

Testimony
Health and Human Services Committee
Representative Weisz, Chairman
June 16, 2010

Chairman Weisz, members of the Health and Human Services Committee, I am Nancy McKenzie, Statewide Director of the Regional Human Service Centers (HSCs) for the Department of Human Services (DHS). I am here today at the committee's request to provide a summary of the cost of substance abuse and mental health services in each region, including contract costs. I will also provide number of clients served and percentage of those clients who are Native American.

Human Service Center Contracted vs. Provided Services

The eight Regional Human Service Centers provide an important community safety net for our most vulnerable citizens, to ensure that services are available and accessible at the most appropriate and cost-effective level of care.

- Each of the centers provides identified core services. We continue to place a high value on alignment across the regions, operating as one public system that shares resources as needs and demands shift.
- Services are provided within the clinic setting, various rural outreach centers, in client homes, or other community settings, and include 24-hour emergency services as well as follow-up services.
- We place a high value on our partnerships with private providers across the state, with a goal of collaborating to provide the array of needed services without unnecessary duplication or additional cost.

Each HSC provides identified direct services while contracting with private providers for other services. In keeping with the DHS mission to serve North Dakota's most vulnerable individuals, the HSC may be the only available provider for identified populations. Availability of other services and providers varies in different parts of the state; therefore, to assure access, the HSC may directly provide the services (particularly in the most rural regions).

A number of factors contribute to the decision as to what will be provided vs. contracted.

Contracted services may be preferable because:

1. A provider has services not available through the HSC, or it wouldn't be efficient or realistic to duplicate those services (i.e. local inpatient hospital services, community recovery centers);
2. The HSC is oftentimes not equipped to provide 24/7 residential services and the required supervisory coverage for those services (i.e. residential crisis beds or transitional living facilities); and,
3. The HSC may not have access to needed credentialed staff on either a short or long-range basis (i.e. psychiatrists, psychologists, advance practice nurses).

Particularly in the case of #3, this can vary from region to region and change as recruitment/retention patterns change.

The **attached table** shows the breakdown of provided and contracted mental health and substance abuse services by region and by statewide total. You will see that, in total, over 25% of the total amount budgeted to the HSCs for these services are contracted to other providers.

HSC Clients Served

The following identifies total clients served in SFY 2008 and 2009, the number of those clients who were Native American, and the change in number served in these two years.

	SFY 2008	SFY 2009	Increase	% Change
Total # Served by 8 Regions	24,975	25,289	+314	+1.3%
# Native American	2639	2803	+164	+6.2%

As a percentage of clients served, Native Americans accounted for 10.6% of those served in 2008 and 11.1% of those served in 2009.

That concludes my testimony; I would be happy to answer any questions you may have.