Behavioral Health
What's New in ND?

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NORTH DAKOTA BEHAVIORAL HEALTH

north dakota department of human services

SUBSTANCE USE & MENTAL ILLNESS

in North Dakota Adults (18+)

2013-2014 National Survey on Drug Use and Health (NSDUH)

SUBSTANCE USE | MENTAL ILLNESS

9.1% OR **51,950** adults had a Substance Use Disorder (SUD) in the past year

16.1% OR **91,912** adults have Any Mental Illness (AMI) in the past year

In the past month, **30.0%** OR **171,264** adults engaged in binge drinking

4.0% OR **22,835** adults have Serious Mental Illness (SMI) in the past year

In the past month, **7.3%** OR **41,674** adults used illicit drugs

18,839 adults have both co-occuring behavioral health disorder (SUD & AMI)

BEHAVORIAL HEALTH IS

a state of mental/ emotional being and/or choices and actions that affect wellness.

FACT

By 2020 mental & substance use disorders will surpass all physical diseases as a major cause of disability worldwide.

3 Substance Use Disorder (SUD): Individuals with alcohol or illicit drug dependence or abuse are defined as having SUD. The questions used to measure dependence and abuse are based on criteria in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

4 Population estimates from 2014 Census estimates

1 Any Mental Illness (AMI) is defined as individuals having any mental, behavior, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental and substance use disorders)

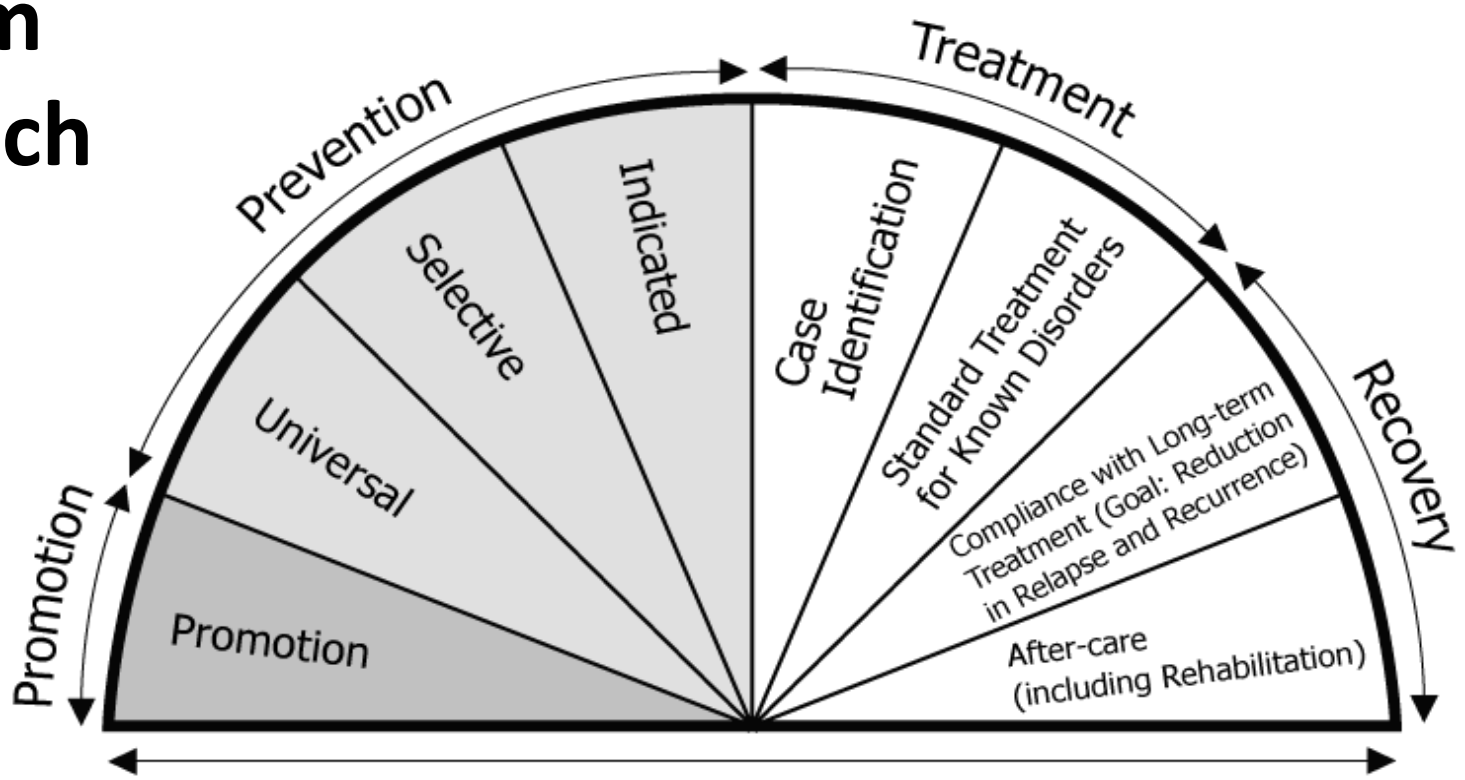
2 Serious Mental Illness (SMI) is defined as adults with any mental, behavior, or emotional disorder that substantially interfered with or limited one or more major life activities

Created by the North Dakota State Epidemiological Outcomes Workgroup (SEOW) www.preventionnd.gov/data

Key Points


ND's Behavioral Health system is in a state of reform
Need for community based services
Stop criminalizing behavioral health
Support full continuum of care

System Approach



	Prevention/ Promotion	Early Intervention	Treatment	Recovery
FUNDING				
WORKFORCE				
BEST PRACTICE				

READINESS & SOCIAL DETERMINANTS OF HEALTH

Behavioral Health Reform

Human Services Research Institute

HSRI

What HSRI does

HSRI is a nonprofit organization located in Cambridge, MA and Portland, OR and formed in 1976.

Across the fields of behavioral health, intellectual and developmental disabilities, and child welfare, we:

- Partner with leaders and change agents to identify best practices, add value, and solve problems
- Help design robust, sustainable systems based on qualitative and quantitative data
- Assess new and better ways to serve and support people by studying the viability of emerging practices
- Engage service users and other stakeholders early and often in our processes

North Dakota Behavioral Health Systems Analysis Work Plan

Human Services Research Institute, March 17, 2017

Project Goal: Support the State in ensuring a 21st century behavioral health system driven by quality and scientific merit, efficient in coordinating service provisions across agencies, and focused on outcomes leading to recovery with minimal barriers to access.

Project Scope: In this work plan, "behavioral health needs" refer to challenges related to mental health and/or substance use. "Behavioral health services" are those that a) promote social and emotional wellness, b) prevent or reduce the severity or incidence of mental health or substance use problems, and/or c) address existing mental health or substance use-related needs through treatment and support. The populations of focus include individuals of all ages who receive behavioral health services through the publicly funded behavioral health system.

Behavioral Health Systems Analysis Aims

The aims and associated research questions are outlined below:

Aim 1: Conduct an in-depth review of North Dakota's behavioral health system

1.1 What are the behavioral health-related needs of North Dakotans?
1.2 What behavioral health services are currently available to meet the needs of North Dakotans?
1.3 How do needs and access to behavioral health services differ by population group, including members of tribal communities, early childhood, youth and young adults in transition, justice-involved populations, persons with other disabilities, individuals who are homeless, nursing facility residents, military service members and their families, persons with traumatic brain injury, and the uninsured?
1.4 How does North Dakota's behavioral health system compare with national guidelines for comprehensive systems of care, including the use of evidence-based practices?

Aim 2: Analyze current utilization and expenditure patterns by payer source

2.1 What are the current utilization and expenditure patterns for behavioral health services in North Dakota, including mental health promotion, prevention and early intervention, evidence-based practices, community-based services, emergency room and inpatient, corrections-based care, and unreimbursed care?
2.2 How do utilization and expenditure patterns differ by payer source, including Medicaid, Medicare, and state and local funds?

Aim 3: Provide actionable recommendations for enhancing the comprehensiveness, integration, cost-effectiveness and recovery orientation of the behavioral health system to effectively meet the needs of the community

3.1 What behavioral health services should be adjusted, reduced, or added?
3.2 How can the State target behavioral health services to ensure they are meeting the needs of all population groups?
3.3 How can the State leverage multiple financing streams and target resources to meet the behavioral health needs of the community in as cost-effective a manner as possible?

Aim 4: Establish strategies for implementing the recommendations produced in Aim 3.

4.1 What management structures and processes will be required for implementing recommendations?
4.2 What financing options will fill the identified gaps in a sustainable way?
4.3 How should the State prioritize the recommended system changes?

North Dakota Behavioral Health Systems Analysis: Crosswalk of Past Recommendations

Human Services Research Institute, September 2017

The following table compiles past recommendations made in recent reports, presentations, and work groups related to improving the behavioral health system in North Dakota. This synthesis is one part of an ongoing *Behavioral Health Systems Analysis* being conducted by the Human Services Research Institute (HSRI) for the North Dakota Department of Human Services. The overall project aims are to 1) conduct an in-depth review of the State's behavioral health system, 2) Analyze current utilization and expenditure patterns, 3) Provide actionable recommendations for enhancing the comprehensiveness, integration, cost-effectiveness, and recovery orientation of the behavioral health system to effectively meet the needs of the community, and 4) Establish strategies for implementing those recommendations. Project activities include an in-depth review of existing reports and data, analysis of claims and service utilization data, and key informant interviews with a range of stakeholders including service users and families, providers, advocates, and state and local agency administrators.

Sources and Recommendations

The following documents were identified as recent, key sources that outlined recommendations for improving behavioral health systems. The recommendations included in the table below are grouped into overarching categories. There has been some progress made toward some of these recommendations and not others. Our continuing project work will chart progress and explore barriers and facilitators to that progress.

A. Bossing, L. Legal Obligations for Behavioral Health Services: What's at Stake for North Dakota? Judge David L. Bazelon Center for Mental Health Law. http://www.mhan.org/reports-presentations/lewis-bossing-legal-obligations-for-nd-bh-system/
B. Mental Health Advocacy Network. Let's Hear it From the People: The State of Mental Health Care in North Dakota. http://www.mhan.org/wp-content/uploads/2017/04/MHAN%20Hear%20it%20From%20the%20People.pdf
C. North Dakota Behavioral Health Stakeholders (2016). Summary Report: November 2015 Behavioral Health Stakeholders Summit. https://ruralhealth.und.edu/projects/nd-behavioral-health/pdf/summary-report-nov-2015.pdf
D. North Dakota Department of Human Services Behavioral Health Division (2016). North Dakota Behavioral Health Assessment: Gaps and Recommendations. https://www.nd.gov/dhs/info/pubs/docs/mhsa/nd-behavioral-health-assessment.pdf
E. North Dakota Hospital Association (2016). 2017 Issue Brief: Behavioral Health. https://www.ndha.org/image/cache/NDHA-Issue_Brief_-_Behavioral_Health.pdf
F. Schulte Consulting (2014). Behavioral Health Planning Final Report. http://www.ndpanda.org/news/docs/20140722-behavioral-health.pdf

Note: The recommendations included here do not necessarily represent the recommendations that will be delivered in HSRI's final report. HSRI's final recommendations will be informed by past recommendations and based on our own qualitative and quantitative data analysis.

#	Recommendation	Sources
Provider Credentialing and Training		
1.	Expand professional credentialing and reimbursement practices (e.g., Marriage and Family counselors, other Masters-level practitioners)	F
2.	Establish reciprocity with other states in credentialing policies	F
3.	Establish credentialing for prevention, screening, use of evidence-based practices (EBPs)	D
4.	Make all educational requirements available within state, preferably online	F
5.	Streamline and standardize requirements of various licensing boards	F
6.	Standardize policies and procedures related to job vacancies	F
7.	Increase education opportunities/internships for behavioral health providers, including training in EBPs	C,D,F
8.	Increase/mandate behavioral health-related training for law enforcement (e.g. Crisis Intervention Team training), emergency personnel, and corrections staff, with common curriculum for consistency	A,C,F
Workforce Expansion		
9.	Encourage hiring throughout the state, not just in Human Service Centers (HSCs)	F
10.	Recruit behavioral health professionals from out of state	A
11.	Create incentives for staff in workforce shortage areas	C,E
12.	Increase use of peer/family support and recovery coaches, with fair wages; partner peer support with case management	B,C,F
Crisis and Intensive Support Services		
13.	Increase after-hour options for treatment, including mobile crisis support in urban areas	A,F
14.	Ensure access for all levels of crisis services including assessment, in-home crisis response, short-term residential, and inpatient treatment	C
15.	Use telemedicine, (e.g. Electronic ICU model) for crisis assessments and response	F
16.	Better coordination between 911 and crisis services	A
17.	Establish and expand assertive Community Treatment (ACT)	A,F
Screening and Prevention		
18.	Increase funding and use of screening, e.g. Early Periodic Screening Diagnosis and Treatment (EPSDT) and Screening, Brief Intervention, Referral to Treatment (SBIRT)	A,C,D
19.	Increase resources for mental health promotion and serious mental illness prevention	D,E
20.	Develop a public awareness and education campaign	C
21.	Use Department of Transportation driving under the influence (DUI) data to identify individuals at risk of substance use disorders	D
Substance Use Treatment		
22.	Increase substance use treatment services including detox, possibly with block grant funding	C,F
23.	Establish oversight and expand drug and alcohol education, including first offenders of alcohol-related offenses	D
24.	Increase access to Integrated Dual Disorder Treatment (IDDT)	F

#	Recommendation	Sources
Schools and Children's Services		
25.	Improve coordination of care with education, early childhood and county service system for youth	D,F
26.	Develop a formal children's behavioral health leadership group	C
27.	Integrate behavioral health awareness, treatment, and care coordination in schools	C
Telemedicine		
28.	Increase use of telemedicine, including non-physicians	C,F
Critical Access Hospitals		
29.	Expand use of critical access hospitals for behavioral health services	F
Models of Care		
30.	Establish Person-Centered Care Model (e.g. Washington State)	C
31.	Increase disease management principles	D
Special Populations		
32.	Establish case management for homeless and justice-involved persons and individuals who are difficult to engage in services	C
33.	Establish formal structure for alternatives to incarceration at both state and local levels	C
Insurance, Reimbursement and Funding		
34.	Re-evaluate Essential Health Benefit package	F
35.	Determine if insurance coverage meets federal parity standards and conduct a parity-focused utilization review of substance use disorder treatment providers	C,F
36.	Decide between federal or state and private funding to fill gaps	F
37.	Apply for a 1915(i) state plan amendment or a 1915(c) waiver to increase Medicaid reimbursement for home and community-based behavioral health services	A,C,F
38.	Apply for a Medicaid 1115 demonstration project to expand coverage for behavioral health services	A
39.	Create integrated physical and behavioral health services including care coordination in Medicaid	F
40.	Seek additional federal funding for age 0 to 5 Visiting Nurses programs for behavioral health	F
41.	Change Medicaid definition of Partial Hospitalization to Outpatient	F
42.	Shift funding from "legacy" services to increase utilization, payment and infrastructure support for EBPs	F
Services Information		
43.	Standardize and distribute rules for uniform access to HSCs	F
44.	Create a comprehensive list of all services only provided by the Department of Human Services (DHS)	F
45.	Map current resource distribution outside the HSC system	F
46.	Create a public-facing repository or registry for all behavioral health services	C,D,F
47.	Create bed status database	C,F
48.	Streamline and standardize application processes including residential facilities	C,D,F

#	Recommendation	Sources
Electronic Health Records		
49.	Review record sharing options, e.g. Health Information Network	A,C,F
50.	Change regulations to accept electronic releases and treatment documentation across the system	F
Use of Data		
51.	Establish authority and resources to require and/or incentivize programs to submit data	D
52.	Include mental health and substance use data in proposed Health Data Hub	C
53.	Use universities or other current systems to build a cost and outcomes-based system	C,F
54.	Communicate data to stakeholders, decision makers and the public	D
Governance and Roles		
55.	Clarify public and private service system roles	D,F
56.	Communicate changes in public system functions to stakeholders and the public	D
57.	Increase oversight and accountability for contracts with an independent appeal process	F
58.	Increase legislative oversight of HSC system	F
59.	Create Intra-agency council for coordination of services	F
Advocacy, Rights and Choice		
60.	Create an independent/conflict-free consumer appeal and grievance process	B, F
61.	Strengthen advocacy voices, including on the Behavioral Health Planning Council	C,F
62.	Privatize case management to add choice	C,F
63.	Establish vouchers for private choice, including Scattered-Site Supported Housing	A,B,C

Behavioral Health Workforce Development (SB 2015)

The Center for Rural Health has been contracted by the North Dakota Department of Human Services, Behavioral Health Division to develop an action oriented behavioral health workforce development plan. The intent of this plan is to prioritize and expand on recommendations from the various behavioral health reports and assessments done recently in North Dakota. The workforce development planning process will included two main goals.

- The **first goal** will be to create a comprehensive plan for increasing behavioral health providers that will include prioritized recommendations and actionable steps. To accomplish this the Center for Rural Health will be distributing a survey to prioritizing the recommendations made by previous assessments. The information from the survey will be used to facilitate stakeholder work groups to assist with expanding on the recommendations and clarifying the process needed to execute the proposed recommendations. The expanded information from the work groups will be compiled into a final development plan that will propose strategies for increasing behavioral health workforce and identify key outcome metrics.

- The **second goal** of the workforce development is to facilitate the development of a Peer Support Specialist Certification. Peer Support Specialist is an identified workforce development strategy currently utilized by over 30 states. A Peer Support Specialist is an individual with lived experience of either mental illness or substance use disorder who is in recovery and trained to support others in non-clinical, person-centered and recovery-focused ways. The Peer Support Certification development is being done simultaneously with the development of the larger plan due to the fact that Peer Support has been so frequently identified as a mechanism to address workforce shortages and the certification creates an crucial entry level behavioral health position. To develop the certification the Center for Rural Health has reviewed the training and certification process for numerous other states. The review of other state processes will now be utilized to develop North Dakota certification standards, certification processes, and provide technical assistance to support the adoption of peer support services.

Center *for* Rural Health

North Dakota Survey of Behavioral Health Workforce Interventions: Impact and Likelihood

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Survey Method

Survey period: November 27, 2017 – December 15, 2017

- Reminder sent December 6, 2017

Electronic survey disseminated to all North Dakota behavioral health stakeholders – snowball sample (no exclusion criteria)

- Center for Rural Health electronic newsflash
- North Dakota behavioral health stakeholder email listserv
- Behavioral health licensing boards
- North Dakota Department of Human Services

Survey conducted by the Center for Rural Health under funding from the North Dakota Department of Human Services

UNIVERSITY OF NORTH DAKOTA

During 2014-2016, multiple reports addressed the need for behavioral health services in North Dakota. Recommendations from these reports have been reviewed and combined into a comprehensive list of recommendations dealing specifically with behavioral health workforce development. In order to identify actionable proposals for the State, we ask that you identify the impact and likelihood of each.

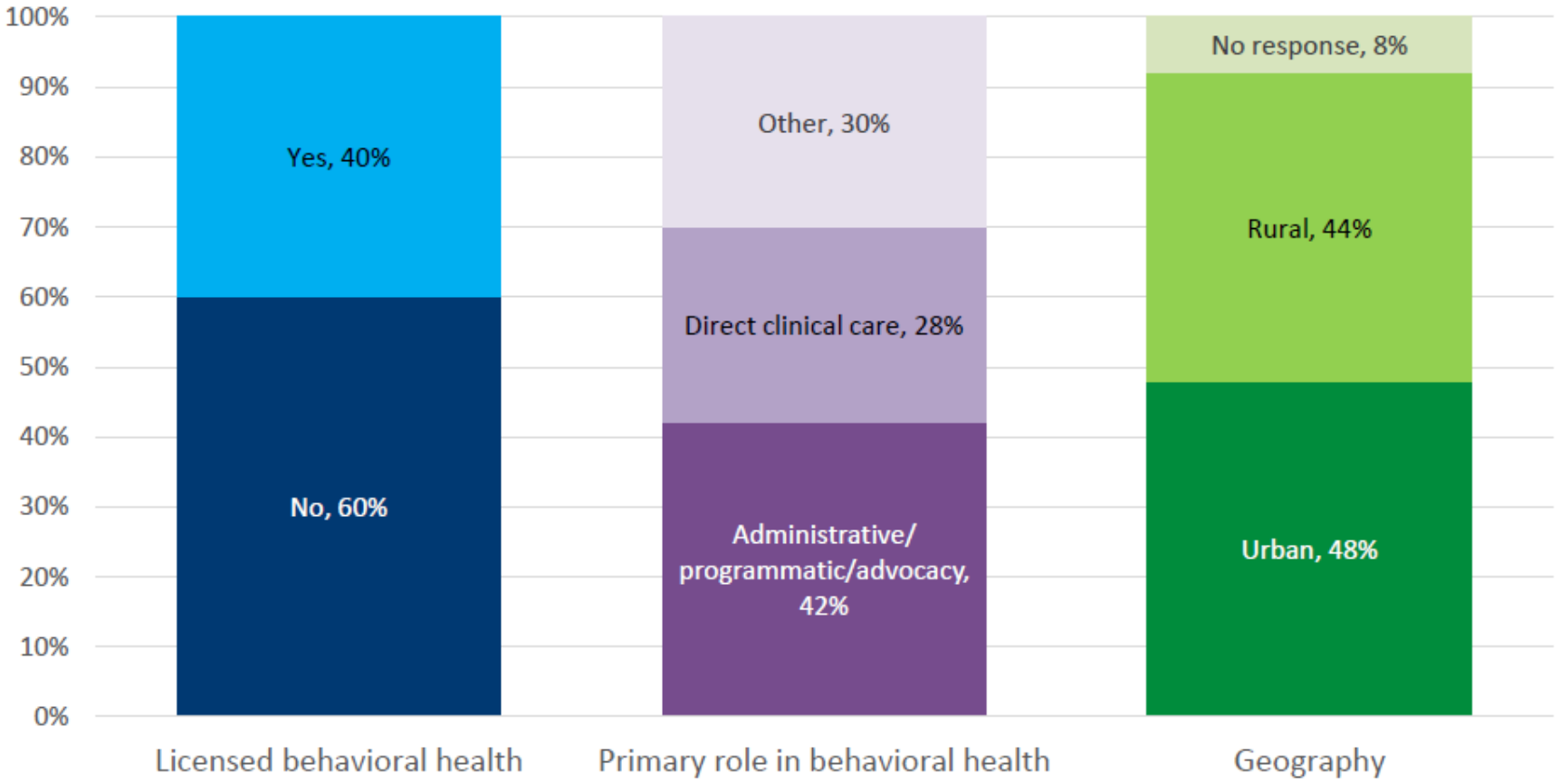
	Impact: How great of an impact would each of the proposed interventions have on increasing the available behavioral health workforce in North Dakota?	**Likelihood:** How likely is it, given the current environment in North Dakota (political, economic, social, demand) that each of the proposed interventions could be implemented within two years?
Develop a single electronic database of available statewide vacancies for all professional behavioral health provider types. The registry would not serve as a licensing authority, but as a separate tracking mechanism.		
Tuition assistance for behavioral health students, to include internship stipends and other financial assistance for those working in areas of need in North Dakota.		
Review the State Loan Repayment Program (SLRP) and identify opportunities to transition the program away from loan repayment, and into student scholarship with a required service component post-graduation.		
Educate behavioral health providers on the benefits of student internships and rotations, growing a statewide list of available student placements for all behavioral health provider types. This will include identifying financial incentives, or cost coverage, for facilities willing to host behavioral health student internship/rotations.		
Provide opportunities for, and require, behavioral health training for health providers, teachers and daycare providers, law enforcement, correction officers, and other employees within the criminal justice system.		
Integrate behavioral health prevention screenings, which are reimbursable, into primary health.		
Establish behavioral health licensure reciprocity with bordering states in an effort to recruit and grow the		

Response

506 responses; cut all respondents who only answered demographic questions

- Final response (*n*) = 284

Figure 1. Respondent Demographics (n=284)



Strategic Initiative Behavioral Health

Behavioral Health in North Dakota
Primary Initiatives/Leaders

PREVENTION

Governor's Prevention Advisory Council (GPAC)

A Day For Prevention

- Data
- Communication
- Strategy/System
- Workforce Development

TREATMENT

Public Behavioral Health Service System (Field Services)

Behavioral Health Division (Policy and Workforce Development)

NGA Learning Lab: Improve outcomes and reduce cost

RECOVERY

Recovery Reinvented

Free Through Recovery

Peer Support

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)

Human Services Research Institute (HSRI) Assessment: North Dakota Behavioral Health Systems Analysis

Senate Bill 2015 $500,000 to create, initiate and facilitate the implementation of a strategic plan to increase the availability of all types of behavioral health services in all regions of the state

Children's Behavioral Health Task Force (Senate Bill 2038)

Mission: To improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services, linked with effective community supervision.

Key Principles:

- Recidivism is reduced by attending to criminogenic risk and need.
- Recovery from substance use and mental health disorders is a process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential.

Outcomes:
Stable Housing
Stable Employment
Recovery
Reduced Criminal Justice Involvement

Reimbursement:

- Providers will be paid a base rate per participant, per month, for providing care coordination and recovery services, including peer support.
- Providers may receive an additional 20% per participant per month for each participant who meets at least 3 out of the 4 identified outcomes.

FREE THROUGH Recovery

Program Implementation:

January 22-26 – care coordination training
January 29-February 2 – peer support specialist training
February 1 – Client services begin

Thirteen providers ready to serve 530-565 individuals across ND.

Providers:

Lutheran Social Services (75-80)
Community Options (105)
Community Medical Services (45)
STAND (18-23)
Native American Development Center (20)
F5 Project (45-50)
Elliott Kabanuk (15-30)
Fraser Ltd. (20)
Warriors of the 21st Century Re-Entry Program (55)
Face It Together (27)
Heartview Foundation (40)
Redemption Road (50)
Lighthouse Church Fargo (25)

Capacity by Region:

Fargo	237-267
Bismarck	150-155
Minot	40
Dickinson	10
Jamestown	15
Williston	15
Devil's Lake	15
Grand Forks	28
Cando	20


Thank you!
Questions?