APPENDIX B

Behavioral Health Planning

FINAL REPORT

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Prepared for
The State of North Dakota

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Executive Summary

The North Dakota mental health and substance abuse system is in crisis.

Countless stories were told during the study period about challenges facing North Dakota when trying to access services. Children are being sent out of state for treatment after failing at every in state placement first. Providers are closing practices due to changes in benefits packages and reimbursement options. Drug use is on the rise and is seen as a critical issue in the West. Data to measure needs in the state is incomplete with collection only within the public sector. Legacy services, not data driven with proven outcomes, are being used state wide making it difficult to fight for additional funding in the legislature. Sky-rocketing bad debt at hospitals is a reality throughout the state. These stories are only a glimpse of the challenges facing the mental health and substance abuse system.

The Bad News

Many of the challenges facing North Dakota are self-imposed: choosing a poor essential health benefits package for Medicaid, refusing to spend state funds on services, and not applying for Medicaid waivers to assist with chronic mentally ill. Having cut off each funding source separately, the system has not been able to maintain core services, let alone add services desperately needed due to population growth.

Workforce shortages are debilitating. Although funding contributes to this challenge, the strength of independent licensing boards has harmed reciprocity and made obtaining licensure "difficult to impossible" where many from out of state do not even apply. In addition, lack of coursework for licensure within the state hampers individuals from seeking credentials. Few reimbursement opportunities outside of the Human Service Center (HSC) system makes it difficult to attract quality providers leaving critical shortages state wide.

Even Worse News

North Dakota has a unique challenge in the Western region. Where services are poor across the state, the situation is dire in the West. Cost of living, lack of housing, and other challenges in the oil patch make hiring nearly impossible in the lower paid service areas. Additionally, the increase in population is significantly adding to the mental health crisis in numbers by the quantity of people seeking treatment and difficulty of the issues being reported. More intravenous drug users, increased sex trafficking, growing numbers of physical assaults, and domestic violence reports are only part of the picture out west. The lack of infrastructure is causing a great deal of stress on behavioral and physical healthcare workers. The situation is dire.

Caution

The proposal to combine county and state behavioral health services is not good for behavioral health services in North Dakota. Although, we do recognize the benefit of taking behavioral health off the backs of the property tax payer, in North Dakota, that only strengthens the dominance of DHS services. In this system, that decision would eliminate one remaining funding stream and decrease service providers once again.

Lawsuits are happening across the country in which states are not offering a choice of services to individuals or requiring that they seek only institutional care. The need for home and community based services is critical with changes in the federal landscape and the expectation of integration of individuals with needs into the general population. The desire to alleviate the pressures of institutional care, long term care and behavioral health treatment and to increase quality services can only be achieved within greater access to community based services. Research proves that better outcomes are seen when individuals are closer to family and natural supports.

The Good News

In spite of the bleak news, there are options. North Dakota has all the resources and experience it needs to turn things around. This study breaks down the challenges in the MH/SA system into opportunities, goals, and strategies. Within each

section, quotes of North Dakotans are used to emphasize the specific challenges. The document delineates 51 strategies to implement change in these key areas:

- Service Shortages
  - Improve Access to Services
  - Conflict-free case management
  - Access to crisis assessment
- Expand Workforce
  - Oversight for licensing issues and concerns
  - Increase use of lay persons in expanding treatment options
- Insurance Coverage Changes Needed
  - Increase funding options for services for youth and adults
  - Increase behavioral health professional coverage in Medicaid and private insurance
- Changes in DHS Structure and Responsibility
  - Build transparency and choice in services
  - Consider structural changes to DHS
- Improve Communication
  - Create an integrated system of care
  - Improve record sharing
  - Improved communication among MHSA service providers
- Data Collection and Research
  - Determine what providers are available within the state and map gaps
  - Determine what services are available outside the HSC system for youth and adults
  - Use data to determine the best use of limited funding on treatment

A request for future interim study committees is made to address these additional areas of need. Follow up recommendations are made in the document. Additional time and resources are needed to address the following five issues:

1. Transportation - Urban and rural plans are needed in order to create access standards for core services.
2. Judicial matters – 24-hour holds, termination of parental rights, and court committals need to be addressed.
3. Definition of core services – Standardization of core services with outcomes and access standards are needed.
4. Tribal partnerships – Long standing partnerships are needed to address disproportionate numbers of Native Americans in treatment and detention placements.
5. Advocate training – Advocates need a stronger voice in North Dakota in order to assist with pressing forward changes needed in the system.

The Best News

North Dakota is fully equipped to deal with the behavioral health crisis at hand.

North Dakota has a history of pulling together to address workforce shortages. A great example of cutting edge programming is the corrections system. Financial options to either pay outright or partner with the federal government to care for persons with mental illness and substance disorders are possible. And, universities are willing to provide the data based outcomes research necessary to improve the system. The legislature must decide the best course of action and act. The strategies outlined in the study will set the course for much needed change. With proper leadership and oversight, North Dakota has the resources to become a model program for the nation in mental health and substance abuse services.

Introduction

The task assigned "to create a plan based on specific goals and objectives to improve behavioral health services in North Dakota" has been a challenging yet invigorating opportunity. The people of North Dakota should be proud of their hard work and dedication to serving persons with behavioral health and substance abuse issues. Both chambers of the legislature, both political parties and the executive branch should be commended for their willingness to participate and speak honestly about the challenges facing the state. Advocates and stakeholders should be excited about the momentum being built and the vision being cast for change.

Our first task was to identify stakeholders and gaps in the service system. In order to do this, Schulte Consulting, LLC, traveled to North Dakota six times in a course of six months. During that travel, over 35 face-to-face meetings were held with various groups and individuals. Five public hearings were conducted statewide. Throughout the study, bi-weekly public conference calls occurred. Over 414 separate people participated for a total of over 19,738 minutes logged by North Dakotans. These calls do not include our one-on-one conversations or private calls made outside the conference call program. Finally, well over 230 documents, not including email, were reviewed and considered for this report.

This report focuses on six main goals and strategies for improvement followed by recommendations for continued work. The goals chosen incorporate issues seen across geographic areas, age ranges, and demographics. Examples and strategies are used throughout to highlight the various regional discussions and groups. Citations and links for specific recommendations are throughout the body of the document. The appendix that follows includes five sections: acronyms used in the document, strategies broken down by impact and cost, evidence-based practices in North Dakota, a bibliography of substantive documents reviewed for this project, and an implementation plan with prioritized action steps.

Opportunity 1: Service Shortages

The number one concern across the state can be summed up in one phrase: "*Not enough services.*" The statement includes services at all levels from preventative services, case management, substance abuse services including residential, detox, psychiatric services, lack of state children's residential services, etc. Many blame lack of funding for this issue. It is crucial to look at funding for behavioral health services collectively, rather than in individual pieces. Tools for funding include, but are not limited to, Medicaid waivers; federal block grants; essential health benefit plans; state funding; insurance company investments; property taxes; Medicare; business investment; and other sources of federal funding. When every tool is being cut in silos, without regard to the impact on behavioral health services as a whole, there will be problems. The current crisis in North Dakota stems from exactly that issue.

De-linking services from state government is key to improving state funding opportunities. As long as providing services equals growing the size and scope of state government, funding for services will be problematic politically. De-linking is possible in many ways including, but not limited to, privatizing services; using federal monies like Medicaid and Medicare to expand funding options; increasing expectations of private insurance coverage; and increasing essential benefits offered in Medicaid plans. The consistent call for a hold even budget is evidence that services must be separated from state government if funding is to be addressed. In spite of these challenges, there are options available to improve the system with funding other than state funds.

Three challenges addressed in this section include:

- Access to services
- Lack of case management
- Lack of crisis assessment options

Goal 1: Improve access to services

In spite of funding challenges, several strategies are plausible to increase service access and availability. There is no one-stop-shop in North Dakota for services. Those programs outside of the Human Service Center (HSC) system, are not tracked nor included in data. It is difficult to determine the actual gaps in the service system without a registry of services or providers.

Examples:

What services are available in North Dakota? "That issue is very real. We do not know what is available." – MHSA Director

"We are seeing a definite increase in young substance abusing consumers age 24 and younger and a definite increase in IV use, primarily methamphetamine." - A Lake Region HSC staff

Strategy	Who is responsible	Timing	Financial Options and Cost Estimate
1. Increasing use of telemedicine	DHS; legislature; providers; advocates; consumers and families	Today	Federal grants like HRSA[1] Insurance community reinvestment Cost: $1K to $10K per site for equipment
2. Use of critical access hospitals (CAH)[2 3] for BH services	DHS; legislature	Today	Current CAH funds allow BH services
3. Create bed management system MN Model[4 5]	DHS; legislature	65th Legislative Assembly	State funding Cost: $200K implementation $25K sustaining
4. Utilize HCBS waivers for MHSA services MT Model[6]	DHS; legislature	Today	Federal Medicaid funding Most state's cost neutral: ND evaluating at present
5. Increase substance abuse services including detox	Legislature; DHS	64th Legislative Assembly	SAMHSA block grant; state funding; alcohol tax; private funding Cost: $2-10M depending on funding source chosen

1. http://www.hrsa.gov/ruralhealth/about/telehealth/
2. https://www.ndhealth.gov/HF/PDF_files/Hospital/hospital_feb_2014.pdf
3.https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNProducts/downloads/critaccesshospfctsht.pdf
4. http://www.health.state.mn.us/divs/orhpc/rhac/presentations/behealth.pdf
5. http://www.mnmhaccess.com/
6. http://www.dphhs.mt.gov/amdd/services/hcbswaiver.shtml

Goal 2: Conflict-Free case management[7]

The issue of lack of care coordination or case management was the second most common concern noted throughout the state. Challenges include not being able to access case management, with the lack of choice due to having only one provider of services (DHS), a culture of dependence upon the government system, and a lack of uniform eligibility criteria for program participation.

Examples:

"In North Dakota, the culture has been for consumers to have case management for life, which fills up the case load rather than provide openings for persons in crisis." – Bismarck area provider

"IDDT [Intensive Dual Disorder Treatment] is awesome but it only helps a selected few." – South East HSC provider

"There are no provisions for emergency admittance for kids until all the paperwork is done. So if we are hung up on a form or a note that takes us a week to get it back, that kid may have to be sent home for three or four days. Once we get the paperwork completed they will say that the child is better because he's been out of a psychiatric facility and no longer eligible for care." –Private provider

"North Dakota facilities act like they are doing you a favor if they take a teen… [And] they always need one more piece of information before they can give an answer. Out-of-state facilities give one an answer quickly and most times the answer is yes." –State program director

Strategies	Who is Responsible	Timing	Financial Options and Cost Estimate
1. Increase access to IDDT[8]- expand statewide	DHS; legislature; Governor	Today	State funding; private contract options; discontinue less effective services and transfer funds Cost: Estimate in process in ND to determine if staff resources are needed
2. Privatize case management to add choice	DHS; Legislature; Governor	65th Legislative Assembly	Cost savings: transfer cost to private or county providers
3. Partner case management/care coordination with peer support[9]	DHS; legislature; advocates; consumers and families	65th Legislative Assembly	Use existing Recovery Center staff to assist in care coordination; state funds to grow peer support through private entities Cost: no state funds if using Medicaid waiver to expand or use integrated health model

7. http://www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies
8. http://www.centerforebp.case.edu/stories/southeast-center-in-north-dakota-achieves-significant-outcomes-honored-as-champion-of-integrated-treatment
9. http://www.innovations.ahrq.gov/content.aspx?id=3387

Goal 3: Access to crisis assessment

Huge challenges occur when trying to access evaluations for individuals in crisis. A system is needed outside of emergency rooms and the state hospital for assessment. In addition, the persons screening for placement should have the proper credentials to provide behavioral health assessments, rather than lower level practitioners, practicing outside their scope of practice, who are allowed to veto a doctor or mental health professional's recommendation. Transportation becomes a huge barrier to assessment in the current limited options.

Examples:

"*Mobile crisis data is very good. However, in Fargo it was only used by a few individuals who really liked the program and rated it high every time." – Fargo provider*

"Mobile crisis is not a well-publicized program. They refused to come assist our clients." – County staff

"If we had proper crisis assessment on children, placements could be made that could help kids succeed rather than being placed wherever there is an opening, even if inappropriate. Openings are usually out-of-state, far from their families." – Provider

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Increase after hour options like Devils Lake NIATx[10] walk in clinic and create after hour intake options	DHS; HSCs	Today	Adjust current work schedules to accommodate
2. Increase mobile crisis in urban areas after hours	DHS; HSCs	65th Legislative Assembly	State funding; private contract options; block grant funding; adjust current work days/times Cost: $120K-$200K per urban location per year
3. Use telemedicine for crisis assessments IA model	DHS; legislature; providers; advocates; consumers and families	64th Legislative Assembly	Federal grants like HRSA[1;] Insurance community reinvestment[11] Cost: $225K per region
4. Model after eICUs to create ePsychiatry in the state[12]	DHS; legislature; providers; advocates	64th Legislative Assembly	Medicaid; Medicare; private insurance; insurance community investment[11] Cost: $1.7M conferencing fee and support (20 sites)

10. http://www.niatxfoundation.net/
11. http://www.magellanofiowa.com/for-providers-ia/community-reinvestment.aspx
12. http://www.nursezone.com/nursing-news-events/devices-and-technology/Critical-Care-Beyond-the-Bedside-The-Collaborative-Effort-of-the-eICU-Team_24170.aspx

Opportunity 2: Expand Workforce

Challenges in providing services are complicated by the workforce shortage throughout the state of North Dakota. The shortage is statewide but is exacerbated in the Western part of the state due to the growth in the Oil Patch. One large issue that must be addressed is the licensing challenges that make North Dakota non-competitive with neighboring states for behavioral health workers. Reciprocity issues, lack of required education available, burdensome licensing requirements, and lack of coordinated oversight of licensing boards can all be addressed to facilitate the building of this state's workforce. Also, the increased use of peers, family peers, recovery coaches and other lay persons to support the professional staff is required to expand service opportunities in the state and build evidence-based practices.

Two challenges addressed in this section include:

- Professional licensing issues
- Lack of use of peers, family support peers, recovery coaches and other alternatively trained persons

Goal 1: Oversight for licensing issues and concerns

An important area to address is the individual licensing boards operating in the state of North Dakota. These boards have not standardized their requirements; education experience and internship expectations, reciprocity, etc., making every license unique and challenging to obtain, in various ways. Some boards require face-to-face meetings to approve licensure but only meet a couple of times a year. Providers have a difficult time even contacting the board with questions. Without options for provisional license status, providers cannot bill or be paid equitably while waiting for a board to meet. Not being able to be fully reimbursed for six or more months, proves to be a significant deterrent to those who may be interested in relocating to North Dakota.

Other licenses like the Licensed Addiction Counselor (LAC), require a set of educational courses that are above national accreditation standards and are not even available in the state. The LAC also requires a large unpaid internship to complete that cannot be counted concurrently with other mental health licenses like the Licensed Professional Counselor (LPC) and doctorate level psychologist. Although Century Code 43-45-05.1 states that the LAC "board may grant reciprocity," reciprocity is "difficult to impossible" according to many who have been licensed in other states trying to relocate to North Dakota. With the extreme shortage of workforce in behavioral health areas, especially LACs, this issue must be addressed quickly.

Examples:

A private organization tried to recruit an LAC from Iowa who had 3 levels of licensure in Iowa including a national accreditation for licensed addiction counseling. "The candidate could not obtain an LAC in North Dakota without completing several required educational courses. The University of Mary actually asked our candidate to teach one of the courses that North Dakota determined that she herself needed to obtain licensure." – Bismarck provider

"I applied four times to three different VA programs in the state of North Dakota, and did not even get an email response back." – Elle Victoria-Gray, Schulte Consulting, LLC

"The extreme lack of substance abuse treatment options in Western North Dakota for youth and adults is a crisis situation. I cannot stress that enough." – Western provider

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create an oversight system for licensing boards utilizing public health as overseer	Legislature; Department of Public Health	64th Legislative Assembly	No funding required
2. Change Behavioral health professional definition in 25-03.2-01 for MA level like IA[13] model or two levels including practitioner level in MN[14] model	Legislature; DHS	64thLegislative Assembly	No funding required
3. Create reciprocity language to "shall" accept all professional licenses meeting international[15] and national accreditation standards and qualified state equivalent for each BH license.	Legislature	64th Legislative Assembly	No funding required
4. Make sure all educational requirements are available within state and preferably online for access	Legislature; licensure boards	Today	Adjust course offerings to reflect required courses.

13. https://www.legis.iowa.gov/docs/ico/code/228.1.pdf
14. https://www.revisor.mn.gov/statutes/?id=245.462
15. http://internationalcredentialing.org/

Goal 2: Increase use of lay persons in expanding treatment options

The use of peers, family support peers, recovery coaches, and other persons with lived experience, is an evidence-based practice and a growing national trend with good treatment outcomes. In rural areas with behavioral health professional

shortages, like North Dakota, using peers and other interested persons like teachers, law enforcement personnel, emergency workers, etc., are instrumental to expanding the workforce. In addition, increasing the number of out-stationed workers in the community is key to improving access to critical services.

Examples:

"Recovery Coaches have been trained and are a successful part of our program."- Bismarck provider

"We need to recruit and retain local behavioral health providers, which are established and rooted in the local areas to work with us on the tribal lands, especially mid-level providers [like a dental assistant to a dentist. We need both levels.]"- Indian Affairs staff and regional staff

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Increase use of peer support and recovery coaches[16]	DHS; providers; advocates	65th Legislative Assembly	State funding; private contracts; federal grants; Medicaid[17] Cost: Depends on source of funding $750K
2. Increase training for law enforcement, emergency personnel, corrections and teachers using MH First Aid[18] and other training	DHS; providers; advocates	64th Legislative Assembly	MH First Aid is a low cost program- $15-$25 per person
3. Increase law enforcement in schools	Schools; advocates; providers; law enforcement	65th Legislative Assembly	State funding; federal grants Cost: $50K per officer
4. Increase education opportunities for behavioral health providers	Universities; online learning	64th Legislative Assembly	Re-prioritize existing courses to train new providers

16. http://www.recoverycoaching.org/
17. http://cmhconference.com/files/2013/cmh2013-1a.pdf
18. http://www.mentalhealthfirstaid.org/cs/

Opportunity 3: Insurance Coverage Changes Needed

The third area requiring attention is the use of insurance including federal Medicaid, Medicare and private third party funders to address gaps in the behavioral health system in North Dakota. Two specific issues include lack of funding for various services and lack of coverage for licensed professionals to provide services.

The Century Code is inconsistent with the current Essential Health Benefits (EHB) package selected. North Dakota Century Code 26.1-36-08 authorizes 60 day minimum for inpatient treatment; 120 days minimum for partial hospitalization and 20 outpatient visits for substance abuse treatment. North Dakota Century Code 26.1-36-09 authorizes a minimum of 45 days for inpatient, a minimum of 120 days for partial hospitalization, minimum of 120 days for residential treatment for youth 21 years and under, and 30 hours of outpatient treatment. The current EHB package allows insurance providers to decrease services to the level of services recommended in the Sanford plan selected.

The Affordable Care Act (ACA) allows a decrease in services, especially residential substance abuse treatment in Medicaid in order to cover more total lives. There are multiple complaints to the Attorney General and pending lawsuits regarding changes made in the state based on the chosen EHB plan for Medicaid. Upon the final ruling, a change in North Dakota code to reflect this decision may be necessary. Also, the ACA has expanded mental health coverage through the use of Medicaid, Health Care Exchanges, and the Mental Health Parity and Addiction Equity Act (MHPAEA). Medicaid Alternative Benefit Packages (ABPs) must comply with MHPAEA. If surgical/physical treatments are covered, then

behavioral health services are covered to the same extent. This federal law is also inconsistent with the Century Code sections 26.1-36-08 and 26.1-36-09.

Two challenges addressed in this section include:

- Lack of funding options for services
- Lack of coverage for providers

Goal 1: Increase funding options for services for youth and adults

There is a large gap in funding options for services in North Dakota. The following is an incomplete list of services that do not have coverage, including: residential treatment for adolescent substance abuse; lower level residential treatment (between acute hospital care and outpatient services) for adults; private insurance options for IDDT and other evidence-based programs; ambulance coverage for "behavioral or suicidal issues;" and in state detox option. In addition, the current system encourages failure at various treatment levels before authorizing treatment. This is not recovery focused treatment. Parity for mental health services is not currently happening within the state as mandated by federal law.

Examples:

"*Treatment is a privilege." – Eastern ND Consumer*

"Everything in North Dakota is a work around, rather than a system of care." – Grand Forks provider

"We adjusted to the Essential Benefits Package selected." – NDBCBS testimony

"There is still a strong sense that substance abuse is self-induced and therefore shouldn't be paid for in North Dakota." – Comment at public meeting

…"Minnesota offers a lot more for help so these people can be successful in their recovery. North Dakota needs to offer more aftercare programs and support." – Concerned mom after denied insurance coverage

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Re-evaluate Essential Health Benefit Package selected[19] and unintended consequences	Legislature; DHS; and providers	Today	None Needed
2. Determine if insurance coverage meets federal parity standards	Legislature; DHS; and insurance department	Today	None Needed
3. Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps	Legislature; DHS	Today	None Needed
4. Determine what 3rd party payers should be covering	Legislature; DHS	Today	None needed
5. Apply for Medicaid waiver for SDMI Population MT Model[6]	DHS	Today	Medicaid funding, may be state funding match Cost: ND currently calculating possible cost

19. http://www.nd.gov/ndins/uploads/18/ehbcommunication.pdf

Goal 2: Increase behavioral health professional coverage in Medicaid and private insurance

In spite of the workforce shortages in the state, many qualified behavioral health professionals are not reimbursed in the state. Licenses like Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor, Licensed Master of Social Work (LMSW), and Licensed Addiction Counselors (LAC), and all other qualified behavioral health providers must be reimbursed in the state to grow the workforce.

Examples:

"I am an LAC and it easier for me to work in Minnesota than in North Dakota." – Valley City LAC

"I moved to North Dakota with a license from Wyoming, and cannot get reimbursed." – *Devils Lake provider*

"North Dakota is one of only three states in the country that does not extend reciprocity for internationally credentialed professionals. We have had the opportunity to hire behavioral health providers, with these credentials, for tribal regions in North Dakota but were unable to, as a result."– Indian Health Services administrator

"I was an experienced clinical psychologist, licensed in two states, on the national registry and in good standing. When I applied for a job in North Dakota, they said I would need to retake my national exams again because they could not accept my old scores. That's why I work in South Dakota." – Director of government mental health services

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Change administrative code to reimburse qualified Behavioral Health Professionals as defined above. IA Model[20]	Legislature	64th Legislative Assembly	Medicaid, 3rd party funders
2. Increase funding to assist BH professionals in training including LACs	Legislature	65th Legislative Assembly	State funding; insurance reinvestment Cost: $45K per position

[20]Iowa Code 249A.15A added Licensed Marital and Family therapists, Licensed Master Social Workers, Licensed Mental Health Counselors, and Certified Alcohol and Drug counselors to providers reimbursed by Medical Assistance in Iowa.

Opportunity 4: Changes in DHS Structure and Responsibility

When looking at the system in North Dakota, one thing that sets it apart from many other systems is the almost total reliance on DHS as provider of services. In this role, there is no independent appeal mechanism for families or consumers. DHS is the provider, regulator and oversight to itself. The lack of checks and balances makes a very poor business model in any field. Determining which parts of the system that only the Department can do and allowing others including the private sector to provide services that they do well, will strengthen choice for consumers and oversight for the system as a whole.

Two challenges addressed in this section include:

- Lack of transparency and choice in services
- Proposed structural changes

Goal 1: Build transparency and choice in services

Although some may think that this DHS directed system is more functional and streamlined, in actuality it has created less competition and thereby a lower standard of care. Private entities, which are few, must compete against the large human service centers for funding. The HSCs are the sole provider of many services not giving consumers any options.

On the youth side of services, the counties play a funding role, yet have limited to no control over services selected or even management of cases. Counties are seen as funders through property taxes, but are not allowed to provide services that they could do, often more effectively, closer to the community, the consumer and his or her family. In a state where all available providers are needed in order to get the work accomplished, the dominance of the HSC system of care is counter-productive.

Examples:

"If you get on to the bad side of DHS, you will be put into a situation where you cannot succeed" - Department of Corrections staff

"*We have a list of inmates banned from HSCs, yet they are the only provider of services needed." – Department of Corrections staff*

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create an independent appeal process for consumers IA model[21]	Legislature; advocates; families and consumers	64th Legislative Assembly	Re-allocation of funds
2. Standardize and distribute rules for uniform access to HSCs	DHS; Legislature oversight; advocates; families and consumers	Today	No funding needed
3. Encourage hiring throughout the state not just in HSCs	DHS; Providers; advocates	Today	No funding needed
4. Increase oversight and accountability for contracts with an independent appeal process	DHS; Legislature	64th Legislative Assembly	Re-allocation of funding prioritizing oversight over provider function
5. Create list of all services only provided by DHS	DHS; legislative council; legislature oversight	Today	Staff time

21. https://www.legis.iowa.gov/docs/ico/code/331.394.pdf

Goal 2: Consider structural changes to DHS

This may be the most needed yet most difficult piece of this plan to implement. The legislature must decide which services only DHS can do and should be doing, and which services others can do. They should determine if other providers, including county providers, could assist in growing access in the state. In addition, DHS needs to move away from "legacy" services that do not show proven outcomes and instead fund evidence-based services.

Caution: The proposal to combine county and state behavioral health services is not good for behavioral health services in North Dakota. Although, we do recognize the benefit of taking behavioral health off the backs of the property tax payer, in North Dakota, that would only strengthen the dominance of DHS services. In this system, that decision would eliminate one remaining funding stream and decrease service providers once again.

If a structural change should occur to combine county and state systems, governance boards made up of counties within the region could be lifted up as one way to balance the system. If county managers or commissioners were raised up to have oversight of the monies spent, that would be a great way to add much needed checks and balances to the system. That governance structure could also be an option for an independent appeal process that is currently missing.

Examples:

"Some providers do not give quality care but there is little to no recourse for a family or choice of other providers." – Provider of youth services

"*Counties have many financial responsibilities for children that are unfunded mandates.*" *– Eastern North Dakota county staff*

"It is not uncommon for suicidal Native American juveniles to be housed in jails awaiting placement…to stay for months at a time in these adult jails without being provided educational or counseling services. Tribal governing authorities and tribal courts need to initiate a conversation with the State of North Dakota to discuss services for Native juveniles." – Member of the state judiciary

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Change HSCs to oversight; regulatory functions; and program management at state hospital like ND DD system	DHS; Legislature	65th or 66th Legislative Assembly	Re-allocation of funds
2. Improve coordination of care with county service system for youth	DHS; Legislature; counties	Today	Staff time; county and state funding; Chaffee funds[22]
3. If counties combine with State, create regional governance system NE Model[23]	DHS; Legislature	66th Legislative Assembly	State and county funding re-allocation
4. Legislative oversight of HSC system to uphold powers and duties outlined in 50.06-05.3	Legislature and Executive branch	64th Legislative Assembly	State funding re-allocation

22. http://www.nrcyd.ou.edu/chafee
23. http://www.region5systems.net/nebraska-behavioral-health-regions

Opportunity 5: Improve Communication

Another state wide concern relates to poor communication within the system of Human Services. This was observed and verbalized in every region throughout the state. There was a pervasive lack of information and knowledge of what DHS was doing, unavailable data on services or providers outside of the HSCs, inconsistent knowledge of services available, lack of coordinated care and discharge planning, unknown openings of HSC positions; a lack of integrated treatment planning, and many other examples.

Three challenges addressed in this section include:

- Lack of integrated physical and behavioral health treatment
- Lack of record sharing and real time information
- Lack of communication between HSCs and everyone else

Goal 1: Create an integrated system of care

Without effective communication, care coordination is not possible. The key to integrated care is working partnerships with all providers, advocates and consumers at the table. When there is a lack of trust and/or animosity among parties, the objective to provide coordination on any level is not possible. The majority of HSCs were noted as having poor to no

coordination with providers outside of their own system. One region, Devils Lake, was noted as working well with others. In fact, many stated that Devils Lake region should be a model for others to follow. Challenges were noted in transition between corrections and HSCs. Reintegration into the community has been difficult with delays in getting services and lack of prioritization for those most at risk of re-offending. In the past, inmates have moved from evidence-based practices within the correctional system to antiquated and punitive services in the HSC system. In a letter dated July 9, 2014, DHS is currently partnering with ND Department of Corrections to offer evidence based options outlined in the 2nd Chance Grant application to develop a comprehensive and collaborative approach to reducing crime and recidivism.

Individuals with traumatic brain injuries or autism spectrum disorders are not seen as included in behavioral health services. Yet, in an integrated physical and behavioral health system, they should not be excluded. Public health assessments in North Dakota indicate that behavioral health is a significant need. In addition, chronic conditions of obesity and diabetes make the top of the list. These are the exact issues addressed in integrated health programming across the country.

Examples:

"Of surveys taken across our region, Behavioral Health is always top three. Other issues include chronic health conditions like obesity and diabetes." – Public health employee

"Traumatic brain injury is included in the MHSA division, but there is no dedicated staff time or funding to move forward the services needed." – Brain injury advocate

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Creation of Integrated health services including care coordination in Medicaid IA Model[24]	DHS; Legislature	65th Legislative Assembly	Federal Medicaid funding; state funding; block grants Cost savings projected in Iowa
2. Seek additional federal funding for age 0-5 Visiting Nurses programs for BH	DHS	64th Legislative Assembly	Federal funding
3. Strengthen Advocacy voices in ND	DHS; Providers; stakeholders; Advocates	Today	No funding needed

24. http://dhs.iowa.gov/ime/about/initiatives

Goal 2: Improve record sharing

Treatment time is often wasted waiting for paper document transfers between providers for releases of information (ROI) and other treatment documents. Technology is available to maintain HIPAA compliance while getting information in real time. Working toward a global standardized ROI that could be shared across providers would be a first step to more coordinated care. For example, in Iowa, the Certification of Need (CON) is a one page document. The authorization for insurance is only two pages. North Dakota's Universal Application (UA) started out as nine pages and is now over fourteen pages in length due to complications with the CON process. Streamlining the record exchange protocols, record sharing requirements and the length of time for decisions to be made, is key to timely treatment. Timely treatment saves lives, not to mention time and money.

Note: DHS clarified that the CON form in North Dakota for Ascend is only one page. The Psychiatric Residential Treatment Facility (PRTF) Review and the North Dakota under 21 Acute Review form are both three pages each. The question remains, how does the process require dozens of pages of additional documentation for an admission? There has to be a more streamlined option to benefit everyone in North Dakota.

Examples:

"*Every time I see a new provider, I have to start over and re-tell my story." – Western North Dakota consumer*

"The Universal Application for residential treatment can be very daunting for many families. If it is not filled out completely, with all documentation, the application is not considered. This often causes delays of 1-4 weeks resulting in lost placements."- Executive at residential facility

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Review record sharing options for ND and stream line	Legislative council; DHS; Legislature	Today	Staff time
2. Change regulations to accept electronic releases and all other treatment documentation	Legislature; DHS	64th Legislative Assembly	Cost reduction in printing and transportation
3. Streamline application process for residential facilities[25 26]	Legislature	Today	Cost reduction in time and processing

25. http://www.humana-military.com/library/pdf/RTCApplication.pdf
26. http://harborpointbhc.com/files/2013/05/Family-Form-Tri-North.pdf

Goal 3: Improved communication among MHSA service providers

Improved communication is key to increasing services and workforce in North Dakota.

Examples*:*

"Western North Dakota hospital wants to build psychiatric services, yet cannot get DHS to sit down and brainstorm solutions that might work." – Williston hospital executive

"The Century Code directs people to jail rather than treatment." – Eastern ND county jail staff

"I am moving to Colorado next week. When our provider closed, I could not find another position here in my community." There was a current opening at the HSC in this community. *– Licensed prescriber Devils Lake*

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Intra agency council for coordination of services Idaho model[27]	DHS; Corrections; DPH; Education; Vocational Rehabilitation; Veterans Affairs; DD and others.	65th Legislative Assembly	Staff time, reallocation of priorities within departments
2. Improve regional communication HSCs to all providers	Stakeholders/advocates lead; DHS at the table; Legislative Oversight	Today	Staff time, re-allocation of resources
3. Standardize policies and procedures that foster better communication including job vacancies	DHS; Legislative oversight	Today	Staff time

27. http://www.bhic.idaho.gov/

Opportunity 6: Data Collection and Research

Of all the assignments given to this project, collecting objective data became the most difficult and cumbersome task. North Dakota has no collecting mechanism of data of services or providers outside of the HSC system. Many children of minority status are disproportionately represented in the child welfare system. Yet, there is no data available that separately tracks who these kids are or where they go. This is especially true for children from tribal communities.

The Corrections system in North Dakota recently underwent overwhelming culture change in order to become more data driven and evidence focused in provision of services. The MHSA division would do well to consider following their example of allowing data to drive funding decisions rather than less objective measures.

Three challenges addressed in this section include:

- Lack of data for providers outside the HSC system
- Lack of data for services provided outside the HSC system
- Lack of data driven services utilized for treatment

Goal 1: Determine what providers are available within the state and map gaps

Without a comprehensive list of providers in the state, there is no way to determine the exact shortage of providers. There is a long list of providers needed in the HSC service system. There are also multiple private providers and unemployed providers, throughout North Dakota, unwilling to work in the public sector. They are unaccounted for in the current system.

Examples:

"There is no central data collection system outside the HSC system for providers or services." – MHSA Director

"We have no separate data for tribal children, our out-of-state placement data includes all youth." – DHS Interstate compact employee

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create a provider registry GA model[28] veterans model[29]	DHS; Legislature	65th Legislative Assembly	Staff time; possible state funding Cost $200K
2. Give task of oversight of licensing boards to public health	DHS; Legislature; Department of Public Health	64th Legislative Assembly	Staff time

28. http://news.emory.edu/stories/2014/04/star_providers_registry_launches/index.html
29. http://www.starproviders.org/

Goal 2: Determine what services are available outside the HSC system for youth and adults

Without a comprehensive list of providers, it is not possible to create a comprehensive list of services available for the residents of North Dakota. Providers with national accreditation are not required to submit data to DHS, and by that measure are not held accountable for services provided.

Examples:

"I had no idea those services were available in my community." – Conference call participants

"Where is that located again?" – Commonly heard among providers on calls and in public meetings.

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create a repository for services using 211/ First Link[30]	Legislature; DHS; providers; advocates; stakeholders	64th Legislative Assembly	Currently funded; state funding; private sources
2. Map current resource distribution outside the HSC system	DHS; Legislature; advocates; stakeholders	Today	State funds; current resources re-allocated

30. http://www.myfirstlink.org/

Goal 3: Use data to determine best use of limited funding on treatment

Without the use of fidelity standards and outcome measurements, it is impossible to prove if the funding provided for services are worth the money. Research is needed to determine which evidence-based services work in North Dakota, specifically, with the population present. In most systems, current funding can be used more efficiently and with better outcomes. Research is critical to the advancement of behavioral health systems in states. In a state like North Dakota, which has not had excess funding coming into the system, research becomes even more critical to advance the system.

Example:

"Corrections now prioritizes inmates who receive services based on research, showing which inmates will benefit from treatment. They get it." – Service provider

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Use universities or other current systems to build outcomes based system[31]	DHS; Universities	Today	Re-allocation of current funds
2. Create list of "legacy" services and cost to state and consider reinvesting in evidence-based services.	DHS; legislature; providers; advocates	Today	Staff time; state funds

31. http://www.thenationalcouncil.org/wp-content/uploads/2013/12/BHCOE-draft-FINAL-12-18-13.pdf

Follow up Recommendations:

As with any statewide system review, there are multiple pieces that require further investigation and review in order to move forward in a coordinated direction. This section will outline several areas that require additional time and resources in order to create a comprehensive recommendation.

- **Transportation:** In any rural state, transportation is a huge issue. Critical questions range from who transports someone to the state hospital to how a person gets himself to treatment. Due to the complicated nature of this subject, partnerships between federal and state funding sources, and the agencies required, this issue should be looked at separately and in greater detail.
- **Judicial matter**s: Due to the number of additional agencies and branches of government involved in issues including the 24-hour hold, termination of parental rights, and court committals, an interim committee should be established to fully investigate each need and set forth a plan.
- **Definitions of services:** Due to the various definitions of services and differing expectations across regions, future work should center on finding agreement in core service definitions and access standards. Advocates, providers and consumers should come to the table with DHS to more clearly define exactly what services are and are not available in the state. Additionally, standardized procedures must be agreed

upon and applied uniformly for access to services and hospitalization, based on qualified mental health professionals working within their licensure and scope of practice.

- **Tribal partnerships**: Due to the short nature of this study, necessary relationships with tribal partners were not able to be cultivated in a manner conducive to significant change. In addition, the partnership between state and federal government requires additional stakeholders to be at the table in order to truly build a plan for the future.
- **Advocate training:** The advocate voice for MHSA services could be much stronger in the state. Helping people find their voice and learn how to advocate for change is imperative to move any huge system forward. The advocate voice and inclusion in all change is critical to the process. Building an advocate base can be done in many ways and would help create the change needed.
- **Future interim study**: As with any system change, this process is only truly beginning. It will require the legislature to follow the process and maintain oversight into future Legislative Assemblies. Leadership of this process needs to remain independent of the state system if true system change is to be expected and accomplished.

In conclusion, there are multiple opportunities available to the state of North Dakota for improving the behavioral health system. Opportunities exist to address service shortages, expand the behavioral health workforce, improve insurance coverage, change the DHS structure, improve communication, and increase data collection and research. Although lack of funding can be a challenge to implementing some recommendations, there are many strategies outlined in this document that are of low cost and high impact. These are specifically noted in Appendix B. An implementation plan of prioritized strategies is noted in Appendix E.

The people of North Dakota are asking for change. Many examples of issues were outlined throughout the document. There are pockets of great work being done with very innovative providers and services being offered. The challenge is getting those services provided across the state to all North Dakotans and offering choice to the consumer. This report outlines opportunities for advancement of the behavioral health system. The strategies, if implemented, would provide uniform access to efficient services giving choice to the consumer and families.

Appendix A

Common Acronyms

BH – Behavioral Health

CAH - Critical Access Hospitals

CON – Certification of Need

DD – Developmental Disabilities

DHS –North Dakota Department of Human Services

eICU – Electronic Intensive Care Unit

HIPAA – Health Insurance Portability and Accountability Act

HSC – Human Service Center

IDDT – Integrated Dual Disorder Treatment

LAC – Licensed Addiction Counselor

LMFT – Licensed Marriage and Family Therapist

LMSW – Licensed Master Social Worker

LPC – Licensed Professional Counselor

MA – Master's Level clinician

MH – Mental Health

MHSA – Mental Health Substance Abuse Division of DHS

NIATx – Originally meant "Network for the Improvement of Addiction Treatment." Now called NIATx to reflect expansion to broad based behavioral healthcare.

RT – Residential Treatment

SAMHSA – Substance Abuse and Mental Health Services Administration

TBI – Traumatic Brain Injury

VA – Veterans Affairs

Appendix B

Low Cost High Impact Strategies

Opportunity 1: Service Shortages

Goals	Low Cost High Impact Strategies
Improve access	Utilize HCBS waiver for MHSA services MT Model
Improve access	Use of Critical Access Hospitals for BH services
Access to crisis assessment	Increase After Hour options like Devils Lake NIATx Walk in Clinic

Opportunity 2: Expand Workforce

Goals	Low Cost High Impact Strategies
Oversight for Licensing Issues	Make all Education Requirements Available in State (or remove requirements)
Oversight for Licensing Issues	Change Behavioral Health Professional definition in 25-03.2-01 for MA level -see IA Model or two levels including a practitioner level in MN Model
Oversight for Licensing Issues	Create Reciprocity language to "shall" accept all professional licenses meeting international and national accreditation standards and qualified state equivalent for each BH license.

Opportunity 3: Insurance coverage changes needed

Goals	Low Cost High Impact Strategies
Increase funding options for services for youth and adults	Re-evaluate Essential Health Benefit Package selected and unintended consequences
Increase funding options for services for youth and adults	Determine if insurance coverage meets federal parity standards
Increase funding options for services for youth and adults	Determine what 3rd party payers should be covering
Increase funding options for services for youth and adults	Apply for Medicaid waiver for SDMI population. MT Model
Increase behavioral health professional coverage in Medicaid and private insurance	Change administrative code to reimburse qualified behavioral health professionals

Opportunity 4: Changes in DHS structure and responsibility

Goals	Low Cost High Impact Strategies
Build transparency and choice in services	Standardize and distribute rules for uniform access to HSCs
Build transparency and choice in services	Encourage hiring throughout the state not just in the HSCs
Build transparency and choice in services	Create list of all services only provided by DHS
Consider structural changes to DHS	Coordinate care with county service system for youth

Opportunity 5: Improve Communication

Goals	Low Cost High Impact Strategies
Create an integrated system of care	Strengthen Advocacy voices in ND
Improve record sharing	Review record sharing options for ND and streamline
Improve record sharing	Change regulations to accept electronic releases and all other treatment documentation
Improve record sharing	Streamline application process for residential facilities
Improved communication among MHSA service providers	Improve regional communication HSCs to all providers
Improved communication among MHSA service providers	Standardize policies and procedures that foster better communication including job vacancies

Opportunity 6: Data Collection and Research

Goals	Low Cost High Impact Strategies
Determine what providers are available within the state and map gaps	Give task of oversight to the group created to oversee licensing issues
Determine what services are available outside the HSC system for youth and adults	Map current resource distribution outside the HSC system
Use data to determine best use of limited funding on treatment	Use universities to build outcomes based system
Use data to determine best use of limited funding on treatment	Create list of "legacy" services and cost to state and consider reinvesting in evidence-based services

Appendix C

Evidence-Based Practices, Best Practices & Promising Practices currently in parts of North Dakota

Crisis Stabilization Services means short term individualized mental health services provided to an individual following the crisis screening or assessment which are designed to restore the individual to prior functional level. Mental Health crisis stabilization services shall be provided in a setting that is safe and appropriate.

Dialectical Behavioral Therapy (DBT) means a therapy designed to help people change patterns of behavior that are not effective, such as self-harm, suicidal thinking and substance abuse. This approach works helping individuals identify triggers that lead to reactive states and building coping skills.

Eye Movement Desensitization and Reprocessing (EMDR) means a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning.

Evidence-Based Mobile Response means an on-site, face-to-face mental health crisis service for individuals experiencing a mental health crisis. Mobile crisis staff have the capacity to intervene, wherever the crisis is occurring, including but not limited to the individual's place of residence, emergency rooms, police stations, outpatient mental health settings, schools, recovery centers and any other locations where the individual lives, works, attends school, and socializes.

Equine-Assisted Therapy (EAT) means a treatment that includes equine activities and/or an equine environment in order to promote physical, occupational, and emotional growth in persons suffering from ADD, Anxiety, Autism, Cerebral Palsy, Dementia, Depression, Developmental Delay, Genetic Syndromes (such as Down Syndrome), traumatic brain injuries, behavioral issues, abuse issues, and many other mental health problems.

Targeted Capacity Expansion Technology-Assisted Care (TCE-TAC) means a piloted program utilizing a private social network (similar to Facebook) to provide support and education to its members. In August of 2013, a Bismarck provider was awarded a grant funded by SAMHSA to enhance and expand its social network, NAR (Network Assisted Recovery) and study the effectiveness of it as a treatment tool. NAR is available for individuals who have completed primary treatment.

Illness Management and Recovery (IMR) means a curriculum used to help people to develop personal strategies for coping with mental illness and moving forward with life. IMR practitioners use a combination of motivational, educational, and cognitive-behavioral techniques.

Individual Supported Employment means services, including ongoing supports, needed by an individual to acquire and maintain a job in the integrated workforce at or above the state's minimum wage. The outcome of this service is sustained paid employment that meets personal and career goals.

Integrated Dual Disorder Treatment (IDDT) means an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services.

Integrated Health Homes means a service model that facilitates access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Services may include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.

Matrix Model means an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period.

Mindfulness-Based Stress Reduction (MBSR) means a form of psychoeducational training for adolescents and adults with emotional or psychological distress due to medical conditions, physical pain, or life events. MBSR is designed to reduce stress and anxiety symptoms, negative mood-related feelings, and depression symptoms; increase self-esteem; and improve general mental health and functioning.

Motivational Interviewing (MI) means a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change. The examination and resolution of ambivalence becomes the key goal.

Nurtured Heart Approach (NHA) means a social emotional strategy that transforms negative behaviors into positive behaviors, increases interrelatedness and connectivity among family members, couples, teachers and students**.**

Parent-Child Interaction Therapy (PCIT) means a treatment program for young children with conduct disorders that place emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

Peacemakers Program is a traditional Native American approach to justice that focuses on healing and restoration rather than punishment including local elders working with juveniles using traditional Native methods.

Peer Recovery Coaches means a one-on-one relationship in which a peer leader uses their own substance abuse recovery experience to encourage, motivate and support a peer seeking to establish or strengthen his or her own recovery.

Peer Support Services means a service provided by a peer support specialist, including but not limited to, education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

Permanent Supportive Housing means voluntary, flexible supports to help individuals with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community.

Solution-Focused Group Therapy (SFGT) means a strengths-based group intervention for clients in treatment for mental or substance use disorders that focuses on building solutions to reach desired goals.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) means a 16-session group intervention specifically designed to address needs of chronically traumatized adolescents living with ongoing stress and experiencing problems in several areas of functioning.

Structured Sensory Intervention for Traumatized Children, Adolescents and Parents At-risk Adjudicated Treatment Program (SITCAP-ART), means a program for traumatized adolescents 13-18 years on probation for delinquent acts. These youth, court ordered to attend the program, are at risk for problems including dropping out of school, substance abuse, and mental health issues.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) means a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents.

Youthworks means a program for at risk youth and runaway by maintaining a 24/7 crisis line answered by licensed professionals to help with crisis intervention and referrals.

Appendix D

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Appendix E

Implementation Plan

In Process or Beginning Today

Action Steps	Legislation Required	Priority
DHS shall utilize CAHs for behavioral health services utilizing telemedicine to its full potential	None	High
DHS shall utilize HCBS waiver and SDMI waiver for MHSA services	None	High
DHS shall continue to expand IDDT services throughout regions	None	High
DHS shall increase after hour options like Devils Lake NIATx walk in clinic including assessment options	None	High
DHS or Legislature along with universities shall make sure all required BH coursework is available in ND	None	High
Legislature shall re-evaluate Essential Health Benefit option selected partnering with other interim committee	None	High
Legislature and executive branch shall determine if insurance coverage meets federal parity standards and determine what core services should be covered.	None	High
DHS shall create opportunities to strengthen advocacy voices to assist in making system change	None	High
DHS shall review record sharing options and stream line including application for residential facilities	None	High
DHS shall document efforts to improve communication among providers, including county youth providers	None	High
DHS shall standardize policies and procedures that foster better communication including HSC admission access criteria and job vacancies	None	High
DHS and stakeholders together shall map current resource distribution inside and outside of HSC system including "legacy" services and services ONLY provided by DHS	None	High

2015 Legislature

Action Steps	Legislation Required	Priority
Legislature shall increase funding for adult and youth substance abuse services including detox	Yes- Appropriations	High
Legislature shall authorize use of telemedicine for crisis assessment and remove barriers for full utilization	Yes	High
Legislature shall increase funding for equipment for CAHs to create ePsychiatry	Yes- Appropriations	High
Legislature and DHS shall create an oversight system for licensing boards utilizing public health as overseer	Yes	High
Legislature shall change definition of behavioral health professional in Century Code to include all qualified professionals	Yes	Medium
DHS or Legislature shall create reciprocity language for BH professionals	Maybe	High

DHS shall train law enforcement as first responders using MH First Aid	Yes - Appropriations	High
Legislature shall change Century code to reimburse all qualified behavioral health professionals	Yes	High
Legislature shall create an independent appeal process for consumers increasing oversight and accountability	Yes	High
DHS shall seek to maximize federal funding for Visiting Nurses and other 0-5 prevention programs	No	High
DHS or Legislature shall change regulations to accept electronic documentation including ROIs	Maybe	Medium
DHS shall assist First Link/211 in obtaining access to provider information	No	Medium
DHS shall partner with universities to build an outcomes based data system	Maybe	Medium
Legislature create an interim committee to look at DHS structure changes and provide oversight to current HSC system including defining core services throughout system	Yes	High
Legislature create an interim committee to study judicial issues such as 24 hour hold, termination of parental rights; and court committals	Yes	High

2017 Legislature

Action Steps	Legislation Required	Priority
Legislature shall create a bed management system and provider registry	Yes	Medium
DHS shall privatize case management to add choice	Maybe	Medium
Legislature shall increase funding for peer support and recovery coaches, mobile crisis, and law enforcement in schools	Yes- Appropriations	Medium
Legislature shall increase funding to BH professionals in training including LAC	Yes- Appropriations	Medium
Legislature pass legislation to begin DHS structural changes outlined in 2015 Legislative Assembly	Yes	Medium
DHS and Legislature shall move toward integrated health in Medicaid including care coordination with peer support	Yes	Medium
DHS shall create an intra-agency council for coordination of services	No	Medium
Legislature shall create an interim committee to continue DHS changes and address transportation issues across agencies	Yes	High

2019 Legislature

Action Steps	Legislation Required	Priority
DHS shall continue structural changes outlined in 2017 Legislative Assembly	No	Medium
Legislature shall authorize interim committee to monitor transition of DHS structure and monitor unintended consequences.	Maybe	High