Testimony

Senate Bill 2012 – Department Of Human Services
House Appropriations Human Resources Division
Representative Pollert, Chairman
February 23, 2007

Chairman Pollert, members of the House Appropriations Human Resources Division, I am Nancy McKenzie, Director of the Regional Human Service Centers (HSCs) for the Department of Human Services (DHS). I am here today to provide you with an overview of statewide service trends and programmatic direction in the (8) regional centers. Your committee will receive specific testimony from each of the center directors.

Human Service Centers

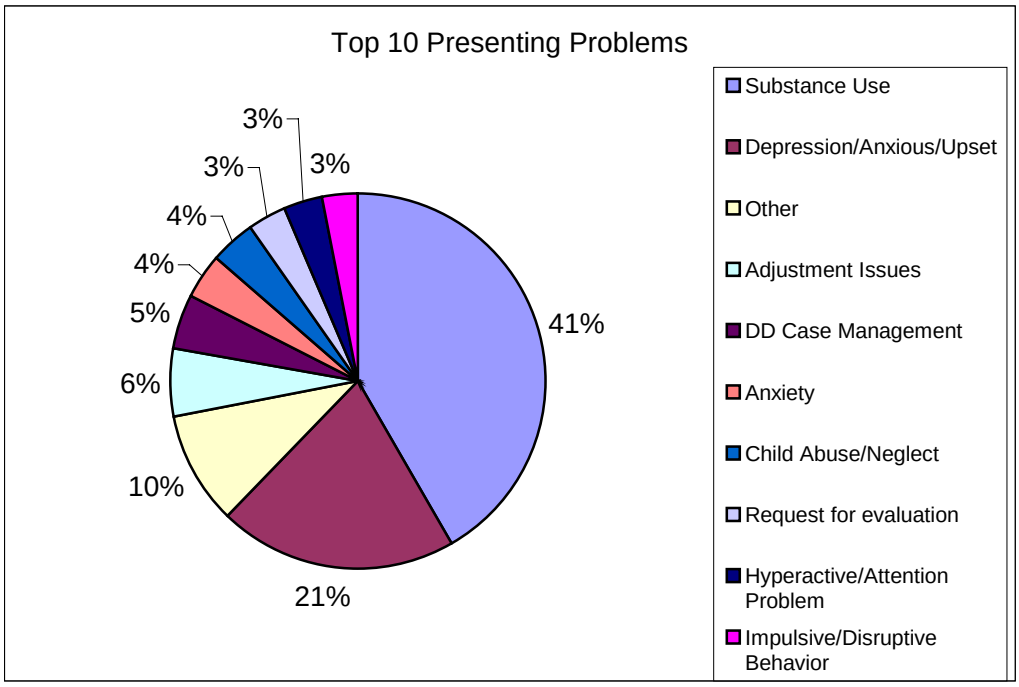
- Each of the Human Service Centers provides identified core services in the community for individuals whose illness, addiction, disability or conditions place them at risk of harm or institutional placement. They provide a safety net function for our most vulnerable citizens and insure that required services can be accessed.
- In addition to direct evaluation and treatment services, the HSCs are responsible for program supervision and regulatory oversight of the child welfare services provided by county social services and oversight of the Aging Services programs in their regions.
- The centers function as a network of clinics providing community based services. It is the Department's goal to continually improve alignment across the regions, implement common quality measures, and assess/share resources.

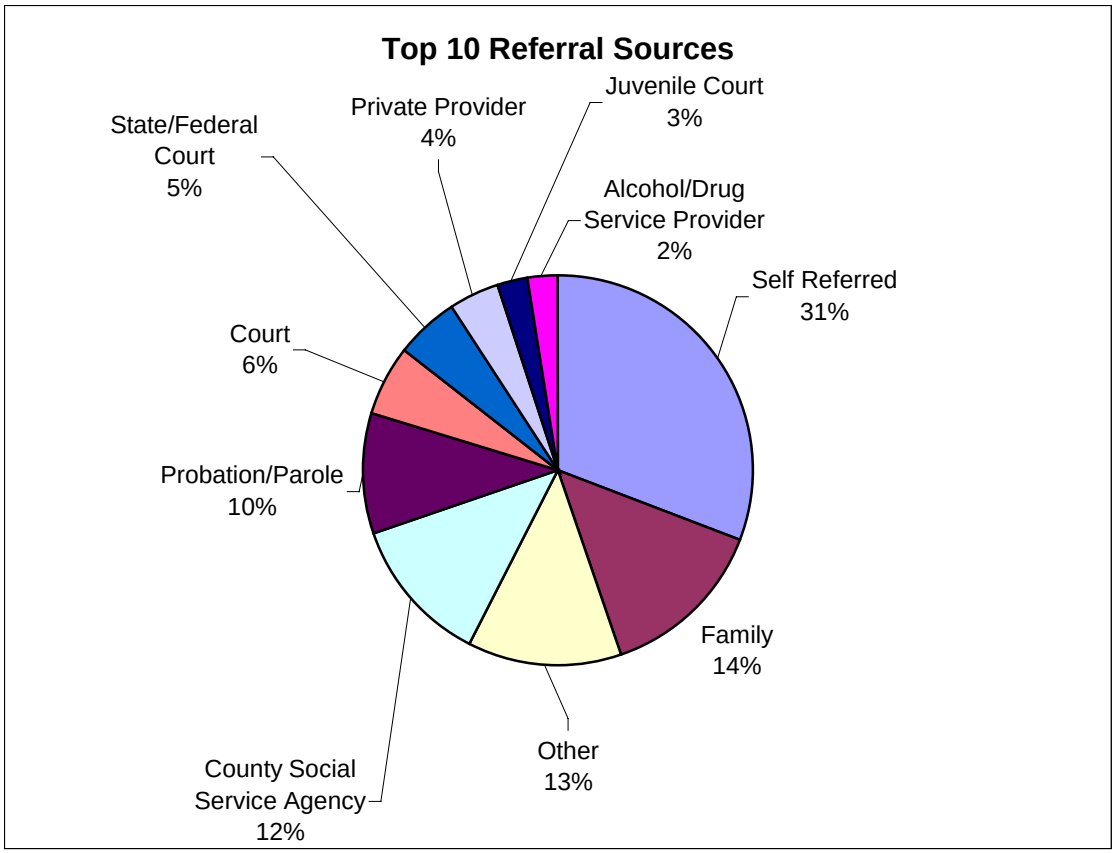
Clients Served

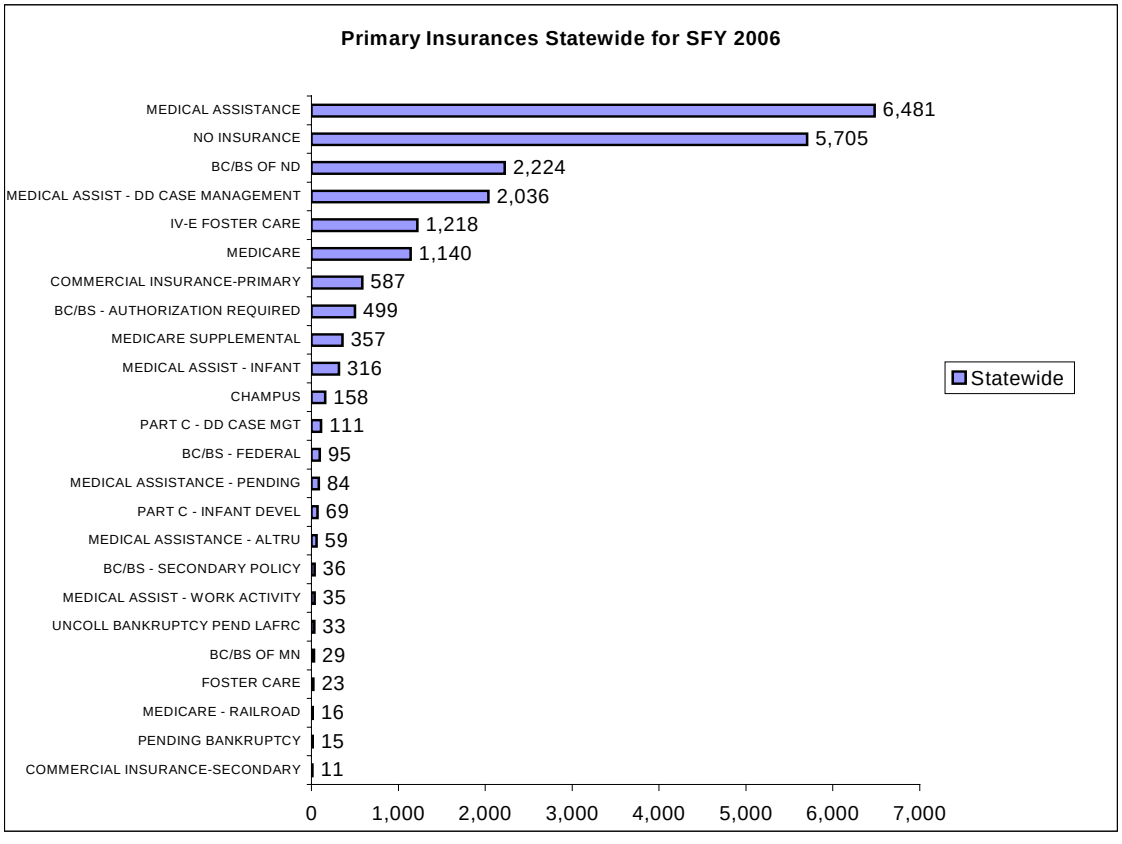
Demographics of those served in State Fiscal Year 2006 include:

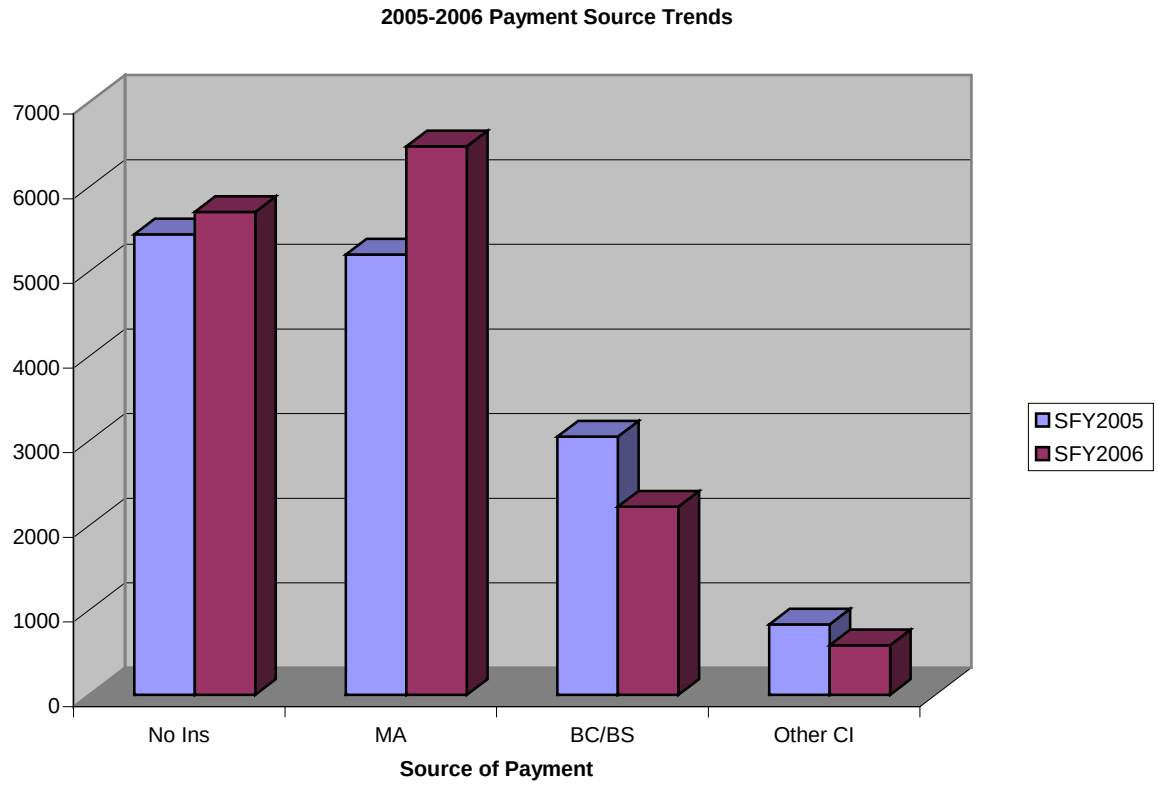
- Over 24,000 individuals were served (excluding Vocational Rehabilitation (VR)); this is nearly 4% of the state's population.
- The total number served is consistent with SFY 2005; this was an increase of just under 4% (890) individuals over SFY 2004.
- During the same period, VR served 7,939 clients, many of whom also received other HSC services.
- 68% of HSC clients qualify for no fee on the sliding fee scale; of those, 13% have no 3rd party payment source.

The HSCs truly perform a safety net function in the communities. The following charts further show the demographics of statewide HSC clients.




Top 10 Referral Sources
Juvenile Court 3%
Private Provider 4%
State/Federal Court 5%
Alcohol/Drug Service Provider 2%
Self Referred 31%
Court 6%
Probation/Parole 10%
Family 14%
Other 13%
County Social Service Agency 12%


Primary Insurances Statewide for SFY 2006
MEDICAL ASSISTANCE 6,481
NO INSURANCE 5,705
BC/BS OF ND 2,224
MEDICAL ASSIST - DD CASE MANAGEMENT 2,036
IV-E FOSTER CARE 1,218
MEDICARE 1,140
COMMERCIAL INSURANCE-PRIMARY 587
BC/BS - AUTHORIZATION REQUIRED 499
MEDICARE SUPPLEMENTAL 357
MEDICAL ASSIST - INFANT 316
CHAMPUS 158
PART C - DD CASE MGT 111
BC/BS - FEDERAL 95
MEDICAL ASSISTANCE - PENDING 84
PART C - INFANT DEVEL 69
MEDICAL ASSISTANCE - ALTRU 59
BC/BS - SECONDARY POLICY 36
MEDICAL ASSIST - WORK ACTIVITY 35
UNCOLL BANKRUPTCY PEND LAFRC 33
BC/BS OF MN 29
FOSTER CARE 23
MEDICARE - RAILROAD 16
PENDING BANKRUPTCY 15
COMMERCIAL INSURANCE-SECONDARY 11
0
1,000
2,000
3,000
4,000
5,000
6,000
7,000
Statewide



A composite client representing the most common attributes of an individual served in SFY 2006 would be male, approximately 32 years old, at 100% or below of poverty level, based on income and household size. He would qualify for 100% discount on the sliding scale fee, would likely have no insurance at all, and is probably not Medicaid eligible. Primary diagnosis would be in the substance abuse category, with strong possibility of co-occurring psychiatric problems such as depression. The most likely services provided would be nursing services, addiction evaluation and treatment, medication review and case management.

Statewide Trends

- Demand for services tends to exceed current capacity. For example, with State Hospital occupancy frequently exceeding 100%, local hospitals under contract with the HSCs experience longer lengths of stay, placing additional burden on those facilities

and causing disruption to client flow. Local crisis bed and residential program capacity are limited.

- Referrals from the correctional system continue to increase, as the Department of Correction and Rehabilitation (DOCR) and the Parole Board work to establish appropriate alternatives to incarceration, or follow-up treatment services for individuals under their supervision. The HSCs do serve this population; however, capacity issues have resulted in limitations.
- Providing treatment for the HSC population continues to be very complex, with approximately 15% of clients diagnosed with both mental illness and substance abuse. In addition, many substance abuse clients use multiple substances. These individuals need services wrapped around them in the community, to support their stability, minimize symptoms, and decrease potential for hospitalization.
- Growth has continued in referrals for infants/children with special needs. During the current biennium, the Department contracted with a private provider for Infant Development services in order to better meet growth needs in this area.
- The HSCs have fallen behind in their ability to compete for professional staff in the marketplace. Staff vacancies in hard-to-fill positions result in longer client wait times.

Accomplishments

I am pleased to report progress in several initiatives undertaken by the Human Service Centers:

- Evidence-based practices are being implemented/piloted in all of the centers, including Matrix Model for individuals whose primary drug of choice is methamphetamine, Recovery Model for individuals

with serious mental illness, and Integrated Dual Disorders Treatment for individuals with co-occurring substance abuse and mental illness.

- Expanded residential bed capacity in the Jamestown region will allow for transition of 21 additional State Hospital patients to the community by summer 2007.
- The Department is regularly meeting with DOCR staff to assess service needs of common clients and determine priorities. This closer collaboration will result in better joint strategic planning, reduced program duplication, and improved treatment services.
- Likewise, DHS is working more closely with the ND Long Term Care Association to determine possible partnerships that would utilize available basic care beds to meet residential needs of some of our clients, with ongoing psychiatric consultation and support from the HSCs. This, too, would be a mutually beneficial arrangement for both systems.
- New models of service delivery such as telemedicine are being piloted and explored for potential expansion. This can have very positive outcomes for our rural state and for individuals who have difficulty accessing needed treatment.
- Electronic data systems are producing service reports with increasing accuracy and usefulness for managerial planning/decision-making. For example, all centers are using common measures to insure maximum use of resources; this data can be used to identify resource needs and determine potential shifts/savings.

Overview of Budget Changes – Human Service Centers Combined

Description	2005 - 2007 Current Budget	Changes	2007 - 2009 Executive Budget	Senate Changes	Request to House
HSCs / Institutions	115,075,502	12,843,150	127,918,652	294,232	128,212,884
General Funds	53,817,232	10,453,546	64,270,778	263,173	64,533,951
Federal Funds	55,098,428	2,318,572	57,417,000	31,059	57,448,059
Other Funds	6,159,842	71,032	6,230,874	0	6,230,874
Total	115,075,502	12,843,150	127,918,652	294,232	128,212,884

FTE	829.48	9.25	838.73	-	838.73

Budget Changes from Current Budget to the Executive Budget:

The major increases can be explained as follows:

- The Governor's salary package recommendation requires $6.5 million total funds (50% of the overall increase) with $4.3 million being from the general fund.
- Increased FTEs to meet capacity needs in treatment services, drug court efforts, and sex offender services. $0.9 million total funds with $0.6 from the general fund.
- Other salary changes have been required to meet critical market shortages or to provide temporary staff to meet increased demand and to fund the current biennium year two increase for 24 months - $1.7 million, approximately $1.1 million from the general fund.
- Operating increases in rent, utilities, IT telephone services and motor pool costs have increased the budget by just over $650,000 due to increased rates as well as need for additional space for growing programs. (approx. $400,000 is general fund)
- In order to better provide more appropriate levels of care and reduce dependence on inpatient treatment locally and at the State

Hospital, the budget includes funding for additional crisis beds in the Fargo region, transitional living beds in the Grand Forks region, short-term residential beds in the Bismarck region, and long term residential beds in the Jamestown region - $3.0 million total funds with $2.4 million from the general fund.

- Funding for a 3% inflationary increase each year of the biennium for contract services - $0.9 million total funds with $0.8 million from the general fund.
- The above increases are offset by the bond issue for the Southeast HSC being paid in full December 2008 resulting in a $0.5 reduction in bond costs (approx. $300,000 general funds) and reductions in overall operating costs of about $275,000 in total funds (approx. $175,000 from the general fund.)
- The remaining increase in general fund is the result of the decrease in the Social Services Block Grant (SSBG).

Senate Changes:

- The changes made by the Senate are related to increasing the inflation to providers from 3% in the Executive Budget to 4% each year of the biennium.

In summary, while increased demand and client complexity have presented challenges, the HSCs have taken a number of positive steps to meet needs in a cost-effective manner. The 2007-2009 budget before the House will allow us to continue and improve those efforts. This concludes my overview testimony for the Human Service Centers. I would be happy to answer any questions.