

NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HUMAN SERVICES COMMITTEE

Tuesday and Wednesday, March 8-9, 2016
Archibald Room, Second Floor, LaHaug Building, State Hospital
Jamestown, North Dakota

Representative Kathy Hogan, Chairman, called the meeting to order at 8:00 a.m.

Members present: Representatives Kathy Hogan, Dick Anderson, Chuck Damschen, Alan Fehr, Curt Hofstad, Dwight Kiefert, Gail Mooney, Naomi Muscha, Kylie Oversen, Jay Seibel, Peter F. Silbernagel; Senators Tyler Axness, Dick Dever, Oley Larsen, Tim Mathern

Members absent: Representative Bert Anderson and Senator Judy Lee

Others present: Jessica Haak, State Representative, Jamestown
See [Appendix A](#) for additional persons present.

It was moved by Senator Dever, seconded by Representative Fehr, and carried on a voice vote that the minutes of the January 5-6, 2016, meeting be approved as distributed.

The committee conducted a tour of the State Hospital, including the LaHaug Building, New Horizons Building, Gronewald Middleton Building, Tompkins Building, and the Learning Resource Center.

The committee conducted a tour of the James River Correctional Center, including the Special Assistance Unit.

COMMITTEE RESPONSIBILITIES

Chairman Hogan distributed information ([Appendix B](#)) regarding a summary of the November 2015 Behavioral Health Stakeholder's Summit.

Memorandum of State Holding Periods for Emergency Involuntary Commitments

The Legislative Council staff presented a memorandum entitled [State Holding Periods for Emergency Involuntary Commitments](#). He said the memorandum provides information regarding the statutorily authorized holding period for emergency involuntary commitments of each state and information regarding laws relating to the holding period for emergency involuntary commitments for selected states.

Dr. Rosalie Etherington, Superintendent/Administrator, State Hospital, distributed information ([Appendix C](#)) regarding involuntary treatment laws.

Memorandum of Hospitals Using Accountable Care Organizations

The Legislative Council staff presented a memorandum entitled [Hospitals Using Accountable Care Organizations](#). He said the memorandum provides information regarding Accountable Care Organizations (ACO) and the number of hospitals in the state that have an ACO.

Memorandum of 2015 House Bill No. 1279 - CARE Act Overview

The Legislative Council staff presented a memorandum entitled [2015 House Bill No. 1279 - CARE Act Overview](#). He said the memorandum provides information regarding [2015 House Bill No. 1279](#) and a comparison of the AARP Caregiver Advise, Record, Enable (CARE) Act provisions for North Dakota, Nevada, Oregon, and Utah. He said AARP has drafted model legislation which it refers to as the CARE Act to address supports for family caregivers during a patient's transition from a hospital. He said the original 2015 House Bill No. 1279 included provisions similar to provisions in the CARE Act.

Memorandum of Recommendations Provided to the Interim Human Services Committee

The Legislative Council staff presented a memorandum entitled [Recommendations Provided to the Interim Human Services Committee](#). He said the memorandum summarizes the recommendations provided to the committee relating to the assigned studies during its meetings on November 3, 2015, and January 5-6, 2016.

Chairman Hogan said the committee will use this document as a tool to identify any proposed bill drafts. She asked the committee members to review the proposed recommendations and be prepared to prioritize and choose those that should be considered for inclusion in proposed bill drafts.

Representative Silbernagel suggested the committee determine which recommendations will require additional funding.

Memorandum of States Comparison of Quality and Use of Outpatient Commitment Laws

The Legislative Council staff presented a memorandum entitled [States Comparison of Quality and Use of Outpatient Commitment Laws](#). He said the memorandum provides information relating to a selected state comparison of the quality and use of outpatient commitment laws that were published as part of a report by the Treatment Advocacy Center entitled *Mental Health Commitment Laws: A Survey of the States*.

STUDY OF BEHAVIORAL HEALTH NEEDS

Mental Health Commitment Issues

Chairman Hogan called on Honorable John E. Greenwood, District Judge, Southeast Judicial District, who provided information ([Appendix D](#)) regarding mental health commitment issues. Judge Greenwood said that it is not uncommon for individuals to be charged with a criminal offense, in a criminal court system, for an issue that could be treated as a mental health case. He said Rule 32.2 of the North Dakota Rules of Criminal Procedure, relating to pretrial diversion, may help address mental health commitment issues. He said the rule provides for an individual that is charged with a criminal offense to enter an agreement that will suspend prosecution and provide for conditions, that if followed, will result in dismissal of the charged offense. He said the agreement is subject to court approval. He said the agreement is different from a voluntary agreement which allows an individual to leave treatment at any time. He said a permitted condition pursuant to Rule 32.2 includes a rehabilitation program, which may include treatment, counseling, training, and education. He said treatment can be monitored by human service center staff members.

Judge Greenwood said implementation of Rule 32.2 to address mental health commitment issues may require additional procedures, including a review of the current treatment structure to determine if existing treatment plans are adaptable, a review of coordinated treatment among agencies, including county social services and Job Service North Dakota, a review to determine if current language in Rule 32.2 is sufficient, and efforts to inform prosecutors and defense attorneys to consider use of Rule 32.2.

In response to a question from Representative Silbernagel, Judge Greenwood suggested the Department of Human Services (DHS) provide additional awareness of pretrial diversion services that are available and the North Dakota State's Attorneys' Association provide additional awareness to prosecutors regarding pretrial diversions.

In response to a question from Senator Mathern, Judge Greenwood said he will involve the North Dakota Supreme Court Joint Procedure Committee in the process of possibly expanding Rule 32.2 to address rehabilitation program changes to include pretrial diversions for mental health cases.

In response to a question from Chairman Hogan, Judge Greenwood said many larger metropolitan areas have mental health courts that address mental health cases. Judge Greenwood said mental health courts are not usually feasible in smaller populated areas. He said Rule 32.2 is similar to a mental health court, but on a smaller scale. He said because DHS provides services in all areas of the state, the use of Rule 32.2 is feasible in all areas of the state.

In response to a question from Chairman Hogan regarding extending the holding periods for emergency involuntary commitments from 24 hours to 72 hours, Judge Greenwood said the 24-hour emergency involuntary commitment period is effective in the Southeast Judicial District. Judge Greenwood said many of the emergency involuntary commitment cases get referred to the State Hospital because the hospital is in the Southeast Judicial District.

In response to a question from Chairman Hogan regarding the use of alternative treatment orders, Judge Greenwood said a lack of beds at facilities may cause a delay in using alternative treatment orders, but they are used often and are effective.

In response to a question from Representative Kiefert, Judge Greenwood encouraged the committee to seek input from the Protection and Advocacy Project and patient rights organizations regarding voluntary and involuntary commitment issues.

Chairman Hogan said the committee will review the number of states that require pretrial diversions.

In response to a question from Representative Mooney, Judge Greenwood said the percentage of mental health cases that use pretrial diversion is small compared to the total criminal cases in the judicial system.

Public Behavioral Health Emergency Services

Dr. Etherington presented information ([Appendix E](#)) regarding the role of human service centers, regional intervention services and emergency services, hospital diversion, crisis mobile response teams, and State Hospital commitment proceedings. She said North Dakota Century Code (NDCC) 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. She said this "gatekeeper" function ensures services are provided in a least restrictive and community-based environment. She said 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. She said North Dakota Administrative Code (NDAC) Section 75-05-03-02, relating to emergency services, allows telephonic or face-to-face 24-hour-a-day crisis services that are provided directly or through contact. She said NDAC Section 75-05-03-08, relating to regional intervention services, requires regional intervention services to refer individuals to appropriate community services rather than admitting individuals to the State Hospital.

Dr. Etherington said the emergency services continuum requires the capacity to prevent, respond, de-escalate, and followup from a crisis across a continuum of services, including:

- **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. The initial assessment may help identify the type of care the individual will receive from the regional human service center.
- **Crisis line** - Which includes a 24-hour crisis line that provides immediate telephonic support for the resolution of a behavioral health crisis. There were 1,400 crisis calls for 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 for the second quarter of fiscal year 2016, which includes face-to-face and intervention services. Crisis services are provided in all eight regions of the state.
- **Mobile crisis services** - Which includes behavioral health emergency responses of prompt and effective support to resolve a crisis and defer hospitalization. There were 105 interventions that averaged 113 minutes each for the second quarter of fiscal year 2016. Of the 105 interventions, 103 resulted in crisis resolutions and 2 required hospitalization. Mobile crisis services are provided in the Southeast region of the state.
- **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 for 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 for the second quarter of fiscal year 2016. The majority of State Hospital admissions are from individuals that do not stabilize at a local community hospital.

Dr. Etherington said NDCC Section 25-03.1-20 provides that a person may be committed for involuntary treatment of mental illness only if a district court finds the individual is a person requiring treatment. She said 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. She said there were 330 hospital admissions to the State Hospital for the second quarter of the state fiscal year 2016. In addition, she said, there were 219 petitions for court-ordered treatment and 27 petitions for court-ordered medication.

In response to a question from Representative Oversen, Dr. Etherington said the North Central and Northwest Human Service Centers are fully functional with open-access assessments for all types of addiction and mental health care. Dr. Etherington said the South Central and Southeast Human Service Centers are currently in the process of implementing open-access assessments.

In response to a question from Chairman Hogan, Dr. Etherington said crisis stabilization services are meeting the needs, as they are known, for individuals that are seeking assistance. Dr. Etherington said services may not be addressing all of the needs of a community.

In response to a question from Chairman Hogan, Dr. Etherington said DHS will provide information to the committee regarding the number of hospital diversions by each region of the state.

In response to a question from Chairman Hogan regarding the feasibility of closing the State Hospital and serving all patients in their local communities, Dr. Etherington said Vermont is the only state that has successfully closed its state hospitals. Dr. Etherington said other states that have closed their state hospitals have had to subsequently reopen them to adequately serve individuals needing more intensive services.

Commitment Issues and Options

Mr. Gary E. Euron, Assistant State's Attorney, Cass County, provided information ([Appendix F](#)) relating to commitment issues and options. He said in 2015 Cass County had 171 involuntary commitment proceeding cases. He said procedures for accepting cases may vary from county to county. He said some counties will only allow petitions to be filed for residents of that county.

Mr. Euron provided the following recommendations:

- Add additional services in Grand Forks, Minot, Bismarck, Dickinson, and Williston similar to the Robinson Recovery Center program in Fargo;
- Add more juvenile and adult drug courts;
- Add additional funding for existing drug courts to help address the needs of individuals with a dual diagnosis; and
- Provide for the State Hospital to designate more beds for involuntary commitment patients.

In response to a question from Representative Silbernagel regarding pretrial diversions, Mr. Euron said pretrial diversions are a tool that can be used effectively. Mr. Euron said, however, if services available in that area are lacking, the individual may fail the rehabilitation program.

Mr. Jacob T. Rodenbiker, McKenzie County State's Attorney, provided information ([Appendix G](#)) relating to commitment issues and options. He said challenges with involuntary commitments in McKenzie County include transportation-related issues. He said often times the nearest hospital with an appropriate bed may be 2.5 hours away. He said transporting individuals to other locations consumes much of a police deputy's time and may require overtime costs.

Mr. Rodenbiker provided the following recommendations:

- 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;
- Reimburse counties for the costs of transporting an individual outside of a county;
- Consider reviewing NDCC Section 25-03.1-04 to allow a qualified medical professional to conduct a screening for admission to the State Hospital;
- Consider reviewing NDCC Section 25-03.1-04 to establish a statewide screening system that would allow any regional human service center to provide prescreening services, rather than limiting prescreenings to only the local regional human service center; and
- Consider reviewing NDCC Section 25-03.1-04 to allow for individuals to be screened via interactive television.

At the request of Chairman Hogan, Ms. Sally Holewa, State Court Administrator, Supreme Court, provided additional information ([Appendix H](#)) regarding a comparison of mental health cases filed in all counties in the state.

Comments by First Responders

Mr. Sherm Syverson, Executive Director, F-M Ambulance Service, Fargo, presented information ([Appendix I](#)) relating to behavioral health-related issues and concerns from the perspective of first responders. He said F-M Ambulance Service is the largest ambulance operator in the state. He said F-M Ambulance Service responds to more than 26,000 calls for service annually. He said one-third of those calls involve behavioral health components, including substance abuse, suicide, anxiety, and depression. He said emergency medical services

agencies have identified gaps in behavioral health coverage, which include capacity to care for people locally, the inability of ambulance services to be compensated for transporting behavioral health patients to non-emergency room destinations, a lack of behavioral health practitioners available to respond quickly at all times, and barriers that prevent agencies, practitioners, and institutions from sharing health information.

Mr. Syverson recommended 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.

In response to a question from Chairman Hogan, Mr. Syverson said over the last 5 years the number of behavioral health-related calls in Fargo has increased 30 percent. Mr. Syverson said during that same period inpatient bed capacity has not increased. He said individuals are being transported to other locations in Minnesota and North Dakota to receive needed care.

Mr. Jason Eblen, Community Paramedic, F-M Ambulance Service, Fargo, said emergency medical services agencies also provide information to the State Department of Health regarding ambulance services.

Comments by Interested Persons

Mr. Donald Moore, Forbes, presented testimony relating to nursing homes. Mr. Moore discussed recent issues relating to nursing home services provided for his wife. He expressed concern regarding the system of care.

Ms. Monica McConkey, Director of Business Development, Prairie St. John's, Fargo, presented testimony ([Appendix J](#)) that was submitted by Dr. Ammar Ali, Prairie St. John's, Fargo, relating to the behavioral health needs study. Dr. Ali's testimony provided recommendations for the committee to consider including:

- Extend the state's holding period for emergency involuntary commitments from 24 hours to 72 hours; and
- Maintain doctor-patient relationships by providing for an independent examiner to assess a patient, collect required data, and represent a county during hearings.

STUDY OF BEHAVIORAL HEALTH NEEDS - ADULT BEHAVIORAL HEALTH SERVICES

Adult Mental Health Continuum of Services

Chairman Hogan called on Ms. Pamela Sagness, Director, Behavioral Health Services Division, Department of Human Services, and Dr. Etherington to present information regarding adult behavioral health issues.

State Epidemiological Outcomes Workgroup

Ms. Sagness presented information ([Appendix K](#)) regarding adult mental health in the state. She said the State Epidemiological Outcomes Workgroup's (SEOW) mission is to identify, analyze, and communicate key substance abuse and related behavioral health data to guide programs, policies, and practices. She said SEOW's goal is to use data to inform and enhance state and community decisions regarding behavioral health programs, practices, and policies, and to promote positive behavioral health.

Ms. Sagness said 16.2 percent of adults age 18 years or older in the state have any mental illness (AMI). She said AMI is the presence of any mental, behavioral, or emotional disorder in the past year that has met the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 criteria. She said 5.4 percent of adults age 18 years or older in the state have a serious mental illness. She said a serious mental illness is defined as an adult with any mental, behavioral, or emotional disorder that substantially interfered with or limits one or more major life activities.

Effective Adult Behavioral Health System

Ms. Sagness said key factors for developing programs to address adult behavioral health include:

- Community-based;
- Consumer-driven;
- Culturally and linguistically competent; and
- Holistic.

Ms. Sagness said key principles for developing an effective adult behavioral health system include:

- Need for integration;

- Least restrictive settings;
- Resist criminalizing; and
- Broad array of services and supports that include accessibility, quality, tailored to consumer, strength-based, and recovery-focused.

Dr. Etherington presented information ([Appendix L](#)) regarding adult mental health treatment services. She said safety net providers are defined as public behavioral health services, which by mandate and mission, provide a full continuum of care for a proportionately greater share of poor and uninsured, the most vulnerable of which are those suffering severe and persistent mental illness and substance use disorders. She said safety net services provided through the human service centers include specialized recovery and rehabilitation services and specialized residential and transitional treatment. She said safety net services provided through the State Hospital include specialized inpatient rehabilitation treatment, specialized transitional treatment, and specialized residential treatment for sex offenders.

Dr. Etherington said adult behavioral health treatment services address health, home, and community issues. She said treatment services relating to restoring health issues include:

- Medication management services;
- Intensive case management;
- Psychotherapy services;
- Integrated dual disorders treatment; and
- Restoration to competency.

Dr. Etherington said 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.

Dr. Etherington said treatment services relating to restoring community issues include:

- Regional recovery centers;
- Peer support services;
- Sex offender treatment; and
- Family therapy.

Dr. Etherington provided information regarding adult public treatment services for the second quarter of fiscal year 2016. She said 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. She said there were 11,358 episodes of psychotherapy from clients that received residential services and 69,384 case management services documented. She said 2,918 adult mental health individuals received contracted transitional living services. She said State Hospital admissions totaled 330.

Dr. Etherington provided information ([Appendix M](#)) regarding the unduplicated number of adults and children receiving behavioral health services for the first and second quarters of fiscal year 2016, and information regarding contracted residential services by each regional human service center.

In response to a question from Representative Fehr, Dr. Etherington said human service centers currently provide information and referrals of other services that may be available in the community.

In response to a question from Representative Fehr, Dr. Etherington said companion animals are regularly provided for mentally ill individuals and they do provide a level of purpose in the continuum of care.

Dr. Andrew J. McLean, Medical Director, Department of Human Services, and Chair, Department of Psychiatry and Behavioral Science, University of North Dakota School of Medicine and Health Sciences, said DHS and the University of North Dakota School of Medicine and Health Sciences are addressing issues regarding access to and shortage of services by increasing residency programs, expanding use of telehealth services, and providing more services in rural areas of the state.

Challenges of Adult Mental Health

Captain Andy Frobis, Cass County Sheriff's Office, Fargo, provided information regarding challenges of adult mental health from the perspective of local law enforcement and jails. He provided the following recommendations:

- Address the service gaps for individuals that become incarcerated. The continuum of care does not currently extend to incarcerated individuals;
- Consider changes to reduce the need for transporting individuals to other communities for hospitalization and subsequently to the original community for a hearing.
- Allow the hospital conducting a mental health commitment evaluation to have jurisdiction.
- Provide more partial outpatient treatment services.

The committee recessed at 4:30 p.m. and reconvened at 8:00 a.m. on Wednesday, March 9, 2016.

Adult Mental Health Services Needs and Issues

Dr. Rachel Fleissner, Sanford Health, Fargo, provided information ([Appendix N](#)) regarding adult mental health services needs and issues. She recommended addressing the following issues:

- Lack of available case management services at human service centers;
- Limited funding and resources available for chemical dependency patients;
- A shortage of workers at human service centers, including psychiatry, therapy, and case management services; and
- A delay in transferring patients to the State Hospital after they are approved for admission.

Dr. Etherington provided comments regarding posthospitalization requirements for individuals with mental illness. She said posthospital requirements are set by the federal Centers for Medicare and Medicaid Services (CMS). She said all CMS certified hospitals must provide a followup appointment within 7 days of a hospitalization of a person with a mental illness. She said DHS anticipates the implementation of the open-access model of care at regional human service centers to decrease the wait time to serve individuals with a mental illness at the human service centers.

Chairman Hogan provided comments regarding the state's system of care. She said definitions for service eligibility may need clarifications and the role of partners, including the State Hospital, regional human service centers, and private providers may need defining. She said the key to an effective system is partnerships and transparency. She said the committee will begin to develop a plan at its May 2016 meeting.

Adult Mental Health Needs - Shelters and Supportive Housing Challenges

Ms. Denise Kramer, Chief Program Officer, and Ms. Becky Vakoc, Chief Financial Officer, Prairie Harvest Mental Health, Grand Forks, provided information ([Appendix O](#)) regarding challenges of both shelters and supportive housing for adults with mental health needs. Ms. Kramer provided an informational booklet ([Appendix P](#)) entitled *Prairie Harvest Mental Health*. She said Prairie Harvest Mental Health serves individuals with serious mental illness. She said the Northeast Human Service Center refers individuals to Prairie Harvest Mental Health for mental health recovery, including permanent supportive housing. She said permanent supportive housing is an evidence-based practice recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). She said Prairie Harvest Mental Health facilities may not be appropriate for certain individuals that require 24-hour staff services. She said other challenges relate to Prairie Harvest Mental Health facilities being near capacity.

Ms. Laurie J. Baker, Chairman, North Dakota Coalition for Homeless People, and Executive Director, Fargo-Moorhead Coalition for Homeless Persons, Fargo, provided information ([Appendix Q](#)) regarding challenges of both shelters and supportive housing for adults with mental health needs. She provided the following recommendations:

- Continue the North Dakota housing incentive fund;

- Continue the North Dakota Homeless Grant;
- 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 addressing youth issues, including foster care transitional living situations and youth runaways;
- Authorize one-time funding for development of a regional coalition relating to homelessness, hunger, and poverty;
- Review residency laws relating to vulnerable adults; and
- Authorize a homeless prevention program.

In response to a question from Representative Fehr, Ms. Baker said the uses of landlord risk mitigation funds include paying a landlord for lost rent because of abandonment of property and reimbursements of up to \$3,000 for property damages. Ms. Baker said other funds, including the tenant's deposit, must be used before landlord risk mitigation funds would be accessed.

Adult Mental Health Recovery Support Services

Ms. Carlotta McCleary, Executive Director, North Dakota Federation of Families for Children's Mental Health, and Executive Director, Mental Health America of North Dakota, presented information ([Appendix R](#)) regarding an overview of adult mental health recovery support services, including social clubs and peer supports. She said 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. She said the mission of Mental Health America of North Dakota is to promote mental health through education, advocacy, understanding, and access to quality care for all individuals.

Ms. McCleary said social clubs are now referred to as recovery centers. She said recovery centers address holistic needs of individuals. She said SAMHSA identifies four dimensions that support a life in recovery, including health, home, purpose, and community. She said the North Dakota Federation of Families for Children's Mental Health and Mental Health America of North Dakota focus on individuals overcoming and managing their disease or symptoms, finding a safe place to live, obtaining a job, enrolling in school, becoming a volunteer, being a family caretaker, and developing healthy social networks and relationships.

Ms. McCleary said peer-to-peer support is an evidence-based practice that utilizes an individual with experience to support another consumer in their recovery journey. She said SAMHSA defines peer-to-peer support as a one-on-one relationship with a peer leader or mentor that encourages, motivates, and supports a peer that is establishing or strengthening the recovery. She said mentors assist peers with tasks, including setting recovery goals, developing recovery action plans, and solving problems directly related to recovery. She said mentors also assist in finding appropriate housing, making new friends, finding new uses of spare time, and improving job skills. She said the relationship is supportive instead of directive. She said the duration of the relationship depends on factors, including how much recovery time the peer has, how much other support the peer is receiving, or how quickly the peer's most pressing problems can be addressed.

Ms. McCleary said peer-to-peer support is currently not available through the North Dakota Federation of Families for Children's Mental Health or Mental Health America of North Dakota. She said services were provided in prior bienniums through state-funded grants. She said peer-to-peer support services were the top service priority among consumers.

In response to a question from Chairman Hogan, Ms. McCleary said Mental Health America of North Dakota is in the process of reviewing the curriculum and certification process for the peer-to-peer training program.

In response to a question from Representative Larson, Ms. McCleary said the North Dakota Federation of Families for Children's Mental Health has parent coordinators that work one-on-one with families and youth relating to all aspects of identified needs.

Referral, Suicide, and Resources Available in the State

Ms. Cindy Miller, Executive Director, and Mr. David Vining, Director of Program Development, FirstLink, Fargo, presented information ([Appendix S](#)) relating to referral, suicide, and resources available in the state. Ms. Miller said FirstLink is a 24-hour hotline service that assists people with identifying, accessing, and making effective use of community and volunteer resources. She said FirstLink helpline was incorporated in 1971. She said the Public Service Commission designated FirstLink as the 2-1-1 provider for the entire state in 2010. She said in 2015 FirstLink averaged one call every 10 minutes and answered a total of 53,748 calls.

Ms. Miller provided the following recommendations:

- Establish a minimum wage for individuals answering suicide calls in the state;
- Assist with a marketing campaign for the 2-1-1 hotline similar to the National Suicide Prevention Lifeline campaign currently being sponsored by the State Department of Health;
- Provide state funding to assist FirstLink with the National Suicide Prevention Lifeline service; and
- Add for-profit mental health and human service providers to the database by increasing funding received from DHS from 31 percent of FirstLink's budget to 50 percent, which would increase current funding from \$275,000 to \$440,000 per year.

In response to a question from Senator Axness, Ms. Miller said she suggests requiring organizations to provide updated information to FirstLink when an organization changes its information. Senator Axness said a challenge with behavioral health services is that many providers are not aware of the other behavioral health-related services available in communities.

Representative Silbernagel provided comments regarding behavioral needs initiatives. He said one of the state's greatest needs has been to build a database of resources. He said the inclusion of private nonprofit organizations in the database is critical for identifying gaps in services.

Comments by Interested Persons

Ms. Carlotta McCleary, Mental Health Advocacy Network, provided testimony ([Appendix T](#)) regarding adult behavioral health services. She said the Mental Health Advocacy Network advocates for a consumer and family driven mental health system of care that provides various service choices that are timely, responsive, and effective. She supports adding funding to provide peer-to-peer and family-to-family support, allowing more consumer choices for services through a voucher system, diversion of more youth and adults from the correctional system, defining core services, creating a zero-reject model, and providing adequate funding for both public and private services, and providing an adequate grievance and appeals process.

Mr. Tim Fode, Director of Service, Mental Health America of North Dakota, provided testimony regarding support for mental health issues. He expressed concern regarding budget reductions to regional human service centers and mental health services. He recommended adding more resources for educating individuals on the importance of mental health-related issues, and adding more funding to provide additional services for mental health-related issues.

Ms. Maggie D. Anderson, Executive Director, Department of Human Services, provided information ([Appendix U](#)) regarding targeted case management criteria and services. She said targeted case management is a Medicaid service. She said targeted case management is not included in most private insurance plans. She said a number of years ago, the state established the program and allows only the regional human service centers and the North Dakota Indian tribes to provide targeted case management services under the state's Medicaid plan.

Ms. Siobhan Deppa, consumer of behavioral health services, provided testimony ([Appendix V](#)) related to the study of behavioral health. She expressed support for including a formal one-on-one peer support program.

STUDY OF FAMILY CAREGIVER SUPPORTS AND SERVICES

North Dakota State University Extension Service -

Status Update for the Family Caregiver Supports and Services Study

Dr. Jane Strommen, Extension Gerontology Specialist, North Dakota State University Extension Service, presented information ([Appendix W](#)) regarding an update on the status of the study of family caregiver supports and services. She said the study is currently on schedule. She said the research team anticipates the final report will be complete by May 11, 2016.

In response to a question from Representative Anderson, Dr. Strommen said critical access hospitals are considered to be a stakeholder of caregiver supports and services. Dr. Strommen said the study includes receiving input from critical access hospitals.

State and Federal Laws Relating to Family Caregivers

Chairman Hogan called on Mr. Troy T. Seibel, Commissioner, Department of Labor and Human Rights, to present information ([Appendix X](#)) regarding state and federal laws that support and protect family caregivers. Mr. T. Seibel said state laws generally do not require employers to provide paid annual or sick leave. He said if leave programs are provided, they must be administered in a nondiscriminatory way.

Mr. T. Seibel said there are federal laws that require certain employers to provide unpaid leave to an employee, including the federal Family Medical Leave Act (FMLA) and the federal Americans with Disabilities Act. He said FMLA is a federal law that requires employers to provide certain employee leave, including a requirement that an employer provides up to 12 weeks of unpaid leave each year for an employee with a health condition or for an employee because of a health condition of a family member related to that employee. He said a family member includes a child, spouse, or parent. He said an employer covered by FMLA includes:

- Private-sector employer with 50 or more employees that have worked 20 or more workweeks in the current or preceding calendar year;
- Public local, state, or federal government agency regardless of the number of employees; and
- Public or private elementary or secondary school regardless of the number of employees.

Mr. T. Seibel said an employee is covered by FMLA if that employee has worked for the employer for at least 12 months, has at least 1,250 hours of service during the 12-month period immediately preceding the leave, and works at a location that has at least 50 employees within 75 miles. He said pursuant to provisions of 2015 House Bill No. 1387 state employees may now use up to 12 weeks of paid leave to care for a child, spouse, or parent.

In response to a question from Representative Oversen, Mr. T. Seibel said state employees must accrue leave time before it can be used. Mr. T. Seibel said a new employee will generally accrue 1 day of annual leave and 1 day of sick leave each month.

Mr. T. Seibel said the association provision of the Americans with Disabilities Act is a federal law that prohibits discrimination against individuals that associate with an individual that has a disability. He said the act applies to employers with 15 or more employees. He said the North Dakota Human Rights Act does not have an association provision.

In response to a question from Chairman Hogan, Mr. T. Seibel said there have been situations relating to individuals filing a complaint because of discrimination from a disability. Mr. T. Seibel said some situations are related to family caregivers.

Other State's Options for the CARE Act

In response to a question from Representative Oversen, Mr. Dan Hannaher, Legislative Affairs Director, Sanford Health, and Executive Director, Health Policy Consortium, and Mr. Josh Askvig, Advocacy Director, AARP North Dakota, provided information regarding an update on the work between Sanford Health, other medical providers, and AARP relating to issues of mutual agreement to benefit patients after discharge from a medical facility.

Mr. Hannaher said there have been discussions regarding how Utah, Nevada, and Oregon have approved the CARE Act. He said attorneys at Sanford Health and various provider groups have held discussions, including review of the bill approved in Oregon. He said the two groups are continuing to discuss issues relating to provisions of the CARE Act approved in Nevada and Utah.

Mr. Askvig said a review of Utah, Nevada, and Oregon was suggested because of feedback received from hospitals in other states that have expressed support with how each of these three states have approved the CARE Act. He said AARP has been providing contact information to hospitals seeking additional information regarding how other hospitals have implemented the CARE Act. He said AARP continues to work with Sanford Health and the other medical providers.

OTHER COMMITTEE REPORTS

Behavioral Health Services

Dr. Etherington presented information ([Appendix Y](#)) regarding DHS's quarterly behavioral health services report pursuant to Section 24 of 2015 Senate Bill No. 2012. She said the new report has been designed to be consistent with other reports provided in DHS's *Quarterly Budget Insight* report.

Chairman Hogan requested DHS to include the total number of unduplicated clients receiving services each month.

Ms. Sagness presented information ([Appendix Z](#)) regarding DHS's quarterly behavioral health services report pursuant to Section 17 of 2015 Senate Bill No. 2012. She said the Legislative Assembly appropriated \$10,922,324 for the 2015-17 biennium for behavioral health services. In addition, she said, the report includes the number of individuals served in each program for the quarter.

In response to a question from Representative Oversen, Ms. Sagness said DHS's budget allotment reductions are not reflected in the report. Ms. Sagness said the report will be adjusted to include DHS's budget allotment reductions when the report is prepared for the July 2015 through March 2016 period.

Chairman Hogan requested DHS to also include a column for a comparison of the percentage of funding spent to date for the biennium to the percentage of the biennium completed.

Eligibility of Developmental Disabilities Waivers

Ms. Tina Bay, Director, Developmental Disabilities Division, Department of Human Services, presented information regarding eligibility for developmental disabilities waivers pursuant to Section 1 of 2015 Senate Bill No. 2234. She said DHS continues to review information that was received from a survey distributed to a group of stakeholders in 2015. She said any suggestions for changes relating to eligibility for developmental disabilities waivers will be considered when DHS prepares its budget request for the 2017-19 biennium.

In response to a question from Chairman Hogan, Ms. Bay said stakeholder groups have identified various eligibility criteria for waivers. Ms. Bay said some stakeholder groups have also identified concerns with current eligibility criteria, including a requirement relating to intellectual disability or related condition.

Ms. Bay also presented information regarding the committee's bill draft [[17.0049.01000](#)] relating to Down syndrome and eligibility for assistance, which was presented at the January 5-6, 2016, committee meeting. She said DHS requested guidance from CMS regarding eligibility of developmental disabilities case management services. She said 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, she said that individual may not qualify for any services because the individual does not meet the institutional level of care requirement.

In response to a question from Representative Oversen, Ms. Bay said a state may choose its own level of care for determining eligibility for developmental disabilities waivers, which includes hospitalization, intermediate care facility, or nursing. Ms. Bay said various tools are available to help states make a determination. She said states must receive approval from CMS for its level of care. She said North Dakota chose an institutional level of care.

Developmental Disabilities System Reimbursement Project

Ms. Bay presented information ([Appendix AA](#)) regarding the status of the developmental disabilities system reimbursement project pursuant to Section 14 of 2015 Senate Bill No. 2012. She said implementation of the new system was originally planned for July 1, 2015. She said the North Dakota Association of Community Providers requested delaying implementation of the new system until provider issues were addressed. She provided updates regarding the following provider issues:

Provider Issues	Current Status of Provider Issues
Development of a multiplier method to replace crosswalks	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 2015-17 budget estimates 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 having a transition period. Additional funding will not be included in the 2015-17 biennium 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, Ms. Bay provided an update regarding other tasks that need to be finalized by DHS to implement the new system. She said the first draft of administrative code changes, service descriptions, and related policies and procedures are being reviewed. She said DHS resubmitted another waiver amendment to CMS because of DHS's budget allotment reduction changes. She said resubmitting the waiver amendment to CMS will delay

implementation of the new system until January 2017. She said the vendor for the case management system anticipates implementation of a billing module within the case management system by January 1, 2017.

In response to a question from Chairman Hogan, Ms. Bay said DHS's budget allotment reduction includes removing the second year provider inflationary increases of 3 percent for developmental disabilities service providers which were scheduled to increase on July 1, 2016. Ms. Bay said the total impact of the inflationary adjustment reduction is \$8,114,276, of which \$4,047,111 is from the general fund.

In response to a question from Chairman Hogan, Ms. Bay said after internal review of Administrative Code changes, there will be a public comment period, then an administrative rules hearing.

Adult Protective Services Program

Ms. Michelle Gayette, Elder Rights Program Administrator, Aging Services Division, Department of Human Services, presented information ([Appendix BB](#)) 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. She said the program addresses the safety of vulnerable adults at risk of harm because of the presence or threat of abuse, neglect, or exploitation. She said 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. She said the program is offered statewide through the regional human service centers or local partner agencies. She said the Aging Services Division administers a statewide toll-free number that includes accepting adult protective services program reports. She said since July 2015, 1,041 reports have been received by telephone or other communications.

Ms. Gayette said 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. She said DHS is also standardizing the screening process to develop appropriate screening questions that will ensure worker safety during home or in-person visits.

Ms. Gayette said 973 adult protective services cases were reported. Of the 973 cases reported in 2015:

- 580 were identified as "at-risk" cases, 256 cases were identified as "no-risk" cases, and 137 cases were identified as cases that were unable to be determined.
- 481 cases related to self neglect, 200 cases to exploitation, 164 cases to neglect, 120 cases to abuse, and 8 cases to other allegations.
- 353 cases were completed, 150 cases were closed due to refusal of services, 112 cases were closed for no evidence, 100 cases due to long-term care placement, 98 cases due to protective arrangements, 57 cases were referred to other agencies, 45 cases were closed due to client relocation, 45 cases due to death, and 13 cases due to other reasons.

Ms. Gayette said adult protective services program workers are responsible for providing community training and education. She said an online training program was created to assist. In addition, she said, DHS has also partnered with the Abused Adult Resource Center and other Bismarck agencies to obtain an Enhanced Training and Services To End Abuse In Later Life Program grant from the federal Office on Violence Against Women. She said the grant provides for statewide training and education to law enforcement and victim service workers that will focus on addressing issues of abuse in later life. She said the grant also focuses on development of a coordinated community response team and implementation of a response plan in Burleigh County, promotion of available services, project outreach efforts to communities, and direct services for identified victims.

Ms. Gayette said, after DHS's budget allotment reduction, funding provided for the 2015-17 biennium totals \$2,271,920, which includes \$178,350 for Badlands Human Service Center in Dickinson, \$324,899 for West Central Human Service Center in Bismarck, \$200,984 for South Central Human Service Center in Jamestown, \$425,550 for Southeast Human Service Center in Fargo, \$324,936 for Northeast Human Service Center in Grand Forks, \$190,282 for Lake Region Human Service Center in Devils Lake, \$303,261 for Northwest and North Central Human Service Centers in Williston and Minot, and \$323,658 for other statewide services.

Addiction Treatment Services Voucher System

Ms. Sagness presented information ([Appendix CC](#)) 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. In addition, she provided information ([Appendix DD](#)) regarding the development of the administrative rules relating to the substance use disorder treatment voucher system. She said the report is a draft report that has been through public hearing. She

said the report has not been reviewed by the interim Administrative Rules Committee. She said DHS anticipates adopting the administrative rules by July 1, 2016, if the extension for adoption of the rules is granted by the interim Administrative Rules Committee.

Ms. Sagness said providers at the public hearing identified the following issues which will not be addressed even if the proposed changes to administrative rules are approved:

- Medical detoxification services will be excluded from the substance use disorder treatment voucher system because the system is for licensed substance abuse providers. Medical detoxification is provided by medical providers; and
- Detoxification services provided by jails will be excluded from the substance use disorder treatment voucher system because the services are not licensed programs; therefore, the substance use disorder treatment voucher system does not address the service gap for jails.

In response to a question from Chairman Hogan, Ms. Sagness said it may be possible for a jail to be included if they contract with a licensed provider to provide detoxification services.

Committee Discussion

Senator Mathern suggested receiving additional information from DHS regarding current expenditures for the State Hospital and secured and traditional services. He expressed concern regarding the lack of awareness of the expenditures in the programs and the current structure of the programs. He said it may be difficult to address program needs if there is a lack of understanding of the structure and expenditures of the programs.

In response to a question from Representative Oversen, Ms. Anderson provided information regarding DHS's budget allotment reduction process. Ms. Anderson said the Legislative Assembly appropriated \$1,332,202,833 from the general fund to DHS for the 2015-17 biennium. She said the budget allotment reduction was \$53,954,215 from the general fund.

Chairman Hogan requested the Legislative Council staff to prepare a list of all recommendations provided to the committee and to determine whether each recommendation will require additional funding.

Chairman Hogan said the next meeting is tentatively scheduled for Tuesday and Wednesday, May 10-11, 2016, in Grand Forks.

No further business appearing, Chairman Hogan adjourned the meeting at 2:30 p.m.

Michael C. Johnson
Fiscal Analyst

ATTACH:30