**Testimony**
**Human Services Committee**
**Representative Chuck Damschen, Chairman**
**August 28, 2014**

Chairman Damschen, members of the Human Services Committee, I am Maggie Anderson, Executive Director of the Department of Human Services and I appear before you to provide the Department's response to recommendations in the consultant's final report for the study of behavioral health needs of youth and adults in North Dakota and plans to implement the recommendations involving the Department.

To facilitate the Department's input, I have copied the recommendations from the consultant's report and added a column for the Department Response.

**Goal 1: Improve access to services:**

| **Strategy** | **Who is responsible** | **Financial Options** | **DHS Response** |
|---|---|---|---|
| 1. Use of telemedicine | DHS; legislature; providers; advocates; consumers and families | Federal grants like HRSA; Insurance community reinvestment | DHS currently provides 54 hours of telemedicine each month, and there are several private providers that do so also. By the end of the biennium, all Regional Human Service Centers will have the technological capabilities to provide telemedicine in the regions. |
| 2. Use of critical access hospitals (CAH) for BH services | DHS; legislature | Current CAH funds allow BH services | The Department is willing to partner with critical access hospitals. |
| 3. Create bed management system<br>MN Model | DHS; legislature | State funding | The Department will include this topic on the agenda for the Regional Advisory Council and Coordinating Committee meetings for discussion and input. |
| 4. Utilize HCBS waivers for MHSA services<br>MT Model | DHS; legislature | Federal Medicaid funding; DHS note: and general funds needed for match (FMAP) | DHS has been exploring the 1915(i) Medicaid state plan amendment option for mental health services. DHS will continue working on this option with the Centers for Medicare and Medicaid Services. |

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| 5. Increase substance abuse services including detox | Legislature; DHS; Governor | SAMHSA block grant; state funding; alcohol tax; private funding | The Department has struggled to fill addiction counselor positions in Western ND. DHS has contracted with a private provider in the NW Region. In addition, we are implementing staffing plans where staff from other regions will travel to the Western areas to assist in providing services; and we are exploring the use of telemedicine from the NE Region to provide addiction evaluations.<br><br>The Department is facilitating meetings with local (Bismarck/Burleigh) law enforcement officials, hospital administrators and staff, and private and public treatment providers with regard to detox (intoxication/withdrawal management) services. The intent of the meetings is to develop a needs assessment and community approach to establishing a detox model that can be replicated across the state. The Department also has a contract with Clay County, MN, for detox services. This arrangement has served as a mutually beneficial partnership and this partnership will help as we formulate the eventual model noted above.<br><br>Department staff members from NEHSC have also been engaged in a community detox services committee. The committee includes representation from the city, county, hospital (Altru) and NEHSC and they have a business plan developed for social detox in Grand Forks.<br><br>WCHSC Licensed Addiction Counselors (LAC) are providing addiction evaluations for BLHSC clients via telehealth. The LAC is at WCHSC and the client is at BLHSC. |

**Goal 2: Conflict-Free case management**

| Strategies | Who is Responsible | Financial Options | DHS Response |
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| 1. Increase access to IDDT- expand | DHS; legislature; Governor | State funding; private contract options; discontinue less effective services and transfer funds. | IDDT (Integrated Dual Disorder Treatment) is available state-wide through the public (Human Service Center) system. The maturity of the program varies by region and there are wait lists for the service in some regions. Capacity needs are being discussed as the Department prepares its 2015-17 budget request. |

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| 2. Privatize case management to add choice | DHS; Legislature; Governor | Cost savings; transfer cost to private or county providers. DHS NOTE: Allowing private providers to bill for case management for the seriously emotional disturbed and the seriously mentally ill would not be a cost savings. | This is a targeted, intensive case management services for individuals who are seriously emotional disturbed (SED) and seriously mentally ill (SMI). The service includes being involved in all aspects of the consumer's life including housing, interactions with law enforcement, family and support network, as well as employment resources. |
| 3. Partner case management/care coordination with peer support | DHS; legislature; advocates; consumers and families | Use existing Recovery Center staff to assist in care coordination; state funds to grow peer support through private entities | Recovery Centers currently have a part-time peer support coordinator. Without knowing more about what is being proposed, DHS is not sure that peer support specialists could meet the qualifications set forth for Medicaid-funded SED/SMI targeted case management. |

**Goal 3: Access to crisis assessment**

| Strategies | Who is Responsible | Finance Options | DHS Response |
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| 1. Increase after hour options like Devils Lake NIATx walk in clinic | DHS; HSCs | | The Department agrees the walk-in clinic at Lake Region HSC has been successful. All HSCs are in the process of working with a consultant on strategies to implement walk-in clinics to decrease wait times and to promote engagement and retention of consumers.<br><br>Through a process improvement approach, other centers have also implemented other processes, such as the Central Intake process at SEHSC, which reduces wait times for intakes and consolidates various intakes into one evaluation; allowing the client to access treatment more rapidly. The UND psychiatric residents at SEHSC also take part in "crisis clinic" rotations. The Department agrees that evening intake evaluation times should be discussed statewide, and will need to plan steps that include registration, security, and support staff. |
| 2. Increase mobile crisis in urban areas after hours | DHS; HSCs | State funding; private contract options; block grant funding; adjust current work days/times | The Department agrees that the Crisis mobile public-private partnership has been very successful and is discussing this service as we prepare the 2015-17 budget request. |

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| 3. Use telemedicine for crisis assessments<br>IA model | DHS; legislature; providers; advocates; consumers and families | Federal grants like HRSA; Insurance community reinvestment11 | The Department currently provides telemedicine in various areas and supports expansion of this delivery model. DHS helped to launch private, contracted telebehavioral health services in North Dakota and currently, the public system is providing 54 hours per month of telepsychiatry with more planned.<br><br>WCHSC Licensed Addiction Counselors (LAC) are providing addiction evaluations for BLHSC clients via telehealth. The LAC is at WCHSC and the client is at BLHSC.<br><br>Dr. McLean, DHS Medical Director, has been working with the Department of Clinical Neuroscience at the UND School of Medicine on a proposal for psychiatric residents to conduct telebehavioral health for direct care (acute and chronic) as well as consultation to primary care providers. |
| 4. Model after eICUs to create ePsychiatry in the state | DHS; legislature; providers; advocates | Medicaid; Medicare; private insurance; insurance community investment | DHS has not had the opportunity to discuss how this idea may be supported through current or expanded tele-medicine efforts. |

**Opportunity 2: Expand Workforce**
**Goal 1: Oversight for licensing issues and concern**

| **Strategies** | **Who is Responsible** | **Finance Options** | **DHS Response** |
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| 1. Create an oversight system for licensing boards | Legislature | No funding required | |
| 2. Change Behavioral health professional definition in 25-03.2-01 for MA level like<br>IA model or two levels including practitioner level in MN model | Legislature; DHS | No funding required | The Department has not planned to address this through a request for definition changes. The Department understands the committee is considering a bill draft and will provide comments after we have been able to review the bill draft. |

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| 3. Create reciprocity language to "shall" accept all professional licenses meeting international and national accreditation standards and qualified state equivalent for each BH license | Legislature | No funding required | |
| 4. Make sure all educational requirements are available within state and preferably online for access | Legislature; Licensure Boards | Adjust course offerings to reflect required courses. | |

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

| **Strategies** | **Who is Responsible** | **Finance Options** | **DHS Response** |
|---|---|---|---|
| 1. Increase use of peer support and recovery coaches | DHS; providers; advocates | State funding; private contracts; federal grants; Medicaid | An expansion of peer support services was included in the Executive Budget request for 13-15. DHS is discussing this area as we prepare the 2015-17 budget request. |
| 2. Increase training for law enforcement; emergency personnel, corrections and teachers using MH First Aid and other training | DHS; providers; advocates; legislature consider mandates for BH training | MH First Aid is a no cost program<br><br>State funding, county funding | Mental Health First Aid would have costs to train the trainers and provide the training. DHS has supported First Link to become a trainer and in August a group of people were trained. Higher Education has implemented Mental Health First Aid at the University level and one of the Federally Qualified Health Centers has a trainer on staff. |
| 3. Increase law enforcement in schools | Schools; advocates; providers; law enforcement | State funding; federal grants | |
| 4. Increase education opportunities for behavioral health providers | Universities; online learning | Re-prioritize existing courses to train new providers. | |

**Opportunity 3: Insurance Coverage Changes Needed**
**Goal 1: Increase funding options for services for youth and adults**

| Strategies | Who is Responsible | Finance Options | DHS Response |
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| 1.Re-evaluate Essential Health Benefit Package selected and unintended consequences | Legislature; DHS; and providers | None Needed<br>DHS Note: Adding services to the benefit plan may increase premiums paid on behalf of Medicaid Expansion enrollees. | DHS is reviewing any changes needed to the Medicaid Alternative Benefit Plan for the Medicaid Expansion population. |
| 2. Determine if insurance coverage meets federal parity standards | Legislature: DHS | None Needed | DHS is monitoring the application of the mental health parity standards; however, the insurance piece seems to be outside of DHS authority. |
| 3. Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps | Legislature; DHS | None Needed | DHS would need additional discussion about what the Legislature would want to consider for this. |
| 4. Determine what 3rd party payers should be covering | Legislature; DHS | None needed | DHS does not understand our responsibility with this item. |
| 5. Apply for Medicaid waiver for SDMI Population MT Model | DHS | Medicaid funding, may be state funding match | DHS has been exploring the 1915(i) Medicaid state plan amendment option for mental health services. DHS will continue working on this option with the Centers for Medicare and Medicaid Services. |

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

| Strategies | Who is Responsible | Finance Options | DHS Response |
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| 1. Change administrative code to reimburse qualified Behavioral Health Professionals as defined above.<br>IA Model | Legislature | Medicaid, 3rd party funders | ND Medicaid enrolls and reimburses services provided by Licensed Addiction Counselors, Licensed Professional Clinical Counselors, Licensed Professional Counselors, Licensed Independent Clinical Social Workers, Licensed Social Workers, Licensed Certified Social Workers, Behavior Modification Specialists, and Human Relations Counselors. |

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| 2. Increase funding to assist BH professionals in training, including LACs | Legislature | State funding; insurance reinvestment | DHS implements an array of strategies to address this issue, including accepting trainees at the Human Service Centers and the State Hospital. |

**Opportunity 4: Changes in DHS Structure and Responsibility**
**Goal 1: Build transparency and choice in services**

| Strategies | Who is Responsible | Finance Options | DHS Response |
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| 1. Create an independent appeal process for consumers<br>IA model | Legislature; advocates; families and consumers | Re-allocation of funds | After the Department's review of the recommendation and our current process, we would offer that we have an "independent consumer appeal process" as part of our existing appeals provisions. The consultant's report did not address the process that currently exists.<br><br>Generally, we do not see many appeals from the HSCs for services denied. This is likely because the nature of the HSCs is to do everything they can to provide a service and we don't have a lot of denials.<br><br>The Iowa code cited includes the following:<br><br>If a person appeals a decision regarding a service authorization or other services-related decision made by a regional administrator that cannot be resolved informally, the appeal shall be heard in a contested case proceeding by a state administrative law judge.<br><br>This is the process currently used by the Department for appeals.<br><br>NDAC Chapter 75-01-03, which contains the Department's appeals provisions, is under review – and the Department will keep the recommendation in mind as we update the chapter to ensure our current process is clearly articulated. |

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| 2. Standardize and distribute rules for uniform access to HSCs | DHS; Legislature oversight; advocates; families and consumers | No funding needed | DHS would need additional information on what is intended and how "uniform access" is defined. |
| 3. Encourage hiring throughout the state not just in HSCs | DHS; Providers; advocates | No funding needed | The Department has a large number of contracts with private providers for various services throughout the state. The Department will continue to look for partnerships with private providers. |
| 4. Increase oversight and accountability for contracts with an independent appeal process | DHS; Legislature | State funds, re-allocation of funding prioritizing oversight over provider function | DHS uses a contract monitoring process, and most, if not all, contracts include deliverables, expectations and/or outcomes. If services do not meet contract terms, DHS will initiate action to correct, or where necessary, to terminate the contract. |
| 5. Create list of all services only provided by DHS | DHS; legislative council; legislature oversight | Staff time | The Department has an existing list of core services; however, we do not have information on the services provided by each private provider. Would need discussion about the expectations for the list (posting, updating, fielding questions, etc.). |

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

| **Strategies** | **Who is Responsible** | **Finance Options** | **DHS Response** |
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| Change HSCs to oversight and regulatory functions only like ND DD system | DHS; Legislature | Re-allocation of funds | Currently, the public system is often referred to as a "safety net" meaning when there is nowhere else to go, services are provided. We work closely with private partners to minimize referrals to high-level, institutional services. HSCs were developed to be "one stop shops" for those who need behavioral health services, and the structure lends to continuity of care. This model has been noted as a positive approach by block grant reviewers in the past. HSCs are known by many for their use of collaboration, consultation, care coordination, and case management efforts.<br><br>The overarching message from the consultant's report is the need for more services. Moving to public-funded services delivered by private providers will not in and of itself result in more services. It will only change who provides them. |

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| | | | If the decision is that public services be provided by private providers, this would be a significant undertaking. Just as deinstitutionalizing (institutional to community) required careful planning, moving the deinstitutionalized services currently provided by the regional HSCs to private providers will require in-depth planning to address the various transition needs. Of paramount importance for this most vulnerable population: assuring a seamless transition and continuity of care. |
| 2. Improve coordination of care with county service system for youth | DHS; Legislature; counties | Staff time; county and state funding; Chaffee funds | Currently, County Social Service offices use the Wrap Around process and Department staff are members of these teams. The Department would need additional information and input to understand the concern leading to the recommendation. |
| 3. If counties combine with State, create regional governance system NE Model | DHS; Legislature | State and county funding re-allocation | Each HSC has an Advisory Council and a Community-Coordinating Committee. Each of these two groups meets quarterly. Each county in the region has representation on the Advisory Councils. |
| 4. Legislative oversight of HSC system to uphold powers and duties outlined in 50.06-05.3 | Legislature and Executive branch | State funding re-allocation | |

**Opportunity 5: Improve Communication**
**Goal 1: Create an integrated system of care**

| **Strategies** | **Who is Responsible** | **Finance Options** | **DHS Response** |
|---|---|---|---|
| 1. Creation of Integrated health services including care coordination in Medicaid<br>IA Model- | DHS; Legislature | Federal Medicaid funding; state funding; block grants | DHS is very interested and is studying the various models to integrate behavioral health and primary care. |
| 2. Seek additional federal funding for age 0-5 programs like Head Start and Visiting Nurses for BH | DHS | Federal funding | DHS would need additional direction from the legislature about the intent of this recommendation. |
| 3. Strengthen Advocacy voices in ND | DHS; Providers; stakeholders; Advocates | No funding needed | This is not a DHS activity. |

**Goal 2: Improve record sharing**

| Strategies | Who is Responsible | Finance Options | DHS Response |
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| 1. Review record sharing options for ND and stream line | Legislative council; DHS; Legislature | Staff time | This appears to tie to the Health Information Network and DHS is involved in this, along with other providers. |
| 2. Change regulations to accept electronic releases and all other treatment documentation | Legislature; DHS | Cost reduction in printing and transportation | The Department will discuss this item at an upcoming field services meeting to determine current practices. |
| 3. Streamline application process for residential facilities | Legislature | Cost reduction in time and processing | This is a child welfare application and the Department will review the forms and process to determine how the process might be streamlined. |

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

| Strategies | Who is Responsible | Finance Options | DHS Response |
|---|---|---|---|
| 1. Intra agency council for coordination of services Idaho model | DHS; Corrections; DPH; Education; Vocational Rehabilitation; Veterans Affairs; DD and others. | Staff time, reallocation of priorities within departments | There are various committees, councils and task force groups in place today. The Department would welcome direction from the Legislature regarding the intent of this proposed council; and determine if an existing group should be changed, or if a new group is needed. |
| 2. Improve regional communication HSCs to all providers | Stakeholders/advocates lead; DHS at the table; Legislative Oversight | Staff time, re-allocation of resources | The Department agrees that we can always improve communication. Earlier in the year, I restructured the Public Information Office of the Department. As part of the restructuring, each of the two Public Information Specialists carry a portfolio of Department Divisions. One person is assigned to oversee the communication and public information areas of Field Services. This new structure is intended to assure more awareness of the services provided, ensure our messages are clear and consistent, and to make sure we "tell our story!"<br><br>The Department works very hard to communicate with our stakeholders, and the HSC Directors and Director of Field Services make extra efforts because of the collaboration necessary to operate the HSCs. Examples of these efforts include educating groups on HSC services, referral processes, |

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| | | | fees for services, department-wide biennial stakeholder meetings, public forums, surveys to clients, and providing the community with presentations on behavioral health topics such as depression, suicide prevention, and how to detect substance use in the workplace,. Each HSC also has an Advisory Council and a Community-Coordinating Committee. Each of these two groups meets quarterly. |
| 3. Standardize policies and procedures that foster better communication including job vacancies | DHS; Legislative oversight | Staff time | All state agency vacancies (including DHS) are listed on the State Human Resource Management System website. In addition, the Department is planning to move the link for job vacancies from the left navigation bar to a specialized launch box from its main web site. |

**Opportunity 6: Data Collection and Research**

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

| Strategies | Who is Responsible | Finance Options | DHS Response |
|---|---|---|---|
| 1. Create a provider registry GA model veterans model | DHS; Legislature | Staff time; possible state funding | The Department understands this is being considered by the committee and we are willing to participate in the discussion about and design of a registry. |
| 2. Give task of oversight to the group created to oversee licensure issues | DHS; Legislature | Staff time | This does not appear to be a DHS task. |

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

| Strategies | Who is Responsible | Finance Options | DHS Response |
|---|---|---|---|
| 1. Create a repository for services using First Link | Legislature; DHS; providers; advocates; stakeholders | Currently funded; state funding; private sources | The Department understands this is being considered by the committee and we are willing to participate in the discussion about and design of a registry. |
| 2. Map current resource distribution outside the HSC system | DHS; Legislature; advocates; stakeholders | State funds; current resources re-allocated | Same as above. |

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

| Strategies | Who is Responsible | Finance Options | DHS Response |
|---|---|---|---|
| 1. Use universities to build outcomes based system | DHS; Universities | Re-allocation of current funds<br>DHS Note: Not certain which funds would be re-allocated. | The Department would support working with external research staff to review public and private programs and services. |
| 2. Create list of "legacy" services and cost to state and consider reinvesting in evidence-based services | DHS; legislature; providers; advocates | Staff time; state funds | The Department does review services and evaluates outcomes and effectiveness. |