Good Morning Chairman Damschen and members of the committee. Thank you for the time on your busy agenda this morning.

My name is Joy Ryan. I am Executive Vice President of The Village Family Service Center. The Village operates 10 physical offices providing behavioral health and human services in the state of North Dakota and employs over two hundred North Dakotans. We have been providing services in the state since 1891, when we were founded as the North Dakota Children's Home. I have been with The Village for twenty years and in my current role since 2010.

Today I am here to tell you about the earnest efforts of a stakeholders group that is working in concert with consultant Renee Schulte, who your committee engaged to conduct an interim study of *"behavioral health needs including consideration of behavioral health needs of youth and adults and consideration of access, availability and delivery of services."* My two goals today are:

Number 1: To share the work and role of this self-convened, volunteer, self-managed group,

and

Number 2: To give faces to the behavioral health issues in North Dakota today.

The interim study is important. Behavioral health issues in North Dakota have reached a critical stage and your committee has recognized the concerns. However, to many in the trenches of service delivery in North Dakota, and other concerned

people – some from this committee – it seemed that the scope of the study would quickly exceed the resources available to do the work.

Doing this right is important. When we say "behavioral health" folks often glaze over. Behavioral health isn't about how crabby we get over what seemed like the never-ending winter. Instead, behavioral health is about the faces of the North Dakotans who need us to get this right. People like the career police officer in Fargo whose body was found in a cemetery where he had died of suicide. Or, the seventh grade girl who struggles in school during the day and at night cuts her skin to let out rage and gain control. These are the real faces of the behavioral health issue.

The stakeholders group began their work late last year, knowing that a consultant would be selected and would need to gather information quickly. Our goal was to have that information ready to flow when he or she was selected. Plans were made to hold an initial stakeholders meeting in Fargo on February 6 and 7 of this year. Professionals from across the state attended the meeting. Attendees included Dr. Michael Dallolio, head of psychiatry with Trinity Hospital in Minot, Dr. Lisa Peterson with the Department of Corrections here in Bismarck, Sandi Christoffferson – career social worker in private practice from Devils Lake, Assistant Chief Michael Reiten from the West Fargo Police Department, Lieutenant Colonel Davina French from the National Guard, Joanne Hoesel from the DHS, Chief Deputy Attorney General Tom Trenbeath, Steve Reiser from Dakota Central Social Services, Dr. Gwen Halaas from UND Medical School in Grand Forks and nearly 3 dozen others. Ms. Schulte, and her partner were also able to attend. They were an impressive group – many meeting each other for the first time. The group drew from every conceivable involved

profession. It included private, public, government, law enforcement, and education decision makers. Every person in the room had hold of one "part of the elephant" that is behavioral health. Some could talk to the lack of access to treatment services in jails; some could talk about the progress being made with the treatment of human service center patients who struggle with dual diagnosis. Others could explain kids' mental health and "developmental repair." There were those who were experts on rule changes needed for commitment or workforce issues limiting access to psychiatric service or veteran's reintegration challenges. This meeting began the hard work of gathering information to provide to the consultant. This was a significant step.

The meeting focused on need assessment and evidence based and promising practices in the categories of Adult Mental Health, Children's Mental Health and Substance Abuse and Treatment. The information was categorized, clarified, organized and sent to Ms. Schulte. Also at that meeting Ms. Schulte's plans for ongoing visits to the state and open forum conference calls were announced. The attendees were encouraged to help drive participation from across the state.

More faces began to emerge over these 2 February days. The face of the 8 year old North Dakota child in residential placement in Montana, a thousand miles from home, struggling to control behaviors he doesn't even begin to understand came into focus. The face of the law enforcement officer, who has driven 4 hours across county lines from hospital to jail to hospital with his charge in the backseat. Not a criminal, but yet law enforcement carrying the burden, looking for someplace with an open crisis bed or detox services.

As this effort moves forward, the volume regarding behavioral health concerns continues to increase. In December of last year, the Center for Rural Health at the University of North Dakota Medical School identified behavioral health (mental health and substance abuse) as the 3rd most significant health need in North Dakota behind only workforce shortages and obesity. In a regional health needs assessment conducted in the Fargo metro area by Sanford and Essentia, behavioral health was ranked as the number one concern.

Following the February meeting the stakeholders group spread the word about this study to others. The information provided to Ms. Schulte was also sent back to attendees for redistribution, comment and feedback. Information about Ms. Schulte's conference calls was again disseminated. Huge amounts of research from other states, SAMSHA, Harvard, UND, University of Minnesota, the Children's Bureau and others was collected, analyzed, vetted and passed on. An emerging draft of strategic initiatives began, again shared with Ms. Schulte for her input and consideration. The information was also shared with state legislators.

A second stakeholders meeting was held on March 25 here in Bismarck at the new UND medical school building downtown. Many of the February attendees came and many new interested folks joined the process. Kurt Snyder from Heartview Foundation, Tim Eissinger from Dakota Boys and Girls Ranch, Mike Kaspari from First Step Recovery and President of the Treatment Providers Coalition, Maggie Anderson , Director of ND DHS and others joined the group. Ms. Schulte came to this meeting also. This time the group took the information from the original meeting combined with the input received, and began to build possible solutions,

outcomes measures and timelines which could be provided to the consultant. Following this meeting a group of stakeholders met with Governor Dalrymple, Lieutenant Governor Wrigley and staff to apprise them of the group's investment in the efforts sponsored by this committee.

Other faces now seen. The new North Dakotan, young, strong, hardworking who stumbles with his sobriety while working in the oil patch, and must leave his dreams for his future to get treatment elsewhere because none is available near his workplace. The adult psychiatrist who, asked to see a child patient, struggles with the ethical dilemma and liability of providing care for which they are not specifically trained, or leaving the child without services because there are 8 open child psychiatrist positions in just the Minot region. Those too are faces of North Dakota behavioral health.

The March 25th meeting created a framework of a draft action plan, again provided to the consultant, which begins to offer possible solutions for some of the identified behavioral health needs. This is what this committee and all of us are working toward. Strategic solutions that lead to needed change. One of the wonderful "findings" of this working document has been that not all solutions are complicated, require long term planning or funding. Some do, but not all.

For example, some changes can take place immediately. As a matter of fact, the University of North Dakota Medical School has already taken the initiative to ask host facilities for residency opportunities specifically in behavioral health.

Some changes regarding licensure, internships, assessment tools may require only rule change or administrative adjustments. Other changes may require legislation

in this biennium, or the next or the next... but the process begins with small incremental changes at the same time we work on "Big Hairy Audacious Goals" as Jim Collins would say. This stratification of activity by time line will allow for success throughout the process. Small successes over time will lead to big success overall.

The stakeholders group has worked very hard to expand the resources and the access for Ms. Schulte as she meets the requirements of her task for your legislative committee. We are approaching this effort as a conduit for the legislative process so that behavioral health services in North Dakota keep our folks healthier, safer, and happier and with rightly deserved access to excellent services. It is our sincere desire that you see our efforts as complimentary, informed and useful.

Ms. Schulte's current work will be completed in July and presented to the committee. We are confident her report will be a strong, insightful and actionable product. But, then her home is Iowa. The stakeholders group works with the people here in North Dakota each and every day. This group is committed to this process for the long haul. When she finishes her work we will continue ours in assisting your committee and our state in establishing a behavioral health system that meets all of our citizens' needs.

As noted, included with my testimony is a list of all stakeholders and also most importantly, the group's current work product, a Strategic Vision with separate sections dedicated to Adult Mental Health, Children and Adolescent Mental Health and Substance Abuse and Treatment. These are draft documents at this point, provided to you and Ms. Schulte as a way to study and understand the work ahead.

In summary I share one last face. The face of my mother, your mother, father or grandfather searching for the happiness that once came so easy and is now drowned out by the chronic depression that is all too common in our elders. That is one more face of behavioral health in North Dakota. They deserve the best we can give.

Thank you, Mr. Chairman and Committee members for your time and kind attention.

North Dakota Behavioral Health Stakeholders

Mari Bell West Fargo Public Schools	Scott Davis ND Indian Affairs Commission	Dr. Gwen Halaas UND School of Medicine
Brenda Bergsrud Veterans Affairs	Michelle Dillenburg Essentia Health	Dan Hannaher Sanford Health
Arlene Biberdorf Sanford Health – Fargo	Dr. Mark Doerner Sanford Health Bismarck	Brad Hawk ND Indian Affairs
Aaron Birst ND Association of Counties	Tom Eide Prairie St. John's	Melanie Heitkamp Youthworks – North Dakota
Tim Blasl ND Hospital Association	Tom Eissinger Dakota Boys and Girls Ranch	JoAnne Hoesel ND Dept. of Human Services
Jacki Bleess-Toppen Prairie St. John's	Dr. Rosalie Etherington ND State Hospital	Rep. Kathy Hogan District 21
Brad Brown South East Human Service Ctr.	Jennifer Faul Prairie St. John's	Sally Holewa State Court Administrator
Sharon Buhr City-County Health	Dr. Rachel Fleissner Sanford Health Fargo	Jeff Hoss Sanford Health Fargo
Dr. Ronal Burd Sanford Health – Fargo	Jean Frei St. Sophie's Psychiatric Clinic	Toby Jezzard Essentia Health
Mitch Burris Cass County Sheriff's Office	Lt. Col Davina French ND National Guard	Jane Johnson ND National Guard
Kathleen Busch St. Alexius Medical Center	Anna Frissell Red River Children's Advocacy	Gene Kaseman Dakota Boys and Girls Ranch
Laurel Carey Sanford Health – Fargo	Emily Gard Sanford Health Fargo	Micheal Kaspari First Step Recovery
Kari Chaffee ND National Guard	Susan Gerenz Pride Manchester House	Courtney Koebele, JD ND Medical Association
Sandi Christofferson LICSW	Jeanette Gratton UND School of Medicine	Dr. Laura Kroetsch South East Human Service Ctr.
Greg Clark Prairie St. John's	Paul Griffin Consensus Council, Inc.	Greg LaFrancois Prairie St. John's
Dr. Mike Dallolio Trinity Health	Dr. Naveed Haider Sanford Health Fargo	Andrew Larson Sanford Health Fargo

4/07/2014

North Dakota Behavioral Health Stakeholders

Senator Judy Lee District 11	Shelly Peterson ND Long Term Care Assoc.	Liz Sterling Essentia Health
June Lehr Custer Health – Mandan	Rep. Chet Pollert District 29	Debbie Svobodny Sanford Health Fargo
Dr. Leland Lipp Clinical Psychologist	Dr. Sara Quam South East Human Service Ctr.	Dr. Eric Swensen Sanford Health Fargo
Mario Marberry Prairie St. John's	Rebecca Quinn UND School of Medicine	Lynette Tastad Cass County Sheriff's Office, CIT
Senator Tim Mathern District 11	Kristi Rehn South East Human Service Ctr.	Tami Ternes ND Governor's Office
Carlotta McCleary ND Federation of Families for Children's Mental Health	Steve Reiser Dakota Central Social Services	Sandy Thompson Bismarck/Dickinson Human Service Center
Dr. Andrew McLean ND Dept. of Human Services	Michael Reitan West Fargo Police Department	Tom Trenbeath Chief Deputy Attorney General
Vickie Meyer South East Human Service Ctr.	Joy Ryan Village Family Service Center	Dale Twedt PATH North Dakota
Cindy Miller FirstLink	Rod St. Aubyn	Dr. Jon Ulven Sanford Health Fargo
Kathy Moraghan Sanford Health Fargo	Alex Schweitzer ND Dept. of Human Services	John Vastag Blue Cross Blue Shield ND
Dr. Stephen Nelson Sanford Health Fargo	Jacqueline Seminary Sanford Health Fargo	Jim Vetter ND Boys and Girls Ranch
Elysia Neubert Prairie St. John's	Rep. Pete Silbernagel District 22	Nancy Vogeltanz-Holm UND School of Medicine
Katie Nystuem South East Human Service Ctr.	Kurt Snyder Heartview Foundation	Rep. Robin Weisz District 14
Tracy Peters Cass County Assistant State's Attorney	Tonya Sorenson Prairie St. John's	Theresa Will City-County Health District
Dr. Lisa Peterson ND Dept. of Corrections	Jeff Stenseth South East Human Service Ctr.	Don Wright Heartview Foundation

4/07/2014

Adult Mental Health Strategic Vision

Strategic Initiative 1: Increase accessibility to behavioral health services through a more consistent, coordinated and transparent system of care

Adult Goal 1.1 Identify core services available in all regions of the state including public and private providers. Have a consistent public sector delivery system that is routinely monitored based on public data.

Adult Goal 1.2 Identify and inform consumers/partners of available services

Adult Goal 1.3 Expand and train workforce and key partners

Adult Goal 1.4 Develop crisis response system with accountability standards

Adult Goal 1.5 Improve Discharge Planning and Coordination

Strategic Initiative 2: Identify and address changes in Rules/NDCC/Licensing issues

Adult Goal 2.1 Review and Revise commitment procedures/processes

Adult Goal 2.2 Review Licensing requirement for various mental health/LAC professionals

Adult Goal 2.3 Revise the NDCC to permit Law Enforcement to access behavioral health information to assure public safety

Children and Adolescent Mental Health Strategic vision

Strategic Initiative 1: Increase accessibility to specialized behavioral health services through a more consistent, coordinated and transparent system of care

Children/ Adolescent_Goal 1.1 Identify core services available in all regions of the state including public and private providers. Have a consistent public sector delivery system that is routinely monitored based on public data.

Children/ Adolescent_Goal 1.2 Evaluate residential treatment services options/ expand community alternatives

Children/ Adolescent_Goal 1.3 Expand and train workforce and key partners

Strategic Initiative 2: Expand availability of behavioral health services within the schools

Children/ Adolescent_Goal 2.1 Expand onsite behavioral health services within the schools

Strategic Initiative 3: Establish early childhood behavioral health screening and assessment

Children/ Adolescent_Goal 3.1 Establish consistent early childhood behavioral health screening, assessment and treatment to be available for all pre-school children.

Adult/Adolescent Substance Abuse Strategic Vision

Strategic Initiative 1: Increase accessibility to specialized behavioral health services through a more consistent, coordinated and transparent system of care

Substance Abuse Goal 1.1 Identify core services available in all regions of the state including public and private providers. To have a consistent public sector delivery system that is routinely monitored based on public data.

Substance Abuse Goal 1.2 Expand Medical and Social detoxification resources

Substance Abuse Goal 1.3 Identify funding structures both public and private that support a comprehensive system of care.

Substance Abuse Goal 1.4 Expand and train workforce and key partners

Strategic Initiative 2: Inform the public of the risks of substance abuse through education and media efforts to reduce abuse

Substance Abuse Goal 2.1 Develop a major public information campaign and primary prevention initiative.

December 2013

Center *for* Rural Health
School of Medicine & Health Sciences
University of North Dakota

Fact Sheet

North Dakota's Significant Health Needs as Identified by Community Health Needs Assessments

Aggregate Results for all North Dakota Hospitals

Karin Becker, PhD Candidate

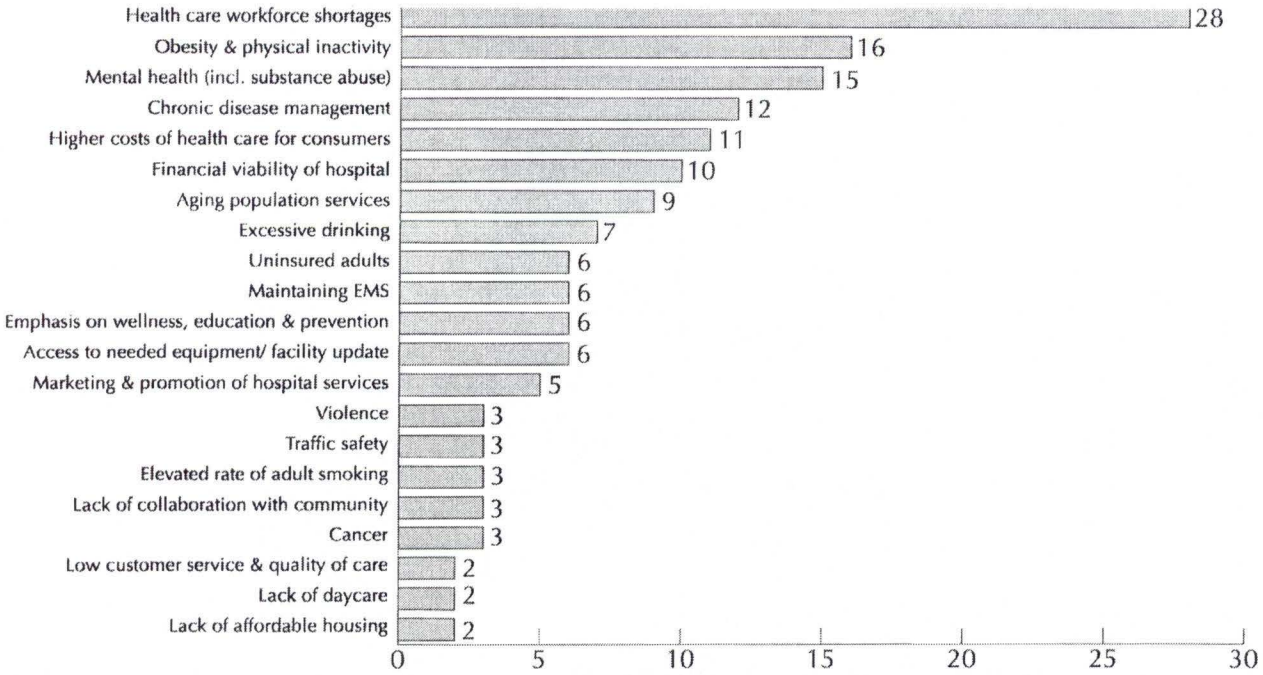
Overview

The Affordable Care Act (ACA) mandates that a Community Health Needs Assessment (CHNA) be conducted on all non-profit hospitals once every three years. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences has conducted CHNAs on more than half of the Critical Access Hospitals (CAHs) in North Dakota. The Center for Rural Health's involvement is funded through Health Resources and Services Administration (HRSA), Office of Rural Health Policy and Medicare Rural Hospital Flexibility (Flex) Grant Program.

Method

The CHNA process is informed by both primary (community member interviews, focus groups, and surveys) and secondary data. Although methodologies differ between assessments, as a whole, the goal of the CHNA is to solicit community input on health needs and service gaps. A systematic review of all the significant needs collected from the CHNAs was conducted to establish a broader understanding of community health needs in rural North Dakota. The aggregated needs reflect health concerns selected and ranked as most prevalent, most persistent, and most substantial. With this prioritized list, policy makers and invested stakeholders can develop more targeted solutions to address the needs impacting North Dakota constituents.

Health Needs Most Frequently Prioritized in CHNAs



Sample Size

North Dakota has 36 CAHs. The CRH conducted 21 CHNAs for hospitals across the state representing 58% of all CAHs. An additional 18 CHNA reports have been completed by hospital staff or consultants, making a total sample size of 39 hospitals out of a total of 41 hospitals in the state. These hospitals represent both rural and urban areas and are geographically dispersed throughout the state, making for a representative sample.

Economic Value

A rigorous mixed methods research design was used for the 21 CHNAs conducted by the CRH. To gain community input, CRH staff traveled to each community to facilitate two focus groups, interview 6-8 community leaders, and disseminate between 500 to 1,500 surveys into the community. Bids from consulting firms to conduct CHNAs range from $20,000-$60,000. Taking an average of $40,000, the CRH has provided technical assistance to North Dakota's CAHs for a combined total value of $840,000 (21 x $40,000).

Key Research Findings: Most Significant Health Needs

- The significant need most frequently reported in CHNAs is a health care workforce shortage. In 28 separate community health needs assessments, the need for more health care staff was expressed. This concern includes a need for more physicians, visiting specialists, and other health care professionals.
- The next most frequently perceived community health needs were:
  - Obesity and physical inactivity (N=16).
  - Mental health, including substance abuse (N=15).
  - Chronic disease management which includes diabetes, cardiovascular and respiratory disease (N=12).
  - Higher costs of health care for consumers (N=11).

Summary

As a whole, the identified needs paint the current picture of health needs confronting rural communities and affecting the state. They provide a baseline for which to measure change in the future and a way to chart progress of successful interventions and programming activities.

It is important to look at the identified needs not as a weakness but as an opportunity to make improvements in the health of our communities. In order for change to occur, participants must be willing to change and choose to change. The high numbers of community member and health care professional involvement in the CHNA process are testament to this readiness. Completing the first round of the ACA mandate is an exciting time to document the service gaps at this point in time and work collaboratively to leverage resources and reduce the scope of burden.

For more information, contact

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January 2014

Center *for* Rural Health
School of Medicine & Health Sciences
University of North Dakota

Fact Sheet

North Dakota's Significant Health Needs as Identified by Community Health Needs Assessments Aggregate Results for Rural Critical Access Hospitals

Karin Becker, PhD Candidate

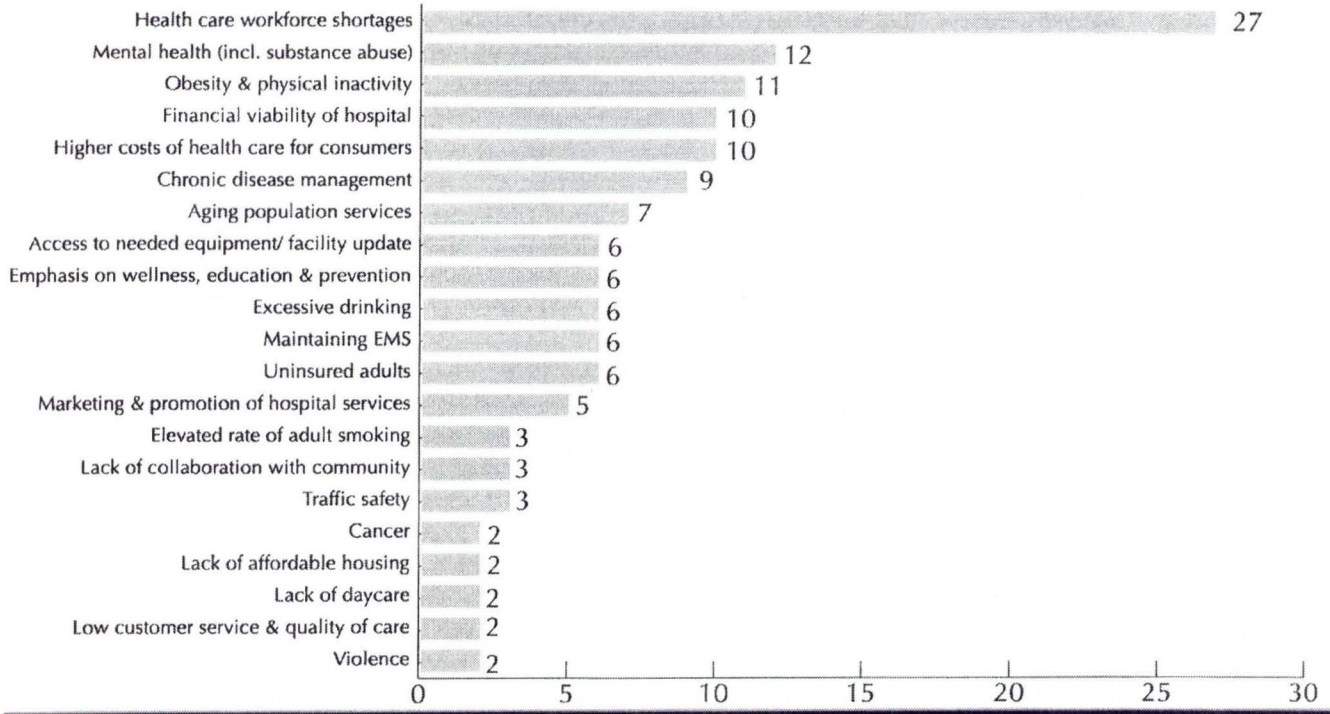
Overview

The Affordable Care Act (ACA) mandates that a Community Health Needs Assessment (CHNA) be conducted on all non-profit hospitals once every three years. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences has conducted CHNAs on more than half of the Critical Access Hospitals (CAHs) in North Dakota. The Center for Rural Health's involvement is funded through Health Resources and Services Administration (HRSA), Office of Rural Health Policy, and Medicare Rural Hospital Flexibility (Flex) Grant Program.

Method

The CHNA process is informed by both primary (community member interviews, focus groups, and surveys) and secondary data. Although methodologies differ between assessments, as a whole, the goal of the CHNA is to solicit community input on health needs and service gaps. A systematic review of all the significant needs collected from the CHNAs was conducted to establish a broader understanding of community health needs in rural North Dakota. The aggregated needs reflect health concerns selected and ranked as most prevalent, most persistent and most substantial. With this prioritized list, policy makers and invested stakeholders can develop more targeted solutions to address the needs impacting North Dakota constituents.

Health Needs Most Frequently Prioritized in CHNAs in Rural Communities



Sample Size

North Dakota has 36 Critical Access Hospitals. The Center for Rural Health conducted 21 CHNAs for CAHs across the state representing 58% of all CAHs. An additional 14 CHNA reports have been completed by hospital staff or consultants, making a total sample size of 35 CAHs. These hospitals represent rural communities that are geographically dispersed throughout the state, making for a representative sample.

Economic Value

A rigorous mixed methods research design was used for the 21 CHNAs conducted by the CRH. To gain community input, CRH staff traveled to each community to facilitate two focus groups, interview 6-8 community leaders, and disseminate between 500 and 1,500 surveys into the community. Bids from consulting firms to conduct CHNAs range from $20,000-$60,000. Taking an average of $40,000, the CRH has provided technical assistance to North Dakota's CAHs for a combined total value of $840,000 (21 x $40,000).

Key Research Findings: Most Significant Health Needs

- The significant need most frequently reported in CHNAs is a health care workforce shortage.
- In 27 separate community health needs assessments, the need for more health care staff was expressed. This concern includes a need for more physicians, visiting specialists, and other health care professionals.
- The next most frequently perceived community health needs were:
  - Mental health, including substance abuse (N=12).
  - Obesity and physical inactivity (N=11).
  - Higher costs of health care for consumers (N=10).
  - Financial viability of hospital (N=10).

Summary

As a whole, the identified needs paint the current picture of health needs confronting rural communities and affecting the state. They provide a baseline for which to measure change in the future and a way to chart progress of successful interventions and programming activities.

It is important to look at the identified needs not as a weakness but as an opportunity to make improvements in the health of our communities. In order for change to occur, participants must be willing to change and choose to change. The high numbers of community member and health care professional involvement in the CHNA process are testament to this readiness. Completing the first round of the ACA mandate is an exciting time to document the service gaps at this point in time and work collaboratively to leverage resources and reduce the scope of burden.

For more information, contact

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