

ND Behavioral Health Stakeholders Group Testimony  
Health Care Reform Review Committee Meeting  
October 1, 2014

Chairman Keiser and Committee Members, my name is Rod St. Aubyn and I am representing the steering committee of the Behavioral Health Stakeholders Group. Thank you for the opportunity to testify before your committee.

I was asked to update your committee on our work as it relates to one of the studies assigned to the Human Services Committee in the area of Behavior Health. I know your committee has been looking into the issue of substance abuse benefits as it relates to insurance coverage and also with the concerns expressed by some substance abuse providers when the state established the "benchmark" plan as required by the Affordable Care Act.

I want to first provide you a brief history of our work. Several people recognized the behavioral health issues that exist in our state. They were aware of the Behavioral Health Study being done by the Human Services Interim Committee. This group decided that it would be productive to bring together all the behavioral health stakeholders to find some solutions. About the same time, the Human Services Interim Committee voted to hire a consultant to review the current behavioral health system that exists in ND and to make some recommendations for future legislative consideration. The Behavioral Health Stakeholder Group steering committee wanted to sponsor a conference with all stakeholders to find these solutions. They felt that the information they got would be valuable for the consultant that was to be hired. I was asked by this "steering committee" if I would facilitate this future meeting. Because of my past interest and legislative experience with behavioral health issues I enthusiastically agreed to become part of their steering committee and to facilitate a larger meeting.

Renee Schulte from Schulte Consultants was selected by the Legislative Management Committee based on a recommendation by the Human Services Committee to be the entity providing the Behavioral Health Study for the Human Services Interim Committee. We immediately contacted Renee and offered our assistance for her study.

Our steering committee was comprised of John Vastag, Joy Ryan, Sen. Tim Mathern, Sen. Judy Lee, Rep. Pete Silbernagel, Rep. Kathy Hogan, and me. Our efforts were not meant to compete with the Consultant's report, but instead be a resource for their efforts by working with all stakeholders. Our final product was meant to complement the Consultant's final report.

Our steering committee secured some grants to establish two behavioral health (BH) stakeholder meetings. The first meeting was held in Fargo on February 6-7, 2014 and we invited numerous stakeholders representing a comprehensive array of interests, such as consumer advocates, Department of Human Services, law enforcement, hospitals, all behavioral health professionals, ND Medical Association, ND Hospital Association, the UND Medical School, the Governor's Office, judicial representatives, schools, Department of Corrections and Rehabilitation, ND National Guard, Association

of Counties, State and County Health Departments, ND Indian Affairs, long term care, Attorney General's Office, and health insurers. During the two day meeting, this motivated group of stakeholders first identified the BH challenges that existed in our state. This group then spent many hours trying to identify possible solutions to these challenges.

We followed up with a second meeting held in Bismarck on March 25, 2014 and opened up participation to anyone else that wanted to participate. The preliminary findings were presented and subgroups identified specific action steps. The discussions and recommendations were structured in four areas - Substance Abuse, Adult Mental Health, Children's Mental Health and Workforce issues.

We have had several conference calls with stakeholders to further refine our recommendations/action plans. Our final recommendations are included. I do not want to go over the entire report, but wanted you to see the finished product. In reality, we don't see it as a final product, because the entire BH issue is an evolving one. I want to stress that we worked cooperatively with Renee Schulte and her partner and they participated in our meetings and conference calls as well.

We established a website for communication purposes and the Center for Rural Health agreed to house it on their website. That website is <http://ruralhealth.und.edu/projects/nd-behavioral-health> .

The issues we face with the behavioral health system did not occur overnight, nor will the solutions be able to be accomplished immediately. I am reminded of what my friend and former co-worker, Dan Ulmer, used to say when faced with a monumental problem. He would often say "that it is like trying to eat an elephant whole. I guess we just need to do it one bite at a time." This is what the Human Services Committee and ultimately the Legislature is facing. Though it may look daunting, we need to systematically address the issues over a period of time. Some solutions will take legislative "fixes", some may only require collaboration among key stakeholders, and others may be accomplished administratively.

Our Steering Committee reviewed the recommendations of our Stakeholders Group and those from the Schulte Report for the Human Services Committee and combined these recommendations into one summary. That information is compiled in the handout that I have provided. The first part is a summary of Appendix A which lists all items recommended for now until the end of the next Legislative Session. The combined recommendations are identified as the "Master List" and we have also included 3 appendices (A, B, and C).

Appendix "A" contains the items from the Schulte report that had "today" or 2015 Legislative Assembly and items from the stakeholders' report that had dates of 2014, 2015 or 2016.

Appendix "B" contains the items from the Schulte report that had "65<sup>th</sup> Legislative Assembly" and items from the stakeholders' report for 2017 and 2018.

Appendix "C" contains the items from the Schulte report that had as the "66<sup>th</sup> Legislative Assembly" and items from the stakeholders' report for 2019 and beyond.

As has been discussed previously, some items can be accomplished simply by collaboration with stakeholders and others, some items can be accomplished administratively, some items would need legislative actions, and some items would be a combination of all of these.

What our stakeholders group is offering is a "road map" for providing better behavioral health services for our state's residents in the future. The Schulte Report provides you with the framework for system changes, while our stakeholders have given specific changes to execute the Schulte Report. We feel that whatever changes are incorporated, they need to be measurable and "evidence based". These need to be evaluated periodically to ensure that these changes are effective. The potential is there for a lawsuit over behavioral health issues not unlike what the state faced with the ARC lawsuit over developmental disability issues. We feel strongly that through collaboration with the stakeholders we can avoid costly and needless litigation and develop services that can be a model for other states.

We feel that the work of the Stakeholders Group is not done. In fact, it is just beginning. Through collaboration with all these stakeholders, a review of the BH system should be evaluated periodically to ensure effective BH services for our citizens. Our steering committee has never seen such motivation among the stakeholders. All are committed to building the best behavioral health system in the country.

Our Stakeholder group has provided or will provide testimony for the Human Services Committee at their meetings on April 9, 2014, July 22, 2014, August 27, 2014, and their next meeting on October 8, 2014. The Human Services Committee considered bill drafts from the Schulte Report and also at their last meeting requested bills to be drafted from our report which will be considered at their next (last) meeting on October 8, 2014. Many issues were identified, but access to BH providers was significant. Some of our bills will actually amend some of the original bills. The bills to be considered from our report that were not included in the Schulte Report address:

- Establishing an adult and children/adolescent mental health assessment network with an appropriation to ensure TIMELY access of critical mental health services.
- Establishing a pilot project in one area involving key behavior health partners (law enforcement, health care providers, and private partners) to develop discharge planning protocols including outcome measures.
- Establishing stipends for Licensed Addiction Counselors to increase the number of treating professionals and keep them in our state.
- Establishing a requirement for licensing reciprocity that must be completed within 30 days. Providers have expressed frustration with trying to become licensed within the state.
- Establish a student loan buy down program for licensed behavioral health clinical staff similar to that used in the Stem Program.

- Providing funding to train partners to provide basic training in schools on behavioral health issues for teachers, child care providers using the Mental Health First Aid model.
- Amending Bill # 15.0230.01000 to clarify that licensed professional clinical counselors are included in the payable providers under Medicaid.
- Recommending future legislative studies of the Pre-school screening/assessment process and for the Visiting Nurse Program for Behavior Health for ages 0-5. The other study would continue the study of behavioral health needs within the state and track changes that are implemented during the next legislative session.

I was also asked to address the issue of insurance coverage for private health insurance and discuss past discussions when the state selected the “benchmark plan”, in particular for Residential Treatment Center coverage.

Our group did discuss insurance benefits and whether the Essential Health Benefits should be revisited for not only Residential Treatment Centers, but also issues of benefits for marriage and behavioral health services. Because it was our understanding that changing the benefits within the Benchmark Plan may not be an option afforded to the state at this time, that was not one of the recommendations that we recommended. Our understanding according to the ACA was that any additional costs due to State changes (mandates) that are made to the Benchmark Plan would have to be paid by the state. In addition, the existing ND law on mandates would have to apply to only the NDPERS plan for two years to establish the actual costs of any new mandate before the mandate can be applied to all health insurance products. Complicating this issue was a new Attorney General’s Opinion regarding private insurance and Medicaid coverage for Residential Treatment Center coverage for youth and adults and how it relates to the Federal Mental Health Parity Law. It is my understanding that some resolution was happening with the Insurance Department and the health insurers, but I am not totally knowledgeable on this issue. In addition, I think the Department of Human Services is still trying to get some clarification from the Federal government for Medicaid.

Regarding this committee’s past discussions on selection of the Benchmark Plan about two years ago (I believe), I want to make it very clear that my comments do not represent the views of our Behavioral Health Stakeholder’s Group, or that of any insurer. I am only recollecting my memories of discussions from a panel of insurers when I did represent an insurer and was part of that panel. The state was given the opportunity to select a benchmark plan among many different options offered by the Federal government. That “Benchmark Plan” was to determine the essential health benefits that must be included in all health plans under the ACA. If I recall correctly, this State selection was to be used until 2017. The determination of the Essential Health Benefits after that date will be determined by the Secretary of HHS. My personal opinion is that this temporary option was really a political decision by HHS to temper some of the rate shock that was expected with the ACA. ND has few mandated benefits when compared to other states. If ND had to design products based on New York’s mandates, insurance premiums would have increased even more than just the other ACA benefit changes. So for that reason

I think HHS made the political decision to give the states the option to select a benchmark plan temporarily.

The Insurance Department contracted with a private consultant to lay out the choices that the state had to select from based on the Federal requirements. The Insurance Commissioner was asking for input from this committee to determine what this committee would recommend. However the final decision was to be made by either the Insurance Commissioner or the Governor as I recall.

During this panel discussion, I recall that I mentioned that selection of a plan would definitely cause some potential problems for consumers and for providers. I mentioned in this panel that there were 3 glaring differences between the BCBSND plan option and that of the Sanford plan option. I don't remember all three now, but one was that of Residential Treatment services and a second one was that of infertility services that the BCBSND plan offered but was not provided in the Sanford Plan option. I mentioned that selecting the "leaner" plan may have impacts to the consumers using those benefits not selected in the benchmark plan as well as the providers who provided those services. As I recall further discussion, there was concern by the legislative committee that expected premium increases under the ACA should dictate that a "leaner" plan should be considered and thus I believe the Sanford Plan was recommended for consideration to the Insurance Department.

Mr. Chairman and Committee members, thank you again for the opportunity to address your committee and update you on what our Behavioral Health Stakeholder's Group has been working on, the progress we have made, and the work of the Human Services Committee on this issue. As I have said the issues of Behavioral Health are real and significant within our state and the proposed solutions are critically needed. Our broad spectrum of stakeholders offers our assistance in finding solutions. I would be willing to try to answer any questions your committee may have. Thank you.

## APPENDIX A SUMMARY

### Opportunity One – Addressing Service Shortages

- Increase use of telemedicine
- Establish assessment centers in each region of the state
- Train Critical Access Hospitals to triage Behavioral Health issues
- Establish a Hennepin County “like” model
- Use HCBS waivers for MHSA services
- Increase Substance Abuse Services
- Increase access to IDDT
- Develop discharge planning protocols, including the establishment of outcome measures. Fund one year pilot project.
- Increase after hour options like Devils Lake NIATx walk in clinic
- Use telemedicine for crisis assessments – IA model
- Model after eICUs to create ePsychiatry in the state.

### Opportunity Two – Expand Workforce

- Create an oversight system for licensing boards utilizing public health as overseer
- Support changes in expert examiners including expansion of nurse practitioners as health care expert witnesses
- Expand numbers of LAC by establishing a stipend program for LAC interns
- Expand LAC training slots by providing stipend for organizations that offer training slots
- Establish professional licensing board standards for mental health professionals
- Establish a student loan buy down system for licensed BH clinical staff
- Change Behavioral Health Professional definition
- Create reciprocity language to “shall” accept all professional licenses meeting international and national accreditation standards and qualified state equivalent for each BH license
- Make sure all educational requirements are available within state and online for access
- Expand the behavioral health training model for first responders used in Cass County to the whole state and integrate into Post Training standards
- Provide basic training in schools on behavioral health issues for teachers and child care providers using Mental Health First Aid model
- Increase training for law enforcement, emergency personnel, corrections and teachers
- Increase education opportunities for behavioral health providers

### **Opportunity Three – Insurance Coverage Changes Needed**

- Re-evaluate Essential Health Benefit Package selected and unintended consequences
- Determine if insurance coverage meets federal parity standards
- Work with insurance providers to fund ASAM Core Services
- Broaden Insurance
- Amend state Medicaid plan to include LPCC and LMFT licensed Professionals
- Expand community based services through mental health HCBS waiver
- Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps
- Determine what 3<sup>rd</sup> party payers should be covering
- Apply Medicaid waiver for SDMI population
- Change administrative code to reimburse Behavioral Health Professionals
- Expand Medicaid to licensed addiction agencies and others that are eligible for other 3<sup>rd</sup> party reimbursements

### **Opportunity Four – Changes in DHS Structure and Responsibility**

- Create independent appeal process
- Standardize and distribute rules for uniform access to HSCs
- Encourage hiring throughout the state not just in HSCs
- Increase oversight and accountability for contracts with independent appeal process
- Adopt ASAM Core Service Grids for Adult and Adolescent – Define HSC Roles and move to private and/or voucher system
- Create list of services only provided by DHS
- Improve coordination of care with county service systems for youth
- Legislative oversight of HSC system to uphold powers and duties in outlined in 50.06-05.3

### **Opportunity Five – Improve Communication**

- Pre-school screening/assessment
- Support DHS task force that addresses hearing timelines
- Seek additional federal funding for age 0-5 Visiting Nurse program for BH
- Strengthen advocacy voices in North Dakota
- Review record sharing options for ND
- Change regulations to accept electronic releases and all other treatment documentation
- Streamline application process for residential facilities

9/29/2014

- Improve regional communications HSCs to all providers
- Standardize policies and procedures that foster better communication

### **Opportunity Six – Data Collection and Research**

- Give task of oversight of licensing boards to public health
- Assure that 211 has access to all funded provider information and that consumers are aware of services through 211 and SAMHSA
- Commitment related legislation – Establish mechanism to law enforcement can access information on individuals who may have been committed
- Create a repository for services using 211/First Link
- Map current resources distribution outside the HSC system
- Use Universities or other current systems to build outcomes based system
- Create a list of “legacy” services

**The North Dakota Behavioral Health Stakeholders website is now being housed within the Center for Rural Health’s webpage.**

**The new web address is - <http://ruralhealth.und.edu/projects/nd-behavioral-health>**

## BEHAVIORAL HEALTH PLANNING MASTER LIST

Opportunity 1: SERVICE SHORTAGE			
Goal1: Improve access to services			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Increasing Telemedicine	DHS; legislature; providers; advocates; consumers and families	2014 - 2015 (64th Legislative Session)	Federal grants like HRSA Insurance community reinvestment Cost: \$1K to \$10K per site for equipment
<b>2. ASSESSMENT CENTERS</b> Establish 4 Adult Mental Health Assessment Centers in the 4 largest communities in ND Train Critical Access Hospitals to triage behavioral health issues including access to telemedicine to Mental Health Assessment Centers Establish a Hennepin county "like" model; may need to look at the 72 hour hold that MN has in place; to include developing process to make sure people receive a diagnosis or the correct diagnosis	Hospital Association; Medical Association; DHS; Legislature	2015 (64th Legislative Session)	Establish four assessment units, one every 6 months starting - January 1, 2016
<b>3. ASSESSMENT SERVICES</b> Establish children/adolescent assessment network or centers in each region of state to incorporate attendant/shelter care with a system like STEP at DBR These services should include access through critical access hospitals using telemedicine	DHS; Stakeholders; DJS/Youthworks; DBGR	2015 (64th Legislative Session)	More consistent comprehensive assessments to ensure that functional needs are addressed; Decrease the number of children inappropriately placed in county or DJS custody
4. Use of Critical Access Hospitals	DHS; legislature	2014 - 2015 (64th Legislative Session)	Current CAH funds allow BH services
5. Create bed management system MN Model	DHS; legislature	2017 (65th Legislative Session)	State funding Cost: \$200K implementation \$25K sustaining
6. Utilize HCBS waivers for MHSA services MT Model	DHS; legislature	2014 - 2015 (64th Legislative Session)	Federal Medicaid funding Most state's cost neutral: ND evaluating at present
7. Increase substance abuse services including detox	Legislature; DHS	2015 (64th Legislative Session)	SAMHSA block grant; state funding; alcohol tax; private funding Cost: \$2-10M depending on funding source chosen
Goal 2: Conflict-Free case management			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Increase access to IDDT - expand statewide	DHS; legislature; Governor	2014 - 2015 (64th Legislative Session)	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	2017 (65th Legislative Session)	Cost savings: transfer cost to private or county providers

<b>3. DISCHARGE PLANNING</b> Involve key behavioral health partners (law enforcement, health care providers and private partners) in one region to develop discharge planning protocols in one region including the establishment of outcome measures Fund a one year pilot project for one year	DHS; Private providers; Private insurance companies; DHS for HSC clients; Medicaid funding (traditional and expansion populations)	2015 (64th Legislative Session)	Consistent system of care for hospital discharges
4. Partner case management/care coordination with peer support	DHS; legislature; advocates; consumers and families	2017 (65th Legislative Session)	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
<b>Goal 3: Access to crisis assessment</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Increase after hour options like Devils Lake NIATx walk in clinic and create after hour intake options	DHS; HSCs	2014 - 2015 (64th Legislative Session)	Adjust current work schedules to accommodate
<b>2. MOBILE CRISIS UNITS</b> Expanding the crisis mobile response team to other regions with outcome standards and reporting requirements after the establishment of comprehensive assessment services	DHS	2017 (65th Legislative Session)	To have crisis response services available in all regions by 2019 that have standardized protocols and data outcomes
3. Increase mobile crisis in urban areas after hours	DHS; HSCs	2017 (65th Legislative Session)	State funding; private contract options; block grant funding; adjust current work days/times Cost: \$120K-\$200K per urban location per year
4. Use telemedicine for crisis assessments IA model	DHS; legislature; providers; advocates; consumers and families	2015 (64th Legislative Session)	Federal grants like HRSA Insurance community reinvestment Cost: \$225K per region
5. Model after eICUs to create ePsychiatry in the state	DHS; Legislature; providers; advocates	2015 (64th Legislative Session)	Medicaid; Medicare; private insurance; insurance community investment Cost: \$1.7M conferencing fee and support (20 sites)
<b>Opportunity 2: EXPAND WORKFORCE</b>			
<b>Goal 1: Oversight for licensing issues and concerns</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Create an oversight system for licensing boards utilizing public health as overseer	Legislature; Department of Public Health	2015 (64th Legislative Session)	No funding required
<b>2. COMMITMENT RELATED LEGIS.</b> Support changes in expert examiners including the expansion of nurse practitioners as health care expert witnesses	Dr. Etherington; Interim Committee; State's Attorneys	2015 (64th Legislative Session)	Report by October 2014 Legislation should be prepared by DHS (Administrative and Legislative)

<p><b>3. LICENSED ADDICTION COUNSELORS (LAC) STIPEND</b> Expand numbers of LAC by establishing a stipend program for LAC interns that would be forgiven if LAC practices in state for 4 years Proposed \$25,000/applicant</p>	<p>NDACA/NDATPC/DHS; Legislature; Stakeholders; various other professional Boards and Associations; NDUS</p>	<p>July 2015 (64th Legislative Session) 40 slots - \$1,000,000</p>	<p>Increase LAC</p>
<p><b>4. LAC TRAINING SLOTS</b> Expand LAC training slots by providing stipends for organizations that offer training slots (\$5,000/slot)</p>	<p>Legislature; Stakeholders; Six LAC training Consortiums</p>	<p>July 2015 (64th Legislative Session) 40 slots - \$200,000</p>	<p>Increase LAC</p>
<p><b>5. LICENSING STANDARDS</b> Establish professional licensing board standards for mental health professional to allow: 1. One year practice if licensed in another state 2. Process for meeting ND licensing standing during the 1 year period 3. Reciprocity of licenses between Montana, South Dakota and Minnesota Method for issuing licenses within 30 days</p>	<p>Various Licensing Boards</p>	<p>2015 (64th Legislative Session)</p>	<p>Reduce barriers for applicants and increase providers</p>
<p><b>6. STUDENT LOAN BUY DOWNS</b> Establish a student loan buy down system for licensed BH clinical staff</p>	<p>Legislature; DHS; NDUS</p>	<p>July 2015 (64th Legislative Session)</p>	<p>Increased BH providers throughout state</p>
<p>7. Change Behavioral Health Professional definition in 25-03.2-01 for MA level like IA model or two levels including practitioner level in MN model</p>	<p>Legislature; DHS</p>	<p>2015 (64th Legislative Session)</p>	<p>No funding required</p>
<p>8. Create reciprocity language to "shall" accept all professional licenses meeting international and national accreditation standards and qualified state equivalent for each BH license</p>	<p>Legislature</p>	<p>2015 (64th Legislative Session)</p>	<p>No funding required</p>
<p>9. Make sure all educational requirements are available within state and preferably online for access</p>	<p>Legislature; licensure boards</p>	<p>2014 - 2015 (64th Legislative Session)</p>	<p>Adjust course offerings to reflect required courses.</p>

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

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
<p>1. Increase use of peer support and recovery coaches</p>	<p>DHS; providers; advocates</p>	<p>2017 (65th Legislative Session)</p>	<p>State funding; private contracts; federal grants; Medicaid Cost: Depends on source of funding \$750K</p>
<p><b>2. TRAIN 1<sup>ST</sup> RESPONDERS</b> Expand the behavioral health training model for first responders used in Cass County to the whole state and integrate into Post Training standards</p>	<p>JICC workgroup and MHA Stakeholders</p>	<p>July 2016 (64th Legislative Session)</p>	<p>Full implementation of training</p>

<b>3. TRAIN PARTNERS</b> Provide basic training in schools on behavioral health issues for teachers, child care providers using Mental Health First Aid model	DPI and ND University System; Stakeholders; NDSU Extension	2014 - 2015 ( 64th Legislative Session)	When fully implemented it will provide a network of trained first responders This could be administrative or if funding is needed consider 2017
4. Increase training for law enforcement, emergency personnel, corrections and teachers using MH First Aid and other training	DHS; providers; advocates	2015 (64th Legislative Session)	MH First Aid is a low cost program - \$15-\$25 per person
5. Increase law enforcement in schools	Schools; advocates; providers; law enforcement	2017 (65th Legislative Session)	State funding; federal grants Cost: \$50K per officer
6. Increase education opportunities for behavioral health providers	Universities; online learning	2015 (64th Legislative Session)	Re-prioritize existing courses to train new providers

**Opportunity 3: Insurance Coverage Changes Needed**

<b>Goal 1: Increase funding options for services for youth and adults</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Re-evaluate Essential Health Benefit Package selected and unintended consequences	Legislature; DHS; and providers	2014 - 2015 (64th Legislative Session)	None Needed
2. Determine if insurance coverage meets federal parity standards	Legislature; DHS; and insurance department	2014 - 2015 (64th Legislative Session)	None Needed
<b>3. INSURANCE COVERAGE</b> Work with insurance providers to fund ASAM Core Services	SA Providers and DHS/Insurers; NDACA/NDATPC/DHS; Stakeholders; Legislators	On-going	Consistency between insurers and public funders. (Administrative)
<b>4. BROADEN INSURANCE</b> Encourage private 3 <sup>rd</sup> party payers include coverage for couples and marriage & family therapy as part of behavioral health services and include all licensed mental health professionals with established competencies in couples, relationship and family therapy as eligible providers Provide coverage for CPT Codes for Family Psychotherapy (e.g. 90846 Family psychotherapy without the patient present, 90847 Family psychotherapy, conjoint psychotherapy with patient present, and 90849 Multiple-family group psychotherapy) Providers will need to have established competencies by their licensure boards	Legislature; Insurance Providers; DHS; Various Licensing Boards including Psychologists; Social Workers; Licensed Counselors; Licensed Marriage and Family Therapists	July 2015 (64th Legislative Session)	Expand available service providers Administrative - work with 3 <sup>rd</sup> party payers
<b>5. EXPAND MEDICAID</b> Amend state Medicaid plan to include LPCC and LMFT licensed Professionals in its coverage - It is time to provide a more comprehensive array of professionals	DHS May require additional matching funds	July 2015 (64th Legislative Session)	Increase numbers of providers and expand consumer options

<b>6. HCBS WAIVER</b> Expand the range of community based services through mental health HCBS waiver to assure access in both rural and urban areas	DHS	2015 (64th Legislative Session)	Full implementation statewide - target date 2017 (Administrative)
7. Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps	Legislature; DHS	2014 - 2015 (64th Legislative Session)	None Needed
8. Determine what 3rd party payers should be covering	Legislature; DHS	2014 - 2015 (64th Legislative Session)	None Needed
9. Apply for Medicaid waiver for SDMI Population MT Model	DHS	2014 - 2015 (64th Legislative Session)	Medicaid funding, may be state funding match Cost: ND currently calculating possible cost

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

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Change administrative code to reimburse qualified Behavioral Health Professionals as defined above IA Model	Legislature	2015 (64th Legislative Session)	Medicaid, 3rd party funders
2. Increase funding to assist BH professionals in training including LACs	Legislature	2017 (65th Legislative Session)	State funding; insurance reinvestment Cost: \$45K per position
<b>3. EXPAND MEDICAID</b> Expand Medicaid to licensed addiction agencies and others that are eligible for other 3 <sup>rd</sup> party reimbursements	Legislature; Stakeholders; NDACA/NDATPC/ DHS	July 2015 ( 64th Legislative Session)	Expansion of available resources Could be administrative rather than legislative

### Opportunity 4: Changes in DHS Structure and Responsibility

#### Goal 1: Build transparency and choice in services

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Create an independent appeal process for consumers IA Model	Legislature; advocates; families and consumers	2015 (64th Legislative Session)	Re-allocation of funds
2. Standardize and distribute rules for uniform access to HSCs	DHS; Legislature oversight; advocates; families and consumers	2014 - 2015 (64th Legislative Session)	No funding needed
3. Encourage hiring throughout the state not just in HSCs	DHS; Providers; advocates	2014 - 2015 (64th Legislative Session)	No funding needed
4. Increase oversight and accountability for contracts with an independent appeal process	DHS; Legislature	2015 (64th Legislative Session)	Re-allocation of funding prioritizing oversight over provider function
<b>5. CORE SERVICES</b> Adopt ASAM Core Services Grids - one for Adult and one for Adolescent Define HSC Roles, move to a private and/or voucher system whenever possible	ND Legislature; Stakeholders	2015 (64th Legislative Session)	Clear expectations, for public and private providers Regular data reporting and possible expansion of available resources
<b>6. CORE SERVICES</b> Establish a unified system of DHS core services - that are available and accessible through HSC or private providers or by vouchers (Use SAMHSA Guidelines/Grid)	DHS; ND Legislature	2017 (65th Legislative Session)	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)

<b>7. CORE SERVICES</b> Adopt core service standards or grid for children/adolescent mental health through DHS	DHS; ND Legislature; Stakeholders	2017 (65th Legislative Session)	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)
8. Create list of all services only provided by DHS	DHS; legislative council; legislature oversight	2014 - 2015 (64th Legislative Session)	Staff time
<b>Goal 2: Consider structural changes to DHS</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Change HSCs to oversight; regulatory functions; and program management at state hospital like ND DD system	DHS; Legislature	2017 or 2019 (65th or 66th Legislative Session)	Re-allocation of funds
2. Improve coordination of care with county services system for youth	DHS; Legislature; counties	2014 - 2015 (64th Legislative Session)	Staff time; county and state funding; Chaffee funds
3. If counties combine with State, create regional governance system NE Model	DHS; Legislature	2019 (66th Legislative Session)	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	2015 (64th Legislative Session)	State funding re-allocation
<b>Opportunity 5: Improve Communication</b>			
<b>Goal 1: Create an integrated system of care</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Creation of Integrated health services including care coordination in Medicaid IA Model	DHS; Legislature	2017 (65th Legislative Session)	Federal Medicaid funding; state funding; block grants Cost savings projected in Iowa
<b>2. PRE-SCHOOL SCREENING/ASSESSMENT</b> Evaluation outcome data on behavioral health screening tools done with Health Tracks and Health Steps - monitor referral patterns and unmet needs Prepare recommendations to establish routine standardized screening using evidence based practice throughout the state to routinely screen all 2,3 and 4 year olds at primary care sites - Pilot project in 2015 - Full implementation in 2017	DHS/DPI; Stakeholders; Legislators	2015 (64th Legislative Session)	Evidence based system implementation across the state integrated into primary care system Interim Committee monitoring next session (Administrative and Legislative)
<b>3. COMMITMENT RELATED LEGIS.</b> Support DHS Task Force that addresses hearing timelines	Dr. Etherington; Interim Committee; State's Attorneys	2015 (64th Legislative Session)	Report by October 2014 Legislation should be prepared by DHS (Administrative and Legislative)
4. Seek additional federal funding for age 0-5 Visiting Nurses program for BH	DHS	2015 (64th Legislative Session)	Federal funding

5. Strengthen Advocacy voices in ND	DHS; Providers; stakeholders; Advocates	2014 - 2015	No funding needed
<b>Goal 2: Improve record sharing</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Review record sharing options for ND and stream line	Legislative council; DHS; Legislature	2014 - 2015	Staff time
2. Change regulations to accept electronic releases and all other treatment documentation	Legislature; DHS	2015 (64th Legislative Session)	Cot reduction in printing and transportation
3. Streamline application process for residential facilities	Legislature	2014 - 2015 (64th Legislative Session)	Cost reduction in time and processing
<b>Goal 3: Improved communication among MHPA service providers</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Intra agency council for coordination of services Idaho model	DHS; Corrections; DPH; Education; Vocational Rehabilitation; Veterans Affairs; DD and others	2017 (65th Legislative Session)	Staff time, reallocation of priorities within departments
2. Improve regional communications HSCs to all providers	Stakeholders/advocates lead; DHS at the table; Legislative Oversight	2014 - 2015 (64th Legislative Session)	Staff time, reallocation of resources
3. Standardize policies and procedures that foster better communication including job vacancies	DHS; Legislative oversight	2014 - 2015 (64th Legislative Session)	Staff time
<b>Opportunity 6: DATA COLLECTION AND RESEARCH</b>			
<b>Goal 1: Determine what providers are available within the state and map gaps</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Create a provider registry GA model veterans model	DHS; Legislature	2017 (65th Legislative Session)	Staff time; possible state funding Cost: \$200K
2. Give task of oversight of licensing boards to public health	DHS; Legislature; Department of Public Health	2015 (64th Legislative Session)	Staff time
<b>Goal 2: Determine what services are available outside of HSC system for youth and adults</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
<b>1. FIRSTLINK/211</b> Assure that 211 has access to all funded provider information including for profit providers (make it a requirement for MA and contracts) Assure that consumers aware of services through 211 and SAMHSA	FirstLink; DHS	2015 (64th Legislative Session)	At completion
<b>2. COMMITMENT RELATED LEGIS.</b> Establish mechanism so that law enforcement can access information on individuals who may have been committed	Dr. Etherington; Interim Committee; State's Attorneys	2015 (64th Legislative Session)	Report by October 2014 Legislation should be prepared by DHS (Administrative and Legislative)
3. Create a repository for services using 211/First Link	Legislature; DHS; providers; advocates; stakeholders	2015 (64th Legislative Session)	Currently funded; state funding; private sources
4. Map current resources distribution outside the HSC system	DHS; Legislature; advocates; stakeholders	2014 - 2015 (64th Legislative Session)	State funds; current resources re-allocated

<b>Goal 3: Use data to determine best use of limited funding on treatment</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Use universities or other current systems to build outcomes based system	DHS; Universities	2014 - 2015 (64th Legislative Session)	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	2014 - 2015 (64th Legislative Session)	Staff time; state funds
<b>3. CORE SERVICES</b> Establish a unified system of DHS core services - that are available and accessible through HSC or private providers or by vouchers (Use SAMHSA Guidelines/Grid)	<b>DHS; ND Legislature</b>	<b>2017 (65th Legislative Session)</b>	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature
<b>4. CORE SERVICES</b> Adopt core service standards or grid for children/adolescent mental health through DHS	<b>DHS; ND Legislature; Stakeholders</b>	<b>2017 (65th Legislative Session)</b>	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)

The North Dakota Behavioral Health Stakeholders website is now being housed within the Center for Rural Health's webpage.

The new web address is - <http://ruralhealth.und.edu/projects/nd-behavioral-health>

## APPENDIX A

### 64th Legislative Assembly

#### BEHAVIORAL HEALTH PLANNING MASTER LIST

Opportunity 1: SERVICE SHORTAGE			
Goal1: Improve access to services			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Increasing Telemedicine	DHS; legislature; providers; advocates; consumers and families	2014 - 2015 (64th Legislative Session)	Federal grants like HRSA Insurance community reinvestment Cost: \$1K to \$10K per site for equipment
<b>2. ASSESSMENT CENTERS</b> Establish 4 Adult Mental Health Assessment Centers in the 4 largest communities in ND Train Critical Access Hospitals to triage behavioral health issues including access to telemedicine to Mental Health Assessment Centers Establish a Hennepin county "like" model; may need to look at the 72 hour hold that MN has in place; to include developing process to make sure people receive a diagnosis or the correct diagnosis	Hospital Association; Medical Association; DHS; Legislature	2015 (64th Legislative Session)	Establish four assessment units, one every 6 months starting - January 1, 2016
<b>3. ASSESSMENT SERVICES</b> Establish children/adolescent assessment network or centers in each region of state to incorporate attendant/shelter care with a system like STEP at DBR These services should include access through critical access hospitals using telemedicine	DHS; Stakeholders; DJS/Youthworks; DBGR	2015 (64th Legislative Session)	More consistent comprehensive assessments to ensure that functional needs are addressed; Decrease the number of children inappropriately placed in county or DJS custody
4. Use of Critical Access Hospitals	DHS; legislature	2014 - 2015 (64th Legislative Session)	Current CAH funds allow BH services
5. Utilize HCBS waivers for MHSA services MT Model	DHS; legislature	2014 - 2015 (64th Legislative Session)	Federal Medicaid funding Most state's cost neutral: ND evaluating at present
6. Increase substance abuse services including detox	Legislature; DHS	2015 (64th Legislative Session)	SAMHSA block grant; state funding; alcohol tax; private funding Cost: \$2-10M depending on funding source chosen
Goal 2: Conflict-Free case management			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Increase access to IDDT - expand statewide	DHS; legislature; Governor	2014 - 2015 (64th Legislative Session)	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

<b>2. DISCHARGE PLANNING</b> Involve key behavioral health partners (law enforcement, health care providers and private partners) in one region to develop discharge planning protocols in one region including the establishment of outcome measures Fund a one year pilot project for one year	DHS; Private providers; Private insurance companies; DHS for HSC clients; Medicaid funding (traditional and expansion populations)	2015 (64th Legislative Session)	Consistent system of care for hospital discharges
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**Goal 3: Access to crisis assessment**

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Increase after hour options like Devils Lake NIATx walk in clinic and create after hour intake options	DHS; HSCs	2014 - 2015 (64th Legislative Session)	Adjust current work schedules to accommodate
2. Use telemedicine for crisis assessments IA model	DHS; legislature; providers; advocates; consumers and families	2015 (64th Legislative Session)	Federal grants like HRSA Insurance community reinvestment Cost: \$225K per region
3. Model after eICUs to create ePsychiatry in the state	DHS; Legislature; providers; advocates	2015 (64th Legislative Session)	Medicaid; Medicare; private insurance; insurance community investment Cost: \$1.7M conferencing fee and support (20 sites)

**Opportunity 2: EXPAND WORKFORCE**
**Goal 1: Oversight for licensing issues and concerns**

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Create an oversight system for licensing boards utilizing public health as overseer	Legislature; Department of Public Health	2015 (64th Legislative Session)	No funding required
<b>2. COMMITMENT RELATED LEGIS.</b> Support changes in expert examiners including the expansion of nurse practitioners as health care expert witnesses	Dr. Etherington; Interim Committee; State's Attorneys	2015 (64th Legislative Session)	Report by October 2014 Legislation should be prepared by DHS (Administrative and Legislative)
<b>3. LICENSED ADDICTION COUNSELORS (LAC) STIPEND</b> Expand numbers of LAC by establishing a stipend program for LAC interns that would be forgiven if LAC practices in state for 4 years Proposed \$25,000/applicant	NDACA/NDATPC/DHS; Legislature; Stakeholders; various other professional Boards and Associations; NDUS	July 2015 (64th Legislative Session) 40 slots - \$1,000,000	Increase LAC
<b>4. LAC TRAINING SLOTS</b> Expand LAC training slots by providing stipends for organizations that offer training slots (\$5,000/slot)	Legislature; Stakeholders; Six LAC training Consortiums	July 2015 (64th Legislative Session) 40 slots - \$200,000	Increase LAC

<p><b>5. LICENSING STANDARDS</b>                  Establish professional licensing board standards for mental health professional to allow:                  1. One year practice if licensed in another state                  2. Process for meeting ND licensing standing during the 1 year period                  3. Reciprocity of licenses between Montana, South Dakota and Minnesota                  Method for issuing licenses within 30 days</p>	<p>Various Licensing Boards</p>	<p>2015 (64th Legislative Session)</p>	<p>Reduce barriers for applicants and increase providers</p>
<p><b>6. STUDENT LOAN BUY DOWNS</b>                  Establish a student loan buy down system for licensed BH clinical staff</p>	<p>Legislature; DHS; NDUS</p>	<p>July 2015 (64th Legislative Session)</p>	<p>Increased BH providers throughout state</p>
<p>7. Change Behavioral Health Professional definition in 25-03.2-01 for MA level like IA model or two levels including practitioner level in MN model</p>	<p>Legislature; DHS</p>	<p>2015 (64th Legislative Session)</p>	<p>No funding required</p>
<p>8. Create reciprocity language to "shall" accept all professional licenses meeting international and national accreditation standards and qualified state equivalent for each BH license</p>	<p>Legislature</p>	<p>2015 (64th Legislative Session)</p>	<p>No funding required</p>
<p>9. Make sure all educational requirements are available within state and preferably online for access</p>	<p>Legislature; licensure boards</p>	<p>2014 - 2015 (64th Legislative Session)</p>	<p>Adjust course offerings to reflect required courses.</p>

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

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
<p><b>1. TRAIN 1ST RESPONDERS</b>                  Expand the behavioral health training model for first responders used in Cass County to the whole state and integrate into Post Training standards</p>	<p>JICC workgroup and MHA Stakeholders</p>	<p>July 2016 (64th Legislative Session)</p>	<p>Full implementation of training</p>
<p><b>2. TRAIN PARTNERS</b>                  Provide basic training in schools on behavioral health issues for teachers, child care providers using Mental Health First Aid model</p>	<p>DPI and ND University System; Stakeholders; NDSU Extension</p>	<p>2014 - 2015 ( 64th Legislative Session)</p>	<p>When fully implemented it will provide a network of trained first responders This could be administrative or if funding is needed consider 2017</p>
<p>3. Increase training for law enforcement, emergency personnel, corrections and teachers using MH First Aid and other training</p>	<p>DHS; providers; advocates</p>	<p>2015 (64th Legislative Session)</p>	<p>MH First Aid is a low cost program - \$15-\$25 per person</p>
<p>4. Increase education opportunities for behavioral health providers</p>	<p>Universities; online learning</p>	<p>2015 (64th Legislative Session)</p>	<p>Re-prioritize existing courses to train new providers</p>

**Opportunity 3: Insurance Coverage Changes Needed**

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

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
<p>1. Re-evaluate Essential Health Benefit Package selected and unintended consequences</p>	<p>Legislature; DHS; and providers</p>	<p>2014 - 2015 (64th Legislative Session)</p>	<p>None Needed</p>

2. Determine if insurance coverage meets federal parity standards	Legislature; DHS; and insurance department	2014 - 2015 (64th Legislative Session)	None Needed
<b>3. INSURANCE COVERAGE</b> Work with insurance providers to fund ASAM Core Services	SA Providers and DHS/Insurers; NDACA/NDATPC/DHS; Stakeholders; Legislators	On-going	Consistency between insurers and public funders. (Administrative)
<b>4. BROADEN INSURANCE</b> Encourage private 3 <sup>rd</sup> party payers include coverage for couples and marriage & family therapy as part of behavioral health services and include all licensed mental health professionals with established competencies in couples, relationship and family therapy as eligible providers Provide coverage for CPT Codes for Family Psychotherapy (e.g. 90846 Family psychotherapy without the patient present, 90847 Family psychotherapy, conjoint psychotherapy with patient present, and 90849 Multiple-family group psychotherapy) Providers will need to have established competencies by their licensure boards	Legislature; Insurance Providers; DHS; Various Licensing Boards including Psychologists; Social Workers; Licensed Counselors; Licensed Marriage and Family Therapists	July 2015 (64th Legislative Session)	Expand available service providers Administrative - work with 3 <sup>rd</sup> party payers
<b>5. EXPAND MEDICAID</b> Amend state Medicaid plan to include LPCC and LMFT licensed Professionals in its coverage - It is time to provide a more comprehensive array of professionals	DHS May require additional matching funds	July 2015 (64th Legislative Session)	Increase numbers of providers and expand consumer options
<b>6. HCBS WAIVER</b> Expand the range of community based services through mental health HCBS waiver to assure access in both rural and urban areas	DHS	2015 (64th Legislative Session)	Full implementation statewide - target date 2017 (Administrative)
7. Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps	Legislature; DHS	2014 - 2015 (64th Legislative Session)	None Needed
8. Determine what 3rd party payers should be covering	Legislature; DHS	2014 - 2015 (64th Legislative Session)	None Needed
9. Apply for Medicaid waiver for SDMI Population MT Model	DHS	2014 - 2015 (64th Legislative Session)	Medicaid funding, may be state funding match Cost: ND currently calculating possible cost
<b>Goal 2: Increase behavioral health professional coverage in Medicaid and private insurance</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Change administrative code to reimburse qualified Behavioral Health Professionals as defined above IA Model	Legislature	2015 (64th Legislative Session)	Medicaid, 3rd party funders

<b>2. EXPAND MEDICAID</b> Expand Medicaid to licensed addition agencies and others that are eligible for other 3 <sup>rd</sup> party reimbursements	Legislature; Stakeholders; NDACA/NDATPC/ DHS	July 2015 ( 64th Legislative Session)	Expansion of available resources Could be administrative rather than legislative
<b>Opportunity 4: Changes in DHS Structure and Responsibility</b>			
<b>Goal 1: Build transparency and choice in services</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Create an independent appeal process for consumers IA Model	Legislature; advocates; families and consumers	2015 (64th Legislative Session)	Re-allocation of funds
2. Standardize and distribute rules for uniform access to HSCs	DHS; Legislature oversight; advocates; families and consumers	2014 - 2015 (64th Legislative Session)	No funding needed
3. Encourage hiring throughout the state not just in HSCs	DHS; Providers; advocates	2014 - 2015 (64th Legislative Session)	No funding needed
4. Increase oversight and accountability for contracts with an independent appeal process	DHS; Legislature	2015 (64th Legislative Session)	Re-allocation of funding prioritizing oversight over provider function
<b>5. CORE SERVICES</b> Adopt ASAM Core Services Grids - one for Adult and one for Adolescent Define HSC Roles, move to a private and/or voucher system whenever possible	<b>ND Legislature; Stakeholders</b>	<b>2015 (64th Legislative Session)</b>	<b>Clear expectations, for public and private providers</b> <b>Regular data reporting and possible expansion of available resources</b>
6. Create list of all services only provided by DHS	DHS; legislative council; legislature oversight	2014 - 2015 (64th Legislative Session)	Staff time
<b>Goal 2: Consider structural changes to DHS</b>			
1. Improve coordination of care with county services system for youth	DHS; Legislature; counties	2014 - 2015 (64th Legislative Session)	Staff time; county and state funding; Chaffee funds
2. Legislative oversight of HSC system to uphold powers and duties outlined in 50.06-05.3	Legislature and Executive branch	2015 (64th Legislative Session)	State funding re-allocation
<b>Opportunity 5: Improve Communication</b>			
<b>Goal 1: Create an integrated system of care</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
<b>1. PRE-SCHOOL SCREENING/ASSESSMENT</b> Evaluation outcome data on behavioral health screening tools done with Health Tracks and Health Steps - monitor referral patterns and unmet needs Prepare recommendations to establish routine standardized screening using evidence based practice throughout the state to routinely screen all 2,3 and 4 year olds at primary care sites - Pilot project in 2015 - Full implementation in 2017	DHS/DPI; Stakeholders; Legislators	2015 (64th Legislative Session)	Evidence based system implementation across the state integrated into primary care system Interim Committee monitoring next session (Administrative and Legislative)

<b>2. COMMITMENT RELATED LEGIS. Support DHS Task Force that addresses hearing timelines</b>	<b>Dr. Etherington; Interim Committee; State's Attorneys</b>	<b>2015 (64th Legislative Session)</b>	<b>Report by October 2014 Legislation should be prepared by DHS (Administrative and Legislative)</b>
3. Seek additional federal funding for age 0-5 Visiting Nurses program for BH	DHS	2015 (64th Legislative Session)	Federal funding
4. Strengthen Advocacy voices in ND	DHS; Providers; stakeholders; Advocates	2014 - 2015	No funding needed
<b>Goal 2: Improve record sharing</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Review record sharing options for ND and stream line	Legislative council; DHS; Legislature	2014 - 2015	Staff time
2. Change regulations to accept electronic releases and all other treatment documentation	Legislature; DHS	2015 (64th Legislative Session)	Cot reduction in printing and transportation
3. Streamline application process for residential facilities	Legislature	2014 - 2015 (64th Legislative Session)	Cost reduction in time and processing
<b>Goal 3: Improved communication among MHPA service providers</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Improve regional communications HSCs to all providers	Stakeholders/advocates lead; DHS at the table; Legislative Oversight	2014 - 2015 (64th Legislative Session)	Staff time, reallocation of resources
2. Standardize policies and procedures that foster better communication including job vacancies	DHS; Legislative oversight	2014 - 2015 (64th Legislative Session)	Staff time
<b>Opportunity 6: DATA COLLECTION AND RESEARCH</b>			
<b>Goal 1: Determine what providers are available within the state and map gaps</b>			
<b>Strategies</b>	<b>Who is Responsible</b>	<b>Timing</b>	<b>Financial Options and Cost Estimate</b>
1. Give task of oversight of licensing boards to public health	DHS; Legislature; Department of Public Health	2015 (64th Legislative Session)	Staff time
<b>Goal 2: Determine what services are available outside of HSC system for youth and adults</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
<b>1. FIRSTLINK/211 Assure that 211 has access to all funded provider information including for profit providers (make it a requirement for MA and contracts) Assure that consumers aware of services through 211 and SAMHSA director</b>	<b>FirstLink; DHS</b>	<b>2015 (64th Legislative Session)</b>	<b>At completion</b>
<b>2. COMMITMENT RELATED LEGIS. Establish mechanism so that law enforcement can access information on individuals who may have been committed</b>	<b>Dr. Etherington; Interim Committee; State's Attorneys</b>	<b>2015 (64th Legislative Session)</b>	<b>Report by October 2014 Legislation should be prepared by DHS (Administrative and Legislative)</b>
3. Create a repository for services using 211/First Link	Legislature; DHS; providers; advocates; stakeholders	2015 (64th Legislative Session)	Currently funded; state funding; private sources
4. Map current resources distribution outside the HSC system	DHS; Legislature; advocates; stakeholders	2014 - 2015 (64th Legislative Session)	State funds; current resources re-allocated

<b>Goal 3: Use data to determine best use of limited funding on treatment</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
1. Use universities or other current systems to build outcomes based system	DHS; Universities	2014 - 2015 (64th Legislative Session)	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	2014 - 2015 (64th Legislative Session)	Staff time; state funds

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## APPENDIX B

### 65th Legislative Assembly

#### BEHAVIORAL HEALTH PLANNING MASTER LIST

<b>Opportunity 1: SERVICE SHORTAGE</b>			
<b>Goal1: Improve access to services</b>			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Create bed management system - MN Model	DHS; legislature	2017 (65th Legislative Session)	State funding Cost: \$200K Implementation \$25K
<b>Goal 2: Conflict-Free case management</b>			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Privatize case management to add choice	DHS; legislature; Governor	2017 (65th Legislative Session)	Cost savings: transfer cost to private or county providers
2. Partner case management/care coordination with peer support	DHS; legislature; advocates; consumers and families	2017 (65th Legislative Session)	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
<b>Goal 3: Access to crisis assessment</b>			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
<b>1. MOBILE CRISIS UNITS</b> Expanding the crisis mobile response team to other regions with outcome standards and reporting requirements after the establishment of comprehensive assessment services	DHS	<b>2017 (65th Legislative Session)</b>	<b>To have crisis response services available in all regions by 2019 that have standardized protocols and data outcomes</b>
2. Increase mobile crisis in urban areas after hours	DHS; HSCs	2017 (65th Legislative Session)	State funding; private contract options; block grant funding; adjust current work days/times Cost: \$120K-\$200K per urban location per year
<b>Opportunity 2: EXPAND WORKFORCE</b>			
<b>Goal 2: Increase use of lay persons in expanding treatment options</b>			
Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Increase use of peer support and recovery coaches	DHS; providers; advocates	2017 (65th Legislative Session)	State funding; private contracts; federal grants; Medicaid Cost: Depends on source of funding \$750K
2. Increase law enforcement in schools	Schools; advocates; providers; law enforcement	2017 (65th Legislative Session)	State funding; federal grants Cost: \$50K per officer
<b>Opportunity 3: Insurance Coverage Changes Needed</b>			
<b>Goal 2: Increase behavioral health professional coverage in Medicaid and private insurance</b>			
Strategies	Who is Responsible	Timing	Financial Options and Cost Estimate
1. Increase funding to assist BH professionals in training including LACs	Legislature	2017 (65th Legislative Session)	State funding; insurance reinvestment Cost: \$45K per position

**Opportunity 4: Changes in DHS Structure and Responsibility**

**Goal 1: Build transparency and choice in services**

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. CORE SERVICES Establish a unified system of DHS core services - that are available and accessible through HSC or private providers or by vouchers (Use SAMHSA Guidelines/Grid)	DHS; ND Legislature	2017 (65th Legislative Session)	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)
2. CORE SERVICES Adopt core service standards or grid for children/adolescent mental health through DHS	DHS; ND Legislature; Stakeholders	2017 (65th Legislative Session)	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)

**Goal 2: Consider structural changes to DHS**

1. Change HSCs to oversight; regulatory functions; and program management at state hospital like ND DD system	DHS; Legislature	2017 or 2019 (65th or 66th Legislative Session)	Re-allocation of funds
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**Opportunity 5: Improve Communication**

**Goal 1: Create an integrated system of care**

Strategies/Action Steps	Who is Responsible/Key Leaders	Timing/Date Implemented	Financial Options and Cost Estimate/Outcome
1. Creation of Integrated health services including care coordination in Medicaid IA Model	DHS; Legislature	2017 (65th Legislative Session)	Federal Medicaid funding; state funding; block grants Cost savings projected in Iowa

**Goal 3: Improved communication among MHSa service providers**

Strategies	Who is Responsible	Timing	Financial Options and Cost Estimate
1. Intra agency council for coordination of services Idaho model	DHS; Corrections; DPH; Education; Vocational Rehabilitation; Veterans Affairs; DD and others	2017 (65th Legislative Session)	Staff time, reallocation of priorities within departments

**Opportunity 6: DATA COLLECTION AND RESEARCH**

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

Strategies	Who is Responsible	Timing	Financial Options and Cost Estimate
1. Create a provider registry GA model veterans model	DHS; Legislature	2017 (65th Legislative Session)	Staff time; possible state funding Cost: \$200K

<b>Goal 3: Use data to determine best use of limited funding on treatment</b>			
<b>Strategies/Action Steps</b>	<b>Who is Responsible/Key Leaders</b>	<b>Timing/Date Implemented</b>	<b>Financial Options and Cost Estimate/Outcome</b>
<b>1. CORE SERVICES</b> Establish a unified system of DHS core services - that are available and accessible through HSC or private providers or by vouchers (Use SAMHSA Guidelines/Grid)	DHS; ND Legislature	2017 (65th Legislative Session)	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)
<b>2. CORE SERVICES</b> Adopt core service standards or grid for children/adolescent mental health through DHS	DHS; ND Legislature; Stakeholders	2017 (65th Legislative Session)	DHS will provide data on provision of NDCC core services by regions (like quarterly budget summary) starting 1/2015 Next interim to study core adult mental health needs to prepare recommendations to Legislature (Administrative)

The North Dakota Behavioral Health Stakeholders website is now being housed within the Center for Rural Health's webpage.

The new web address is - <http://ruralhealth.und.edu/projects/nd-behavioral-health>

## APPENDIX C

### 66th Legislative Assembly

#### BEHAVIORAL HEALTH PLANNING MASTER LIST

Opportunity 4: Changes in DHS Structure and Responsibility			
Goal 2: Consider structural changes to DHS			
Strategies	Who is Responsible	Timing	Financial Options and Cost Estimate
1. If counties combine with State, create regional governance system NE Model	DHS; Legislature	2019 (66th Legislative Session)	State and county funding re-allocation

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