

**ND INTERIM HUMAN SERVICES COMMITTEE**  
**April 9, 2014**  
**Testimony presented by Susan Rae Helgeland, MS**

Chairman Damschen and members of the ND interim Human Services Committee, I am Susan Rae Helgeland, Project Director of the ND Rural Behavioral Health Network (NDRBHN). The documentary I would like to present today, *Resolana: Voice of the People*, was actually the catalyst for the creation of the NDRBHN. NDRBHN's Vision and Mission statements are:

**Vision: Rural, frontier and tribal residents of North Dakota have access to equitable and quality behavioral health services regardless of age, gender, race, culture, ethnicity, religion, sexual orientation, or income.**

**Mission Statement: To improve access to behavioral health care and eliminate behavioral health disparities in rural and tribal communities**

NDRBHN is here today to present the needs for behavioral health services in ND rural and tribal communities. The needs will be communicated through the perspective of rural North Dakotans telling their own stories.

**RESOLANA: VOICE OF THE PEOPLE** documentary presentation identifies needs that exist when accessing behavioral health services (mental health and substance use) in rural and tribal communities in North Dakota. NDRBHN believes that ***Resolana: Voice of the People*** is a significant advocacy and educational tool to promote a solution-based dialogue among consumers, policy makers, advocates and community leaders. The documentary features interviews with mental health consumers who talk candidly about the difficulty they have in obtaining necessary behavioral health services. The disparity in the delivery of behavioral healthcare as compared to more traditional healthcare (such as diabetes and heart disease) is confirmed through interviews with rural health providers. The following are examples of the most prevalent needs identified in the documentary:

- ✓ **A lack of collaboration, communication and coordination between existing behavioral health care providers;**
- ✓ **Transportation/distance issues;**
- ✓ **Demand for behavioral health services that exceed the capacity of existing services;**
- ✓ **The myth that Indian Health Services (IHS) serves all the behavioral health needs on reservations;**
- ✓ **The behavioral health delivery system has layers of bureaucracy;**
- ✓ **The lack of beds/inpatient and recovery services;**
- ✓ **The disparity in the provision of timely services for mental illness/substance use when compared to traditional medical issues such as heart disease, diabetes, etc.**

The documentary was filmed in 2010. The needs identified have not been met; in fact they have increased and become even more critical. The pace of population growth in the Oil Patch has been a factor in the increase of behavioral health needs. For example it has resulted in a corresponding increase in crime rates and arrests. The number of federal inmates increased by 50% (The Forum, Kevin Bonham, *Forum News Service* April 7, 2014) and needs have increased at domestic violence shelter's (Lana Bonnet, Director, Family Crisis Shelter, Williston). I interviewed Ms. Bonnet, the Director of the Family Crisis Shelter in Williston, on Friday, April 4, 2014. She related two recent experiences. One woman presented herself as homeless and delusional. One of the advocates transported the woman to Bismarck, because no other transportation was available. The woman came back to Williston one week after being put on medication, talking of getting a hold of the FBI, etc. The story the woman told of domestic violence was part of her delusions. Ms. Bonnet said that these stories are sometimes made up by women to obtain shelter because they have no other choice.

The police found another woman who was delusional and hearing voices and brought her to the Family Crisis Shelter. She thought a beam of light was watching her and talked to the computer. Ms. Bonnet referred her to NW Human Service Center; subsequently the woman was referred to Trinity Hospital in Minot for inpatient care. The woman was eventually put on a train to Lansing, MI to live with a family member. Ms. Bonnet said that the Family Crisis Shelter has had an increase in numbers served because women in Williston have no other place to receive shelter and/or services. Ms. Bonnet said that these kinds of incidents happen all the time. Transport and referrals are challenging. There are no resources for support of recovery or other community based services to ease the increasing numbers of individuals being served by the Family Crisis Shelter.

ND Legislature passed Medicaid Expansion and we are grateful. However, reduced insurance reimbursements for ND behavioral health providers have risen as a significant issue. Kurt Snyder, Executive Director of the Heartview Foundation wrote in the March NDRBHN Newsletter, "The implementation of the Affordable Care Act (ACA) results in more people obtaining health insurance coverage but unfortunately it includes a loss of benefits for substance use. ND's benchmark plan was allowed to apply exclusions for individuals 21 or older for residential treatment. New marketplace and Medicaid Expansion plans will have no residential coverage for adults age 21 or older. Furthermore, BCBSND discontinued Low Intensity Residential services as a covered benefit. High Intensity Residential is a short stay treatment that deals with those in mild to moderate withdrawal and possibly with coexisting mental health or medical issues. Low Intensity Residential provides a safe and supportive environment to allow individuals to learn and apply early recovery skills. It is a critical benefit in light of the rural nature of our state, as well as those in areas with deficient or sub-standard service availability. Elimination of residential treatment leads to a greater number of individuals remaining at risk of suicide, overdose and a variety of other destructive consequences."

He continues, "The same individuals create a huge burden on ERs, walk-in clinics, hospital admissions for detoxification and high utilization costs of healthcare services, not to mention the impact on the ND corrections system. Allowing insurers to significantly cut substance use treatment coverage to all plans, not just ACA plans, is in direct conflict with the legislative intent of the ACA, Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and current North Dakota mandates."

NDRBHN was created to meet the need for improving communication and coordination between behavioral health providers that were identified in *Resolana: Voice of the People*. It was awarded a HRSA ORHP Development grant. We will have completed our first three years at the end of April. The NDRBHN Governance Committee has decided to continue the work for the network beyond the life of the original grant.

The NDRBHN's 36 member Advisory Council, including diverse groups and organizations, has played an active role in the network and increased communication between public and private behavioral health providers as well as consumer, family member, advocate and tribal community representation.

NDRBHN has made a decision to support and advocate for the implementation of telebehavioral health in ND to help address our mission, to increase access to behavioral health services in rural and tribal communities. We will sustain the NDRBHN, convening partners and collaborative entities around the issues for implementation of telebehavioral health. The network will be applying for an HRSA ORHP Outreach grant to develop a pilot telebehavioral health project in western ND to learn what works.

NDRBHN has identified the following significant issues related to the delivery of telebehavioral health:

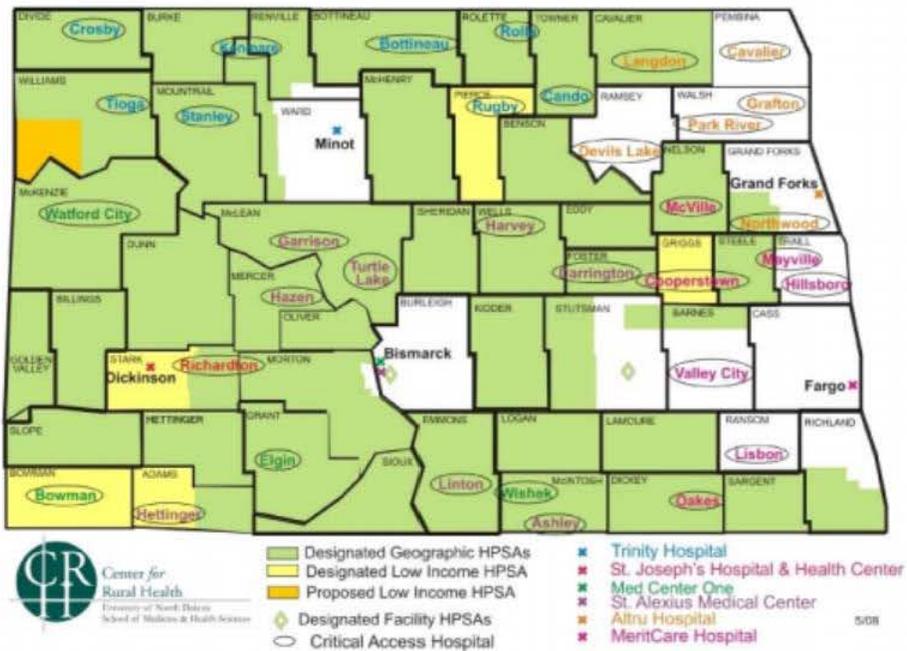
### **Support for Telebehavioral Health**

- Some infrastructure for telehealth is already in place, for example:
  - Avera eEmergency and ePharmacy
  - NDSU telepharmacy program
  - MHA Nation is using both the pharmacy and emergency telehealth programs
  
- Funding is available for further infrastructure:
  - HRSA(<http://www.hrsa.gov/publichealth/guidelines/BehavioralHealth/behavioralhealthcareaccess.pdf>):
  - USDA grant [http://www.rurdev.usda.gov/UTP\\_DLT.html](http://www.rurdev.usda.gov/UTP_DLT.html)
  - US Department of Defense and Department of Veterans Affairs <http://hearing.health.mil/research/fundinginformation/DoDAndVeteransAffairsFunding.aspx>
  
- Research in North Dakota demonstrated the effectiveness of telebehavioral health: Dr. James Mitchell and colleagues conducted “A randomized trial comparing the efficacy of cognitive-behavioral therapy for bulimia nervosa delivered via telemedicine versus face-to-face”. The study found that a manual-based form of psychotherapy for a specific psychiatric disorder can be effectively delivered via telemedicine.
  
- The climate is changing for parity and behavioral health. As of November 8, 2013,
  - The Mental Health Parity and Addiction Equity Act (MHPAEA) requires insurance plans that cover mental health or substance abuse disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions. (<http://beta.samhsa.gov/health-reform/parity>)
  
- ND participated in the Medicaid expansion, allowing more people to be eligible for services. (<http://www.nd.gov/dhs/medicaidexpansion/>)

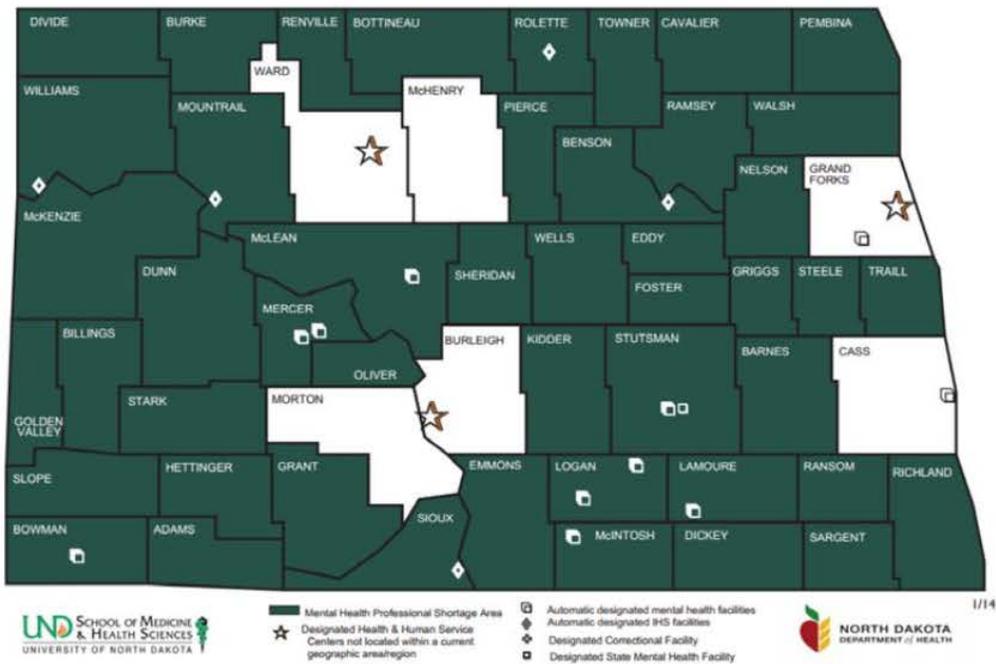
### **Barriers to Telebehavioral Health**

- Much of the state is considered a medically underserved area. [http://www.commonwealthfund.org/usr\\_doc/1130\\_McCarthy\\_North\\_Dakota\\_experience.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/1130_McCarthy_North_Dakota_experience.pdf?section=4039)

## Exhibit 2. North Dakota Health Professional Shortage Areas, Critical Access Hospitals, and Network Affiliates



## North Dakota Mental Health Professional Shortage Areas



- Providers and consumers are not familiar with using telebehavioral health.
- Funding for telebehavioral health is inadequate
  - Medicaid Medical Policy: <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/telemedicine-policy.pdf>

- Medicare Medical Policy: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsht.pdf>
- Policies that make carrying out telehealth difficult, such as “Requiring a medical professional such as a nurse, to be present during telehealth service; and to ensure a connection has been established with the distant physician (should a medical emergency materialize).”  
<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/telemedicine-policy.pdf>

Transportation – 37 North Dakota counties are considered frontier counties; people will still have difficulty traveling to the location where telehealth services can be provided.

NDRBHN speaks with one voice to support improvement of access to behavioral health care and to eliminate behavioral health disparities in rural and tribal communities. Thank you for the opportunity to testify today. I will be happy to answer any questions.