NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HUMAN SERVICES COMMITTEE

Tuesday, January 5, 2016
Harvest Room, State Capitol, Bismarck, North Dakota
Wednesday, January 6, 2016
Roughrider Room, State Capitol, Bismarck, North Dakota

Representative Kathy Hogan, Chairman, called the meeting to order at 9:00 a.m.

Members present: Representatives Kathy Hogan, Dick Anderson, Chuck Damschen, Alan Fehr, Curt Hofstad, Dwight Kiefert, Gail Mooney, Naomi Muscha, Kylie Oversen, Jay Seibel, Peter F. Silbernagel; Senators Tyler Axness, Dick Dever, Oley Larsen, Judy Lee, Tim Mathern

Member absent: Representative Bert Anderson

Others present: Vonette J. Richter, Assistant Code Revisor, Legislative Council
Joan Heckaman, State Senator, New Rockford
See Appendix A for additional persons present.

It was moved by Representative Seibel, seconded by Senator Dever, and carried on a voice vote that the minutes of the November 3, 2015, meeting be approved as distributed.

COMMITTEE RESPONSIBILITIES

Chairman Hogan said because health care workforce issues are being considered by both the interim Health Services Committee and the interim Human Services Committee, the Chairman of the Legislative Management has transferred the following responsibilities from the interim Human Services Committee to the interim Health Services Committee:

- Receive a report from the Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, State Board of Psychologist Examiners, State Board of Medical Examiners, and the North Dakota Marriage and Family Therapy Licensure Board regarding plans and any legislative changes necessary to implement those plans for administration and implementation of licensing and reciprocity standards for licensees (Section 1 of 2015 House Bill No. 1048).
- Receive a report from the Board of Addiction Counseling Examiners regarding the status of the periodic evaluation of the initial licensure coursework requirements and clinical training requirements (Section 4 of 2015 House Bill No. 1049).

Chairman Hogan said suggestions that were received by the committee at its November 3, 2015, meeting, relating to incarceration issues, including lower-level drug user sentencing and alternative treatment options have been forwarded to the interim Incarceration Issues Committee. She said the Incarceration Issues Committee is assigned to study cost-effective and evidence-based strategies to enhance public safety and properly manage corrections and supervision of populations.

Memorandum of Recommendations Provided to the Interim Human Services Committee During its November 3, 2015, Meeting

The Legislative Council staff presented a memorandum entitled *Recommendations Provided to the Interim Human Services Committee During its November 3, 2015, Meeting*. The Legislative Council staff said the memorandum summarizes the recommendations provided to the committee during its meeting on November 3, 2015.

The Legislative Council staff presented a bill draft [17.0036.01000] to add tobacco and nicotine to the definition of addiction counseling in North Dakota Century Code Section 43-45-01. The bill draft was prepared for committee discussion and the suggestion was made to the committee at its November 3, 2015, meeting.

The Legislative Council staff presented a bill draft [17.0049.01000] to add Downs syndrome to the definition of developmental disability pursuant to Section 25-01.2-01(1) relating to medical assistance eligibility. The bill draft was drafted for committee discussion and the suggestion was made to the committee at its November 3, 2015, meeting.

Chairman Hogan said the two bill drafts were presented at this meeting to allow committee members and other interested persons to review them before committee discussion of each bill draft. She anticipates the two bill drafts will be discussed at the committee's meeting tentatively scheduled for Tuesday and Wednesday, May 10-11, 2016, in Grand Forks.

Involuntary Commitment Case Law

Ms. Richter presented a memorandum entitled *Recent Involuntary Commitment Case Law*. She said the memorandum discusses a 1999 United States Supreme Court case relating to the application of the federal Americans with Disabilities Act to individuals with mental disabilities. She said the memorandum also discusses case law relating to other issues relating to involuntary civil commitment laws of other states.

Ms. Richter said the memorandum includes a chart relating to states' quality and use of involuntary treatment laws as determined by the Treatment Advocacy Center in 2014. She said North Dakota received an "A" for overall quality of laws, including an "A+" for inpatient commitment laws, a "B" for outpatient commitment laws, and an "A+" for emergency evaluation laws. She said North Dakota received a "C+" for its use of involuntary treatment laws.

Senator Mathern expressed a concern regarding the grade North Dakota received relating to the quality of outpatient commitment laws. He said the quality of outpatient commitment laws are important as the state moves towards having more community care options. He suggested the committee receive information from states that received a higher grade on the survey relating to the quality and use of their outpatient commitment laws and from treatment providers to determine if there are areas the state can improve.

Chairman Hogan said several providers at the November 3, 2015, meeting, suggested extending the emergency hold period for involuntary commitments from 24 hours to 72 hours. She asked the Legislative Council staff to review how other states address emergency hold time periods.

Chairman Hogan said the committee will continue discussion of commitment laws during its review of adult mental health issues at its next meeting. She said the committee will determine whether there are commitment laws that need to be changed or whether changes need to be made with how commitment laws are being implemented.

Department of Human Services - Additional Data Information

Chairman Hogan called on Dr. Rosalie Etherington, Superintendent/Administrator, State Hospital, to present information (Appendix B) regarding data for addiction and substance abuse treatment services that are provided at each of the eight regional human service centers and the State Hospital. She said all eight human service center locations provide substance use disorder outpatient and intensive outpatient treatment services for both adolescent and adult individuals, integrated dual disorders treatment (IDDT) services, and contract for multiple residential levels of care. She said the level of services vary at each of the eight human service center locations for other substance use disorder services, including social detoxification, medical detoxification, residential treatment, adolescent-supported housing, adolescent residential treatment, and population-specific residential treatment.

Dr. Etherington said there were 18,692 individuals that received at least one recorded service at the regional human service centers during the first quarter of fiscal year 2016. She said, of this total, 11,686 individuals received ongoing services for an identified program of care, 2,985 adult individuals received substance abuse disorder services, 245 youth individuals received substance abuse disorder services, 191 individual clients received IDDT services, 119 individuals were admitted to the State Hospital's medically managed substance abuse disorder program, and 84 individuals were admitted to the State Hospital's Tompkins Rehabilitation Center.

In response to a question from Representative Hofstad, Dr. Etherington said each regional human service center and the State Hospital determine what services to provide based on identified needs and the number of individuals seeking services at that location. She said each region has regional advisory councils that discuss services that may be lacking. She said the regional human service centers and the State Hospital also review services private providers may be offering in the region and determine any gaps in services. In addition, she said the level of funding determines availability of services at each regional human service center and the State Hospital.

In response to a question from Chairman Hogan, Dr. Etherington said the Department of Human Services will provide the committee members with information regarding data on the number of clients served by each addiction and substance abuse treatment service at each regional human service center and the State Hospital when the information is available. She said the current software used to store the electronic health records data is outdated; therefore, it is difficult to access the data. She said the department is in the process of updating the software with a new vendor.

STUDY OF FAMILY CAREGIVER SUPPORTS AND SERVICES

Challenges and Risks

Mr. Dan Hannaher, Legislative Affairs Director, Sanford Health, and Executive Director, Health Policy Consortium, presented information (Appendix C) regarding challenges and risks relating to family caregivers. He said Sanford Health has been working with AARP to find consensus on issues of mutual agreement to benefit patients after discharge from a medical facility. He said examples of recent initiatives in Fargo that have enhanced care to patients following a hospital stay include an initiative to partner with the New Life Center in Fargo to designate beds for a respite services program for the homeless to recover after a hospital stay or emergency room visit, and an initiative creating a Community Paramedic program that reduces the need for frequent ambulance services and emergency room visits from patients considered to be high-users because of chronic health conditions or other needs.

Ms. BevAnn Walth, Director of Case Management and Social Work, CHI St. Alexius Health, presented information (Appendix D) regarding current regulatory requirements for hospital discharge planning, including information relating to the current discharge planning process. Ms. Walth said hospitals are required to follow rules and standards for discharge planning, which are established by the federal Centers for Medicare and Medicaid Services and the federal Joint Commission. She provided information regarding current regulatory standards for discharge planning including the following:

- **Centers for Medicare and Medicaid Services - Conditions of Participation for Discharge Planning** (Appendix E) - Requires state surveyors to monitor and assess hospital compliance with regulations to improve quality and to protect the health and safety of beneficiaries.
- **Centers for Medicare and Medicaid Services - Proposed Rules for Discharge Planning** (Appendix F) - Requires additional documentation in a patient's medical records.
- **The Joint Commission - Provisions of Care, Treatment, and Services** (Appendix G) - Provides standards and elements of performance that require a measure of success that hospitals must be able to validate through written documents, collected data, and identification monitors.
- **Centers for Medicare and Medicaid Services - Value-Based Purchasing Program** (Appendix H) - Links Medicare payments to a value-based system to improve quality of care in the inpatient hospital setting.
- **Medicare - Important Message** (Appendix I) - Requires hospitals to provide certain information to patients regarding hospital discharge appeal rights.

In response to a question from Representative Fehr, Ms. Walth said when a patient is ready for discharge, the patient and family are given a written copy of discharge instructions. She said a nurse reviews the instructions and goes over the medications prescribed. She said the patient is also encouraged to allow the hospital to inform and include a family member or caregiver when discussing instructions and other information. She said a patient does have the right to request that a family member or caregiver not be notified. She said a patient and their family member or caregiver are usually encouraged to contact the hospital or the primary care physician if they have questions after they are discharged. She said, generally, a navigator or a coach will contact a patient within a day after discharge to see if there are any questions.

In response to a question from Chairman Hogan, Ms. Walth said patients in the Medicare Shared Savings Program and the new Comprehensive Care for Joint Replacement program have a nurse navigator or coach assigned to them. She said there are two types of coaches--a transition coach which operates in a hospital setting, and a population coach which operates in a clinical setting. She said patients have the option of not releasing medical information to their coach. She said the program began in October 2015.

In response to a question from Representative Oversen, Ms. Walth said regulations and standards determine hospital policies, but policies have to be based on best practices.

Chairman Hogan asked the Legislative Council staff to identify the number of hospitals in the state that have accountable care organizations. For those that do not, identify what type of similar program they are offering.

Family Support and Health Care Discharge Planning

Mr. Josh Askvig, Advocacy Director, AARP North Dakota, presented information (Appendix J) regarding family support and health care discharge planning. In addition, he submitted supplemental information (Appendix K) regarding a letter AARP submitted to the Centers for Medicare and Medicaid Services relating to the proposed rules for discharge processes. He said AARP conducted a telephone survey, an online survey, and a series of "listening lunches" in October 2015 to receive feedback from family caregivers relating to the hospital transition process. He said family caregiver respondents expressed concerns that included the need for family caregivers to receive more specific information and directions from a hospital when a patient is released, more hospital awareness regarding the level of care a patient needs after being discharged, and more information regarding who to call or ask when a family caregiver needs assistance.

Mr. Askvig said AARP has drafted model legislation which they refer to as the Caregiver Advise, Record, Enable (CARE) Act to address supports for family caregivers during a patient's transition from a hospital. He said other states have adopted the CARE Act or similar legislation. He said the CARE Act model recommends the following:

- **Designation of the Caregiver in the Medical Record** - Allows a patient or legal guardian the ability to designate a caregiver when being admitted to the hospital.
- **Notification to the Caregiver of Discharge** - Provides for a hospital to notify a family caregiver if a patient is being discharged or transferred to a different facility.
- **Instruction of Aftercare Tasks** - Creates a framework for a family caregiver to receive instructions for tasks the family caregiver will perform once a patient is discharged from the hospital.

Senator Lee and Senator Dever expressed concerns regarding the potential for the CARE Act to result in additional liability for hospitals.

Comments by Interested Persons

Mr. Askvig submitted testimony (Appendix L) provided by Ms. Marilyn Worner, family caregiver, related to the study of family caregiver supports and services. Ms. Worner's testimony reviewed her personal experience with challenges of her husband's discharge from the hospital. Her testimony expressed support for the need to receive clear and concise directions from the hospital before being discharged.

Mr. Askvig submitted testimony (Appendix M) provided by Ms. Penny Woodward, family caregiver, related to the study of family caregiver supports and services. Ms. Woodward's testimony reviewed her personal experience with her elderly aunt's hospital discharge. Her testimony expressed support for hospitals including family caregivers when providing discharge information to a patient.

Ms. Barbara Handy-Marchello, family caregiver, presented testimony (Appendix N) related to the study of family caregiver supports and services. She reviewed her personal experiences with family caregiving. She expressed support for the need for better communication between hospital staff and patients relating to discharges.

Mr. Mike Tomasko, State President, AARP North Dakota, presented information related to the study of family caregiver supports and services. He thanked committee members and others involved in this study. He expressed support regarding the importance of family caregiving.

North Dakota State University Extension Service - Status Update for the Family Caregiver Supports and Services Study

Dr. Jane Strommen, Extension Gerontology Specialist, North Dakota State University Extension Service, presented information (Appendix O) regarding an update on the status of the study of family caregiver supports and services. She said the study is currently on schedule. She said the research team selected three graduate students that will begin on January 11, 2016, to assist with the study. She said the research team has developed a plan to divide tasks among the three graduate students based on their experiences and strengths. She said the research team is identifying data resources and has met with AARP regarding its data from listening sessions and surveys, and has obtained initial approval from institutional review boards for accessing their data. She said information is being gathered relating to current family caregiver resources, services, and supports available to caregivers in the state. She said the research team is also reviewing articles and resources relating to best practice models and emerging practices and technologies for family caregiving.

STUDY OF BEHAVIORAL HEALTH NEEDS - EARLY CHILDHOOD BEHAVIORAL HEALTH CHALLENGES

Chairman Hogan called on Ms. Pamela Sagness, Director, Behavioral Health Services Division, Department of Human Services, and Dr. Etherington to present information (Appendix P) regarding children's behavioral health issues.

State Epidemiological Outcomes Workgroup

Ms. Sagness said the State Epidemiological Outcomes Workgroup (SEOW) was created in 2006. She said the SEOW mission is to identify, analyze, and communicate key substance abuse and related behavioral health data to guide programs, policies, and practices. She said the SEOW goal is to use data to inform and enhance state and community decisions regarding behavioral health programs, practices, and policies, and to promote positive behavioral health.

Ms. Sagness said based on survey data, the number of high school students who reported consuming alcohol within the past 30 days has fallen from 60 percent in 1999 to 30.8 percent in 2015. She said the National Survey on Drug Use and Health has identified approximately 3.54 percent of students between the ages of 12 and 17 in North Dakota as being alcohol dependent. She said the 3.54 percent represents the targeted group that need additional services. She said the number of high school students who reported using marijuana within the past 30 days has fallen from 19 percent in 1999 to 15.2 percent in 2015. She said the number of high school students who reported having taken a prescription drug without a doctor's prescription during their lifetime was 15 percent in 2009, 16.2 percent in 2011, 17.6 percent in 2013, and 14.5 percent in 2015. She said 29.4 percent of high school students reported gambling in the past 12 months. She said the department began collecting data in 2015 for the number of high school students that have reported gambling.

Ms. Sagness said the number of high school students that have reported feeling sad or hopeless decreased from 25 percent in 1999 to 17.1 percent in 2007. She said the number of high school students that have reported feeling sad or hopeless increased from 17.1 percent in 2007 to 27.2 percent in 2015. She said the number of high school students that have reported seriously considering attempting suicide within the past 12 months decreased from 18.8 percent in 1999 to 16.2 percent in 2015. She said the number of high school students that have reported making a plan about how they would attempt suicide within the past 12 months decreased from 14.3 percent in 1999 to 13.5 percent in 2015. She said the number of high school students reported to have attempted suicide within the last 12 months has increased from 6.4 percent in 1999 to 9.4 percent in 2015.

Effective Children's Behavioral Health System

Ms. Sagness said key factors for developing programs to address youth behavioral health include:

- Community-based;
- Family-driven;
- Youth-guided; and
- Culturally and linguistically competent.

Ms. Sagness said key principles for developing an effective youth behavioral health system include:

- Multi-system collaboration;
- Integration;
- Least restrictive;
- Resist criminalizing; and
- Broad array of services and supports that include accessibility, quality, tailored to youth and family, and strength-based.

Ms. Sagness said a total of 47 licensed private and public adolescent substance abuse treatment programs are operating in the state. She said 22 programs have 1 clinician, 11 programs have 2 to 3 clinicians, 5 programs have 4 to 5 clinicians, 2 programs have 6 to 9 clinicians, and 7 programs have 10 or more clinicians. In addition, she said the Behavioral Health Division of the Department of Human Services administers the voluntary treatment program that provides out-of-home treatment services for a Medicaid-eligible child with a serious emotional disorder. In this program, she said, a parent or legal guardian does not have to transfer legal custody of the child in order to have the child placed in an out-of-home treatment program when the reason for the placement is the need to obtain services for the child's emotional or behavioral problems.

In response to a question from Senator Mathern, Ms. Sagness said the purpose of the Parents Listen, Educate, Ask, Discuss (LEAD) program is to educate parents in an effort to prevent children from engaging in high-risk behaviors. She said the purpose of Parents LEAD for Professionals is to target individuals that have contact with a high-risk parent, including teachers, addiction counselors, social workers, or interested adults. She said material is available on the department's website at www.parentslead.org. In addition, she said the department provides information through presentations and media outlets. She said the Legislative Assembly appropriated $360,000 from the general fund for this program for the 2015-17 biennium.

In response to a question from Representative Fehr, Ms. Sagness said a sober living environment program is a place where those in recovery, whether new or long-term, have a supportive environment to live in. She said sober living environments are typically self-sustaining, require some startup costs, and generally require payments by those residence. She said a sober living environment is considered a community-based program.

In response to a question from Representative Mooney, Ms. Sagness said the North Dakota Board of Addiction Counseling Examiners does not consider gambling within the scope of services provided by a licensed addiction counselor.

Dr. Etherington said youth services provided through the human service centers include specialized rehabilitation services and specialized clinical services. She said the specialized rehabilitation services include:

- **Partnership Program** - A best practice service delivery model to improve youth function in home, school, and community.
- **Transition to Independence Program** - A research-supported model to assist with transitioning individuals between the ages of 14 and 21 to ensure the individual develops independent in-home and employment skills.
- **Supported Employment** - A best practice model to ensure individuals in need may develop necessary skills for competitive employment.

Dr. Etherington said specialized clinical services include:

- **Youth Residential Services** - Services that include psychiatric residential therapeutic services through the Ruth Meiers Adolescent Treatment Center in Grand Forks, residential child care services for females in foster care through Kay's Place in Minot, youth residential services through a residential treatment center in Bismarck, and treatment for youth with substance use disorder through PATH, Inc. in Fargo.
- **Substance Use Disorder Mothers and Children Program** - Services for a child while the child's mother is receiving addiction treatment.
- **In-home and Community Skills Training** - Services for parent-child education, parenting skills, and daily living skills training.
- **Court-ordered Services** - Services for parental capacity evaluation, sex offender risk assessment, and adolescent drug court.

Dr. Etherington provided information regarding public behavioral health services for children for the first quarter of fiscal year 2016. She said the average age of a child receiving services was 12 years old. She said there were 557 youth enrolled in a partnership program, 595 youth enrolled in federal Title IV-E foster care services, 245 youth enrolled in substance use disorder services, 695 youth receiving individual psychotherapy, and 1,292 youth receiving case management services.

Early and Periodic Screening, Diagnostic, and Treatment Services

Chairman Hogan called on Ms. Jodi Hulm, Children's Health Insurance Program and Health Tracks Administrator, Medical Services Division, Department of Human Services, to present information (Appendix Q) regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services in North Dakota, including the screening process, the number of children screened and the number identified with behavioral health issues, and the process of referring children for services and services authorized within the past year. She said EPSDT is a federally mandated health care benefit package, administered in partnership with each state, for approximately all Medicaid-enrolled children, ages 0 through 20. She said EPSDT is referred to as Health Tracks in North Dakota. She said the goal of EPSDT is early detection, prevention, and treatment of problems for all children and youth enrolled in Medicaid. She said any child that is enrolled in Medicaid is eligible for EPSDT benefits until they are 21 years old. She said a state Medicaid plan must provide an EPSDT recipient with any medically necessary health care service, even if the service is not offered under the state's plan for other Medicaid recipients. She said a medically necessary health care service is considered a covered service if the service will:

- Provide a correct medical diagnosis;
- Prevent the individual from the onset of an illness, condition, injury, or disability;
- Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or disability; or
- Assist the individual with achieving or maintaining sufficient functional capacity to perform age or developmentally appropriate daily activities.

Ms. Hulm said the state EPSDT enrollment was 39,742 as of September 2015. She said 69 percent of enrolled Medicaid children were screened during the state fiscal year 2014.

Ms. Hulm said the Health Tracks periodic screening is a comprehensive checkup. She said in order for a comprehensive checkup to be considered a Health Tracks periodic screening, the checkup must include all of the components outlined for a Health Tracks screening. She said components of a Health Tracks screening include health history, physical examination, identification of all medical conditions and needs, immunizations according to the Advisory Committee on Immunization Practices (ACIP) schedule, age appropriate laboratory tests, health education including anticipatory guidance, developmental assessment, nutritional assessment, mental health screening, vision screening, hearing screening, oral inspection, and treatment and referrals for any necessary services. She said immunizations in accordance with the ACIP schedule include laboratory test for lead toxicity, mental health, vision services, hearing services, dental services, and health education.

Early Child Screening, Assessment, and Treatment

Ms. Kelly Olson, Division Director of Behavioral Health and Family Services, The Village Family Service Center, presented information (Appendix R) regarding early childhood screening, assessment, and treatment. She said mental health issues for children ages 0 through 5 is determined by a child's ability to master core developmental tasks including how a child may regulate emotions, how they form relationships, or if they develop the ability to learn and explore their environment. She said core developmental tasks may be affected by internal and external stresses. She said examples of internal stresses include how a child reacts to loud noises, if they scream from human contact, or if they do not like wearing certain types of clothing. She said examples of external stresses include a child's relationship with their parents. She said examples of other common issues that may contribute to mental health concerns include a child experiencing divorce or a loss of a parent, sensory issues, trauma, neglect, abuse, a parent-child stress, or issues with peers or siblings.

Ms. Olson said a full comprehensive assessment that explores a child's developmental capacity in more than one environment and within more than one relationship is critical to understanding mental health issues. She said critical components must be examined to determine a child's ability to actively engage, form mutual relationships, communicate, and express thoughts and feelings. She said lack of screening consistency among providers may cause problems with coordination and continuity of treatment for a child. She said advantages of providers using the same screening tools include more accuracy of results, improved communication among providers, and an increase with the ability to measure a child's progress. She said other challenges include the lack of trained providers to complete assessments, the lack of a reimbursement system for assessments, and the lack of specialized training for assessing children ages 0 through 5.

In response to a question from Senator Mathern, Ms. Olson suggested allowing child care providers to be trained to provide early childhood screenings.

Special Needs Child Care Behavioral Health Services

Ms. Linda Reinicke, Program Director, Eastern Region, Child Care Aware of North Dakota, presented information (Appendix S) regarding special needs and child care behavioral health issues and recommendations. She said Child Care Aware of North Dakota is managed by Lutheran Social Services of North Dakota. She said Child Care Aware of North Dakota provides training and support for the states 1,350 licensed child care programs, assisting parents with finding child care, and working with communities to address child care challenges.

Ms. Reinicke said providers often do not have proper resources including staff, skills, knowledge, and equipment to care for children with certain behavioral challenges.

Ms. Reinicke said behavioral health recommendations relating to child care include:

- Increase funding for child care inclusion services;
- Include the use of child care facilities to provide mental health screenings for early identification and treatment of mental health issues;
- Require child care providers to be included in the development of individualized education plans (IEP) to help address challenging behaviors; and
- Adjust child care assistance rates for providers that care for a child with special needs.

School-Based Behavioral Health Services

Ms. Valerie L. Bakken, Special Education Regional Coordinator and Special Education Preschool Coordinator, Department of Public Instruction, presented information (Appendix T) regarding school-based behavioral health

services. She said the Special Education Office of the Department of Public Instruction works with prescribing rules and regulations for special education, assisting school districts in the development and administration of special education programs, and ensuring that federal programs and laws are carried out.

Ms. Bakken said the federal Individuals with Disabilities Education Improvement Act of 2004 (IDEA) requires free appropriate public education be made available to all children and youth with a disability, ages 3 through 21. She said IDEA identifies and defines the specific disability categories that will make a child eligible for the IEP process, which include intellectual disability, hearing impairment, speech or language impairment, visual impairment, emotional disturbance, orthopedic impairment, autism, traumatic brain injury, other health impairment, specific learning disability, deaf and blindness, and noncategorical delay for children ages 3 through 9 only.

Ms. Bakken said an IEP is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with federal regulations. She said the purpose of an IEP is to ensure that individuals with disabilities have appropriate educational planning to accommodate their unique instructional needs, and that their needs are met in an appropriate learning environment. She said, as of December 1, 2014, there were 1,823 children ages 3 though 5 that were on an IEP.

Ms. Bakken said early childhood special education professionals from across the state have formed the Early Childhood Special Education Advisory Committee. She said the committee's purpose is to assist the Department of Public Instruction with the implementation of new federal policies and regulations relating to early childhood special education. In addition, she said the committee's purpose is to discuss and bring attention to current issues relating to early childhood special education.

Ms. Bakken said early childhood special education professionals have provided recommendations that include the following relating to early childhood special education:

- Support families with a child that has a challenging behavior to ensure the continuity of supports between the child's school and home;
- Improve collaboration among other special education professionals, social service offices, and local agencies; and
- Provide teachers with more professional resources to work with behaviorally challenging students in their classroom.

In response to a question from Senator Axness, Ms. Bakken said parents are allowed to invite anyone to be a part of the IEP process. She said child care providers are welcomed to be a part of the IEP process.

Chairman Hogan encouraged the Early Childhood Special Education Advisory Committee to forward any additional recommendations to the committee.

Behavioral Health Issues - Children Ages 0 Through 6

Dr. Kathy Anderson, Chair of the Department of Pediatrics, CHI St. Alexius Health, presented information (Appendix U), regarding behavioral health issues for children ages 0 through 6. She said a physician caring for a child focuses on optimizing health, wellness, and development through a nurturing environment and good habits.

Dr. K. Anderson said the early childhood period for an individual involves development that is greater than any other stage of human development. She said development includes gross motor, fine motor, speech, and social-emotional development. She said delays in development can occur for various reasons, which include genes, genetic syndromes, trauma in utero, trauma during delivery, trauma during childhood, and other reasons. She said trauma may include vascular trauma, physical trauma, neglect, and toxic exposures. She said trauma can be a one-time event, or ongoing.

Dr. K. Anderson said there are three responses to stress, including a positive stress response, a tolerable stress response, and a toxic stress response. She said a positive stress response is when there is a brief episode of stress. She said a tolerable stress response is when there is a serious stressor that is buffered by at least one strong adult relationship. She said a toxic stress response is when there is a serious stressor, or prolonged stressors without adequate adult support. She said toxic stress may lead to delays in a child's development, difficulty with learning, and behavioral health issues.

Comments by Parent Groups or Other Interested Persons

Ms. Missi Baranko, Inclusion Specialist, Western Region, Child Care Aware of North Dakota, provided testimony (Appendix V) related to early childhood behavioral health challenges. She provided examples of child behaviors in the child care provider setting and the effects it has for the child, family, provider, and other systemic challenges.

Committee Discussion

Senator Mathern suggested exploring ways of improving the current EPSDT assessment tools rather than creating new assessment tools. He suggested expanding EPSDT to include other people rather than just Medicaid-eligible children and youth under age 21. He said a payment system could be developed for the EPSDT process.

Senator Lee suggested the committee request additional information from private insurance companies regarding the number of children being screened.

Representative Silbernagel suggested the committee receive more recommendations from providers regarding how to address prevention.

AUTISM SPECTRUM DISORDER SERVICES

Autism Spectrum Disorder Task Force

Ms. Trisha Page, Chairman, Autism Spectrum Disorder Task Force, presented information (Appendix W) regarding the status of the state autism spectrum disorder plan pursuant to Section 50-06-32. She said the task force includes 14 members appointed by the Governor. She said the task force meets four times per year to review early intervention and family support services, and programs that transition individuals from schools to adult day programs or employment. She said the task force developed a state plan in 2014.

Ms. Page said, within the next year, the task force anticipates merging the goals provided in the state plan by integrating a collective impact design with the intent provided in Section 50-06-32. She said collective impact is a collaborative effort model with a common agenda to share ideas, costs, and information to improve services and supports statewide, regionally, and nationally. She said the new approach will allow the state to maximize efficiency and effectiveness of autism services.

Ms. Page said the task force continues to meet quarterly. For calendar year 2016, she said, the task force anticipates meeting March 21, June 6, September 9, and November 7. She said at its May 4, 2015, meeting, the task force recommended adding two members to the task force. She said the two members include an adult with autism and a tribal representative.

In response to a question from Senator Mathern, Ms. Page said, at the state level, the most current evidence-based practices are being used. She said evidence-based practices are available to providers through the autism waiver program.

Department of Human Services

Ms. Trisha Page, Autism Services Coordinator, Medical Services Division, Department of Human Services, presented information (Appendix X) regarding the autism spectrum disorder program pilot project pursuant to Section 50-06-32.1. She said the voucher program became effective on July 1, 2014. She said individuals served by the voucher program include families with income below 200 percent of the federal poverty level, with a child between the ages of 3 and 18, that has an autism spectrum disorder diagnosis.

Ms. Page said 55 voucher applications have been received since July 1, 2015. She said, of the 55 voucher applicants, 43 families have met the income criteria and 41 families are actively being served. She said each qualifying child is eligible for up to $12,500 per year. She said voucher funds may be used for a one-time item purchase, for ongoing services, or for both a single-item purchase and ongoing services. She said funds are used for various purposes including autism-specific camps, tutoring, monitoring devices, sensory processing equipment, communication devices, and respite care. She said any funds that are not utilized by a family will be released into a voucher pool for other families to access.

In response to a question from Senator Dever, Ms. Maggie D. Anderson, Executive Director, Department of Human Services, said because of new guidance from the federal Centers for Medicare and Medicaid Services, some of the autism services that were previously considered as EPSDT benefits for children will now need to be provided under a state plan regardless of whether the state has a state waiver. She said a challenge with transitioning to the new process is making sure no child loses services.

The committee recessed at 5:00 p.m. and reconvened at 8:30 a.m. on Wednesday, January 6, 2016.

STUDY OF BEHAVIORAL HEALTH NEEDS - BEHAVIORAL HEALTH CHALLENGES

Ms. Kirsten Baesler, Superintendent, Department of Public Instruction, presented information (Appendix Y) regarding behavioral health issues involving students in school. She said the goal of addressing behavioral health

issues is to promote emotional wellness among students in schools. She said the education system plays a major role in the solution. She said educators need to know the risks to students who are having mental health difficulties and ways to protect them. She said educators need to be familiar with treatment and intervention options. She said all elementary, middle school, and high school teachers and administrators are now required to receive at least 8 hours of training every 2 years relating to student mental health issues. She said each school's support staff, including cooks, custodians, secretaries, teachers' aides, and others are also encouraged to take part in the training.

In response to a question from Representative Fehr, Ms. Baesler said a comprehensive plan should include public schools, community health services, mental health services, juvenile services, and criminal justice systems to interact as a solution to address mental health issues for students. She said educators need to be able to identify mental health issues a student may be experiencing. She said educators do not have the experience to provide treatment. She said public schools need to be able to refer and have necessary services provided to students.

In response to a question from Chairman Hogan, Ms. Baesler said three priorities include having more services available, providing students with timely support so students are not waiting for services, and providing families with more opportunities to receive needed professional mental health services.

In response to a question from Senator Lee, Ms. Baesler said there is a lack of immediate availability of supports and services in rural communities and smaller school districts. She suggested more of these communities partner with a regional education association to receive additional resources. She said the North Dakota Regional Education Association is a network of eight regional education associations in North Dakota.

STUDY OF BEHAVIORAL HEALTH NEEDS - ELEMENTARY AGE BEHAVIORAL HEALTH CHALLENGES

Elementary School Students

Dr. Jason Hornbacher, Principal, Dorothy Moses Elementary School, Bismarck, presented information (Appendix Z) regarding behavioral health challenges involving elementary school students. Dr. Hornbacher provided examples of issues that may challenge the productivity of children and prevent them from attending school, learning, remembering, and applying what they have learned. He said children need routine, structure, and consistency to improve their development. He recommended that efforts be made to reduce toxic stress, build executive function and self-regulation, create active skill building including coaching and training, and provide development of human capital to improve outcomes.

Health Training for Elementary School Teachers and Staff

Ms. Heather Simonich, Operations Director for Eastern North Dakota, PATH, Inc., presented information (Appendix AA) regarding the impact of child traumatic stress on mental health and a child's ability to learn, and information regarding health training for elementary school teachers and staff. She said one of four children has experienced a traumatic event. She said traumatic stress reactions may become problematic when they begin to interfere with a child's normal functioning and development. She said research provides that children who experience trauma are more likely to have a lower grade point average, a higher rate of school absences, a higher probability of dropping out of school, more suspensions and expulsions, a decreased IQ score and lower reading ability, deficits in attention, deficits in abstract reasoning, deficits in long-term memory for verbal information, and more special education services. She said many children that are suffering from traumatic stress do not receive a diagnosis of posttraumatic stress disorder, but instead, receive a different diagnosis including attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, bipolar disorder, and reactive attachment disorder. She said the diagnosis may lead to ineffective treatment and educational planning for the child.

Ms. Simonich said the Department of Public Instruction has collaborated with Mid-Dakota Education Cooperative in Minot to develop a 6-hour professional development curriculum for elementary educators and a program to train qualified trainers to deliver training to local school districts so that schools may understand the impact of traumatic stress. She said the goals of the curriculum include describing the effects of childhood trauma and its impact on student behavior and learning, reviewing trauma-sensitive strategies for educators, discussing the impact of trauma on staff, and describing a framework for creating a "trauma-informed" school culture. She said, in December 2015, a group of 10 trainers from across the state participated in a 3-day "train-the-trainer" workshop in Fargo. She said, over the next year, the group of trainers will continue to meet monthly to continue learning, sharing training experiences, and refining the curriculum. She said preliminary feedback from educators and administrators regarding the training has been positive.

Role of Elementary School Counselor

Ms. Robin Lang, Assistant Director of Teacher and School Effectiveness, Department of Public Instruction, presented information (Appendix BB) regarding the role of the elementary school counselor. She said elementary school counselors are required to have a master's degree with a mental health perspective so that they are able to understand and respond to the behavioral and emotional challenges currently in schools. She said a comprehensive development school counseling program allows school counselors to collaboratively work with school staff, parents, and the community to develop knowledge, attitudes, and skills that will allow a child to be a healthy, competent, and confident learner. She said school counselors assist children with education, prevention strategies, and early identification and intervention.

In response to a question from Representative Fehr, Ms. Baesler said it is important to understand the access levels for each of the three roles in the school system. She said school psychologists, school social workers, and school counselors are all required to be licensed. She said school social workers have more knowledge about community services that are available. She said school social workers and school psychologists have more access to student education and health records. In addition, she said they are able to share information more freely with other community support services and law enforcement.

Family Focused Services

Ms. Jodi Duttenhefer, Operations Director for Western North Dakota, PATH, Inc., presented information (Appendix CC) regarding family focused services, including the Family Support Program. She said family support services provide care for individuals in a home setting to transition from higher levels of care. She said services include case management, crisis response, respite care, parent mentoring, education, and treatment. She said reimbursements for family support services are provided by Medicaid for those eligible and from commercial insurances. She said Medicaid programs use the services as a transition from higher levels of care for individuals that have already been removed from their home. She said other insurers use the services to prevent individuals from having to be admitted to a hospital or residential care unit. She said there are currently 64 children receiving services through the Family Support Program. She said the average length of stay is 6 to 9 months. She said barriers that prevent some youth from receiving benefits include:

- A requirement that families expend $15,000 in a 12-month period before Medicaid coverage is provided.
- A Medicaid requirement that provides a child or family may only receive family support services once.

In response to a question from Senator Lee, Ms. Duttenhefer said 63 families were ineligible for the services in calendar year 2015 because of the $15,000 initial expenditure requirement.

Ms. M. Anderson provided information (Appendix DD) regarding the PATH, Inc. Family Support Program. She reviewed the Medicaid policy and procedures for the PATH, Inc. Family Support Program, including the Department of Human Services process for assisting Medicaid staff with managing the PATH, Inc. Family Support Program requests and documentation.

STUDY OF BEHAVIORAL HEALTH NEEDS - ADOLESCENT BEHAVIORAL HEALTH CHALLENGES

Secondary School Students

Mr. Russ Riehl, Principal, Simile Middle School, Bismarck, presented information (Appendix EE) regarding behavioral health challenges of secondary school students. He said there is an increased need for mental health services in schools and the community. He said, at the middle and high school level, student risk factors include depression, family structures, first interaction with law enforcement, addiction, and physical and sexual abuse. He said mental and behavioral health services are needed for students from various demographics, not only for "at-risk" students. He said Simile Middle School is piloting a behavioral and mental health program to provide more direct instruction to students for social and emotional supports. He said the program is staffed with qualified and certified teachers and social workers.

Mr. Riehl discussed his serving on the Juvenile Justice Advisory Board for the state. He said the board discussed a "school to prison pipeline" that included what schools, communities, and families could do to keep students out of the juvenile justice system. He said the earlier a student is introduced to the justice system, the greater the chance that they will become repeat offenders.

In response to a question from Chairman Hogan, Mr. Riehl said three ways to address behavioral health challenges include increasing access to mental health experts in schools for both the students and staff, improving behavioral health-related discussions in schools, and providing more programs to students with behavioral health issues, including appropriate staffing levels for the programs.

Inpatient Treatment Services for Adolescents

Mr. Jeff Herman, Chief Executive Officer, Prairie St. John's, Fargo, presented information (Appendix FF) regarding the roles and challenges of inpatient treatment services for adolescents. He said Prairie St. John's is a 110-bed inpatient facility that provides mental health and chemical dependency services for children, adolescents, and adults. In addition, he said, it offers full psychiatric and addiction continuum of care beyond inpatient services, including partial hospitalization, residential treatment, intensive outpatient services, and clinical services. He said for children and adolescents to be admitted to the inpatient hospital units, they must be considered to be in a psychiatric crisis, suicidal or homicidal, and in need of acute hospitalization for stabilization. He said, in 2015, Prairie St. John's admitted 265 children and adolescents ages 13 to 18. He said the average length of stay is 8 days. He said children and adolescents that are admitted may receive a psychiatric evaluation and psychiatrist visits, including medication management. In addition, children and adolescents receive nursing care, group and individuals therapy, activity therapy, nutrition groups, chemical dependency assessments, and discharge planning services. He said education is provided for 2 hours each day by Fargo Public Schools staff.

Mr. Herman provided the following recommendations to address the challenges of inpatient treatment services for children and adolescents:

- Establish a plan for supporting and training nursing staff by providing incentives to work in the behavioral health field;
- Maximize the use of federal funds that are available for behavioral health services, including the federal Medicaid Emergency Psychiatric Demonstration program; and
- Support education and training programs that address trauma-focused care and treatment that includes all disciplines and placement settings.

In response to a question from Senator Lee, Mr. Herman said the state may have an opportunity to file for a waiver relating to the federal Medicaid Emergency Psychiatric Demonstration program. The program tests whether Medicaid can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable. He said this could be an opportunity to file a waiver to receive federal funds for additional psychiatric services.

Residential Treatment Services

Mr. Jim Vetter, Vice President of Partner and Community Relations, Dakota Boys and Girls Ranch, presented information (Appendix GG) regarding the role and challenges of residential treatment services. He said residential child care facilities and psychiatric residential treatment facilities are the two levels of residential services that are licensed by the Department of Human Services.

Mr. Vetter said residential child care facilities are licensed by the Children and Family Services Division of the Department of Human Services. He said residential child care facilities provide services for youth that are in foster care and require out-of-home placement for a period of time because of treatment and behavioral needs. He said the average period of time a youth stays before returning to their home or foster home is 7 months.

Mr. Vetter said psychiatric residential treatment facilities are licensed by the Behavioral Health Division of the Department of Human Services. He said psychiatric residential treatment facilities have an initial and ongoing certificate of need process that requires a youth's psychiatric treatment to be determined medically necessary. He said treatment plans are developed and then refined based on the youth's treatment needs. He said the average period of time a youth stays before transitioning to a lower level of care or to a home setting with community supports is 5 months.

Mr. Vetter said the state's system of residential care includes the following residential treatment service challenges:

- Retaining a well-trained workforce;
- Accessing and exchanging medical information;
- Transitioning services and resources for youth that are leaving placement;
- Increasing acuity of youth that are in placement; and
- Complexity of the reimbursement system.

In response to a question from Senator Mathern, Mr. Vetter said a child may be placed in an out-of-state facility if the child is extremely aggressive and violent, a female sex offender, or has a serious eating disorder.

In response to a question from Representative Mooney, Mr. Vetter said the bed capacity at the Dakota Boys and Girls Ranch includes 48 psychiatric residential treatment facility beds and 45 residential child care facility beds.

In response to a question from Chairman Hogan, Mr. Vetter said each public school district is required to pay for the cost of tuition to educate youth at the Dakota Boys and Girls Ranch campus. He said the current costs are $75 per day.

In response to a question from Representative Oversen, Mr. Vetter said the Dakota Boys and Girls Ranch primarily receives placements from the Division of Juvenile Services, Department of Corrections and Rehabilitation.

Special Education

Mr. Darren Albrecht, Principal, Grafton High School, Grafton, presented information (Appendix HH) regarding challenges for special education for children with behavioral health issues. He said 30 percent of students in the Grafton Public Schools receive special education services. He said even though ridicule and bullying may happen from peers outside of the school setting, it still causes students to lose motivation during school and makes it harder for students to focus during school. He said other issues that students and school personnel experience on a daily basis include drug and alcohol use, challenges associated with living in a single parent home, abuse and neglect, older siblings caring for their younger siblings, students leaving home, teenage pregnancy, gang influence, dropouts, and suicides. He said there is a need in schools for mental health assistance that includes a long-term teaching approach for students and families.

Behavioral Health Challenges for Adolescents

Ms. Lisa Bjergaard, Director, Division of Juvenile Services, Department of Corrections and Rehabilitation, presented information (Appendix II) regarding behavioral health challenges of adolescents. She said youth in the custody of the Department of Corrections and Rehabilitation are an increasingly challenging group to service. She said complex and often interrelated issues require intensive and sometimes lengthy interventions to allow a youth to successfully return to their home, school, and community. She said attention needs to focus on prevention and early intervention services.

Ms. Bjergaard said the Juvenile Justice State Advisory Group monitors compliance with the federal Juvenile Justice and Delinquency Prevention Act. She said the group reviews the latest research on adolescent development and developmental approaches that include accountability without criminalization, alternatives to juvenile justice system involvement, individualized response based on assessment of needs and risks, confinement only when necessary for public safety, genuine commitment to fairness, sensitivity to disparate treatment, and family engagement. She said the Juvenile Justice State Advisory Group develops the state's 3-year Juvenile Justice Plan and submits it to the federal Office of Juvenile Justice and Delinquency Prevention pursuant to the Juvenile Justice and Delinquency Prevention Act. She said it is important to identify youth early, assess them accurately, and provide diversionary options when possible. She said policies and strategies should keep at-risk youth connected to their homes, schools, and communities.

In response to a question from Representative Silbernagel, Ms. Bjergaard said child neglect is the primary cause of juvenile justice and criminal justice involvement. She suggested developing policies that strengthen families, and strengthen intervention in families to support, encourage, and promote positive child development.

Comments by Parent Groups or Interested Persons

Mr. Carl Young, Mental Health Advocate, Garrison, presented information (Appendix JJ) regarding the study of behavioral health needs. He presented information regarding challenges he experiences as a parent with a child that has a mental health issue. He supports a continuum of care for mental health-related services that would be similar to those of the state's developmental disability system.

Mr. Todd Christlieb, Fargo, presented information (Appendix KK) and provided supplemental information (Appendix LL) regarding the study of behavioral health needs. He presented information regarding challenges he experiences as a parent with a child that has mental health issues and provided suggestions relating to cost-effective preventative measures.

Ms. Deb Jendro, Fargo, presented information regarding the study of behavioral health needs. She expressed concerns regarding a lack of services within the communities for youth with special needs. She also distributed written testimony (Appendix MM) on behalf of an individual from West Fargo regarding the study of behavioral health needs.

Chairman Hogan distributed information (Appendix NN) regarding the study of behavioral health needs.

OTHER COMMITTEE REPORTS

Statewide Family Controlled Parent-to-Parent Support Organization Grants

Ms. Carlotta McCleary, Executive Director, North Dakota Federation of Families for Children's Mental Health, presented information (Appendix OO) regarding the use of grant funds relating to a statewide family controlled parent-to-parent support organization receiving a grant pursuant to Section 19 of 2015 Senate Bill No. 2012. She said the North Dakota Federation of Families for Children's Mental Health is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral, and mental disorders and their families, from birth through transition to adulthood. She said the organization received a grant of $75,000 for the 2015-17 biennium. She said, as of the quarter ending September 30, 2015, the North Dakota Federation of Families for Children's Mental Health has provided support and education for over 121 families during the quarter. In addition, she said the staff has had 5,796 parent contacts, and 43 new referrals during the quarter.

In response to a question from Representative Fehr, Ms. McCleary said the North Dakota Federation of Families for Children's Mental Health currently has two parent coordinators, one in Bismarck and one in Fargo. She said the goal would be to have one parent coordinator in each human service region of the state. She said the two parent coordinator positions provide services throughout the state.

Statewide Family-to-Family Health Information and Education Organization Grants

Ms. Donene Feist, State Director, Family Voices of North Dakota, Inc., presented information (Appendix PP) regarding the use of grant funds relating to a statewide family-to-family health information and education organization receiving a grant pursuant to Section 19 of 2015 Senate Bill No. 2012. She said Family Voices of North Dakota is a health information and education center for families and professionals, that provides information and resources relating to health care, disability, and chronic health illnesses and issues, for affected children with special health care needs. She said the organization received a grant of $75,000 for the 2015-17 biennium. She said use of the grant fund dollars include adding an additional part-time consultant in the Dickinson area, increasing and maintaining hours of existing staff, and adding additional travel for outreach services and to meet with families in areas without staff including Minot and Devils Lake.

In response to a question from Representative Oversen, Ms. Feist said Family Voices of North Dakota receives referrals from numerous sources including from counties, pediatricians, physicians, and hospitals.

North Dakota Suicide Prevention Program

Ms. Alison Traynor, Suicide Prevention Program Director, State Department of Health, presented information (Appendix QQ) regarding the North Dakota Suicide Prevention Program in schools. She said the Sources of Strength program is an evidence-based suicide prevention program in public schools. She introduced Ms. Megan Sletten, Educator and Co-Lead Adult Advisors, Sources of Strength Program, Bismarck High School, Bismarck, Ms. Jessica Bentz, Educator and Co-Lead Adult Advisors, Sources of Strength Program, Century High School, Bismarck, Mr. Christian Kilwein, Student and Peer Leader, Ms. Hannah Iron Eyes, Student and Peer Leader, and Ms. Taylor Veen, Student and Peer Leader, regarding the Sources of Strength program.

Ms. Sletten said Sources of Strength is a major component for the school's Responsible Decision Making initiatives and Continual School Improvement goals. In addition, she said Sources of Strength is a suicide prevention program, anti-bullying program, and a "climate changer," which includes challenging student leaders to help make schools a safe, fun, and positive environment. She said Sources of Strength is one of the few programs listed on the federal Substance Abuse and Mental Health Services Administration's registry of suicide prevention programs. She said the Sources of Strength model uses an "upstream approach" to suicide prevention that is proactive and promotes resilience and positive youth development as protective factors against suicide.

Ms. Bentz said Century High School began using the Sources of Strength program in the fall of 2014. She said, as part of the program, a diverse group of students were identified that were considered leaders by their peers. She said these students were then provided with a one-day training course to help each student begin an internal story about what strengths they have grown in their experiences. She said the program's model focuses on the story process and the sharing of stories. She said peer leaders are the eyes and ears for the school and help connect their peers with help. She said approximately 10 percent or 180 students and 40 teachers have been trained. She said the goal is to include peer leaders from every clique, club, and social group.

Ms. Veen said the Sources of Strength model uses a wheel which provides eight strengths including mental health, family support, positive friends, mentors, healthy activities, generosity, spirituality, and medical access. She said the wheel is used by peer leaders to build resilience and survive struggles.

Ms. Iron Eyes said the purpose of the wheel is to normalize help-seeking and to teach classmates how to identify their areas of strength.

Mr. Kilwein said much of what happens in the club is to spread messages of hope, help, and strength.

Ms. Veen said one in eight students are considered an "isolate," which means they cannot name a friend, and no one names them as a friend. She said individuals considered "isolates" are two times more likely to be suicidal and four times more likely to be bullied.

In response to a question from Senator Lee, Mr. Mark LoMurray, Sources of Strength, Bismarck, said the initial startup costs for the Sources of Strength program for each school is approximately $5,000. He said the cost includes training of adult advisers, training the peer leaders, and various video support, webinars, and teleconference reports. He said the costs of each subsequent year would be approximately $500 for each school. He said Sources of Strength is a program that started in Bismarck. He said the Sources of Strength program is provided to schools throughout the United States and Canada. He said, last year, there were 480 advisers trained for the program.

In response to a question from Chairman Hogan, Mr. LoMurray said there are five schools in North Dakota that participate in the Sources of Strength program.

In response to a question from Representative Silbernagel, Mr. LoMurray said the five schools include schools in Bismarck, West Fargo, Rugby, Dunseith, and Wyndmere.

Children's Health Insurance Program State Plan

Ms. Jodi Hulm, Healthy Steps Program Administrator, Medical Services Division, Department of Human Services, presented information (Appendix RR) regarding enrollment statistics and costs associated with the children's health insurance program (CHIP) pursuant to Section 50-29-02. She said the state reached the federal medical assistance percentage (FMAP) minimum for CHIP of 65 percent on October 1, 2013. She said the 65 percent FMAP continued until September 30, 2015. She said provisions in the federal Affordable Care Act allowed the state to be eligible for an additional 23 percent federal match increase. She said the FMAP for CHIP is 88 percent through September 30, 2016.

Ms. Hulm said, as of December 2015, there were 2,523 premiums paid for children enrolled in CHIP. She said the CHIP appropriation for the 2015-17 biennium is $20,474,924. She said, through December 2015, CHIP expenditures are $3,326,921.

Mental Health Training

Ms. Gail Schauer, Director of Teacher and School Effectiveness, Department of Public Instruction, presented information (Appendix SS) regarding mental health training provided by school districts pursuant to Section 5 of 2015 Senate Bill No. 2048. She said the Department of Public Instruction developed a Youth Mental Health Training fact sheet (Appendix TT) which provides background of the state's mental health data and provides suggestions for ways to implement the youth mental health training. She said school districts are required to provide 8 hours of youth mental health training once every 2 years to all elementary, middle school, and high school teachers and administrators. She said the training must include an understanding of the prevalence and impact of youth mental health disorders; knowledge of mental health symptoms, social stigmas, risks, and protective factors; and awareness of referral sources and strategies. She said districts have flexibility to implement the training. She said 10 training sessions have been held in the state with 290 participants since July 2015. She said five training sessions are planned in the state over the next few months. She said the department anticipates approximately 150 participants.

In response to a question from Representative Mooney, Ms. Schauer said the department has informed school districts of youth mental health training requirements pursuant to Chapter 15.1-07, including presentations at statewide conferences throughout the fall and winter months, and monthly emails to school districts. In addition, she said the department receives calls from school districts requesting information relating to youth mental health.

In response to a question from Senator Larsen, Ms. Schauer said, often times, the training sessions provide continuing education credits for educators. She said each school district is allowed to determine its own training program including whether continuing education credits are allowed.

COMMITTEE DISCUSSION

Senator Mathern suggested the Legislative Council staff prepare a list of all specific suggestions provided to the committee at this meeting.

Representative Oversen suggested the committee receive information from the Department of Human Services regarding the Medicaid Emergency Psychiatric Demonstration legislation that was recently passed by Congress, and information regarding the department's plan to be involved in the demonstration project.

Representative Oversen also suggested the committee consider asking the Community Violence Intervention Center (CVIC) to present information to the committee on its programs.

Chairman Hogan said the committee will discuss the certificate of need program at a future meeting. She said the committee will receive information regarding the process and issues for children in need of additional services beyond Medicaid service limits.

Chairman Hogan said the next meeting will be held on Tuesday and Wednesday, March 8-9, 2016, in Jamestown.

No further business appearing, Chairman Hogan adjourned the meeting at 4:00 p.m.

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Michael C. Johnson
Fiscal Analyst

ATTACH:46