Project, and the State Board of Higher Education. The stakeholder group developed the following tiered model identifying various roles of mental health professionals:

Tier	Description
1	Greatest degree of broad-based comprehensive training in multiple areas of psychiatric illness, including capacity to practice autonomously in those areas; manage the highest level of responsibility and risk; and professionals include psychiatrists, psychologists, and primary care providers: <ul style="list-style-type: none"> a. Specific area of expertise - Include medical doctors, osteopathic physicians, and doctoral-level licensed psychologists. b. Breadth of training allows for oversight of care delivery within those fields - Includes medical doctors, osteopathic physicians, advanced practice registered nurses, and physician assistants.
2	Ability to direct care independently or delineate between various broad-based comprehensive training in diagnosis and modalities of treatment for behavioral health conditions: <ul style="list-style-type: none"> a. Specific area of expertise - Include licensed independent clinical social workers and licensed professional clinical counselors. b. Breadth of training allows oversight of care delivery within those fields - Include licensed marriage and family counselors, licensed addiction counselors, and registered nurses.
3	Behavioral health therapy; clinical direction under supervision; or enacting a treatment plan with comprehensive training in specific dimensions of behavioral health; include licensed associate professional counselors, licensed certified social workers, licensed professional counselors, licensed associate marriage and family therapists, occupational therapists, vocational rehabilitation counselors, school psychologists, and human relation counselors.
4	Supporting clinical services; paraprofessional service workers with some level of behavioral health training, but without formal licensing; or carryout treatment under the guidance of a licensed professional; include direct care associates and technicians.

Committee Recommendation

The committee recommends a bill [[17.0228.03000](#)] to change statutory references for mental health professionals to a tiered system.