15.0178.04000

FISCAL NOTE
Requested by Legislative Council
02/19/2015

Amendment to: SB 2045

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$1,166,092		$2,166,092	
Appropriations			$166,092		$2,166,092	

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Engrossed SB 2045 provides an appropriation to the Department to establish and administer a voucher system for addiction treatment services. It also provides for a legislative management report.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Engrossed SB 2045 includes an appropriation of $1,000,000, all of which is general fund, for the Department to establish and administer a voucher system beginning July 1, 2016, to assist in the payment of addiction treatment services. Not included in the appropriation is the cost of an FTE of $166,092 which would be necessary to administer the voucher system as well as the objectives of SB 2048.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The fiscal impact for the Department of Human Services for the 2015-2017 biennium is $1,166,092, all of which is general fund, which would fund the cost to establish and administer the voucher system for addiction treatment services as well as fund the additional FTE. The fiscal impact for the 2017-2019 biennium, is $2,166,092, all of which is general fund, to continue administering the voucher system and to continue the funding for the FTE.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

In addition to the $1,000,000 appropriated in the bill, the Department will need an appropriation increase of $166,092, all of which would be general fund, for the 2015-2017 biennium. The Department will need an appropriation increase of $2,166,092, all of which would be general fund, for the 2017-2019 biennium to continue to fund the voucher system and for the continuation of the FTE.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 02/19/2015

15.0178.03000

FISCAL NOTE
Requested by Legislative Council
01/12/2015

Amendment to: SB 2045

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$2,166,092		$2,166,092	
Appropriations			$166,092		$2,166,092	

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB 2045 provides an appropriation to the Department to establish and administer a voucher system for addiction treatment services.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

SB 2045 includes an appropriation of $2,000,000, all of which is general fund, for the Department to establish and administer a voucher system to assist in the payment of addiction treatment services. Not included in the appropriation is the cost of an FTE of $166,092 which would be necessary to administer the voucher system as well as the objectives of SB 2046 and SB 2048.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

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C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

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Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/13/2015

15.0178.02000

FISCAL NOTE
Requested by Legislative Council
01/12/2015

Bill/Resolution No.: SB 2045

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$2,166,092		$2,166,092	
Appropriations			$166,092		$2,166,092	

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB 2045 provides an appropriation to the Department to establish and administer a voucher system for addiction treatment services.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

SB 2045 includes an appropriation of $2,000,000, all of which is general fund, for the Department to establish and administer a voucher system to assist in the payment of addiction treatment services. Not included in the appropriation is the cost of an FTE of $166,092 which would be necessary to administer the voucher system as well as the objectives of SB 2046 and SB 2048.

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The fiscal impact for the Department of Human Services for the 2015-2017 biennium is $2,166,092, all of which is general fund, which would fund the cost to establish and administer the voucher system for addiction treatment services as well as fund the additional FTE. The fiscal impact for the 2017-2019 biennium, is $2,166,092, all of which is general fund,to continue administering the voucher system and to continue the funding for the FTE.

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In addition to the $2,000,000 appropriated in the bill, the Department will need an appropriation increase of $166,092, all of which would be general fund, for the 2015-2017 biennium. The Department will need an appropriation increase of $2,166,092, all of which would be general fund, for the 2017-2019 biennium to continue to fund the voucher system and for the continuation of the FTE.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/13/2015

2015 SENATE HUMAN SERVICES

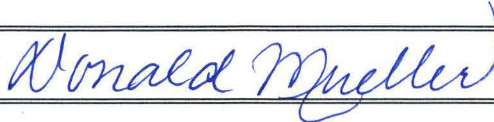
SB 2045

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2045
1/14/2015
J# 21945

☐ Subcommittee
☐ Conference Committee

Donald Mueller 

Explanation or reason for introduction of bill/resolution:

To provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

Attach #1: Testimony of Kathy Hogan
Attach #2: Testimony of Michael Kaspari
Attach #3: FAQ on Fee-for-service Voucher Based Substance Abuse Services
Attach #4: Testimony by Kurt Snyder
Attach #5: Testimony of Chad Mayers
Attach #6: Key Leadership Organizations in North Dakota's Substance Use Disorder System
Attach #7: North Dakota Licensed Private Substance Abuse Treatment Programs
Attach #8: North Dakota Licensed Private Substance Abuse Treatment Programs by ASAM Level of Care
Attach #9: Cost Benefits of Investing Early in Substance Abuse Treatment
Attach #10: Days to Treatment and Early Retention Among Patients in Treatment for Alcohol and Drug Disorders
Attach #11: How to Increase Access to Substance Abuse Treatment: Implementing NIATx Model
Attach #12: Removing Barriers to Treatment & Recovery - The Case for Access and Retention.

Acronym Definitions: ASAM = Addiction Society of American

Alex Cronquist, Fiscal Analyst, Legislative Council, spoke neither in favor or against SB 2045. Provided information regarding SB 2045, and indicated that it was recommended by Interim Human Services Committee.

Senator Dever asked if this was included in the Governor's budget?

Mr. Cronquist indicated that he did not have a voucher program in his budet.

Chairman Judy Lee indicated there is a request for $6 million dollars for the umbrella of mental health services, which may include this.

Rep. Kathy Hogan, District 21, testified IN FAVOR of SB 2045 (attach #1) (testimony ends 8:25)

Senator Dever asked if we are mandating through the amendment that someone should be doing voluntarily, and if so, is it because they are reluctant to do voluntary.

Representative Hogan indicated that we are establishing the standards of care. Rep. Hogan is not sure if there is a lot of resistance to it. She indicated it is totally new. This particular assessment has been researched for 20 years, and has now been adopted by the organization that established it. We are now setting the standards with a lot of support. We will move to it whether in law or not. For the first time, the state will have systemic data across public and private funders and agencies.

Chairman Judy Lee indicated that ASAM (refer to Hogan testimony) is well respected organization; this provides a tool that is more up-to-date that would hold professionals for this kind of a move for positive things.

Rep. Hogan indicated that we currently have assessment tools, but we don't have a consistent format to collect data out of the existing tools, and consistent application of those tools. We are currently doing assessments, but this gives us a much deeper resource for all people in North Dakota.

Chairman Judy Lee provided information about the Schulte report, the stakeholders were anxious to get things going and had strong support for the Schulte report. Several senators, representatives, and community organizations and stakeholders were involved in the meetings with the Schulte report.

Senator Warner asked about amendment to purchase software, the cost, or is their granting software for meeting the costs?

Representative Hogan indicated that the cost for a small provider is $65 per month for the software program. The data is kept on the national site. Sheldon Wolf (ITD) is involved with this. ASAM provides this software at no profit. If it was statewide process and mandated, the rate could be negotiated lower, so that is the maximum cost.

Senator Warner asked if the data is subject to HIPAA rules.

Representative Hogan indicated it is compliant to HIPAA, and there was also some question about linking with electronic health records, there are mechanisms to integrate with those.

Senator Warner asked if it correlates with the codes that with 3rd party payers use or is more granular data?

Representative Hogan was not sure, but they try to address all the issues in the program design, and insurers are willing to work with them on that. It plugs into the ASAM standards and the insurers use the ASAM standards.

Chairman Judy Lee indicated we would want to make sure that we included this in the conversations to make sure it works for everyone engaged.

Senator Howard Anderson, Jr. asked about the voucher system, if a person now needs addiction treatment, Medicaid provides that treatment, is that only through the Human Service Centers or through another provider, and does this change that?

Representative Hogan indicated that if someone is on Medicaid, including expanded Medicaid. Prior to extended Medicaid, single people between the ages of 18 or 21 and 65 were not covered by Medicaid, so Medicaid wasn't a major player. Now, an individual who is on Expanded Medicaid can choose to go to any licensed provider, as well as regular Medicaid. The problem is if you don't have health insurance, sometimes there were limits at the Human Service Centers for those who didn't have insurance and needed treatment. If there were long waiting lists or times they couldn't fill positions, then holes occurred. This would begin to fill the holes for the uninsured.

Chairman Judy Lee discussed the Valley City situation where they had to go to the Jamestown Human Service Center, which could be difficult versus going to a local provider.

Representative Hogan indicated that increasing access to services is the goal.

Chairman Judy Lee indicated the psych department in Dickinson closed years ago because they haven't been able to find providers.

V. Chairman Oley Larsen asked who are the people who are not insured because after January 1, everyone should be insured.

Representative Hogan indicated that many are eligible, but sometimes they haven't applied or have circumstances where they have lost their insurance. The new variable is the unknown. Even people who have health coverage and are on Medicaid need access and vouchers could help.

V. Chairman Oley Larsen indicated that there is some legislation to help defray the cost for education to go to these areas, addiction counselors and others. What should come first, filling the building with professionals before we have the money not being used?

Representative Hogan answered indicated that we need both, they go together. One of the objectives is to improve the relationship between public and private providers, where some services can be provided by the private providers. Private providers at times have better access to employees and have capacity to the services.

Senator Howard Anderson, Jr. quoted "now I have insurance but can't' afford to use it". Does this help that situation?

Representative Hogan indicated that they don't know the answer to that. It is too new.

End of Hogan testimony (21:38)

Megan Smith, director of government relations for BCBSND. Blue Cross Blue Shield of North Dakota supports SB 2046, recognizing the extent of unmet behavioral health and substance abuse treatment needs in North Dakota, and in support on drawing on resources from all sectors to address the statewide need. They also voiced support for the amendment. The ASAM criteria has been developed over 20 years and represents the expert consensus of addiction treatment leaders regarding assessment service planning and treatment delivery for substance abuse. Widespread use of the ASMA criteria software will facilitate accelerate the collection of quantitative data and move the field to outcome based guidelines to provide high quality affordable care to the largest number of North Dakota consumers possible. The result will be that North Dakota will contribute to and benefit from the development of evidence based outcome based driven substance abuse treatment services.

Michael Kaspari, a registered Nurse, testified IN FAVOR of SB 2045. (Attach #2) Testimony end (28:40)

Senator Warner asked to discuss the window idea for optimal period of treatment.

Mr. Kaspari answered that it has more to do with having a patient. He couldn't say if you have better outcomes if you treat someone now or in six months, but you may not have the patient in six months. Frequently, there is some external motivation by legal or family, where right now it is a crisis, so it may be time to intervene now.

Senator Dever indicated that residential bed capacity is adequate. Comment on outpatient capacity. Recognizing that there is a shortage in western ND, are there other areas in the state where there is concern?

Mr. Kaspari answered that outpatient chemical dependency treatment have capacity in their programs, anything from 15% to 20%. The 500 would stretch capacity in outpatient arena, but would be close. Capacity in eastern North Dakota is much better. If 250 came west to Bismarck, we would be in trouble.

Senator Dever asked if it comes down to money.

Mr. Kaspari indicated that money is a big part of it, but there are also other considerations, such as measuring outcomes, evidence based treatment, is it working. Mr. Kaspari is hopeful that the ASAM software will provide good results.

Chairman Judy Lee asked if workforce is a big component

Mr. Kaspari indicated that workforce is a consideration. There is significant capacity today, sometimes more in outpatient than residential programs.

Chairman Judy Lee asked particularly licensed addiction counselors?

Mr. Kaspari indicated yes.

V. Chairman Oley Larsen asked with the voucher system, how many times can someone use the voucher throughout the year; he provided an example of someone who exhausted his funds in one area and then moved to another location to get more services.

Chairman Judy Lee followed up that if North Dakota resident and using North Dakota program, he doesn't get a new start if he moves?

V. Chairman Oley Larsen indicated he has heard of those circumstances.

Mr. Kaspari has also heard that, that they have exhausted services at a Human Service Center site, but sometimes there are other specifics to the issue. Mr. Kaspari indicated he didn't know the answer on the voucher - good for as long as it is needed. Case management would be necessary looking to make sure that clients are progressing in treatment, and looking to make sure the appropriate treatment is being provided.

Mr. Kaspari provided additional information - FAQ for Fee-for-service Voucher based substance abuse services. (Attach #3).
End of Mr. Kaspari's testimony (35:54)

Kurt Snyder, Executive Director of the Heartview Foundation, testified IN FAVOR of SB 2045. (Attach #4) Testimony ends (42:14)

Mr. Snyder provided answers to prior questions asked. He indicated that data supports that immediate access does result in better outcomes. There is a moment of intervention, a moment where they need help, there is a moment of clarity. They schedule an appointment, and if that is two weeks away, there is a 50% no show. Long wait lines means less people showing up and getting the care they need. In that time when they don't show up for care, more bad stuff happens. If they are able to be intervened with at that time of clarity or moment of asking for services, they tap into their motivation. We have an opportunity to engage them, empower them on their journey of treatment. Medicaid for any licensed program in the state is not entirely correct. Medicaid has some special considerations including a Medical Director to oversee it and have to meet the conditions of Medicaid to participate. Many programs that are valuable, but not a Medicaid provider, specifically in the smaller communities. The highest level of care may be partial hospitalization which is a Medicaid covered service, but they don't have the medical director or infrastructure to be a Medicaid provider. This does provide access in their community, but if they don't have it, they have to travel to far, so it becomes a hardship. Outpatient capacity versus residential capacity. They have 12 residential beds, can rotate people through quicker, but still have limited capacity in residential. It is easier to expand outpatient settings because the tools of the trade are secure and safe comfortable room with enough chairs for the people who need to be there, and professionals who do the service. Regarding the exhausting the services comment, Human Service Centers never turn anyone away. Some are very ill become very difficult to treat. The Affordable Care Act took away time limits on services and becomes medical necessity, so if a person has that medical necessity, then the service should and must be available according to insurance provider or within the Human Service structure.

V. Chairman Oley Larsen indicated that his understanding of Affordable Care Act, everybody can be on board. When coming to your facility, they should be able to be enrolled. Some will miss the enrollment period, but if they come into a drug situation, they should do that. Do you have someone on staff so if someone comes in uninsured they go right to that office first and get insured?

Mr. Snyder responded that they do not have a specific person in their organization, but they do work with navigators in the system to do this. Many do not fall within the window. Uncovered services are also a situation for coverages, including Medicaid. There is no coverage for residential services; no coverage for an evaluation. If there was a need for residential care for a Medicaid patient, that would not be available. Any private provider will tell stories of turning people away because they don't have a way to pay for the services, which results in long lines at Human Service Centers, and there is access at the private providers.

End Mr. Snyder testimony (49:32)

Mr. Chad Mayers testified IN FAVOR of SB 2045. (attach #5) Testimony ends (52:20)

OPPOSED TESTIMONY FOR SB 2045
No one testified opposed to SB 2045.

NEUTRAL TESTIMONY FOR SB 2045
Pamela Sagness, Department of Human Services, provided information regarding private providers within the state. Her testimony went through the following attachments:
Attach #6: Key Leadership Organizations in North Dakota's Substance Use Disorder System
Attach #7: North Dakota Licensed Private Substance Abuse Treatment Programs
Attach #8: North Dakota Licensed Private Substance Abuse Treatment Programs, by ASAM Level of Care.

Ms. Sagness requested that the implementation identified in the bill be delayed from July 1, 2015 to July 1, 2016 to allow time for administrative rules to be written. In addition, the last sentence in lines 9 and 10 where it identifies services eligible for the voucher program include only those services recognized affected by ASAM, ASAM doesn't identify programs as being outcome based, but identify by the intensity or the severity for the services to be provided. Depending on the intent of that line, it needs further clarification. If it's meant that the voucher program would include only the level of services recognized by ASAM, then that would be a language change.

Chairman Judy Lee asked for Ms. Sagness to work with the intern, Femi, for clarification of language.

Ms. Sagness reviewed the material (attachments 6, 7, 8) with the committee. There are currently 54 private providers that are licensed. This is important when considering the capacity of the programs, the level of services that programs are providing, but also the amendment proposed, the discussion of the software would need to be a consideration. Approximately 25% of the providers still use paper records and are not electronic. When

asked why, she did not know. ASAM is a practice already used in the state. All of the licensing rules require that licensed programs follow ASAM level of care placement and also includes every assessment, evaluation, discharge, all level of care placement are already written in ASAM.

Chairman Judy Lee asked if there were additional copies of the amendments.

Ms. Sagness indicated that the cost of the software is $65 per user per month, so it depends on number of licensed clinicians. Other professionals would also need access to that, such as nursing staff and physicians, so this would be an additional cost. In addition, there are programs who do not have internet connection or computers. There are also providers who travel from primary office, so outreach offices would need consideration for computer services. Back of map (attach 7) shows where the offices are by region. Attach 8 identifies where there is some availability. These are private providers only so it does not include Human Service Centers, the DOCR (Correction) programs, and ND State Hospital are not included in this chart. Also, ASAM software notes, it is a point in time assessment, it can be used with electronic health records software, but it is not integrated into treatment plans, progress notes, those types of components, so this would need work because it is a point-in-time and not a continuous evaluation. When looking at everyone using one standard software, right now everyone can do their own assessment, but that assessment has core requirements that when Department of Human Services does licensing visits, they can clearly identify what the clear standards are, such as identifying the 6 dimensions. The continuum of care is also listed in the handout which identifies the five levels of services. End of oral testimony of Ms. Sagness (1:02:00)

Chairman Judy Lee asked for something in writing for clerk.

Senator Howard Anderson, Jr. asked for solution that there are providers that are not eligible to be Medicaid providers due to not meeting criteria.

Ms. Sagness indicated that Maggie Anderson will respond later.

Chairman Judy Lee asked if the barriers are so great that should we continue, or that by working with private and public providers there might be some advantage to a consistent assessment tool?

Ms. Sagness indicated that the documents (attachments) she provided gave detailed information. It is more about being informed, who the providers are, what some of the shortages are, and thinking about the continuum, looking at workforce, and then also looking at the appropriation.

Senator Howard Anderson, Jr. stated that the follow-up testimony indicates the software may be an additional barrier to services we didn't have before.

Ms. Sagness indicated that one of the things to note is looking at the providers, the majority are one person providers. There are larger providers that will use electronic health records and will use the software, but it could be a barrier to the smaller private providers.

End Ms. Pamela Sagness testimony and discussion (1:05:18)

Maggie Anderson, Director of the Department of Human Services, addressed some of the prior questions.
Under the Medicaid program, federal Medicaid policy does not allow payment for residential, which is the room and board component. Medicaid dollars can pay room and board for certain situations, which are nursing homes, hospitals, intermediate care facilities, and psychiatric residential facilities for children. CMS will not allow Medicaid dollars to pay for residential and room and board component. Under Medicaid expansion provision, residential is a covered service, but only the treatment portion. Either the provider needs to support that cost, the client, or others will cover the costs, but they cannot claim those as an expense for Medicaid. The physician piece is a requirement for the level of care 2.5 day treatment, where it must be supervised by physician. The Department of Human Services is looking at that to possibly change, and what is allowed within that service. Under Medicaid rehab option, they do enroll licensed addiction counselors, licensed professional clinical counselors, licensed professional counselors, LICSW, who are enrolled and they can provide services; this is a state-plan service. Maggie Anderson (DHS) also addressed that this money/funding is not in the Governor's budget. The increased request is about $6.1 million dollars. This came from the stakeholder meetings and interim hearings, and address things for expanding things such as the crisis beds, residential beds, the transitional living beds that are operated through the Human Service Centers to private contracts, and also some of the employment services that are provided to individuals that are seriously mental ill, to continue expand trauma system of care, and to take the pilot of the mobile crisis unit in the southeast region and expand that statewide. The final thing is a 15 bed expansion to the Thompkins Rehabilitation program that is operated on the grounds of the State Hospital, which is a cooperative agreement with the Department of Corrections and Rehabilitation. They indicated they have a need for more substance abuse treatment, and asked for an expansion to that program.

Chairman Judy Lee asked for a summary document regarding the budget from Maggie Anderson (DHS), and she responded yes.

Senator Dever asked if the funding will be seen in various bills or if it is part of the agency budget?

Maggie Anderson (DHS) indicated that those are part of the agency budget discussions. At this point, other than the dollars that are in the agency budget for the eligibility information technology system, which has been pulled into a separate bill, SB 2177, none of the funding in the department's budget has been pulled out into a separate policy bill

End testimony of Maggie Anderson (DHS).

Mr. Sheldon Wolf, Health Information Technology Director for the Information Technology Department, provided testimony. There needs to be a conversation with the providers in regard to the costs. It is a web-based, $65 fee per person per month, so this could be a barrier to some providers.

Senator Warner asked for Mr. Wolf's opinion on the quality of product.

Mr. Wolf indicated that he was not qualified since he was not a qualified user.

Chairman Judy Lee asked whether or not if the product is reasonably possible to implement and integrate, including with medical data hub.

Mr. Wolf indicated it would likely be easy to implement. Tying in with electronic health record systems would be more challenging, although common API's are available. This does add complexity however. As per the data hub identified in another senate bill, this addresses pulling information from other sources looking at outcomes. This would be a source to add into that hub. When looking at the Health Information Network, everyone is using different standards, so having a common standard for data analysis and quality.

Closed Public Hearing.

Additional documentation that was provided by Mr. Kurt Snyder:

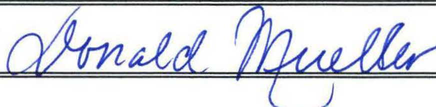
- Cost Benefits of Investing Early in Substance Abuse Treatment (Attach #9)
- Days to Treatment and Early Retention Among Patients in Treatment for Alcohol and Drug Disorders (attach 10)
- How to Increase Access to Substance Abuse Treatment: Implementing NIATx Model (attach 11)
- Removing Barriers to Treatment - the Case for Access and Retention (attach #12)

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2045
1/14/2015
J# 21980

☐ Subcommittee
☐ Conference Committee

Donald Mueller 

Explanation or reason for introduction of bill/resolution:

To provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

No attachments

"Click here to type your minutes"
This set of notes is from the Senate Human Services Committee work, January 14, 2015 at 2:00 p.m.

Maggie Anderson (Department of Human Services) provided information regarding the $6.1 million dollar budget request that is new money for 3 areas in employment services, which includes extended services which helps people with a serious mental illness in retaining their employment; then prevocational and extended services for individuals with a traumatic brain injury, the combination of that is about $600,000, about $550,000 for the extended services piece. There is also a 10 bed crisis residential transitional living program (SB 2048), which is about $900,000 for a 10 bed unit in North Central. Intention is to use existing beds, add 10 beds, and then have a unit between Northwest and Northcentral for crisis residential and transitional living; add 4 beds for acute crisis in Bismarck region; add 10 beds in Badlands area, which is about $600,000; 15 bed at Thompkins at the State Hospital which is $1.5 million, to be used addiction treatment in correction system, a contract with the Department of Corrections for individuals who are within their system who need this treatment.

V. Chairman Oley Larsen indicated that Senator Gravinger talked about this. Is there additional legislation to do something about this?

Chairman Judy Lee indicated that discussion is in regards the Anne Carlson Center, as they plan to build a new center because of the threat of flooding. Senator Gravinger indicated that the State Hospital grounds should only be corrections and the Human Services aspect should go to old Anne Carlson Center.

Maggie Anderson (DHS) informed the committee of a bill from last Friday that came out of interim Government Services committee that toured the James River Correctional Center (JRCC) and the State Hospital that is on the campus of the State Hospital gounds. The interim group put in a bill to develop a master plan for both the JRCC and State Hospital.

As part of that hearing, Senator Mathern brought forward an amendment from Senator Gravinger, but committee took no action after the hearing. This committee is chaired by Senator Dever. Should the Anne Carlson center be specifically designated in the study bill and possibly moving the state hospital. One of the reasons for moving the Anne Carlson school is to repurpose their campus. While there are buildings on the Anne Carlson complex, Alex Schweitzer indicated they need 600,000 square feet more space needed at State Hospital. If we were to move the acute forensic state hospital services, we provide the treatment for the sex offenders which are not a Corrections program, then there is the Thompkins program which are clients from Corrections and Rehabilitation but it is a treatment program at State Hospital. There were flood discussions, indicating that city of Jamestown has always protected the facility. In 2011, they did evacuate the campus. South Central Human Service Center is in the same vicinity as the Anne Carlson School, and Human Services also removed their staff in 2011, not because of the flood threat, but because of access. Since Department of Human Services runs a safety net 24x7, access to a Human Service Center is essential. The last two things as part of the $6.1 million dollars is nearly $300,000 to continue the work for Children and Family Services to implement a trauma and form system of care, and $1 million dollars to expand the mobile crisis program currently operating in the Southeast region to operate in all 8 regions. This would evolve to allow time in building interest, to procure, and complete a tiered implementation.

Chairman Judy Lee indicated this has been very well received.

Chairman Judy Lee asked for Maggie Anderson (DHS) to forward the information regarding the $6.1 million need. What are we seeing in traumatic brain injury that is addressed in the bill in the house? Maggie Anderson (DHS) will provide that information.

Chairman Judy Lee indicated there are a lot of questions on how to do a voucher. Any extra information how to put together a voucher would be helpful.

V. Chairman Oley Larsen asked for clarification - a grant would be granted to a facility that they give a bucket of money to address these needs, where a voucher goes to the individual seeking the services.

Chairman Judy Lee stated that her understanding of the interim committee intentions was that the money goes with the person. Chairman Judy Lee asked the department for any considerations that they can give, as it is obvious to meld with what they are doing. It should supplement what you are doing, not replace what you are doing. Chairman Judy Lee indicated a study would not be the preferred process, so if Department of Human Services and others could provide input, it would be helpful. The interim study wasn't super specific, which is good as it gives us flexibility. Chairman Judy Lee also confirmed that there would need to be a delayed implementation as discussed in all of the bills due to rule making and implementation requirements.

Senator Dever stated in the last hearing (SB 2048), the beginning of hearing sounded like we are just sending kids to PRTF's and to jail. Senator Dever wanted to note that it's not that we are doing nothing, there is a lot of things that can be done, but we are doing a lot of good things too. Senator Dever provided statistics where our Youth Correctional Center

has a capacity of 100; they usually run around 70. Our prison system has around 1,600 adults in it. In contrast, South Dakota has between 350-400 in their youth facility, and 3,500 adults inmates in their correction center. It is likely our counts are better because of the diversion we are already doing.

Senator Howard Anderson, Jr. is not particularly in favor of the amendment by Representative Hogan to change the focus of the voucher program requiring the use of the ASAM software. However, the suggestion that they come up with criteria for the voucher and how they are awarded would be good, otherwise Department of Human Services has to do this. If the coalition could do this and put it in the bill, this would be helpful. From the Department of Human Services perspective, how would it be best to use the money to benefit the clients?

Maggie Anderson, Department of Human Services, indicated the department would appreciate some guidance, using the autism example from last session that worked well. In that bill, it indicates how much you want to allocate per person per year; is there an income criteria, do we need to consider other third party insurance, ASAM levels, licensed based on ASAM levels. Ms. Anderson asked the committee if they want the voucher to focus on the gaps or all levels? We have, for example, a lot of people who can do the evaluation of service, but treatment level is an issue. The voucher is seen as a "choice", as they may not have 3rd party coverage insurance, so they choose where they go. Do you want us to do a dollar amount by person, or 3 months of service, or once per year if they use up their allocated dollars. The Department of Human Services would like dialog and input into all of that. The Department of Human Services doesn't want to misrepresent what the intent is.

Senator Howard Anderson, Jr. asked if the Department of Human Services would be comfortable getting the money to grant to the coalition network?

Chairman Judy Lee voiced concern and not sure if she could support this, as well as V. Chairman Oley Larsen.

Maggie Anderson (DHS) indicated that it then feeds into SB 2046 and SB 2048 in terms of data reporting and outcomes. Would you want the money tied to outcomes? We have heard much about evidence based services, outcomes, this puts a lot of accountability on the department without any controls. So there would need to be some type of contracting back on what we've received for that money. There are a percentage of providers that don't have electronic systems, so this could be problem. The voucher is for client choice, and if it goes to coalition, will the client choice be part of that.

Chairman Judy Lee indicated that coalition might try to get the money for themselves.

Senator Warner commented on the money following the person and go to private provider using Medicaid dollars. It seems to that after hearing the testimony, maybe it is a way to bypass the Medicaid prohibition on residential service.

Maggie Anderson (DHS) responded that the voucher may be used for this. Ms. Anderson indicated that she doesn't know what is going to happen at a federal level. It needs to be

re-examined this for something that was implemented in 1965. For someone who is on Medicaid, they would be eligible for the voucher and using it at Heartview and need residential care. If you have a third party resource who doesn't pay for that, and it's not because we won't pay for it, it's because we can't. If the legislature believes that is an appropriate use of the voucher, than this may be a good method of treatment.

Senator Warner asked can you segment the treatment and have Medicaid pay for the treatment part?

Maggie Anderson (DHS) responded yes, as this is done in Medicaid today. She provided an example where the RCC applications, in 2005-2006, the federal partners said stop paying those daily rates to RCC as they want to know what was in that rate, so the Children and Family Services division of the department pays for the room and board for those children and Medicaid pays for the therauptic services.

Senator Warner asked what does it cost for room and board for juveniles?

Joanne Hoesel indicated that it depends on level of care. Medicaid pays more for the treatment in a PRTF. If they have a child who goes into residential treatment facility, it can be $3,000 to $4,000 per month. Each facility has their own rate. They do break it out by therapeutic and room and board. If a child goes into PATH Foster Care home, it is least expensive.

Senator Warner asked for confirmation that it would be for 3 or 4 months of residential treatment if the voucher were $12,000 per year. Ms. Hoesel responded yes.

Chairman Judy Lee indicated the reason for discussion to figure out how far the money goes. In the autism waiver, you have to be approved for a family member and the use is identified, and a certain amount goes to that therapy.

Ms. Hoesel indicated it comes with the right diagnosis, that they fall into the right category of kids that you want to impact, a treatment plan from a professional that they are working with that would fall within the need they provide that voucher on. Depending on where they purchase it, there are different avenues for paying for that. Some are ongoing and some are one-time costs.

Chairman Judy Lee indicated that autism is an ongoing life issue. It isn't that children's mental health isn't long-term, but one would hope that there would be a lower level of service an ultimately wellness long-term.

Ms. Hoesel indicated it depends on the assessment, as it is individualized. Generally, someone will start in day treatment program or residential and then will drop down after stabilizing to outpatient and then after care and then recovery support. This could potentially pay for all of it or part of it.

Chairman Judy Lee indicated that she doesn't want anyone falling off the cliff. So the committee will need to consider limiting number of individuals so they can get the appropriate support, because there is acknowledgement that they can't treat everybody for

everything. Do we treat the highest in need, or take care of the ones with small problems before they get worse.

Pamela Sagness indicated that those who are not being served currently are those who don't have insurance but would have a sliding fee scale. Some clients are required to receive services from Human Service Center. The focus in the stakeholder groups is that there is a group who does not have choice. There could be a delay, where services might not be available by location for example.

Chairman Judy Lee indicated that the children mental health group is engaged stakeholder group. Chairman Judy Lee suggested they have a conference call prioritizing the most important criteria.

Senator Howard Anderson, Jr. agreed and further suggested that the Senate Human Services committee come up with a half page of criteria, which would be a starting point, then have them come up with decisions of how much to spend, who to serve, and then put it on this bill to be more focused.

Ms. Sagness indicated that one group that is a subcommittee of the stakeholders group is working on a vision for the substance abuse committee. They have providers, center for rural health, the department DOCR, could put together some of the thoughts and go to that subcommittee or everyone?

Chairman Judy Lee indicated that the voucher is for all addiction services, so this workgroup would be helpful. Chairman Judy Lee stated her concern about sending it to all stakeholders as this seems to get stuck, so if we don't have a blank sheet of paper, that'll help.

Ms. Sagness indicated that she is able to help coordinate this, start with the points to start the conversation.

Ms. Sagness also discussed data outcomes, and that they are not in the bill. Ms. Sagness asked if this would be a time to add in as recommendation?

Chairman Judy Lee indicated yes, but perhaps they were in a different bill draft. They can also agree to outcome measures.

Senator Howard Anderson, Jr. also asked that they provide input into the last line.

Chairman Judy Lee did state her confidence in ASAM, recognizing that there are challenges.

Senator Howard Anderson, Jr. commented his hesitation, that it is a barrier if everyone has to pay. If six people need access, that is $65 per person which is a cost. If you use electronic medical records, than they probably have that criteria imbedded in their electronic medical records, doesn't have the need to buy it from ASAM. Senator Howard Anderson, Jr. indicated his reluctance to put that requirement in there. If the elements are included in the bill, that is fine.

Chairman Judy Lee agreed, but doesn't want to ignore the backbone in the assessment to work consistently across public and private facilities.

Senator Dever was wondering if ASAM is the only good program. Is it necessary to give a specific name?

Chairman Judy Lee indicated that is something to consider. Yet, ASAM is highly regarded.

Senator Howard Anderson, Jr. said list the specific criteria.

Ms. Sagness indicated that it is important, all the level of care are already broken down by ASAM, it is mentioned 70 times just in administrative rule for substance abuse providers, it is something they are familiar with. The benefit of the software is it is one standardized tool. Note the intention of the voucher is the focus to the adult, youth, or both. The ASAM software only addresses adults. If this were to be attached to the voucher bill, is this only for people are receiving vouchers? There could be providers who would choose to not participate in the voucher system or accept vouchers and would they still be required to utilize the software. The Department of Human Services hasn't looked in detail at the amendment, but questions if it applies to all licensed programs because that also has an impact on the administrative rules relating to licensing of programs and the requirements of those programs. Ms. Sagness also questions if the voucher would take into consideration the sliding fee schedule?

Chairman Judy Lee indicated yes, Senator Howard Anderson, Jr. said if they pay what the other doesn't pay; the voucher can pay for the other services. There was discussion at the table about a deadline to provide enough time for re-referral. February 9th is the final date for re-referrals.

Ms. Sagness will provide a status early next week.

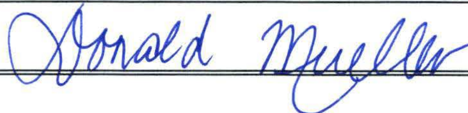
End of committee work today.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

2045
1/26/2015
22547

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature 

Explanation or reason for introduction of bill/resolution:

To provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

Attach #1: Proposed Amendment Attach #2: A Comprehensive Substance Use Disorder (SUD) System handout Attach #3: Testimony by Nate Medhus

These are minutes from the Senate Human Services Committee for January 26, 2015.

Pamela Sagness, Department of Human Services, provided proposed amendments to SB 2045. (attach #1). (end 2:29)

Chairman Judy Lee stated you are talking about ASAM criteria, we wanted the latest ASAM tool used

Ms. Sagness indicated yes. That was the amendment proposed by Representative Hogan. Ms. Sagness provided some discussion regarding that amendment also. The first suggestion is that in the first sentence there is a requirement that all programs would be required to have the software. However, one of the concerns is that there are providers that can be licensed to only serve adolescents. There is no adolescent software. The bill states that it requires all licensed providers through century code section 50.31.05. So if someone is only serving adolescents, they would be required to use software that doesn't exist. The second concern is the second sentence identifies health conditions, and it references the use of the DSM. The DSM is used for addiction also. To require the DSM usage only for co-occurring disorders wouldn't be clear.

Chairman Judy Lee indicated if you can send an email to her that would help.

Chairman Judy Lee indicated that software is at cost right now for service providers getting on board with electronic health records. Recognize there are challenges with that. Chairman Judy Lee is having trouble with resistance that seems to have otherwise merit to have consistent assessment tool for public and private providers.

Ms. Sagness added that one of the recommendations was for her to meet with stakeholders. The ASAM software was part of those discussions. The concerns from that group is that software is launching this month, the concern that it is a point-in-time, not an electronic health record, it is not an electronic health record but an assessment tool. Those that already have an electronic health record are going to have to have another electronic health record component. They are already required by state licensing to assess all addiction clients using ASAM criteria. There is also a concern about smaller providers that don't use computers, this would be a burden.

Chairman Judy Lee indicated that you shouldn't be in the business if you don't have technology.

Ms. Sagness provided the second handout, A Comprehensive Substance Use Disorder (SUD) System (attach #2). Look at gaps and not enhancements. Ms. Sagness went through the document. (9:35)

Chairman Judy Lee stated that Senator Robinson indicated not only that everything we have is full, it is more than a gap, an IMD provision prevents us from going beyond the 16 beds which is a barrier, and explain what that means.

Ms. Sagness referred to Nate Medhus.

Nate Medhus testified (attach #3). (10:54-13:17)

Chairman Judy Lee tell us about IMD

Mr. Medhus answered the IMD exclusion is a Medicaid rule that was established in 1965. It's intent at that time was to prohibit states from warehousing clients. When Medicaid was established, federal dollars would go directly to state coffers. If they limit number of beds eligible, and the IMD exclusion if you have over 16 beds, you are not eligible for any of your clients to receive Medicaid for any services. Clients living with them, if clients go seek treatment elsewhere while under there facility, Medicaid will not cover that procedure. IT is a barrier to treatment. Pilot program at federal level, 11 states involved, doing cost benefit about removing the IMD exclusion, do the overall cost of healthcare for those clients decrease if Medicaid is paying for the treatment in the IMD.

Chairman Judy Lee indicated that North Dakota did not participate in that waiver. Economies of scale could help.

Mr. Medhus indicated that from the provider group, someone will be requesting approval of resolution to CMS/HHS formally requesting that there is a review done of the IMD exclusion. As private provider, we are asking for time to look at the software. Consistency is important, but we need time to look. We aren't against it, but need time to look at it. We are already using ASAM criteria, so we support that.

Chairman Judy Lee asked if it would it be helpful for providers to learn more about this.

Mr. Medhus indicated that there have been numerous emails, requesting conference calls. He referred to training on the software, and timeliness for training could be difficult.

Senator Warner stated he could see the committee steering the Department of Human Services towards permissive language in a more generic term for the software. Is it important to be linked to the voucher or payment for services within the Department of Human Services relative to Medicaid.

Mr. Medhus indicated that could be an option. It could be a financial incentive for the private providers to make that leap. If they want to be in the voucher system, they use the ASAM tool and they provide information back to the state for data gathering.

End Medhus testimony.

Ms. Sangness (19:36) continued. The amendment doesn't give authority to Department of Human Services for the data. Utilizing the ASAM would allow the state the opportunity to see outcomes. But it is important to note that even if a private provider were to be using the software, there isn't anything here that identifies that the Department of Human Services would have any reason or authority to gather the data. As far as the proposal that talks about the key area, private providers wanted to note that if there is another funding source, they use that first and voucher would be last resort. To even have a 1% penetration of those needing but not receiving services right now would be a $9,000,000 investment.

Close hearing.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2045
1/27/2015
22650

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Donald Mueller

Explanation or reason for introduction of bill/resolution:

To provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

Attach #1: Discussion points regarding Amendment by Representative Hogan Attach #2: Proposed Amendments for SB 2045

"Click here to type your minutes"
These are minutes from Senate Human Services Committee on January 27, 2015.

Pam Sagness, Department of Human Services, provided further follow-up. Reference Attachment #1, Attachment #2. Ms. Sagness walked through the documents.

Chairman Judy Lee indicated there are private providers researching this and that we will hold off until next week. In this case, it is important to let addiction and treatment providers, they are not opposed, but they need to know more about it. Private providers didn't want a training program, but more of webinar to do review for information. This will allow them to provide feedback. She does have a note somewhere that it does interact with all electronic health records. One of the big deals is that the software is being offered at cost today. (7:06)

Senator Howard Anderson, Jr. stated that he liked the amendment from Pam Sagness better.

Ms. Sagness indicated the private providers talked to her about learning more about the software and she has also been invited to this. At the same time, it is important to reiterate that all license programs do the same assessment with the same six dimensions that the software does. They are required by administrative rule. Our administrative rule already requires all licensed programs to do the same consistent assessment. We don't mandate how they do that, for example, assessing dimension 2 before 4, but they do address the same 6 dimensions and follow the ASAM.

Chairman Judy Lee asked for clarification about the 6 dimensions.

Ms. Sagness referred to her earlier testimony. It is on the back side of the document, map of providers, and all 6 dimensions are all there, as well as level of care or levels of placement. When we do a licensing review, we ensure that all programs are assessing the 6 dimensions, which equate to the level of placement or the level of care for the clients. There is clinical discretion. There is quite often in our state where a recommended level of care is just not available. These are gaps that we address. Quite often, there may not be residential bed available, so a clinician can use clinical discretion to identify treatment plan that meets the need of the client as best they can without the level of care being available. Being client centered, they could be recommended to a certain level of care but may receive a different level of care.

Chairman Judy Lee will wait on this bill until we hear the conversation from the providers who do the review.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2045
2/3/2015
23085

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Donald Mueller

Explanation or reason for introduction of bill/resolution:

To provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

Attach #1: Proposed Amendment Rep. Hogan
Attach #2: Dr. Elizabeth Faust Information
Attach #3: Substance Use Disorder Voucher Program for Substance Abuse Licensed Private Providers

Chairman Judy Lee handed out Attach #1, read the proposed amendment and information from Rep. Kathy Hogan. (attach #1). Chairman Judy Lee asked Dr. Faust about further information.

Dr. Elizabeth Faust, Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota, provided further information regarding SB 2045. (attach #2) (ends 22:05)

Chairman Judy Lee asked about adolescent evaluations through this software.

Dr. Faust the ASAM criteria as we've been using has an adolescent criteria set imbedded in it. It has been used with Fidelity for a number of years. The software algorithm does not include all of the elements that are unique to adolescents because they haven't had the funding to develop the individual decision trees. It is on their work docket. The criteria set doesn't have evidence based criteria, but when she asked about that, because you are still doing an assessment within the 6 dimensions, you can use the software to collect the information. What happens sometimes, the recommendations may look different for children than for adults. What you can do with the software you can make exceptions. The software doesn't force you to make decisions, it provides the flexibility for exceptions. You can use the bones of the software.

Chairman Judy Lee and it covers young enough children under adolescent for children who are susceptible here. **Ms. Faust** confirmed yes.
Senator Howard Anderson, Jr. you made the statement that ASAM is working with electronic health record suppliers to integrate the elements of the ASAM criteria into health

records. If someone already has that, is that consistent that we should require them to use ASAM criteria software.

Ms. Faust yes, what happens is the program with algorithm can be brought into an electronic health record. The providers have high respect of the software. They haven't gotten to everybody yet. The program gets imbedded into the electronic health record. The advantage is that you do assessment the same as someone who doesn't have the electronic record. It is integrated with the electronic health - assessment looks the same regardless if you have electronic record.

Senator Howard Anderson, Jr. if someone already has separate software that meets ASAM criteria, are they required to pay the $60 per user or has the software provider included that in the cost.

Ms. Faust stated the payment flows to the electronic health record vendor, but it is paid once.

Chairman Judy Lee indicated that this is compatible with all electronic health records; all they need is web access.

Ms. Faust - it is more complicated than that. Every electronic health record can pull this into their system. If you don't have the record, you can still use it on the web.

Senator Dever we have 54 licensed private substance abuse treatment programs, and of those, 34 have only one clinician. Senator Dever is wondering if some of them look at this as being onerous.

Ms. Faust - that some people see this as onerous, but it will be for the right reasons. Having people have access to the internet and standardize assessment tool is not too much to ask. You don't have to have an electronic health record. You don't have to be part of a large system. You can adapt it. It does require clinicians to become fluent in assessing patients in consistent and standardized manner. It could be challenging to small operators, but it will raise all boats. There is a difference between having a technical challenge that causes you issues without any added value to patients. A challenge because you are trying to learn how to do an assessment and do it the same way that follows a standard as all the other clinicians. It helps to raise everyone's ability to do assessments, consistent, objective, and can be translated from one place to another. If we do ASAM assessment in one location and patient moves, they get permission to move the data, and there is continuum. Even if small operator in one location, you can now bring that information to the next place. It saves costs, more efficient and effective. For providers, they spend a great deal of time between them and payers. Payers also spend a lot of time on the same conversation. The data shows that providers are very pleased with the interface with payers.

V. Chairman Oley Larsen will this system be Blue Cross Blue Shield specific or will other entities who have Sanford and Medica be able to use this also?

Ms. Faust it can be. If Sanford would choose to bring this in to their electronic health records, it could. In some ways, it doesn't matter. If we are doing an ASAM assessment, whether using software or just the assessment, it is good quality assessment that you can put forward wherever the patient is seen. The question of whether other payers are going to adopt ASAM as a framework, can't answer that. Blue Cross Blue Shield likes the objectivity of the ASAM standards and software. If a payer doesn't use ASAM and a facility uses ASAM, they are still going to be offer when they communicate with that payer a clear and concise and objective summary of what the patient presents with and the needs. It's just better data than if you didn't have a standardized form.

Chairman Judy Lee asked Mr. Hannaher what their impressions were for Sanford Health. They were enthusiastic to explore as well. She has not talked to Medica. She doesn't want this perceived as a Blue Cross Blue Shield effort.

Curt Snyder, Heartview Association, in support of SB 2045, seeing improved access to services. However, they are NOT IN FAVOR of the amendment. It distracts and threatens the viability of services. It mandates one software across all providers. There are many differences between large and small providers. Many do not have technology. The bill was intended to help rural providers, and the software is a threat. It's a great tool, but it is only a tool, and has limitations. It is a point of entry assessment. It is not meant to be used again. In course of serving someone, not only identifying levels of care for initial assessment, it is a continuation of assessment, when to stay in level of care or less level of care, and then to discharge. In terms of outcomes, tool could provide good outcomes, but only for point of entry, you are not doing it again. You won't show outcomes, you will show when they come in. $65 per user is a concern. His organization has an ASAM tool, about $1000 per user seat, concurrent license. So 4 people can use the same software, and he has 9 seats plus cost of maintenance. The $65 would be additional cost, and it would go to ASAM. It is per user, not concurrent user. If he has 20 counselors, there is 20 x $65. That goes with the electronic health record. It is very comprehensive, treatment plans, progress, doctor's notes, billings, tracking case numbers, etc. This software solely does the assessment, but not comprehensive. If this was placed in as a mandate and not funded, this would have tremendous difficulty for providers. We all do ASAM. This tool would be a great step forward to have a standardized record, but not the right software.

Senator Axness - how many people are not using the internet in 2015? Defer to Pam Sagness. The push date back to 2016. The implementation date of utilizing the software would it be more acceptable if we said "shall 07/01/2016" - gives providers a chance to figure out how to cover the cost and all providers may have internet by then.

Mr. Snyder difficult to speak for some of those providers. It is challenging today to communicate with these providers who don't have internet. If we make sweeping changes and the providers aren't willing to go there, we will lose providers. Providers will not support this.

Chairman Judy Lee indicated that the software provider is providing software at cost at this time. Point of entry assessment is a start, and all the other things that go into the electronic health record, not necessarily an objection to be everything.

Mr. Snyder we have different standards in reviewing cases once placed in level of care, they are guidelines. The lower the intensity, the less you would look at that. Once you do the assessment, when asked, most often you would go into the medical and psychiatric, which is good for high level of care issues, but when patients progress through treatment, they are no longer the important issue. We would have to go back to this tool and pull out pieces that don't apply. Adolescents aren't just little adults - there is a whole different set of criteria and questions. The electronic record is different for adolescents versus adults. It's a great step to go forward, but not in this bill and not in this way.

Chairman Judy Lee if we say those who want to use it, then we gain nothing. We are looking for consistency. How do we encourage and enable and nudge the provider community if they aren't even willing to have an email and exploring efficiency and effectiveness. We spend a lot of time how to do this better, so how do we do it better with some consistency so people in one location gets the same consistent service as another location. It's necessary for all of us to figure out how to move forward.

Mr. Snyder agrees that change is a good thing. As director of his agency, will look and it is a good tool, but he understands his system also. They do have standards, consistency, reviews, all meant to help treat people consistently. There are reviews from the dept.

Chairman Judy Lee how do you do a peer review for someone who doesn't even have a laptop?

Mr. Snyder indicated they would review their paper records. Paper records provide a great history of the care provided.

Chairman Judy Lee stated an example with New Orleans and need for technology. And the security involved. There is a need for electronic records. She would have a hard time going to a professional with no electronic technology.

Mr. Snyder we do have a group of providers, stakeholder group, where they came together. Pam Sagness will provide paper of people involved in the stakeholder group. They take on the licensing issues, we are the first to say that the inconsistency is that evaluations don't look the same from providers, and then can't accept the other persons. With opportunity, want to move forward. Electronic health records may be part of that opportunity. The mandate is not the way to go.

Nate Mehus, Sharehouse. His comment is rhetorical question. Are we requiring standardized assessments for mental health and physical health? Are we requiring them to use uniform software? We do use ASAM criteria for placement of clients. But do we want uniform software between private and public. With 53 licensed providers in the state, we are a broad based profession as well. Granted we don't have the same number of clients that we treat and not on the same scale as a Sanford or the other medical providers.

Chairman Judy Lee if her femur was broken, the providers would figure out the same thing to fix her femur. It's an entirely different issue. Substance abuse and parity are different.

Senator Howard Anderson, Jr. how does a statement like this - if we added information that said all substance abuse treatment programs licensed in North Dakota implement utilize and maintain program and clinical fidelity with the most current version of the ASAM criteria. This would be where we don't require a particular software.

Mr. Mehus feels that's happening now in the state. We are required to use ASAM criteria. It is in administrative rules. Rules are posted in his office. We are all talking the same language regarding the ASAM criteria. The ASAM criteria - agrees with Ms. Faust that the consistency would help. The 53 providers may not be using the ASAM criteria the same way.

Senator Axness that at the hearing, specifically about the software, you hadn't seen it yet. If delayed date of implementation to 07/01/2016, what's your take on this.

Mr. Mehus indicated they are looking at the software, and what the additional costs will be. They currently spend $40,000 a year on their software, and with the clinicians he would need to use the software, it would be an additional $10,000, which is a 20% increase in costs. The evaluations they currently use are similar to what they saw in the ASAM software tool. There is always room for improvement. If we had delayed implementation, it would be helpful, but there are providers who may not feel they can afford the software. If there is a mandate, there will be pushback. If you have early adopters who make the leap, other providers will follow.

Pam Sagness, Department of Human Services, clarified that there are several amendments. The amendment presented by Department of Human Services is clarified the language effective services by ASAM, not accurate, level of care placement. The second amendment was reviewed. The first was from Representative Hogan. Ms. Sagness answered Senator Axness prior question on how many are not using electronic health records - 25% of the private providers. Just because they aren't using technology doesn't mean they don't have paper records - they do. Administrative rules require peer reviews, to be completed by other clinicians who look at charts and records, and also every two years there is an onsite licensing review that is conducted by Department of Human Services for all licensed programs. This is a review of clinical records and ensuring the programs are following the ASAM criteria. In the administrative rules, ASAM is mentioned 70 times. The Department of Human Services has provided training and technical assistance for ASAM.

Chairman Judy Lee asked for clarification on the different proposed amendments. One from the department, one from Representative Hogan.

Ms. Sagness provided additional comment sheet on Representative Hogan's amendment previously. The comment that there is not currently adolescent software, but not that there isn't criteria.

Ms. Sagness indicated there are two different conversations. She discussed the bill itself without the amendments. There were some additional questions asked of the private providers in regard to clarifying of how the voucher would be used. (attach #3). Ms. Sagness went through the document. (1:07:56). The second clarification is with the

software. She did participate in the software demonstration. The data that would be collected from the software would be very rich. Ms. Sagness provided examples, including override of recommendations and why. It is a great tool to collect data at a point-in-time. Outcome based means looking at treatment. ASAM doesn't speak to whether the program was effective. They would not be able to be identified with the software today. Also asked about recommendations if providers could reassess. They don't have this. Software is not live yet - several months away from being in production. Clinicians have discretion. Having this tool make the clinicians follow the recommendations would limit the clinicians. There is a perception that there is not consistency today, and clinicians would disagree. Level of care is where things could be inconsistent. When reviewing if ASAM criteria is consistent, the Department of Human Services works with providers to ensure that consistency.

End of discussion.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2045
2/3/2015
23117

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

To provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

Attach #1: Amendment Re-Referred to Appropriations

Pam Sagness, Department of Human Services, provided more information. To address the question if there is an opportunity to look at something in relation to the ASAM software. The committee would actually recommend that this be an option through the voucher, so that providers who want to participate in the voucher program would participate in the software, or looking at this being a pilot for two of those locations so it doesn't limit access to some of the more rural providers. This would be an opportunity for the state to use the software, and who would be able to use it. **Chairman Judy Lee** restated.

Senator Axness - for Sheldon Wolf, is there a deadline for providers to be using electronic health care records. Considering using ASAM for 07/01/2016.

Mr. Sheldon Wolf, Information Technology Department, indicated there are not for the providers. The providers that we are talking about are probably an exemption, but if they would, they would get a discount on Medicare payments.

Ms. Sagness did participate in the webinar last week. When asked the best way to roll out, they recommended a gradual roll out instead of all at once.

Chairman Judy Lee also heard the gradual rollout is better.

Senator Dever asked are all public clinicians using this software or planning to use the software.

Ms. Sagness said there is a new electronic health record being procured through the Department of Human Services. This was not a requirement that it must be ASAM software. It doesn't mean it won't be. There current and future electronic health record software will be required to use ASAM criteria.

Chairman Judy Lee so there are two parts to this - how we do the voucher, and how we do the ASAM software.

Senator Howard Anderson, Jr. made a motion to ADOPT AMENDMENT presented by Pam Sagness, Department of Human Services. The motion was seconded by **Senator Axness**.

Discussion

Chairman Judy Lee made it clear what this amendment does and doesn't do.

Senator Howard Anderson, Jr. the program already has ASAM criteria, not software.

Roll Call Vote to ADOPT AMENDMENT presented by Pam Sagness
6 Yes, 0 No, 0 Absent. Motion passed.

Chairman Judy Lee then suggested to look separately at the software, and consider as the options from Ms. Sagness, whether to have access to the voucher system requires the provider to use the software, or to look at the pilot project.

V. Chairman Oley Larsen likes the idea of if you are going to take advantage of the voucher, you follow the software program. He explained his experience in school setting, how it evolved to a higher level of technology.

Chairman Judy Lee stated that the assessment is point in time at the beginning, but the electronic health records becomes a long term repository.

Senator Warner regarding an alternative to pilot, a pilot may be limited to geographic areas. Concern about pilot in rural area.

Senator Axness concurs. Looking at ways on how to do pilot, some rural smaller providers that don't have web based electronic records. So then if you have bigger, than Fargo or Bismarck and lacking the rural. Hoping this will provide an incentive to the smaller providers to move forward.

Chairman Judy Lee sees it more as a carrot than a stick.

Senator Warner stated that one of the comments we had early on is that this might provide inpatient care for Medicaid patients for services, which would necessitate the larger providers. The smaller one's won't do that anyways. People who would be eligible for services at Human Service Center but don't want to wait, so they jump to a private provider. Perhaps timeliness of services. How do we allocate it the most efficient way, for treatment at Human Service Centers.

Chairman Judy Lee we have waiting lines at every Human Service Center for these services. If it does enable someone to get services faster, that is okay. Not replacing it,

not taking money away from Department of Human Services, but providing money for the voucher.

JoAnne Hoesel, Department of Human Services, stated that all Human Service Centers have a walk in clinic for addiction services. That is making a difference on wait times. Voucher provides choice.

Chairman Judy Lee and they might be living in a place where they don't have to drive somewhere for services. No one is unhappy with services from Human Service Center, but this is intended to supplement this.

Ms. Hoesel stated one option is to ensure there is increased access; provide to all providers, but do pilot with the software and report back, and then expand.

Chairman Judy Lee not a geographical, but money. What if we use it all up, they like the software and a lot buy it, we want to make sure they could use the regular pot of money.

Ms. Hoesel the Department of Human Services could use the dollars to access services, and second would be to use the software and pilot the software.

Senator Warner would we want to allocate or specify certain type of provider is going into the pilot project? Large, small, some who are hesitant?

Ms. Hoesel one option is you might want to set aside dollars and have the coalition choose inside, and that there be representation to be piloted and then demonstrate how it will work in the variety of settings.

Chairman Judy Lee that could be more complicated.

Senator Dever how will the voucher system work? Will the provider apply for a voucher for a particular client?

Pam Sagness answered there are three key focuses of voucher: access, client choice, and level of care. The voucher system would be administered by the Department of Human Services. Client would contact Department of Human Services division and would be able to go directly to a provider. Voucher is funding of last resort.

Senator Dever if ASAM software is required, are we stating preferred providers. They may not know that unless they go to that preferred provider.

Ms. Sagness one of the considerations is access. Would have to look at contracting with the providers, and will require research.

Senator Dever what is the abbreviation of licensed addiction counselors
Ms. Sagness answered LAC.

Chairman Judy Lee think as a committee member that we would be better off putting provisions in here or better off by enabling administrative rules in conjunction with "the group" so that they would be involved in the administrative rules process.

Senator Howard Anderson, Jr. stated he is struggling where we require a piece of software, not rolled out for a few months (Chairman Judy Lee indicated March), example we heard was to get some leaders in the field and convince the others. He submits that we leave the bill as it is now, and then in 2 years see if there should be particular software.

Senator Dever stated in the amendment that they adopted, it says the Department of Human Services shall develop requirements and provide training and technical assistance. Doesn't that allow them the latitude to require that software?

Chairman Judy Lee doesn't see it that way. She thinks the requirements would be for how you get the voucher, but it doesn't say anything about software. Chairman Judy Lee also respectfully disagrees with Senator Howard Anderson, Jr., that there shouldn't be some kind of consideration of this particular software as an incentive for at least part of the funding we are talking about. It can be limited so that it can't be more than x amount of dollars so that all the big providers don't eat up all the money. Everybody doesn't have to do it, but it would be good to have incentive.

Senator Axness indicated that he thought he would be strongly pushing for this software implementation. After hearing some of the discussion and recommendations, he is worried that the $2,000,000 that is supposed to be for the voucher may be funneled for the purchase of the software. Right now he is reconsidering that maybe we push this out as it is after amendment hoping that the rules get established for the software and then in 2 years we can come back to it.

Chairman Judy Lee would like to see it on the radar screen, and keep it moving forward, especially the voucher system for services. We can't live without technology.

V. Chairman Oley Larsen in one of his other hats he wears, diesel mechanic, can go so far in diagnosing without the software, and then stopped. Even in rural areas, he needs the software for diagnosis on how to fix a vehicle. This is the same. It is a key piece; you need the tool to make the correct assessment.

Chairman Judy Lee it doesn't mention administrative rules in the bill or amendment. So we've talked about it, but would we need to add this to the amendment rather than it being assumed.

Julie Leer, Department of Human Services, has general rule making authority. So any programs they administer they have the authority to make the rules.

Chairman Judy Lee would like to suggest that a report be available to an appropriate interim committee twice during the interim. She would like it before legislative interim ends.

Senator Warner asked having a report before July 2016.

Chairman Judy Lee so we know what is going on before it is implemented.

Senator Warner we'll receive before they eventually do anything.

Chairman Judy Lee wants to know what the rules are on the voucher.

Senator Warner we changed implementation to July 2016. If you want 3 months of data, we might want to consider report in October 2016. **Chairman Judy Lee** we won't have outcomes, but I'd like to see eligibility information.

Senator Dever if we delay implementation for one year, does it reduce the cost for biennium.

Maggie Anderson (DHS) up to the discretion of committee, but it would be $4m for the next biennium if it continues at that level.

Chairman Judy Lee asked how much now.

Maggie Anderson (DHS) it takes millions today when we look at all the locations.

Senator Dever do we need to address the FTE or does appropriations deal with that.

Maggie Anderson (DHS) this is similar to the TBI bill, where we had indicated between SB 2045, SB 2046, and SB 2048, this is an FTE for all three bills.

Senator Dever seems we either commit $1m per year or $2m per year.

Senator Dever made a motion to ADOPT AMENDMENT to reduce the amount of appropriation on line 5 to $1,000,000. The motion dies for a lack of second.

Senator Warner moved to ADOPT AMENDMENT to instruct the Department of Human Services to report to an interim legislative committee before July 1, 2016, the rules they have adopted. The motion was seconded by **V. Chairman Oley Larsen**. No discussion.

Roll Call Vote to Amend to Report
6 Yes, 0 No, 0 Absent.

NOTE: This amendment was missed in the overall final amendments. It has been passed to the Senate Appropriations Committee. (Attach #1).

Senator Warner moved that the Senate Human Services Committee give a DO PASS recommendation to SB 2045 AS AMENDED, AS AMENDED, and Re-Refer to Appropriations Committee. The motion was seconded by **V. Chairman Oley Larsen**.

Roll Call Vote to DO PASS as amended as amended.
5 Yes, 1 No, 0 Absent. Motion passes.

Chairman Judy Lee will carry SB 2045 to the floor.

15.0178.02002
Title.03000

Adopted by the Human Services Committee

February 3, 2015

TD
2/3/15

PROPOSED AMENDMENTS TO SENATE BILL NO. 2045

Page 1, line 8, replace "providers" with "licensed substance abuse treatment programs"

Page 1, line 8, replace "biennium" with "period"

Page 1, line 8, replace "2015" with "2016"

Page 1, line 9, replace "services" with "levels of care"

Page 1, line 10, after "medicine" insert ". The department of human services shall ensure that a private licensed substance abuse treatment program accepting vouchers under this Act collects and reports process and outcome measures. The department of human services shall develop requirements and provide training and technical assistance to a private licensed substance abuse treatment program accepting vouchers under this Act. A private licensed substance abuse treatment program accepting vouchers under this Act shall provide research based services"

Renumber accordingly

Date: 02/03 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2045

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Amendment from Pam Sagness

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ______

Motion Made By Anderson Seconded By Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment ______

If the vote is on an amendment, briefly indicate intent:

Date: 02/03 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2045

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: to Report

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ______

Motion Made By Warner Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent ______

Floor Assignment ______

If the vote is on an amendment, briefly indicate intent:

Date: 02/03 2015
Roll Call Vote #: 3

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2045

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation:
☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Warner Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever		✓			

Total (Yes) 5 No 1

Absent 0

Floor Assignment Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2045: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2045 was placed on the Sixth order on the calendar.

Page 1, line 8, replace "providers" with "licensed substance abuse treatment programs"

Page 1, line 8, replace "biennium" with "period"

Page 1, line 8, replace "2015" with "2016"

Page 1, line 9, replace "services" with "levels of care"

Page 1, line 10, after "medicine" insert ". The department of human services shall ensure that a private licensed substance abuse treatment program accepting vouchers under this Act collects and reports process and outcome measures. The department of human services shall develop requirements and provide training and technical assistance to a private licensed substance abuse treatment program accepting vouchers under this Act. A private licensed substance abuse treatment program accepting vouchers under this Act shall provide research based services"

Renumber accordingly

2015 SENATE APPROPRIATIONS

SB 2045

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2045
2/9/2015
Job # 23441

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes:

Legislative Council - Alex Cronquist
OMB - Sheila Peterson

Chairman Holmberg called the committee to order on SB 2045. Roll Call was taken.

Alex Cronquist: Legislative Council, introduced SB 2045 to the appropriations committee and provided neutral testimony. SB 2045 was recommended by interim Human Services committee. This bill provides an appropriation $2,000,000 to Department of Human Services for the purpose of establishing and administering a voucher system to assist in the payment of addiction treatment services provided by private license substance abuse treatment programs for the period beginning July 1, 2016 and ending June 30, 2017. Services included in the program include only those level of care recognized as effective by the American Society of Addiction Medicine. Department of Human Services will develop the requirements, reports and outcome measures. Private Licenses shall provide research based services.

Senator Kilzer: Line 10 - why not use capital letters for the Society of Addiction Medicine?

Alex Cronquist in bills, words are not capitalized.

Kurt Snyder, Executive Director, Heartview Foundation testified IN FAVOR of SB 2045. They look to this bill to extend and expand services for those individuals in smaller rural communities that are not located near human service centers. It also provides choice for individuals to seek services with a private provider.

Senator Bowman How big do you think this will be in 10 years? It is another program and it will be another administrative cost. We start with a few people and in 10 years do we have 30 or 40 people doing the same thing? Where do you think this is going? Senator

Bowman indicated they are seeing a lot of new programs, and they may be all good programs, but they keep growing.

Mr. Snyder: The state of addiction services in North Dakota is very fragile. There are a lot of needs with a limited workforce and especially in certain areas. This bill is to help leverage the private providers in terms of providing some extra services. Mr. Snyder does not see that this is a bill that will continue to grow, but it is a bill that covers gaps in services.

Senator Erbele: Mentioning gaps in services - what are we talking in terms of numbers and people? Who's falling thru cracks?

Mr. Snyder: Deferred to Pamela Sagness, Department of Human Services, regarding the numbers. In circumstances however, if there is a private program that offers day treatment and intensive services, they may not be eligible for Medicaid coverage, but they are possibly in a small community. Folks with Medicaid coverage will not be reimbursed through that provider. For example, Medicaid does not cover residential.

Senator Kilzer: The Schulte Report (referencing the Schulte Consulting's Behavioral Heatlh Planning Final Report for North Dakota, June 2014) was critical of North Dakota, particularly in the lack of numbers of addiction counselors and said the stated North Dakota should loosen its licensing requirements.

Kurt Snyder: Stated there is a workforce issue for addiction professionals. There is an aging population with the workforce. Last year, 60 people did not renew their license. There are a total of 300+ licensed, so it is critical. The workforce issue compounds this issue. The private provider sometimes are the workforce especially in smaller communities. The Heartview Foundation doesn't have workforce issue because I can keep full staff, but rural communities have difficulty retaining their workforce. This takes advantage of the workforce that exists that is limited to access because of funding mechanisms.

Senator Carlisle asked if this could be done anywhere in the Human Services budget or does it have to be something new.

Maggie Anderson, Director, Department of Human Services: The Department of Human Services does not currently offer a substance abuse voucher system. Last session the legislature required a voucher system for autism services for individuals who do not qualify for the Medicaid autism waiver, so we have that experience within the Department of Human Services. In addition to that, Pam Sagness in Department of Human Services and JoAnne Hoesel and Alex Schweitzer have been working on The Western Initiative to try to work with private providers to do something along these lines. . The fiscal note for SB 2045 indicates that Department of Human Services needs staff. This is in combination for one staff person to administer SB 2045, SB 2046 and SB 2048.

Chairman Holmberg closed the hearing on SB 2045. This bill will go to the Human Services subcommittee.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2045
2/11/2015
Job # 23678

☒ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Donald Mueller for Alice Delzer

Explanation or reason for introduction of bill/resolution:

A Subcommittee hearing for Department of Human Services (Voucher system for Addiction Treatment)

Minutes:

Testimony 1 - 3

Senator Kilzer called the subcommittee to order on Wednesday, February 11, 2015, at 4:00 pm in the Senate Conference Room in regards to SB 2045. All subcommittee members were present: Senator Kilzer, Senator Erbele and Senator Mathern. **Nick Creamer**, North Dakota Office of Management and Budget and Michael Johnson, Legislative Council were also present. This is a free standing bill appropriating $2,000,000 plus $166,000 from the general fund for vouchers for addiction treatment. I would seek more information on what's being done for addiction treatment, and where we are at in the funding.

Senator Erbele stated he would like to know names of organizations and people who would be eligible who would participate in the voucher program.

JoAnne Hoesel, Department of Human Services, stated the division receives the substance abuse prevention and treatment block grant. It is a major source of treatment funding in the state. It is a federal block grant that every state gets based on a complicated formula. Within the grant, the Department of Human Services determines how the funds are distributed. The block grant funding is distributed to the regional human service centers, and they either provide direct services or contract with private providers for substance abuse treatment services. There is a number of levels of care services provided. All treatment providers in the state follow the administrative rule that the division authors, and it is based on the Society of Addiction Medicine, known as the ASAM criteria. And this is for both public and private providers. In addition to the human service center structure, the Department of Human Services also licenses the 54 private substance abuse treatment programs in the state. All 54 private providers would be eligible to apply for the voucher. Pam Sagness, Department of Human Services, has the information of the gaps that could be filled by the voucher program.

Senator Kilzer asked that the 54 private providers would make application to the Department of Human Services division of Mental Health Substance Abuse, you will review the application and issue a license.

Ms. Pamela Sagness, Department of Human Services, Substance Abuse Lead with the Division of the Mental Health and Substance Abuse, provided documents (attach #1). She has worked with a group of private providers and leadership associations in regards to substance abuse disorder. This group, a coalition, has identified there are several gaps in the existing substance abuse system. This is addressing gaps and not enhancing services. The voucher came forward from the Behavioral Health stakeholders group as an opportunity to look at how we could better address the gap in services. The first goal is to improve access to services. They also wanted to avoid waiting list for services. So if someone wants to seek services and they had no insurance and were self-paid, they would currently have to access those services through the human service centers, and at times there are waiting lists. There may not be waiting lists for the initial assessment, but there could be a waiting list for residential services or other levels of care.

Senator Kilzer how many of the 54 providers do not accept Medicaid.

Ms. Sagness provided a second document (attach #2) of who those providers are. It is important when we talk about the services provided by these programs to identify that the majority of licensed programs in North Dakota are one-or-two-person programs. Of the 54 licensed providers, 34 of the programs have one clinician. There are many providers that are cash-only and don't even apply to accept insurance or Medicaid. Many of them are retired from a larger system and do not practice full time. Ms. Sagness described the location of the providers by referencing to the attach #2 document, and pointed out where there are more services available in the urban settings than the rural settings. Ms. Sagness also provided a document (attach #3) that lists the levels of services available in those providers. In North Dakota, any person who is practicing substance abuse must be a licensed program in the state. The division does license those public and private programs. Those licenses are provided based on the level of services that are being provided by that provider. Where we have service gaps, even if there are many providers, it is quite possible that those providers are only providing an after-care or an outpatient service, individual session for example. The stakeholder group looked at not only where there are no providers, but also where there are gaps in higher level services, for example residential or day treatment.

Senator Kilzer asked if the administrative rules accept the requirements that a provider have a master's degree in addiction counseling?

Ms. Sagness responded that there are two different licensing agencies that are responsible when looking at addiction or substance abuse. (1) The Department of Human Services division licenses programs. (2) The North Dakota Board of Addiction Counselor Examiners which actually licenses the individuals. Our administrative rules require that the individuals be licensed through the board as individuals, and then also practice in a licensed program.

Senator Kilzer stated that the Board would probably establish the education and experience in order to become board certified. **Ms. Sagness** confirmed yes.

Senator Erbele asked how large is the block grant.

Ms. Hoesel stated the Substance Abuse Prevention and Treatment Block Grant, intended for both treatment and prevention, has a number of set asides. This means we are required to fund certain things. That block grant is $6,100,000 per year. Out of that, we fund women-specific programs, so they allocate money to North Central Human Service Center and Northeast Human Service Center, and then they contract with private providers for two women's substance abuse treatment programs. They have a statewide adolescent residential program located in Bismarck and the West Central Human Service Center contracts with Pride, Inc. 20% of the block grant has to go towards prevention. They also specifically contract with each of the tribes for prevention services as well. There is a maintenance-of-effort, where they give a certain amount of money, but then require the state to maintain the current effort that we put forward through general funds as well. Ms. Hoesel was told the maintenance-of-effort is roughly $13,000,000 for a state fiscal year. This is included in the Department of Human Services base budget line. In addition to this, the Department of Human Services gets additional dollars for the Robinson Recovery Program, and that is all general fund dollars.

Senator Kilzer you are talking about the total budget for the Mental Health Substance Abuse division of the Department of Human Services. Is that the whole budget for that division?

Ms. Hoesel stated that would be reflected in both the division budget and field services with the human service center budgets. The majority of the funding is there.

Senator Kilzer asked of the total $26,000,000, not all of it is for addiction.

Ms. Hoesel stated that at least 20% is for substance abuse prevention. It is intended to be used for substance abuse treatment and prevention.

Senator Kilzer asked that addiction is not separated out from prevention and other treatments.

Ms. Hoesel restated that it is all substance abuse related, and that 20% has to go to primary prevention, which is targeted to individuals that haven't had any use - we want to prevent them from using. The rest is for treatment.

Senator Kilzer stated that we are talking about addiction as a component of substance abuse. **Ms. Hoesel** confirmed yes.

Senator Mathern stated that they have a request for putting extra money in the Robinson Recovery Center. Would any of the money in this bill be accessible by Sharehouse which operates Robinson Center?

Ms. Hoesel indicated they are a licensed program, and so would have access to the vouchers. They would not be able to supplement what we are purchasing through our contract with them.

Senator Mathern asked how would the Department of Human Services use the voucher system. How does a voucher get to a person and how do they get treatment.

Ms. Sagness described how the voucher system would work. The Department of Human Services would have to write administrative rules first. This would take one year (July 1, 2016), and thus the amendment asking for a delayed implementation date. The second part looks at eligibility. The focus of the group was not to look at enhancements but instead at gaps. Looking at the client eligibility, it would identify who the voucher will be for. The voucher is client-based, so the first area is that it would be for an adult over the age of 18, because there are other options for coverages for youth, as there are fewer gaps for youth and access to services is better, at least relating to payment. The self-pay individuals at all levels of care, based on the ASAM levels of care, from an individual session all the way to residential services. Currently if someone is a self-pay individual who does not have the financial means to pay for services, they need to seek services through the human service center. Prioritizing that group would allow choice, and access to providers in rural areas. The third eligibility criteria requirement would individuals with Medicaid are not currently covered in the private system at levels 2.5, 3.1, or 3.5 which is basically the higher level residential programs and partial hospitalization. There are a few private providers that are able to receive Medicaid at a 2.5 level, but they must have a medical director on site, as that is part of the program requirements. The voucher would be considered the payment-of-last-resort. If there are clients who would be eligible to apply for other types of coverage, it would certainly be encouraged that they do this first. When looking at provider eligibility, the key would be that the providers must be a licensed program in the state, and need to be able to provide services following all of the ASAM requirements in administrative rule. Lastly, the program must comply with the documentation standards that are also identified in administrative rule. The department also recommended that it be data-driven with outcome-based results. The amendment by the department ensures that the programs would not only identify process measures, but also the outcome measures, so the Department of Human Services can identify those programs that are having an impact. In the oversight section, the language was added for outcome measures and the data will guide them to fund future programs that show outcomes.

Senator Mathern stated this was an interim bill and there is substantially more information here today. When did you put all this together?

Ms. Sagness answered in the last four weeks.

Senator Mathern expressed that he was impressed with the progress. Beyond that, the research based requirements and outcome measures, would they apply to the human service centers also.

Ms. Sagness the human service center would not be able to apply for the voucher program. This is specific to private programs. The rest of the work being done in the division would apply to the human service centers. The language is comparable to the

language in the block grant and also other programs like Robinson Recovery so that they can compare the services across all systems.

Senator Kilzer asked how the $2,000,000 is arrived at.

Ms. Sagness answered the $2,000,000 was originally from the behavioral health stakeholder group a placeholder. The subcommittee identified specifically what the dollar amount might be in order to look at even a 1% penetration rate. That dollar amount came to $9,000,000. So it was easily seen that it a program that is much needed, but a small impact on the total amount. This would be looked at as a pilot, and hopefully there would be less gaps in the future as there will be more people enrolled in different coverage.

Senator Kilzer asked how many people would be treated, how many hours, and how many dollars per hour.

Ms. Sagness responded that she doesn't have those numbers from the estimate, but could provide that information. It was brought forward by private providers who actually looked at the numbers. Approximately 5% of people seeking services need residential services, for example. So they took the average length of stay and cost in order to come up with those numbers.

Senator Kilzer asked if these people will be eligible for Medicaid or any other third-party payment. This was confirmed.

Senator Kilzer asked Ms. Hoesel if the $26,000,000 for the biennium, is that the present biennium and for the next biennium, or have the block grants been adjusting yearly?

Ms. Hoesel stated that amazingly the block grant at the federal level has rebounded some sequestration and actually added funding. This $12,000,000 is what the Department of Human Services anticipates for the 2015-2017 biennium. The $12,000,000 would be two years of the block grant money, and the $26,000,000 is the maintenance of effort, including what has been done.

Senator Kilzer asked if part of the block grant can be used or if it is only for Medicaid?

Ms. Hoesel stated that the block grant is not for clients who have Medicaid. It is for individuals who don't have coverage or they don't have enough coverage, or they don't have insurance.

Senator Kilzer so with the block grants, they are for ineligible Medicaid recipients. **Ms. Hoesel** confirmed correct.

Senator Mathern stated there is some issues in regards to the software for the ASAM requirements. Have the issues been resolved? Will we require the software? And are the issues resolved in this bill?

Ms. Sagness responded that there was a lot of testimony with the ASAM software. ASAM is already a requirement in the state through administrative rule. Following ASAM criteria is

something that has been in practice since 2004 in North Dakota. The request for the ASAM software as a requirement was a recommendation that the software would be mandated to all licensed providers in the state. However, there was some opposition by private providers with concerns regarding the status of the software and not tested in actual practice. The software is a great tool that could provide some good data for the state; however, it is a point-in-time assessment, so the data is very specific to when a client first enters into a treatment center. The software doesn't do a follow-up in two weeks or 30 days to say whether or not the programs are effective. Once this was clarified, the software amendment was not brought into the bill, but was strongly recommended by the Senate Human Services Committee to be monitored. Many private providers are interested in the software, but want time to assess the product before they would invest. There is a cost for the software, which is $65.00 per user per month, so this would be a mandate for providers to purchase that software, and this would be an ongoing cost. The intent of the voucher bill was to increase access to services, and the concern with the mandate may actually make some of the private providers stop providing services. Approximately 25% of the providers use paper-charts and don't have electronic health records. Many of them are practicing in retirement, and they may choose to quit providing services instead of learning and investing into a new system.

Senator Mathern what would you use to measure things like effectives.

Ms. Sagness stated there are many measures that could be focused on. Historically, we have seen an abstinence measure; how long did someone stay clean. We try to focus more on quality of life measures, things like in the criminal justice population you want to look for recidivism, look for things like quality of life overall commitment to having a healthy life style, employment, etc. It is important to have those measures consistent across the system so they can evaluate the process and outcome measures and look for effective programs.

Senator Kilzer asked how long Ms. Sagness had been with the department. **Ms. Sagness** stated approximately eight-to-nine years. She came from the public/private addiction system, but have been the administrator in the past 1 ½ years.

Senator Kilzer thanked the Department of Human Services for the information and closed the committee meeting.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2045
2/17/2015
Job # 24027

☒ Subcommittee
☐ Conference Committee

Committee Clerk Signature	

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the department of human services for a voucher system for addiction treatment services.

Minutes: Attachment 1

Senator Kilzer called the sub-committee to order on SB 2045. **Senator Erbele** and **Senator Mathern** were also present.

Senator Mathern handed out amendment 15.0178.03001 and said Senator Lee brought this over to committee and directs a report to Legislative Management from the Dept. of Human Services before July 1, 2016. This regards the rules to establish a voucher program. This is a new way of delivering or getting services out to people. The committee was concerned that the rules could be rather complicated and should be out and reported on by that date so that the public and private providers have an indication on how the program is going. These are her amendments.
One thing in the Schulte Report, we have some areas where the department both funds and regulates services. Having a voucher program would help it to be regulated more easily. This amendment provides more openness and gives people time to weigh in.

Senator Kilzer asked about the rules to administer the voucher system. There will be two systems in competition - the federal grants amounting to about $26M biennium and also $1M of state money for vouchers?

Senator Mathern: I think you meant $1M per year.

Senator Kilzer does the study compare the two systems? It doesn't say what the object of the study is, it just says there has to be a report.

Senator Mathern: It's regarding the rules. Every time the department will issue a draft of the rules. Then there would be time for feedback.

Senator Kilzer we were told that $26M wasn't even affected by sequestration and this wasn't requested by the department.

Senator Mathern: But it was requested by our legislative colleagues.

Senator Kilzer: if we're going to have a cluster of bills, I'd rather have them put together with one FTE and they're all behavioral items. As far as Individually, I'm not happy for it - the money. I'm ok with the bill, but I'm concerned about supplementing another program that's not suffering.

Senator Erbele: If three bills deal in similar areas and use a common FTE, can we pick items we agree on, kill two and advance one? On SB 2045, what if we reduced the $2M to $1M. Then out of SB 2046, take sections 1 & 3. I'm just throwing out ideas and trying to take the best of the three.

Senator Mathern: I could see us taking some pieces out of those three bills. They came as separate bills and the committee thought the package would look too large to really get into the content. Maybe there would be greater willingness to digest the content of these different principles if they were separate bills.

Senator Kilzer: I'd rather see one camel's nose under the tent than three. If you can put the three together, they are all relating to behavioral science. There's a lot of money if you fund all three.

Senator Mathern: I'll work with Senator Erbele and come back with one bill.

Senator Kilzer: I think you should be on an allowance. It sounded like there was $8-9M in the original bills.

Senator Mathern: I think you're saying that the combination of the three bills should cost less than the present fiscal notes.

Senator Kilzer: Then we could keep it alive. The ideas would still be there. I didn't hear the interim report so I don't know what a reasonable amount would be. It wasn't an OAR. Work it out tomorrow morning.

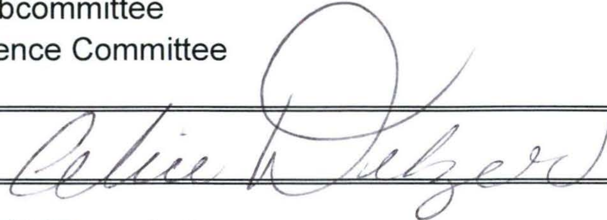
Senator Mathern and **Senator Erbele** are getting together on 2045, 2046, 2048.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2045
2/18/2015
Job # 24087

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation to the DHS for a voucher system for addiction treatment services (Do Pass as Amended)

Minutes:

Testimony # 1

Chairman Holmberg called the committee to order on Wednesday, February 18, 2015 in regards to SB 2045. All committee members were present. Michael Johnson, Legislative Council and Lori Laschkewitsch, OMB were also present.

Senator Erbele explained the amendment # 15.0178.03002, Testimony Attached # 1.

Chairman Holmberg: That is very standard because typically in these kind of things the report is farmed out to the appropriate committee that has the time and expertise to look at these issues rather than to budget section which is too big and the agenda is too long.

Senator Erbele moved the amendment. 2nd by Senator Kilzer.

Chairman Holmberg: Those in favor of the amendment say aye. It carried.

Senator Erbele moved a Do Pass as Amended. 2nd by Senator Mathern.

Senator Mathern: This bill comes from the interim committee. It had considerable more dollars in it and DHS committee reduced those dollars. It attempts to address the waiting list at some of our facilities for getting services for chemical dependency treatment and creates the system of voucher so that not all people eligible for services would need to get them at the regional human service center.

Chairman Holmberg: We heard the other day if you live in Valley City you have to go to Fargo if you want to go to a human service center for the kinds of services you might need.

A Roll Call vote was taken. Yea: 13; Nay: 0; Absent:0. This goes back to Human Services. Senator Judy Lee will carry the bill. The hearing was closed on SB 2045

15.0178.03002
Title.04000

Prepared by the Legislative Council staff for
Senator Erbele
February 18, 2015

TD
2/18/15

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2045

Page 1, line 2, after "services" insert "; and to provide for a report to the legislative management"

Page 1, line 5, replace "$2,000,000" with "$1,000,000"

Page 1, after line 16, insert:

"**SECTION 2. DEPARTMENT OF HUMAN SERVICES REPORT TO LEGISLATIVE MANAGEMENT.** The department of human services shall provide a report to the legislative management or a committee designated by the legislative management before July 1, 2016, regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs as provided in section 1 of this Act."

Renumber accordingly

Date: 2-18-15
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2045

Senate Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: 15.0178 .03002

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ____________

Motion Made By Erbele Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Heckaman		
Senator Bowman			Senator Mathern		
Senator Krebsbach			Senator O'Connell		
Senator Carlisle			Senator Robinson		
Senator Sorvaag					
Senator G. Lee					
Senator Kilzer					
Senator Erbele					
Senator Wanzek					

Total (Yes) ____________ No ____________

Absent ____________

Floor Assignment ____________

If the vote is on an amendment, briefly indicate intent:

voice vote
Carried

Date: 2-18-15
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2045

Senate Appropriations Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐

Motion Made By Erbele Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Heckaman	✓	
Senator Bowman	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator O'Connell	✓	
Senator Carlisle	✓		Senator Robinson	✓	
Senator Sorvaag	✓				
Senator G. Lee	✓				
Senator Kilzer	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Human Serv Judy Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2045, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2045 was placed on the Sixth order on the calendar.

Page 1, line 2, after "services" insert "; and to provide for a report to the legislative management"

Page 1, line 5, replace "$2,000,000" with "$1,000,000"

Page 1, after line 16, insert:

"**SECTION 2. DEPARTMENT OF HUMAN SERVICES REPORT TO LEGISLATIVE MANAGEMENT.** The department of human services shall provide a report to the legislative management or a committee designated by the legislative management before July 1, 2016, regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs as provided in section 1 of this Act."

Renumber accordingly

2015 HOUSE HUMAN SERVICES

SB 2045

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2045
3/9/2015
24507

☐ Subcommittee
☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Provide an appropriation to DHS for a voucher system for addiction treatment services.

Minutes: Attachment 1, 2, 3, 4, 5

Chairman Weisz: Opened the hearing on SB 2045.

Rep. Kathy Hogan: From District 21 introduced and testified in support of the bill. (See Testimony #1)

Rep. Fehr: Can you explain the current system on how things with Medicaid, insurance dollars and that kind of stuff and how does this voucher system work or not work with that in terms of payments and sustain ability?

Rep. Hogan: The first option is private insurance and then Medicaid dollars and the voucher is a payment as a last resort.

Pam ~ From Dept. of Human Services: went through handouts. (See Handout 2,3 and 4).

Chairman Weisz: Can you explain why so many of these programs aren't Medicaid?

Pam: This was a recent change in the last few years and previously licensed addiction counselors were not covered by Medicaid. When that change occurred there really was no public awareness of that so we are finding that providers at this point in time are often unaware but there are some providers that also choose to do a cash business.

Rep. Hofstad: Can you get farther into what makes a provider eligible for Medicare and Medicaid coverage?

Pam: Previously licensed addiction counselor services were not covered because licensed addictions counselors were not identified as being the qualified mental health professionals according to the rules. When that changed a few years ago addiction counselors could

then enroll as a provider. They enroll under their own individual license in the Medicaid system.

Rep. Hofstad: Those previsions are previsions by our department or are they Medicaid previsions? Who sets those parameters?

Pam: I'm not sure who, but it is in statute now the same as when we discussed earlier during SB 2046 this morning about the licenses marriage and family therapist being included. I believe the same thing was brought forward two sessions ago in regards to licensed addition counselors.

Rep. Porter: Between bill SB 2046 and this, when 2046 was presented to us it was just adding the family marriage counselors to the reimbursement system. Was there any discussion on doing the same kind of program with a voucher system to hit those areas of highest needs in demands like this program is trying to do? If not why aren't we looking at it from that aspect rather than just a blanket?

Pam: These bills were brought forward by the behavior health stake holders group and I don't know if there was discussion about that at any stage but there wasn't in SB 2046 on the senate human services side. In fact the previous information on SB 2046 used to include a lot more information including some of the sections from SB 2048 as it stands today but there was no discussion about a voucher system and again the bill from SB 2046 is looking at having those clinicians be identified as reimbursable and the voucher system is looking at filling gaps where there is not reimbursement. There are two specific areas where theses gaps are. One is the rural areas and having access to services without having to drive to a local human service center. The other is Medicaid cannot cover residential treatment service. One of the gaps that are identified is if you need a higher level of service and you are someone who is a Medicaid client you are unable to receive services outside of the human services centers. So even if there are private providers that have availability you can't receive that service and still get the sliding fee scale unless you are at the human service center. That is one of the targets of the voucher system that cannot be remedied through the Medicaid system.

Rep. Hofstad: Is that our department or Medicaid's rule?

Pam: I can't answer that, but will get the answer.

Rep. Mooney: You had mentioned something to the effect that there are a certain number of providers that do not have either software or computers and I am just wondering in the 21st century we actually still have certain individuals who practice with a folder and a file cabinet?

Pam: That is correct. We are responsible for licensing private providers and public providers and currently of the private providers that are listed in the hand out approximately 10 percent don't even have internet connection in their facilities.

Rep. Mooney: Is that because of lack of internet capability in that specific area or they elect not to have internet?

Pam: It is the choice of the provider. One of the concerns that we would have would be that we already have limited access to services and not enough capacity and a lot of those providers are providers that have retired from other systems and are providing individual therapy in their smaller communities. Our concern would be that requiring may cause additional capacity issues because they may choose to just stop practicing.

Rep. Mooney: With regards to the amendment that was provided for us to look at, does that change the fiscal note that we had received?

Pam: I just received this amendment. I do have a couple of comments I can make briefly but I will check on the fiscal note. Regarding number 3, it says the department shall identify rules to follow the DSM manual that is already required in our administrative rules. In regard to number 1 when it talks about the fact that the department should adopt a rule that sets guidelines regarding ASAM (American Society of Addiction Manual), I have a handout here that shows what ASAM is all about what levels of care we already have in this state. Our administrative rules are already base on ASAM. What we don't have is a mandate for providers to have an electronic health record or screening software from ASAM. We even license our programs based on the ASAM license of care so we broke down on the front page of the handout each level of care and what is offered per region.

Rep. Mooney: Do you have any idea of the cost factor to the program?

Pam: It would be 65 dollars per practitioner per month.

Rep. Mooney: Is it online prescriber based not desk top based correct?

Pam: It is web based; however the primary way that they are implementing the program is through electronic health records they do have contracts with more than 20 different electronic health record venders.

Alex ~ Legislative Council: Do you have any questions for legislative council on the bill?

Chairman Weisz: There are none.

Meagan ~ Director of Government Relations for Blue Cross Blue Shield: Handed out the testimony of Elizabeth Faust, Senior Medical Director for Behavioral Health for Blue Cross Blue Shield of ND. (Testimony #5)

Rep. Seiblel: You said it is currently offered at cost, is that a startup cost or will it eventually increase to the practitioners? Do we know how long they will be offered it at cost?

Rep. Hogan: The 65 dollars is the actual cost assuming you are an individual provider. Depending on if we started as a pilot project or implemented it with everyone I think if anything the cost will go down. If a client comes in and has an assessment and they are willing to sign to give you the release of information to find previous assessments the new

provider could get the original history and it would reduce the cost of assessment. You would have to update but you wouldn't have to start with everything.

Rep. Fehr: How does BCBS get the information? Do you get all the records and the whole assessment?

Meagan: My strength isn't on the provider side of the business but I know that at a very high level part of the advantage to this is it is a much more standardized process. There is less objectivity.

Rep. Fehr: Who has access?

Meagan: I'll get back to you.

Pam: There wouldn't be anyway the department can get the data from the providers. There is nothing at this point in time to require the department to require private providers to submit any of that data to analyze that.

NO OPPOSITION

Chairman Weisz: Closed the hearing on SB 2045.

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2045
3/30/2015
Job # 25624

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Marlys Kuenzle

Minutes:

Chairman Weisz: Open the meeting with SB 2045.

Rep. Porter: Made a motion of DO NOT PASS.

Rep Hofstad: Second the motion.

Do Not Pass Yes 11 No 2 Absent 0

Carrier of the bill is Rep Fehr.

Date: 3-30-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2045

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: ____________________

Recommendation:
☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ ____________________

Motion Made By Rep. Porter Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha		✓
Rep. Bert Anderson	✓		Rep. Oversen		✓
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 11 No 2

Absent 0

Floor Assignment Rep. Fehr

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2045, as reengrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed SB 2045 was placed on the Fourteenth order on the calendar.

2015 TESTIMONY

SB 2045

Attach#1
SB2045 01/14/15
J#21945

Testimony in support of
SB 2045
January 15, 2015
By Kathy Hogan, Rep. District 21

Chairman Lee and members of the Senate Human Service Committee, my name is Kathy Hogan, I represent District 21 and I have been a member of the Behavioral Health Stakeholder group.

SB 2045 is one of eight bills that were generated through the Interim Human Services Committee to address a variety of issues creating a crisis in behavioral health services in ND. Ms. Schulte identified 6 major recommendations ND needs to address:

Service Shortages
Expand Workforce
Insurance Coverage Changes needed
Changes in DHS structure and responsibilities
Improve Communication
Data Collection and Research

The primary objective of SB 2045 is to expand available substance abuse services through the establishment of a voucher system. This system would address several of the recommendations, particularly the expansion of available services.

Following the interim committee, the Behavioral Health Care Stakeholders Committee continued to meet. At that point in time, it was discovered the Addiction Society of American (ASAM) has just established a standardized computerized assessment system that is now available. The ASAM criteria and standards are well established and agreed upon protocols. This new assessment offers ND an opportunity to unify the public and private system that will identify unmet needs, collect data on current resources and build a more unified system of care.

Attached is a copy of an amendment to this bill that we would encourage you to consider as ND moves to a more integrated public/private partnership to assure access to services.

Thank you considering this amendment. I am more than willing to answer any questions.

1.3

15.0178.02001
Title.

Prepared by the Legislative Council staff for
Representative Hogan
January 12, 2015

PROPOSED AMENDMENTS TO SENATE BILL NO. 2045

Page 1, line 1, after the first "to" insert "create and enact a new section to chapter 50-31 of the North Dakota Century Code, relating to substance abuse treatment programs; and to"

Page 1, after line 3, insert:

"**SECTION 1.** A new section to chapter 50-31 of the North Dakota Century Code is created and enacted as follows:

American society of addiction medicine - Substance abuse treatment requirements.

All persons, partnerships, associations, corporations, and limited liability companies licensed pursuant to section 50-31-05 shall implement, utilize, and maintain program and clinical fidelity with the most current version of American society of addiction medicine criteria and American society of addiction medicine criteria software. Co-occurring mental health conditions must be described utilizing the most current edition of the diagnostic and statistical manual of mental disorders. Adults with substance abuse conditions must be assessed with the American society of addiction medicine criteria software algorithm. Programs must utilize American society of addiction medicine criteria for service planning and associated level of care placement, continued care, and discharge decisions for adolescents and adults."

Renumber accordingly

Attach #2
01/14/15
SB 2045
J# 21945

Testimony on SB 2045

January 14, 2015

Senate Human Services Committee

Good morning Chairman Lee and members of the committee. My name is Michael Kaspari; I am a registered nurse, agency director of First Step Recovery and current chairman of the North Dakota Addiction Treatment Providers Coalition and a member of the Behavioral Health Stakeholder's Group. I am here this morning to offer testimony in support of SB 2045.

- 2013 National Survey of Drug Use and Health estimates 37.5% of people who sought out alcohol treatment were unable to receive it.

- Many people don't access treatment because of financial reasons, wait lists and lack of program availability. Low income North Dakotans who are fighting the disease of addiction and limited to the public system often have poor access to services. SB2045 would ensure people who are working to overcome their illness would have improved access to services through utilization of private providers.

- A 1% penetration of the 55,000 persons in need of but not receiving treatment in ND would be 550 additional individuals served each year.

- Assuming 90% of these clients would be served in an outpatient setting and of those, 80% could be served at an IOP level of care while 20% would require a PHP level of care. Using the reimbursement rates for Medicaid of $211.00 per diem for IOP and $302.00 per diem for PHP we could serve an additional 500 outpatient clients over the biennium for an approximate cost of $7,320,400.00.

- For the 10% of these currently unserved clients who would require a residential level of care, the statewide residential bed capacity is adequate to meet this increased need. It is more difficult to calculate the cost for serving these clients because there are no Medicaid reimbursement rates for residential levels of care. Using an extrapolation of the Medicaid outpatient rates and average national lengths of stay for residential treatment the 50 clients per year receiving residential care could do so at an estimated cost of $2,384,400.00 for the biennium.

- The ND Addiction Treatment Providers Coalition just became aware of the amendment to utilize the ASAM Criteria software as part of implementation of the voucher program. While we recognize this may be a very beneficial addition to the voucher program, we have not had time to review its use and application and are unable to endorse it at this time. We are actively pursuing additional information about the software and how it might be used with this program.

In many cases, the window of opportunity to help a person suffering from a substance use disorder is small and not open very long. It is very important for the right treatment to be available when and where the person needs it. A state voucher system would go a long way towards providing real options to persons needing substance use disorder services. I urge you to support this bill. Thank you very much for your time and consideration. I will be happy to answer questions should you have them.

Attach #3 01/14/15
SB 2045
J# 21948

An FAQ (Frequently Asked Questions) on Fee-for-Service Voucher Based Substance Abuse Services

What is a Fee-For-Service Voucher Program - FFSV?

A Fee-For-Service Voucher is a financial assistance program created to reduce the barriers for individuals needing and accessing treatment, but not having the ability to pay. It is not intended to supplant other means of financial assistance. It may be used to offset some or all of the costs of services not currently reimbursable through third-party payers (private insurance, Medicaid, etc.). Users of vouchers are expected to contribute, based on ability to pay, toward the financial obligations associated with evaluations and treatment.

What are the advantages of a voucher based program?

SAMHSA says the purpose of a voucher program is "to ensure that clients have a genuine, free, and independent choice among a network of eligible providers that offer an array of clinical treatment and recovery support services. These services must result in cost-effective, successful outcomes for the largest number of people". **All private substance abuse treatment organizations must meet existing state licensing and certification standards for clinical treatment and assessment to be eligible.**

What levels of care can be reimbursed?

SAMHSA indicates the following are considered reasonable ranges by treatment or modality:

- **Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services - $200 to $1,200**
- **Outpatient (Non-Methadone) - $1,000 to $5,000**
- **Outpatient (Methadone) - $1,500 to $8,000**
- **Intensive Outpatient- $1,000 to $7,500**
- **Residential - $3,000 to $10,000**
- **Peer Recovery Support Services- $1,000 to $2,500**

How would the state administer a fee-for-service voucher based program?

This would be determined with input from private providers. Consideration should be given to SAMHSA guidelines for the state agency overseeing a FFSVP:

- ***Developing and maintaining an electronic voucher management system. Eligibility determinations for clinical treatment and recovery support service providers and for which service in the continuum of recovery will be included in the voucher reimbursement system.***
- ***Eligibility determinations for clients, including management of a system for assessment and service determinations.***
- ***Fiscal/cost accounting mechanisms that can track voucher implementation.***
- ***Management of information systems to track performance and outcomes.***
- ***Developing information technology capacity to collect performance data***
- ***Development of a client follow-up system in order to locate and interview client's six-months post-intake.***
- ***Activities to attract, develop, and sustain new clinical treatment and recovery support service providers.***
- ***Oversight of standards and clear procedures to monitor, prevent and remediate fraud, waste and abuse.***
- ***Establishment of referral pathways involving consumers in institutional systems***

such as the criminal justice system, State Departments of Corrections, probation, parole and jail authorities. This may include assistance with developing Memoranda of Understanding (MOUs) and other formal mechanisms to solidify client referrals.

How are vouchers issued?

If the National model is adopted there would be 3 types of vouchers:

- ***Assessment voucher***
  The screening yields the assessment voucher. At the scheduled time, the client is assessed by qualified and trained staff. The assessment is based on ASAM (American Society of Addiction Medicine) criteria.

  Clinical treatment voucher
  Based on the results of the comprehensive assessment, a clinical treatment voucher is generated which includes level of care recommendations and all providers that offer the type and level of care indicated by the assessment. The automated voucher system enables the assessor to help the client compare various clinical treatment providers' services, capabilities and openings (availability) so the client can make an informed choice. The clinical treatment voucher will contain the client's and assessor's signatures along with the client's choice of provider, clear instructions for the client's next steps–admission date, transportation arrangements (if needed), pre-treatment supports, recovery supports, etc.

- ***Recovery support service voucher***
  An assessment provider offers multiple choices to the client in terms of recovery supports while awaiting clinical treatment, during clinical treatment, and during extended treatment along with clear instructions about next steps. The assessment produces a recovery supports voucher which includes services that might benefit the client based upon information gathered in the assessment. After the client chooses recovery supports, the client and assessor sign the voucher. The recovery supports voucher may be updated as the need for additional services arises during the course of the recovery process and in preparation for discharge.

Why is this needed?

- ***Illicit Drug Use. The National Survey on Drug Use and Health (NSDUH, 2013) found that 6.4% of the people surveyed (of the population 12 and older) needed but did not receive specialty addiction treatment for illicit drug use and 6.3% needed but did not receive treatment at a specialty facility for a substance abuse problem.***
- ***Alcohol Use Problem. NSDUH estimates that 37.5% of people who wanted alcohol treatment reported that they were unable to get treatment.***
- ***NSDUH estimates that 64.0% of those who perceived a need for an alcohol use problem did not make an effort and the 36.0% that made an effort but were unable to get treatment***

Many people have not accessed treatment because of financial reasons; wait lists, lack of program availability. The voucher system would begin to address some of these concerns.

Wait times at the state human service centers as of 12/4/14 were:

- ***SEHSC (South East Human Service Center—Fargo): 6 weeks***

- ***NEHSC (North East Human Service Center-Grand Forks): 1 week with walk-ins on Tuesday and Wednesday***
- ***NWHSC (North West Human service Center—Williston): Walk-in on Mondays and Tuesdays, next available appointment in 21 days***
- ***WCHSC (West Central Human Service Center-Bismarck): Appointment available in 1 week; walk-ins on Wednesday and Thursday***
- ***BLHSC (Badlands Human Service Center-Dickinson): 8 weeks***
- ***LRHSC (Lake Region Human Service Center—Devils Lake): Walk-in on Tuesday and Thursday***
- ***SCHSC (South Central Human Service Center-Jamestown): 7 weeks***
- ***NCHSC (North Central Human Service Center—Minot): Immediate—walk-ins Monday and Wednesday***

When would a voucher be used?

A voucher would be assigned on an individual basis based on need. It is designed to assist in the payment of addiction treatment services provided by a private treatment provider for an underinsured or uninsured population.

Who would be eligible?

Vouchers would be available for any individual in need of a substance abuse evaluation (which would be honored by all approved network providers) and /or in need of substance abuse services that currently do not have third-party coverage (private insurance, Medicaid, etc.). Users of vouchers are expected to contribute, based on ability to pay, toward the financial obligations associated with evaluations and treatment.

What program providers would be eligible?

Private providers would need to be approved and licensed by the ND Division of Mental Health and Substance Abuse.

How would this system be tracked and documented?

All participants would need to collect established data to track treatment access, service use, and outcomes. Information will be tracked to demonstrate an impact on disparity with regards to race, and ethnic background, cultural and linguistic needs, sexual/gender minority groups.

Who would be responsible for the implementation of the voucher program?

The North Dakota Division of Mental Health and Substance Abuse will be responsible for the implementation of this program. No more than 10 percent of the allocation may be used for administrative costs (voucher management system, data collection, performance measurement, and performance assessment).

What services could be funded by the FFSV?

The state division will negotiate cost for each substance abuse service:

- *High Intensity Adult Residential Care (Level III.5)* --Patients who require continuous observation, monitoring, and treatment are assigned to this level of care. The residential program is staffed 24 hours a day, seven days a week with residential aides; and patients receive daily clinical services from the multidisciplinary staff. Group therapy, individual sessions and educational programs are utilized and focus on activities of daily living, pro-social behavior and reintegration into family and community.
- *Social Setting Detoxification (Level III.5)* –This program assists patients in achieving initial recovery from the effects of drugs and alcohol, 24 hour monitoring and support will be provided by trained staff.
- *Low Intensity Residential Care (Level III.1)* --This level of care provides a safe alcohol and drug free environment for patients who require structured support to apply recovery skills to their lives to prevent relapse, improve emotional functioning and promote personal responsibility.
- *Partial Hospitalization /Day Treatment (Level II.5)* --Patients who require near daily monitoring, support and interventions to begin the process of change and recovery are assigned to PH/day treatment. Patients participate in group, family and individual sessions and are monitored by the multidisciplinary staff.
- *Intensive Outpatient Services (Level II.1)* --This service is for the patient who is able to establish abstinence and begin recovery within the context of their home environment. Intensive evening and day programs will be offered.
- *Continuing Care Services (Level I)* --This service is for patients who require ongoing support after receiving/completing a more intensive level of care.
- *Medication Assisted Treatment* --Medication-assisted treatment is fully integrated into a comprehensive, holistic treatment approach.
- *Clinical Assessment. A professional evaluation to determine the extent of addiction, co-occurring conditions, and the development of a treatment plan including the recommended level of care*

Attach #4 SB2045 01/14/2015
Kurt Snyder
J# 21945

Dear Chairman Lee and Members of the Committee,

SB 2045

1/14/15

My name is Kurt Snyder and I am the Executive Director of the Heartview Foundation. I am here to testify in support of SB 2045 on behalf of the Heartview Foundation and the North Dakota Addiction Counselors Association.

The Heartview Foundation was established in 1964 and we have served over 26,000 patients and their families. Heartview currently employs 15 Licensed Addiction Counselors and an additional 30 behavioral healthcare professionals. We operate a 12 bed residential program and offer outpatient, partial hospitalization, and medication assisted treatment. We have at any given time over 200 active patients in our services.

- The "Schulte Report" which was completed in July of 2014 made clear that North Dakota is in a dire situation without available mental health and addiction services and an incredible workforce shortage. It is an official report to the legislature and makes clear the liability of inaction.
- The report highlights six major areas of concern. The first of the six is summed up in the report in one phrase, "Not enough services".
- The current funding structure has placed the burden on the human service centers to be the safety net and provide care for the indigent and uninsured. Within this structure, if someone comes to a private agency we have no funding mechanism to serve them.
- The main purpose of the voucher system is to provide choice beyond the human service centers and leverage access where access is available. Many times the only provider that has access is a private provider in a small community.

4.2

- Heartview is in the process of helping to build needed capacity for drug and alcohol treatment in North Dakota by expanding our Bismarck campus and through the acquisition of the former Center for Solutions in Cando, ND. We anticipate we will expand our services by 50% in our Bismarck campus and adding an additional 16 beds, partial hospitalization, outpatient and medication assisted treatment services at our Cando location.

Addiction is a chronic illness that is treatable and access to care is crucial. The cost- benefit of a voucher system more than offsets the investment. Lack of access is directly related to the utilization of high cost healthcare, overcrowding in our jails and prisons, domestic violence, lost work productivity, broken families, loss of life and so much more.

- Drug overdose is the leading cause of accidental death. (An average of 114 people die every day)
- Overdoses resulted in more deaths than HIV/Aids, homicide, or car accidents.
- There are 2.3 million people incarcerated in the U.S. It is estimated that 75% of the 2.3 million meet a diagnosis for a substance use disorder.
- Studies have shown that for every dollar spent on substance use services yields a return of seven dollars.

I thank you for your time and encourage your support of SB 2045.

I would be happy to answer any questions.

Kurt A. Snyder
Executive Director
Heartview Foundation
kurt@heartview.org
701-751-5708
701-426-8677

Attach #5
01/14/15
SB 2045
J# 21945

Chad Mayers

House Bill No. 2045

9:00 A.M.

01-14-2015

My name is Chad Mayers, I am a 38 year old father of 3 beautiful daughters. I live in Bismarck, North Dakota and have been clean and sober for one year. I entered Heartview in January, 2014 for residential drug treatment. I am a person on Medicare and Medicaid, because I became disabled 7 years ago due to the H1N1 virus. My left lung and all the ribs on the left side of my body were removed.

Since 2007 I have been in and out of hospitals for many different reasons, but most of all prescription drug overdoses. One major example of an expensive prescription drug overdose, was in 2010.

My grandmother found me dead in our living room, called 911. The Bismarck fire department and ambulance rushed me to St. Alexius. I stayed in the E.R. until I woke up, but had to stay on the ventilator for 13 days in ICU. I then further stayed in ICU for another week, I have no idea how much that visit cost the state. It must have been in the hundreds of thousands of dollars. In the past year since I have been clean and sober I called my Primary Care physician *once* to get an antibiotic.

As I stated above I do have Medicare and Medicaid, together did not allow me to receive residential treatment at Heartview. It is only through the generosity of Heartview Foundation that I am able to receive treatment that I need. Because of the professionals at

Heartview and my personal recovery in the last year there have been no hospital visits or any other expenses. By sheer luck I was enrolled in residential treatment at Heartview.

Without House Bill Number 2045 others may not be as fortunate as I was to receive residential treatment. Others will be guaranteed an opportunity for much needed treatment. There is no doubt in my mind that I would have died in the last year, instead I am able to stand here today to express how important it is for this grant to be available for more individuals like myself.

Chad Mayers

3540 N. 19th Apt. 3

Bismarck ND, 58503

602-809-1014

Attach 6 01/14/15
SB2045 J# 21945

KEY LEADERSHIP ORGANIZATIONS

in North Dakota's Substance Use Disorder System

North Dakota Board of Addiction Counseling Examiners

- The NDBACE is to set minimum standards for the **license of addiction counselors**; to establish **core curriculum** requirements; to approve addiction counselor **training programs, internship, and clinical supervisors**; and to establish requirements for the **private practice** of addiction counseling.

Department of Human Services, Mental Health and Substance Abuse Division

- Administration of alcohol and drug abuse programs, including establishing quality assurance standards for the **licensure of programs, services, and facilities**.
- Provides **leadership** for the planning, development, and oversight of a system of care for children, adults, and families with severe emotional disorders, mental illness, and/or substance abuse issues.

Department of Human Services, Field Services Division

- **Provides public mental health and substance abuse services** through eight Regional Human Service Centers and the North Dakota State Hospital in Jamestown.
- **Administration of mental health programs**, including planning and implementing preventive, consultative, diagnostic, treatment, and rehabilitative services for persons with mental or emotional disorders and psychiatric conditions.

Mental Health and Substance Abuse Planning Council

- The Council's purpose is to **provide advice and consultation to the Governor** of the State of North Dakota regarding the overall administration and service delivery of mental health and substance abuse services.
- The Council's objective is to monitor, review, and **evaluate the allocation and adequacy of behavioral health services** in North Dakota.

North Dakota Addiction Counselors Association

- The purpose of the Association is to **advance the profession of addiction counseling.** To that end, the Association shall promote the growth of the addiction counseling profession, foster interaction and the exchange of knowledge between addiction counselors, and be an **advocate for addiction counselors** on issues that affect the profession.

North Dakota Treatment Providers Coalition

- The mission of the Coalition is to **enhance opportunitie**s that advance our members' ability **to deliver proactive and holistic treatment services**.

Prevention Resource and Media Center

- North Dakota Substance Abuse Prevention System provides innovative, quality, and culturally appropriate **substance abuse prevention infrastructure, strategies and resources** to the individuals and communities of North Dakota.

North Dakota Coalition of Training Consortiums

- The purpose of the Coalition is to **advance the training of addiction counselors** within the state. To that end, the Coalition shall promote the training of the addiction counseling professional, foster interaction and the exchange of knowledge between addiction counselors and consortiums, and be an **advocate for addiction training** on issues that affect the profession.

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Attach 1 01/14/15 January 2015
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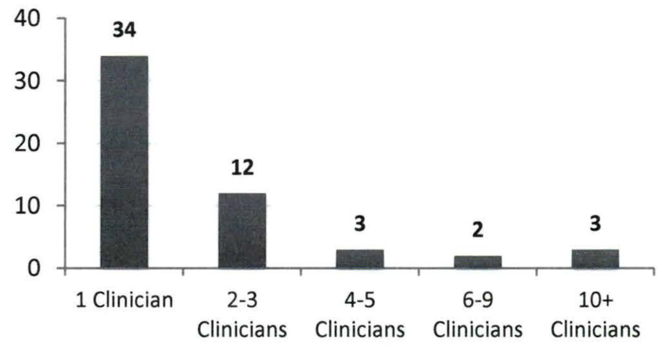
J# 21945

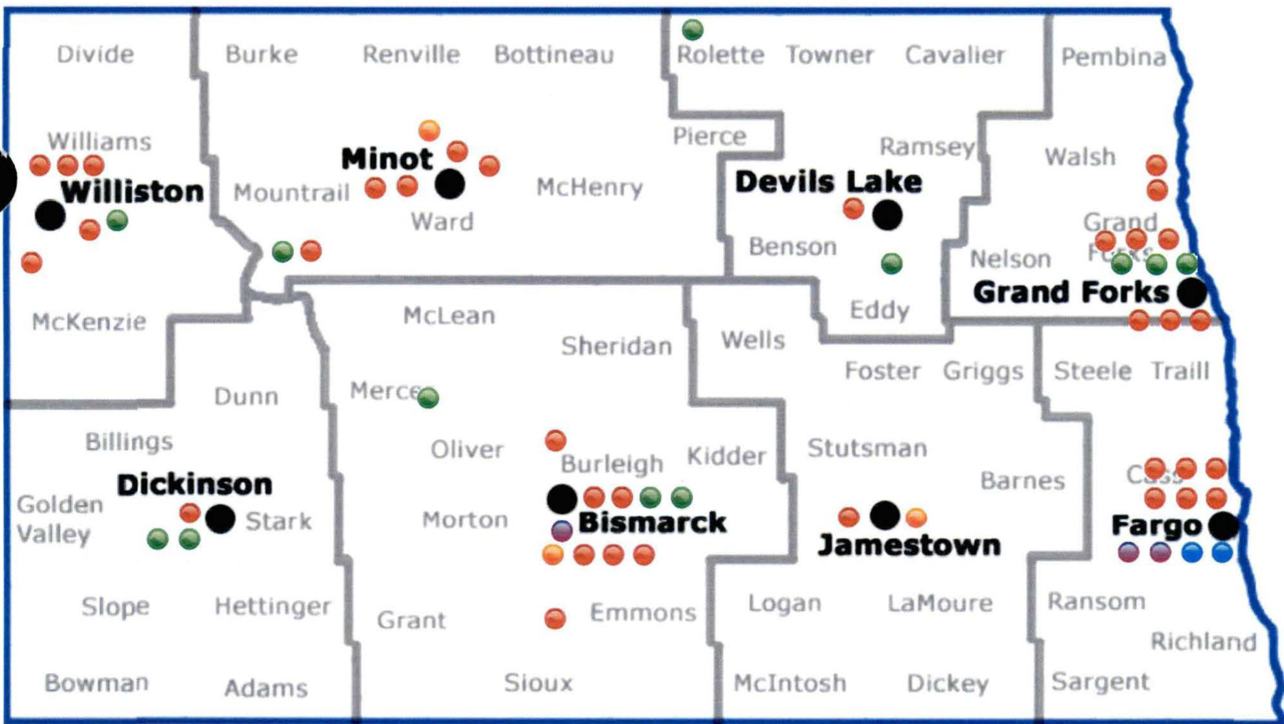
NORTH DAKOTA
Licensed Private Substance Abuse Treatment Programs

Total Number of Licensed Private Programs* = 54

- 34 Licensed Programs have 1 Clinician
- 12 Licensed Programs have 2-3 Clinicians
- 3 Licensed Programs have 4-5 Clinicians
- 2 Licensed Programs have 6-9 Clinicians
- 3 Licensed Programs have 10+ Clinicians



Location and Number of Clinicians per Program



LEGEND
- 1 Clinician
- 2-3 Clinicians
- 4-5 Clinicians
- 6-9 Clinicians
- 10+ Clinicians

Licensed Substance Abuse Treatment Programs are required to follow the levels of care based on the DSM and ASAM patient placement criteria and policies for client admission.

*Does not include DUI providers

List of Programs by Region

Region 1

Programs with 1 Clinician

- **ADAPT, Inc. - Williston**
- **Native American Resource Center** - Trenton
- **Choice Recovery Counseling -** Williston
- **Weishoff Alcohol & Drug -** Williston

Programs with 2-3 Clinicians

Montgomery Counseling Services – Williston

Region 3

Programs with 1 Clinician

- **ADAPT, Inc. -** Devils Lake

Programs with 2-3 Clinicians

- **5th Generation -** Belcourt
- **Spirit Lake Nation Recovery & Wellness Program -** Fort Totten

Region 5

Programs with 1 Clinician

- **ADAPT, Inc. -** Fargo
- **Shiaro, Chris Counseling Services -** Fargo
- **Simon Chemical Dependency Services -** Fargo
- **McGrath, Claudia Counseling -** Fargo
- **Discovery Counseling -** Fargo
- **Fargo VA Medical and Regional Office Center Substance Abuse Treatment Program -** Fargo

Programs with 6-9 Clinicians

- **First Step Recovery, a program of The Village Family Service Center -** Fargo
- **Drake Counseling Services, Inc. - Fargo**

Programs with 10+ Clinicians

- **PSJ Acquisitions, LLC d/b/a Prairie St. John's -** Fargo
- **ShareHouse, Inc. -** Fargo

Region 7

Programs with 1 Clinician

- **Prairie Learning Center -** Raleigh
- **Pathway to Freedom -** Wilton
- **Basaraba, Rose Counseling Service -** Bismarck
- **Be Free Counseling Services -** Bismarck
- **Chambers and Blohm Psychological Services, PC -** Bismarck
- **Kazmierczak, Audrey Counseling Service -** Bismarck
- **One 80 Programs, Dakota Institute of Trauma Therapy, PC -** Bismarck

Programs with 2-3 Clinicians

- **St. Alexius Medical Center/PHP Dual Diagnosis Program -** Bismarck
- **Coal Country Substance Abuse Services -** Beulah
- **ADAPT, Inc. -** Bismarck

Programs with 4-5 Clinicians

- **New Freedom Center, Inc. -** Bismarck

Programs with 10+ Clinicians

Heartview Foundation - Bismarck

Region 2

Programs with 1 Clinician

- **ADAPT, Inc. -** Minot
- **Bob Hayes Addiction Services -** Minot
- **Cornerstone Addiction Services -** Minot
- **Goodman Addiction Services -** Minot
- **Parshall Resource Center -** Parshall

Programs with 2-3 Clinicians

- **Circle of Life Alcohol Program -** New Town

Programs with 4-5 Clinicians

Trinity Hospitals - Minot

Region 4

Programs with 1 Clinician

- **ADAPT, Inc. -** Grand Forks
- **MAB Addiction Counseling Services -** Grafton
- **Quinn DUI/MIP/Evaluations -** Grafton
- **Alcohol & Drug Services, Inc -** Grand Forks
- **Foley, Don Counseling -** Grand Forks
- **Northland Christian Counseling Center -** Grand Forks
- **Stadter, Richard P. Psychiatric Center - Chemical Dependency -** Grand Forks
- **Start Somewhere Counseling Services -** Grand Forks

Programs with 2-3 Clinicians

- **Agassiz Associates, PLLC -** Grand Forks
- **UND Counseling Center Substance Abuse Program -** Grand Forks
- **Drake Counseling Services - Grand Forks**

Region 6

Programs with 1 Clinician

- **Dockter-Evjen Recovery Choice -** Jamestown

Programs with 4-5 Clinicians

- **Addiction & Counseling Services -** Jamestown

Region 8

Programs with 1 Clinician

- **ADAPT, Inc. -** Dickinson

Programs with 2-3 Clinicians

- **Heart River Alcohol & Drug Abuse Services -** Dickinson
- **Sacajawea Substance Abuse Counseling -** Dickinson

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January 2015

NORTH DAKOTA
Licensed Private Substance Abuse Treatment Programs... by ASAM Level of Care

EDUCATIONAL DUI SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
0.5	4	3	5	9	10	4	21	3	59

ADULT SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
I	5	7	4	10	13	2	9	3	53
II.1	2	4	3	3	8	1	5	2	28
II.5		2	1	2	5		5	1	16
III.1		2	3		2		2		9
III.5		1	1	1	2		1		6
III.7		1		1	1				3

ADOLESCENT SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
I	1	4	2	6	7	1	6	2	29
II.1		2	2	2	3		1		10
II.5		1		1	2		1		5
III.1		1			1		1		3
III.5		1		1	1		1		4
III.7		1		1	1				3

WITHDRAWAL MANAGEMENT (DETOX) SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
III.2D		1	1		3		1		6

north dakota
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8.2

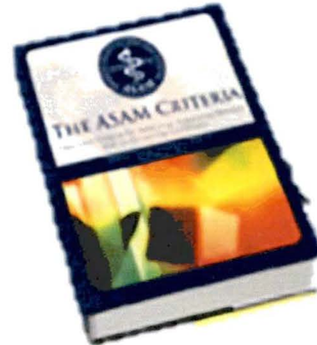
HOW THE ASAM CRITERIA WORKS

The ASAM criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

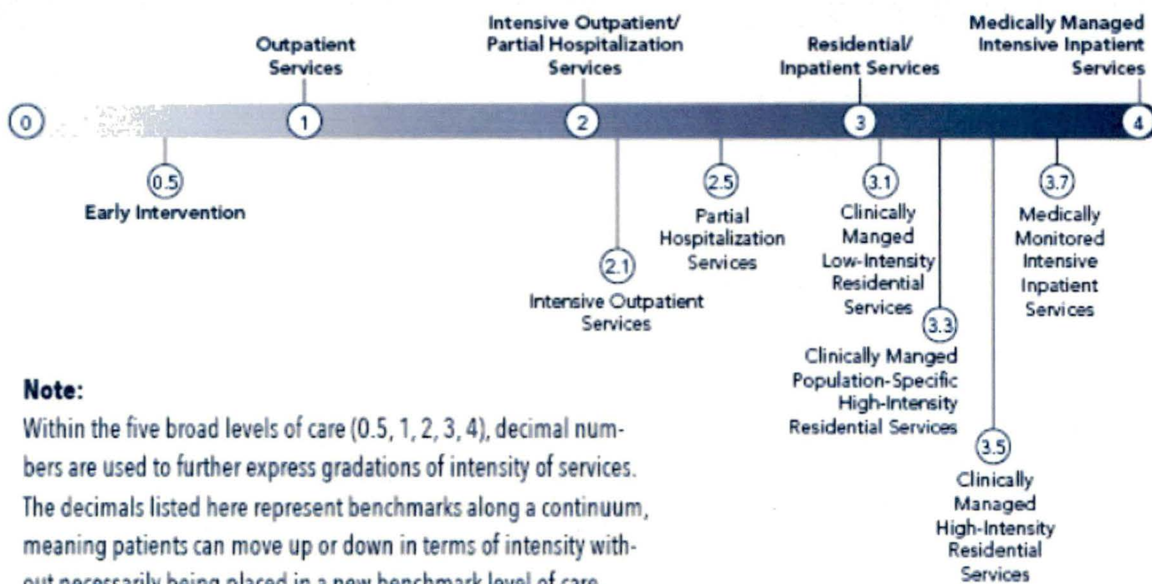
AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1	DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3	DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
5	DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things



REFLECTING A CONTINUUM OF CARE



Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

http://www.asam.org/publications/the-asam-criteria/about/

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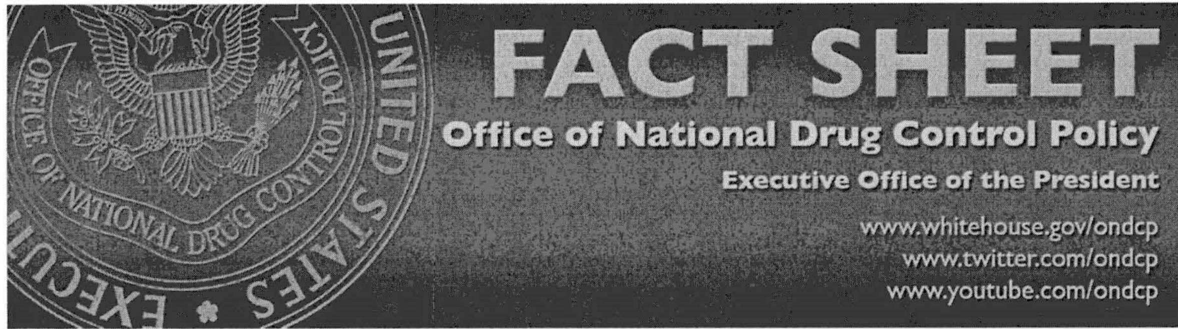

Cost Benefits of Investing Early In Substance Abuse Treatment

Illicit drugs and excessive alcohol use have a harmful effect on health and safety in the United States. Beyond the damage it inflicts on individuals and their loved ones, substance abuse is a significant drain on our Nation's economy. In 2006, excessive drinking cost the United States $223 billion in lost productivity, healthcare expenses, and law enforcement and criminal justice costs.[1] Illicit drug use also exacts a social and economic toll on our Nation. Factoring in public health, crime, and lost productivity, illicit drug use cost the country an estimated $193 billion in 2007.[2] And not enough Americans are getting the treatment they need. Survey results indicate that an estimated 23.1 million Americans ages 12 or older needed treatment for substance use in 2010, but only 2.6 million people received treatment at a specialty facility in the prior year.[3]

In today's difficult economic climate, it is more important than ever to examine the value of substance abuse intervention and treatment, and to invest in cost-effective, evidence-based approaches that will cut costs and save lives.

Early Intervention: SBIRT

Intervening early, before drug use or excessive alcohol use progresses to addiction, is among the most cost-effective ways to address substance abuse, reduce its costs to society, and improve public health.

Too often, individuals with substance use problems believe that only severe cases of addiction require treatment. Thus, many do not seek treatment until long after initiation, when their use has produced significant social, economic, health, and/or legal consequences.[4] Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach for delivering early intervention and treatment services to people with, or at risk of developing, substance use disorders. SBIRT is designed to take place in general medical settings that people routinely visit, and to identify individuals with substance use problems before their problems progress too far.

SBIRT is a three-step process:

- **Screening** quickly assesses the severity of substance use and identifies the appropriate level of treatment. Screenings take place in trauma centers, emergency rooms, community clinics, health centers, and school clinics.
- **Brief intervention** focuses on increasing a person's awareness of substance use and encouraging changes in behavior.
- **Referral to treatment** provides those who need more extensive substance abuse treatment with referral to specialty care.

ONDCP seeks to foster healthy individuals and safe communities by effectively leading the Nation's effort to reduce drug use and its consequences.

Research has shown that, in some instances, a brief motivational intervention appears to facilitate abstinence from heroin and cocaine use at a 6-month follow-up interview, even in the absence of specialty addiction treatment.[5] A 20-minute computerized version of SBIRT for post-partum women prevented relapse to most illicit drugs.[6] Further, SBIRT reduces the time and resources needed to treat conditions caused or worsened by substance use, making our health systems more cost-effective.[7]

SBIRT Saves Lives and Cuts Healthcare Costs

Well-implemented SBIRT programs have demonstrated considerable success. For example:

Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) found significant healthcare cost reductions among 1,315 disabled Medicaid clients who received an intervention through the program. Administrators concluded that the potential reduction in Medicaid costs could be as high as $2.8 million per year for working-age disabled clients who receive a brief intervention.[8]

Specific Medicaid cost reductions included:

- $185-$192 per member per month after receiving a brief intervention; and
- $238-$269 per member per month in costs associated with inpatient hospitalization from emergency department admissions.[9]

In addition, the study found that costs were reduced due to fewer days of hospitalization stemming from emergency department visits. For the 1,315 patients who received at least one brief intervention through the program, there were approximately 1,300 fewer days of hospitalization per year.

Treating Substance Use Disorders

For millions of Americans, substance use progresses to the point where efforts by the individual, his or her family and friends, and social networks may not be sufficient. In these cases of chronic addiction, access to treatment can be a critical and potentially lifesaving resource.

Effective treatment of substance use disorders consists of a range of clinical activities that can include assessment and diagnosis, group and individual therapy, medication (and medication maintenance) for detoxification, relapse prevention, and linkage to community support resources such as 12-step, employment, and housing programs.

Economic Benefits of Investing in Treatment

Research shows that every dollar spent on substance abuse treatment saves $4 in healthcare costs and $7 in law enforcement and other criminal justice costs.[10] On average, substance abuse treatment costs $1,583 per patient and is associated with a cost offset of $11,487, representing a greater than 7:1 ratio of benefits to costs.[11]

Some states have found that providing adequate mental health and addiction-treatment benefits can dramatically reduce healthcare costs and Medicaid spending.

- A study of alcohol and drug abuse treatment programs in Washington State found that providing a full addiction-treatment benefit resulted in a per-patient savings of $398 per month in Medicaid spending.[12]

9.3

- Medical costs for people in treatment were $311 lower per month than for those who needed but did not receive treatment, and state hospital expenses for those in treatment were lower in comparison by $48 per month.[13]
- For those who received treatment, the likelihood of being arrested decreased 16 percent and the likelihood of felony convictions dropped 34 percent, further contributing to cost savings for the state.[14]

- A study in California found that greater than 70 percent of the estimated costs of alcohol abuse can be attributed to lost productivity. These findings suggest that understanding the effects of substance abuse on the workplace can be of significant value to employers.[15]
  - Substance abuse treatment for 60 days or more can save over $8,200 in healthcare and productivity costs.[16]
  - An assessment study of people treated in Kaiser Permanente's Addiction Medicine program demonstrated significant reductions in missed work, conflicts with coworkers, and tardiness.[17]

Conclusion

The benefits of investing in early intervention and treatment for substance use disorders are substantial. Addiction, like other chronic diseases, can be managed successfully with appropriate access to quality treatment. Early intervention tools can be implemented in existing systems, such as primary care settings and hospitals, to allow quick responses to substance use disorders and provide care for greater numbers of people. The overarching goal of treatment is to help individuals achieve stable, long-term recovery and become productive members of society, and to eliminate the public health, public safety, and economic consequences associated with addiction.

For information about drug-use treatment and recovery, and for additional resources, please visit http://www.whitehouse.gov/ondcp/treatment-and-recovery.

Notes

[1] Bouchery, E., Harwood, H., Sacks, J., Simon, C., Brewer, R. (2011). Economic Costs of Excessive Alcohol Consumption in the U.S., 2006. *American Journal of Preventive Medicine, 41*(5), 516-524.
[2] National Drug Intelligence Center (2011). *The Economic Impact of Illicit Drug Use on American Society.* United States Department of Justice. Retrieved from http://www.justice.gov/ndic/
[3] Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD, 2011.
[4] Tucker JA, Vuchinich RE, Rippens PD. A factor analytic study of influences on patterns of help-seeking among treated and untreated alcohol dependent persons. *Subst Abuse Treat.* 2004 Apr;26(3):237-42.
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Days to Treatment and Early Retention Among Patients in Treatment for Alcohol and Drug Disorders

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Abstract

Objectives—Drug and alcohol treatment programs often have long delays between assessment and treatment admission. The study examined the impact of days to treatment admission on the probability of completing four sessions of care within an addiction treatment program implementing improvements in their admission process.

Methods—Mixed-effects logistic regression was used to test the effect of wait time on retention in care.

Results—Findings demonstrate a strong decrement in the probability of completing four sessions of treatment with increasing time between the clinical assessment and first treatment session.

Introduction

Many individuals who seek treatment for alcohol and drug disorders do not keep their first treatment appointment and substantial numbers of those who begin care leave treatment before completing the program (Capoccia et al., 2007). Gaps between service need and service capacity contribute to delays in treatment entry and continued alcohol and drug use.

There are societal and individual implications for delayed treatment including risk for serious health complications, criminal involvement, preventable health care utilization and the disbursement of social program benefits such as unemployment and welfare (Carr et al., 2008; Ettner et al., 2006; Palepu et al., 2001). Missed appointments and early dropouts also contribute to financial inefficiencies among addiction treatment programs; limited resources, such as counselor time, are invested in patients who enter and do not return to treatment.

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The high rate of appointment failures is a paradox of—overbooked staff and a seemingly overburdened treatment facility while, in reality, counselors often wait in their offices for clients who never arrive (Gallant, Bishop, Stoy, Faulkner, & Paternostro, 1966).

Client characteristics have a negligible influence on treatment initiation and compliance–attributes such as legal pressure (Hser, Maglione, Polinsky, & Anglin, 1998), having dependents at home (Leigh, Ogborne, & Cleland, 1984; Orme & Boswell, 1991), family or social stability (Hser et al., 1998; Leigh et al., 1984), health plan coverage (Hser et al., 1998), and prior successful treatment experience (Hser et al., 1998) play only a modest role. Drug and alcohol treatment agencies, therefore, must use organizational and policy changes to improve initiation and retention in care (Appel, Ellison, Jansky, & Oldak, 2004; Condelli, 1994; Miller, 1985).

The Institute of Medicine's —Crossing the Quality Chasm (2001) report suggested that defective processes were a primary cause of poor quality health care. The report called for health care organizations to assess and transform their delivery systems and make substantial improvements in organizational processes. In recent years, efforts have focused on understanding these organizational processes in substance abuse treatment settings and how they affect treatment initiation, continuation, and discharge. It is a substantial barrier to recovery when clients are forced to wait for entry into treatment (Appel et al., 2004; Farabee, Leukefeld, & Hays, 1998). Reducing the wait time between the first contact and the initial visit is an easy and inexpensive intervention that has proven successful in increasing treatment engagement in alcohol (Fleming & Lewis, 1987; Leigh et al., 1984; Miller, 1985; Rees, Beech, & Hore, 1984; Thom et al., 1992), drug (Addenbrooke & Rathod, 1990; Benjamin-Bauman, Reiss, & Bailey, 1984; Claus & Kindleberger, 2002; Festinger, Lamb, Kirby, & Marlowe, 1996; Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Festinger, Lamb, Marlowe, & Kirby, 2002; Stark, Campbell, & Brinkerhoff, 1990), and mental health (Gallucci, Swartz, & Hackerman, 2005; Orme & Boswell, 1991) treatment facilities.

Less attention has been given to retention in care beyond the first treatment session. In small short-term studies, longer wait times appear to negatively impact attendance beyond the first treatment (Leigh et al., 1984; Rees et al., 1984; Woody, O'Hare, Mintz, & O'Brien, 1975), although this is not a universal finding (Addenbrooke & Rathod, 1990; Alterman, Bedrick, Howden, & Maany, 1994; Festinger et al., 1996; Stasiewick & Stalker, 1999). Woody et al. (1975) found that opiate dependent clients who completed intake within 3 days after initial contact had a higher continuous retention in methadone treatment at months 2, 3, 4, and 5. Failure to attend treatment for alcohol dependence was more likely with more than 14 days delay from assessment to first appointment (Leigh et al., 1984). Similarly, shorter wait time to first appointment was associated with more treatment visits for alcohol dependence (Rees et al., 1984).

Network for the Improvement of Addiction Treatment

The NIATX (Network for the Improvement of Addiction Treatment) began as a partnership between the Robert Wood Johnson Foundation's Paths to Recovery program, the Center for Substance Abuse Treatment's Strengthening Treatment Access and Retention program, and addiction treatment agencies across the U.S. It is the first widespread application of process improvement techniques to the organization and delivery of treatment services for alcohol and drug dependence. Community-based addiction treatment centers submitted proposals to either the Robert Wood Johnson Foundation (RWJF) or the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) to participate in NIATx. Awards were made to 10 agencies from RWJF for 18 months, and 13 from CSAT for 36 months in the initial round of awards (cohort 1); and 15 agencies from

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RWJF for 18 months in a second round of awards (cohort 2). For details on the selection of NIATx member sites and data collection, see McCarty et al., 2007 and Hoffman et al., 2008.

NIATx helps substance abuse and mental health treatment organizations improve consumer access to and retention in treatment. Participants learn to implement rapid cycle improvements, monitor impacts and modify the intervention until the desired effect is achieved. Through its learning community, NIATx teststhe effectiveness of adopting and sustaining organizational process improvements through four aims: 1) reduce wait time between first request for service and treatment; 2) reduce client no-shows; 3) increase admissions; and 4) increase continuation rates between first and fourth treatment sessions. Evaluation efforts have documented that process improvement activities, including reducing client waiting time for treatment, can lead to significant improvements in access to treatment and in retention (McCarty et al., 2007). Agencies applying the NIATx process improvement model utilize an agency walkthrough procedure to identify key problems. Change teams used rapid cycle change initiatives to test changes that addressed deficits in admission processes. See the project website for more information about NIATx (www.niatx.net).

In this analysis, relationships between treatment entry delays and treatment attrition rates are examined among treatment admissions that completed at least one treatment session in treatment agencies that participated in NIATx. Quicker treatment entry following assessment was expected to increase the likelihood of clients completing at least 4 treatment sessions.

METHODS

Sample

This analysis uses data from outpatient treatment units from both cohorts of data collection —cohort 1, with data collected during the 15 months from October 2003 to December 2004; and cohort 2, with data collected during the 15 months from January 2005 to March 2006. The analysis was limited to (a) cases with a drug or alcohol dependence diagnosis, and (b) who were admitted during the intervention period for reducing waiting time. We examined data gathered from 15 of 17 agencies with outpatient treatment units; 2 agencies were excluded from analysis due to data quality problems. Five of the 15 agencies belonged to cohort 1, and 10 agencies belonged to cohort 2. Of the 6,698 total requests for outpatient treatment assessments, 583 had a first contact (initial telephone call requesting care) but no clinical assessment; an additional 874 had no first treatment session, or an invalid first treatment date (n=4, first treatment date reported as prior to clinical assessment date), and thus were excluded from analysis. Finally, due to the wide range and skewed distribution of wait times, measured as number of days from clinical assessment to first treatment (0–384 days), we limited the analysis to only individuals who had wait times of 30 days or less (n=4,937; 94% of those with valid first treatment date). Therefore, the final sample included 15 agencies with a total of 4,937 requests for outpatient treatment assessments, ranging from 124 to 887 requests per agency.

Variables

Data were extracted from the agency information system on: a) dates of the first contact, treatment assessment, and first treatment session; b) attendance at the second, third, and fourth treatment sessions (yes/no); c) primary drug; d) court mandated to care; e) age, race, ethnicity, and gender; and f) month during funding period in which first contact took place. The primary independent variable of interest was wait time (number of days from treatment assessment to first treatment). The outcome, retention in care, was defined as attendance at

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the second, third, or fourth outpatient treatment sessions. Group and individual treatment sessions were counted as treatment sessions.

Statistical Analysis

Descriptive statistics for patient characteristics and variables of interest were first calculated for the entire study sample, as well as by agency. Differences in wait time between those attending and not attending each treatment session were first analyzed by 2-tailed, independent samples *t*, Mann Whitney *U*, or chi-square test where appropriate. Mixed-effects logistic regression (McCulloch, Searle, & Neuhaus, 2008) was used to test the effect of wait time on retention in care. We used mixed-effects logistic regression models due to the hierarchical structure of the data—that is, patients clustered within agencies—and because this type of model incorporates both fixed and random effects. In the model, intercept, linear and quadratic trends for wait time were treated as random-effects. We also included fixed effects for a linear trend for month; differences between cohorts; an interaction between wait time and month to test whether the relationship between retention in care and wait time changed over the course of the 15 month study periods; and an interaction between wait time and cohort to test whether the relationship between retention and wait time was different for the two cohorts. Model-based estimated percentages of patients attending each treatment session by wait time, month, and cohort, were calculated using the fitted results of the mixed effects models; we report percent change in retention rates for wait times between 0 to 30 days for each subgroup of month and cohort.

We were not able to adjust for patient characteristics due to large amounts of missing data (see Table A). Five of the fifteen agencies were missing more than 50% of the data on each of the demographic characteristics; two of the five were missing all data on all demographics. Because of this, we could not impute and did not deem it feasible to exclude all cases with missing data.

The study was approved by the Oregon Health and Science University's Institutional Review Board. Data management and analyses were conducted using SAS software Version 9.2 (SAS Institute Inc., 2008) and R Statistical Language (R Development Core Team, 2008). All statistically significant results were significant at $p<.05$.

RESULTS

The 4,937 admissions included 67% men, 51% age 30 years and less and 57% court involved individuals. Primary drugs included alcohol (40%), cocaine (11%), marijuana (27%), methamphetamine (15%), and opioids (5%), while 2% reported use of other drugs. Wait time in days from clinical assessment to first treatment averaged 8.3 (SD 7.6) days, ranging from 0 to 30 days (capped at 30), with approximately one-quarter (26.5%) of all patients having clinical assessment and first treatment on the same day (wait time=0 days).

Patients from the 15 outpatient treatment agencies had retention rates of 77%, 62%, and 49% at the second, third, and fourth treatment sessions, respectively. Retention rates varied by agency; maximum retention rates by agency for second, third, and fourth treatment sessions were 95%, 94%, 91%, respectively, while minimum retention rates for sessions 2, 3, and 4 were 48%, 23%, and 9%, respectively (see Table A). Wait times were consistently longer by approximately 1 to 2 days among those who did not attend treatment sessions two, three, and four, compared to those who did attend subsequent treatment sessions ($p<0.001$). Nearly half of clients (45.3 %) waited more than a week and 8.9 % waited more than 21 days to attend their first treatment session. As expected, there was a significant association between retention at the second, third, and fourth sessions of outpatient treatment and wait time [see Table B].

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Multivariate Analysis

In mixed-effects logistic regression models accounting for wait time, month, and cohort, results varied by treatment session. Table C presents the estimated probability of retention in treatment sessions two, three and four, and demonstrates the multifaceted pattern of results quantitatively. For all treatment sessions, during all month intervals, and for both cohorts, retention in care was lower for wait times of 30 days than for wait times of 0 days, with one exception: treatment session 2, cohort 2, shows little difference in retention rates across wait time and month intervals (over all months, 85.8% retention for 0 days wait time vs. 84.6% retention for 30 days wait time). Note that the percent change in retention from 0 wait days to 30 wait days was consistently greater for cohort 1 than for cohort 2. The greatest differences were seen for treatment session four, where overall retention rates from 0–30 days differed by a factor of 96% for cohort 1, and 40% for cohort 2. Additionally, cohort 2 had higher retention rates at all time points than cohort 1.

Statistical results of the mixed-effects models are presented in Table D. In all treatment sessions, we found reduced retention rates for longer wait times, and a differential effect by cohort (session 2, β=0.053, SE=0.191, p=0.003; session 3, β=0.040, SE=0.020, p=0.049; session 4, β=0.081, SE=0.024, p=0.001). In addition, for treatment sessions 2 and 3, the association of increased wait time and decreased retention rates was mediated by month (β= −0.004, SE=0.001, p=0.001 and β=−0.003, SE=0.001, p=0.002, respectively); differences in retention rates by wait time late in the funding periods (e.g. months 11–15) tended to be higher than differences seen early in the funding periods (months 1–5). For treatment session 4, there were no significant differences in the relationship between wait time and retention by month (β=−0.002, SE=0.001, p=0.132).

To further demonstrate these complex relationships, Figure 1 graphically presents the relationship between wait time and retention in care at the fourth treatment session for all agencies, grouped into three 5-month time intervals, by cohort. For both cohorts 1 and 2, we see a strong decrement in the probability of completing four sessions of treatment with increasing time between the clinical assessment and first treatment session. However, the reduction in retention is greater for cohort 1 and, even at low wait times (e.g. 0 days), retention rates in cohort 1 are low compared to cohort 2.

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DISCUSSION

The study examined the impact of days to treatment admission on the probability of completing four sessions of care within an addiction treatment program implementing improvements in their admission process. In this analysis, relationships between treatment entry delays and treatment attrition rates were examined among treatment admissions that completed at least one treatment session in treatment agencies that participated in NIATx. Quicker treatment entry following assessment was expected to increase the likelihood of clients completing at least 4 treatment sessions. The findings support our hypothesis that as treatment providers improved their wait times to treatment over the course of their participation in NIATx, concurrent improvements in retention in care occurred. Waiting for treatment is an all too common event for women and men seeking treatment for alcohol and drug disorders. Delayed treatment entry significantly reduced retention through four treatment sessions. These results support the use of process improvements to reduce days to admission, enhance retention in care and improve the availability of treatment for alcohol and drug disorders (McCarty et al., 2007). The improvements in retention rates also suggest potential for applying process improvement techniques to other areas of drug and alcohol treatment and imply that process improvement in care delivery is possible in large and complex organizations.

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Limitations and Implications

Participants in NIATx applied to participate and the application process selected for agencies that demonstrated an interest and commitment to making process improvements. As a result, these findings may not generalize to all programs. Moreover, the agencies in this study made a wide variety of improvements and it is not clear which changes were responsible for the observed improvements.

We also were unable to assess the impact of patient characteristics on retention in care, due to large amounts of missing data on patient demographics. It is possible that patients with certain characteristics may be more likely to enter into and continue treatment. For example, patients with a court-mandate to enter into drug treatment may have been more likely to also be retained through four sessions of care.

The sample consists of individuals who completed an assessment and one treatment session and does not include individuals who requested services but did not receive an assessment, or those who received an assessment and were admitted to services but did not attend the first treatment session. Nevertheless, the findings confirm that time to treatment is associated with the length of treatment.

In the United States there are more than 14,000 specialty clinics for the treatment of alcohol and drug disorders. State and local public health departments license and fund many of these services (McBride, Terry-McElrath, VanderWaal, Chriqui, & Myllyluoma, In Press). Public health agencies have an opportunity to reduce the societal burden of alcohol and drug disorders by promoting rapid treatment entry. Delays in treatment entry are associated with reduced retention in care, continued alcohol and drug use, and increased risks for negative public health and public safety consequences.

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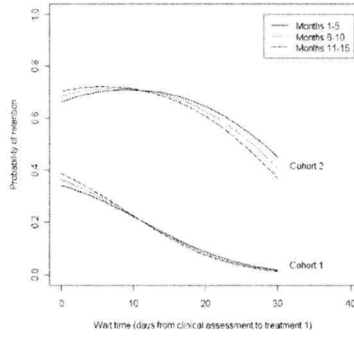

Figure 1.
Estimated probability of retention in care at treatment session 4 by three 5-month intervals, wait time and cohort

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Table A

Characteristics of patients over all agencies

	All 15 Agencies (N=4,937)	By Agency		% Missing, All agencies
		Minimum	Maximum	
Wait Time in days				
Mean (SD)	8.3 (7.6)	2.2 (4.9)	14.4 (5.6)	0%
Median (IQR)	7 (0–14)	0 (0–0)	14 (8–20)	0%
Retained in Care				
Treatment Session 2	77%	48%	95%	0%
Treatment Session 3	62%	23%	94%	0%
Treatment Session 4	49%	9%	91%	0%
Male*	67%	47%	72%	19%
Age ≤ 30*	51%	15%	64%	37%
White*	76%	3%	92%	19%
Hispanic*	9%	1%	26%	19%
Court involved*	57%	0.3%	100%	19%
Primary Drug*				23%
Alcohol	40%	15%	55%	--
Cocaine	11%	2%	23%	--
Marijuana	27%	8%	36%	--
Methamphetamine	15%	0.0%	36%	--
Opioids	5%	0.2%	18%	--
Other drugs	2%	0.0%	19%	--

Notes: SD = standard deviation; IQR = interquartile range.

*Percentages for demographic data by agency and for all agencies were calculated excluding data from agencies with more than 50% missing on demographics.

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Table B

Differences in wait time (days from clinical assessment to first treatment session) by retention in care

	Treatment Session 2		Treatment Session 3		Treatment Session 4	
	No (n=1,133)	**Yes (n=3,804)**	**No (n=1,884)**	**Yes (n=3,053)**	**No (n=2,500)**	**Yes (n=2,437)**
Wait Time[a]						
Mean (SD), in days	9.7 (8.0)	7.8 (7.4)	9.7 (7.8)	7.4 (7.4)	9.4 (7.7)	7.1 (7.4)
Median (IQR)	8 (2–15)	7 (0–13)	8 (3–14)	6 (0–12)	8 (3–14)	6 (0–12)
0–7 days wait time, no. (%)	527 (46.5)	2,175 (57.2)	871 (46.2)	1,831 (60.0)	1,188 (47.5)	1,514 (62.1)
8–20 days wait time, no. (%)	467 (41.2)	1,330 (35.0)	807 (42.8)	990 (32.4)	1,054 (42.2)	743 (30.5)
21–30 days wait time, no. (%)	139 (12.3)	299 (7.9)	206 (10.9)	232 (7.6)	258 (10.3)	180 (7.4)

Note: SD = standard deviation; IQR = interquartile range. Column percentages may not add to 100% due to rounding to the nearest tenth.

[a]Differences in wait time between those attending and not attending each respective treatment session are significant at $p < 0.001$.

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Table C

Estimated* percentage of patients retained in treatments 2, 3, and 4, by cohort, month, and wait time

Treatment Session	Cohort	Month	Wait Time (Clinical Assessment to Tx1) 0 days %	10 days %	20 days %	30 days %	% change (from 0–30 days)
Treatment Session 2	Cohort 1 (n=1,669)	Months 1–5	64.2	61.7	52.6	37.1	−42.21%
		Months 6–10	69.6	63.0	49.3	30.0	−56.89%
		Months 11–15	74.5	64.3	46.0	23.7	−68.12%
		Overall	69.4	63.0	49.3	30.3	−56.38%
	Cohort 2 (n=3,268)	Months 1–5	82.8	88.0	89.6	88.5	6.92%
		Months 6–10	86.0	88.6	88.3	84.9	−1.32%
		Months 11–15	88.7	89.1	86.8	80.3	−9.47%
		Overall	85.8	88.6	88.2	84.6	−1.48%
Treatment Session 3	Cohort 1 (n=1,669)	Months 1–5	46.7	42.3	30.6	16.0	−65.74%
		Months 6–10	50.8	42.2	26.9	11.8	−76.71%
		Months 11–15	54.9	42.0	23.6	8.6	−84.26%
		Overall	50.8	42.2	27.0	12.2	−76.07%
	Cohort 2 (n=3,268)	Months 1–5	75.0	78.9	76.9	68.1	−9.21%
		Months 6–10	78.0	78.8	73.6	60.1	−22.95%
		Months 11–15	80.7	78.7	70.0	51.5	−36.18%
		Overall	77.9	78.8	73.5	59.9	−23.11%
Treatment Session 4	Cohort 1 (n=1,669)	Months 1–5	34.2	22.3	8.7	1.9	−94.45%
		Months 6–10	36.3	22.4	8.1	1.6	−95.57%
		Months 11–15	38.6	22.6	7.5	1.4	−96.47%
		Overall	36.4	22.4	8.1	1.6	−95.54%
	Cohort 2 (n=3,268)	Months 1–5	66.1	70.7	64.3	44.9	−32.02%
		Months 6–10	68.2	70.9	62.5	40.8	−40.15%
		Months 11–15	70.2	71.0	60.6	36.8	−47.56%
		Overall	68.2	70.9	62.5	40.8	−40.07%

*Estimated percentages calculated from fitted results of multivariate models presented in Table E.

10.12

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Table D

Mixed-effects logistic regression models for retention in treatment sessions 2, 3, and 4 (n=4,937)

Retention in Care	Parameter	β	Standard Error	*Z*-statistic	*p*-value
Treatment Session 2	Intercept	0.440	0.191	2.310	0.021
	Month (Linear)	0.049	0.014	3.500	<0.001
	Wait time (Linear)	0.014	0.024	0.557	0.577
	Wait time (Quadratic)	−0.001	0.001	−1.404	0.160
	Cohort				
	Cohort 1 (PATH1/STAR)[a]	--	--	--	--
	Cohort 2 (PATH2)	0.987	0.174	5.660	<0.001
	Wait time * Month	−0.004	0.001	−3.232	0.001
	Wait time * Cohort	0.053	0.018	3.022	0.003
Treatment Session 3	Intercept	−0.234	0.198	−1.183	0.237
	Month (Linear)	0.033	0.014	2.355	0.019
	Wait time (Linear)	0.009	0.025	0.373	0.709
	Wait time (Quadratic)	−0.002	0.001	−1.726	0.084
	Cohort				
	Cohort 1 (PATH1/STAR)[a]	--	--	--	--
	Cohort 2 (PATH2)	1.233	0.201	6.142	<0.001
	Wait time * Month	−0.003	0.001	−3.132	0.002
	Wait time * Cohort	0.040	0.020	1.967	0.049
Treatment Session 4	Intercept	−0.714	0.215	−3.328	<0.001
	Month (Linear)	0.019	0.016	1.171	0.242
	Wait time (Linear)	−0.029	0.026	−1.090	0.276
	Wait time (Quadratic)	−0.003	0.001	−1.983	0.047
	Cohort				
	Cohort 1 (PATH1/STAR)[a]	--	--	--	--
	Cohort 2 (PATH2)	1.323	0.206	6.412	<0.001
	Wait time * Month	−0.002	0.001	−1.507	0.132
	Wait time * Cohort	0.081	0.024	3.330	0.001

[a]Reference category.

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Attach #11 SB2045
J# 21945 01/14/15

How to Increase Access to Substance Abuse Treatment: Implementing NIATx Model

Nalan Ward, MD; Margaret Harvey, PsyD
Department of Psychiatry, Massachusetts General Hospital and Harvard Medical School, Boston, MA

Background

Founded in 2003, the Network for the Improvement of Addiction Treatment. (NIATx) works with behavioral health care organizations across the country to improve access to and retention in treatment for the millions of Americans with substance abuse and/or mental health issues(1).

In 2007, NIATx launched the first clinical trial that examines process improvement in addiction treatment. NIATx 200, funded by the National Institute on Drug Abuse, brought together 200 treatment providers from five states, Massachusetts, Michigan, New York, Oregon and Washington, to study NIATx strategies to improve treatment quality, operations, and finances (1).

The West End Clinic (WEC)-Outpatient Addiction Services at the Massachusetts General Hospital was one of the sites invited to participate in this service improvement project.

WEC is an adult outpatient substance abuse treatment center based in an academic general hospital in Boston, MA.

Access to treatment remains one of the most important aspects of addiction based services. As part of the Niatx200 project, **we aimed to implement "Plan-Do-Study-Act" cycle to study the effect of promising practices on**

- *increasing access to treatment,*
- *reducing wait time to initial assessment*
- *increasing available treatment services for substance abuse.*

Methods

This was a 4-year (2008-2012)prospective examination of promising practices that were implemented to increase access and reduce wait time to intake in substance abuse treatment. 48months of clinic data were examined to determine yearly number of intakes, total visit volume, and wait time for intake.

A "Plan-Do-Study-Act" cycle was applied to try evaluate promising practices. Yearly number of intakes, total patient visit volume and wait time to intake were calculated to measure outcome.

To reduce the wait time to intake and increase number of intake slots "Plan Do Study Act (PDSA)" cycle was used (1).

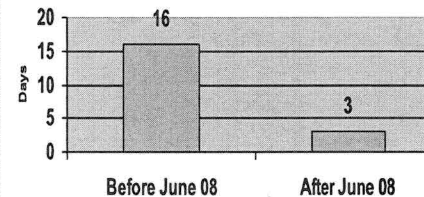
- **Plan**: Identify aim of effort (i.e.: reducing wait time)
- **Do**: Trial run, for short period of time (increase number of intake slots)
- **Study**: Staff looks at benefits and drawbacks of the trial
- **Act**: Staff fixes trial if imperfect results, or implements it in regular practice if no significant problems

Results

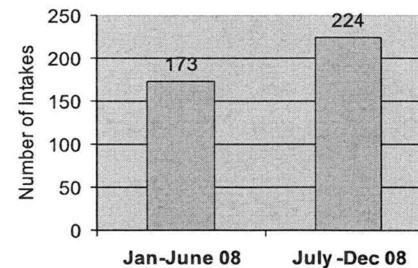
Number of Intakes in 2008 : 6-8 intake slots weekly.
Wait Time to Intake in 2008 :16 days.
Yearly Visit Volume: 6,653 in FY07.
PDSA cycle example:
-eliminate backlog of patients waiting for intake
-increase the number of intake slots

Results

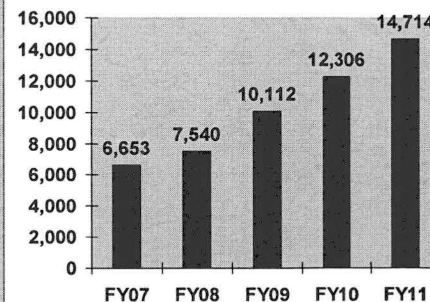
Reduce in Wait Time to Intake



Increase in Intake Volume



Increase in Visit Volume



Conclusions

- Our findings point out to the value of increasing access to substance abuse treatment. By using the PDSA cycle, a timely, efficient and patient–centered service model was developed (2,3).
- Our yearly visit volume was almost doubled from 7.540 in FY2008 to 14,714 in FY2011.
- It is important to emphasize the increase in the number of intake slots was achieved without an increased number of staff. Tow years prior, to accommodate the needs of increased number of patients in treatment at WEC, a 0.5 FTE RN and a 0.5 FTE addiction psychiatrist were hired.
- Increase in treatment services included
  - Intensive Outpatient Programs (Day, Evening, Young Adult for 18-25yo)
  - Opioid Agoinst Maintenance Treatment (Buprenorphine)
  - Naltrexone Injection Clinic
  - Evidence Based Group Therapies

References

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2-Improving care for the treatment of alcohol and drug disorders. McCarty D, Gustafson D, Capoccia VA, Cotter F. J Behav Health Serv Res. 2009 Jan;36(1):52-60.
3-The Network for the Improvement of Addiction Treatment (NIATx): enhancing access and retention.McCarty D, Gustafson DH, Wisdom JP, Ford J, Choi D, Molfenter T, Capoccia V, Cotter F.Drug Alcohol Depend. 2007 May 11;88(2-3):138-45. .

Contact Information

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Attach #12 01/14/15
SB 2045
J# 21945

REMOVING BARRIERS *to*
Treatment & Recovery

The Case for Access and Retention

It's reasonable to consider why a quality improvement partnership should focus on access to and retention in treatment instead of, for example, evidence-based practices or client outcomes. The reason for focusing on access and retention lies in national data and research done by the Institute of Medicine.

According to TEDS data, the average time it takes to begin treatment is 32 days. Addiction treatment is still considered a routine service instead of an emergency or acute care service—despite the fact that the majority of people seeking treatment are in crisis physically or emotionally. And, despite the fact that people die while waiting to access treatment.

Because of long waiting times, fewer than 50 percent of people show up for their screening and assessment appointments. This high no-show rate creates inefficiencies in the treatment system. By organizing systems and processes differently, we can make use of this underutilized capacity. We need to eliminate bottleneck at the front end of the process and get people into treatment quickly when they perceive a need for treatment.

To benefit from treatment, clients need to stay past the first session. TEDS data shows that showing up for the screening and intake appointment does not guarantee a follow-through for further treatment. Client engagement needs to be the first priority in any treatment program. Without the client's active involvement, nothing can be accomplished.

More timely assessments have produced higher attendance rates (Carpenter et al., 1981; Oppenheim et al., 1979; Orme & Boswell, 1991; Raynes & Warren, 1971) and improved treatment initiation by 46 to 83 percent (Festinger et al., 2002; Kirby et al., 1997). Lack of follow-through by people seeking addiction treatment impedes the traditional step from intake and assessment to first clinical treatment session. In one study, 50 percent of applicants approved for admission did not enter the program (Farley & Ebener, 1998). Timeliness is also important. Scheduling the first treatment session within 48 hours of assessment produces greater treatment show rates (Claus & Kindleberger 2002). These research studies suggest that 50 percent of clients attend their scheduled intake session and only 50 percent of those clients attend their first treatment session. Hence, 25 percent of those requesting an intake appointment will attend their first treatment session.

Additional Information

- NIATx Four Aims
- Success Story Database

References

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#22547 SB 2045 01/26/15

PROPOSED AMENDMENTS TO SENATE BILL NO. 2045 Attach #1

Page 1, line 8, replace "providers" with "licensed substance abuse treatment programs"

Page 1, line 8, replace "biennium" with "period"

Page 1, line 8, replace "2015" with "2016"

Page 1, line 9, replace "services" with "levels of care"

Page 1, line 10, after "medicine" insert ". The department of human services will ensure that a private licensed substance abuse treatment program accepting vouchers pursuant to this section will collect and report process and outcome measures. A private licensed substance abuse treatment program accepting vouchers under this section must provide services that are research based. The department of human services shall develop requirements and provide training and technical assistance to any private licensed substance abuse treatment program accepting vouchers under this section"

Renumber accordingly

A comprehensive Substance Use Disorder (SUD) System should include the following services:

SB 2045: SUD Voucher

Voucher system to address gaps within the SUD treatment system

Treatment

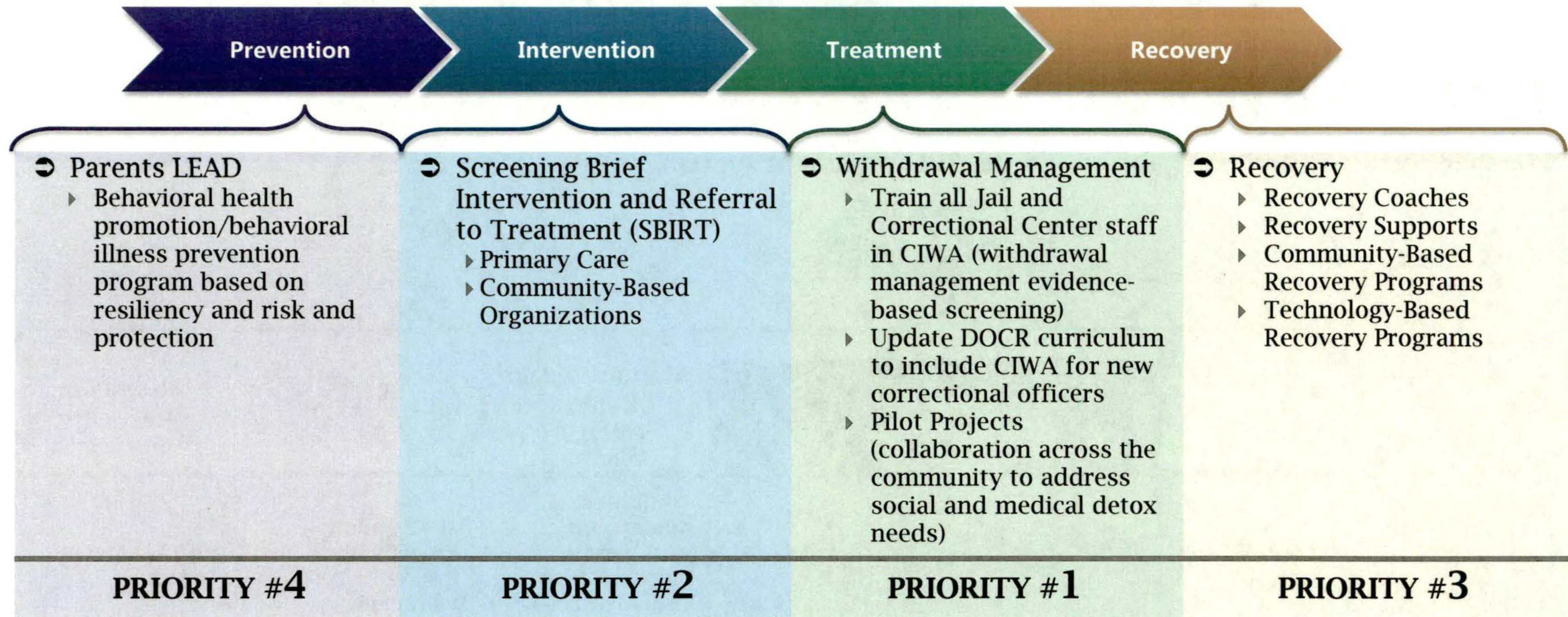
	SB 2045 Voucher	Human Service Centers (Federal Block Grant Funds)	Private Providers	Robinson Recovery (state-funded)
Population Served	Self-pay adults (not otherwise covered)	**Adults** and **Adolescents**; Most **severe;** People **without** insurance; People **without** money	Mostly **adult;** People **with** insurance; People **with** money	Most **severe**; **Adults**
American Society Addiction Medincine (ASAM) Level of Care	ASAM levels II.5, III.1 and III.5 (limited Medicaid coverage for small providers)	**All levels** of ASAM (regional differences)	**Mostly low level ASAM; Limited higher** level ASAM	Residential (III.1 and III.5 ASAM)

In order to qualify for the voucher, programs must collect and report both process and outcome measures and be research based. Other requirements include participation in training and technical assistance.

SB 2045 01/26/15 #2 #22647

SB 2046: Enhance Substance Use Disorder (SUD) System

Grant program to address the gaps in the SUD System



In order to qualify, all programs must collect and report both process and outcome measures, and be research based. Other requirements include sustainability planning, training and technical assistance, reporting, and collaboration.

2.2

north dakota department of human services

attach#3
SB2045
01/26/15
J#22547

North Dakota Senate Human Service Committee

January 26, 2015

Testimony presented by:

Nate Medhus

President/CEO

ShareHouse, Inc.

Chairman Lee and members of the Senate Human Services Committee, my name is Nate Medhus, President and CEO of ShareHouse, Inc., a treatment provider for Substance Use Disorder. ShareHouse operates 116 residential treatment beds in four facilities, with locations in Fargo, ND and New York Mills, MN, as well as outpatient treatment services in Fargo, serving up to 70 clients at any one time at our outpatient program. I also serve as the Vice President of the North Dakota Addiction Treatment Providers Coalition. I am here today to provide testimony on behalf of The North Dakota Addiction Treatment Providers Coalition regarding SB 2045 and the Amendment attached to the bill referencing the ASAM assessment software.

I would like to voice my support for the approval of SB 2045. I believe that this bill will improve access to many North Dakotan's who currently do not have insurance, but are not eligible to receive coverage from Medicaid or Medicaid Expansion.

I do need to state that I am against the Amendment for SB 2045 referencing the ASAM assessment software. I am opposed to this Amendment for the following reasons:

- The private providers who would be required to use this software have not had a chance to see it firsthand.
- I am aware of at least nine different Electronic Health Record software types being used by private providers in this state. At this time we do not know for sure if the ASAM assessment tool is compatible will all of these software types.

- There are providers in the state who currently are not using any Electronic Health Record software, and we do not know if the ASAM assessment tool can "stand alone".
- I am afraid that this requirement of all providers may become a barrier to becoming a licensed treatment provider in this state, at a time when we are looking for solutions to increase access to treatment.

I want to make it known that I am very supportive of the goal of developing a single assessment tool used by the providers in this state, and that tool very well might be the ASAM assessment software. My organization, ShareHouse, works firsthand with the Minnesota Chemical Dependency Treatment Fund (MN CCDTF) so we have seen the value in having one common assessment used by all providers (Rule 25 Assessment). But at this time I feel that we are moving too quickly to pass a law requiring the use of software we haven't been able to test. Once providers (both public and private) have had an opportunity to use the ASAM assessment tool, we can work with DHS to develop the appropriate Administrative Rules implementing some type of requirement, and detailing which providers would be required to use it (maybe only providers who wish to receive funding from the Voucher system?).

Thank you for your time today, and consideration of my request. I would be happy to address any questions you might have at this time.

Attach#1
SB2045
01/27
J# 22650

In regard to the amendment proposed by Representative Hogan:

First sentence –

- ASAM criteria is already required in Administrative Rule for all Substance Abuse Treatment Programs.
- What about programs that are only adolescent and not adult – there is not an adolescent software. They would also be required to have the software by this statement.
- How will fidelity be reviewed?

Second sentence –

- Recommend deletion. DSM is required in Administrative Rule for all Substance Abuse Treatment Programs. In addition, the DSM is the instrument for all substance use disorder diagnosing – not just mental health or co-occurring disorders.

Third sentence –

- As written the Department of Human Services would be required to enforce the use of the software? Therefore, requiring Administrative Rules to be updated including this requirement.

Fourth sentence – Already required in Administrative Rule for all Substance Abuse Treatment Programs.

If the intent of the ASAM software is to gather data – who has the authority to collect the data? How will the data be collected and used? With what funds?

The ASAM Software is an assessment and not an Electronic Health Record.

Attach #2 SB2045 01/27 J# 22650

15.0178.02001
Title.

Prepared by the Legislative Council staff for
Representative Hogan
January 12, 2015

PROPOSED AMENDMENTS TO SENATE BILL NO. 2045

Page 1, line 1, after the first "to" insert "create and enact a new section to chapter 50-31 of the North Dakota Century Code, relating to substance abuse treatment programs; and to"

Page 1, after line 3, insert:

"**SECTION 1.** A new section to chapter 50-31 of the North Dakota Century Code is created and enacted as follows:

American society of addiction medicine - Substance abuse treatment requirements.

1 All persons, partnerships, associations, corporations, and limited liability companies licensed pursuant to section 50-31-05 shall implement, utilize, and maintain program and clinical fidelity with the most current version of American society of addiction medicine criteria and American society of addiction medicine criteria software. 2 Co-occurring mental health conditions must be described utilizing the most current edition of the diagnostic and statistical manual of mental disorders. 3 Adults with substance abuse conditions must be assessed with the American society of addiction medicine criteria software algorithm. 4 Programs must utilize American society of addiction medicine criteria for service planning and associated level of care placement, continued care, and discharge decisions for adolescents and adults."

Renumber accordingly

Attach#1
02/03/2015
J# 23085

SB2045
proposed
Rep. Kathy Hogan

SECTION 1. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $2,000,000, or so much of the sum as may be necessary, to the department of human services for the purpose of establishing and administering a voucher system to assist in the payment of addiction treatment services provided by private providers, for the biennium beginning July 1, 2015, and ending June 30, 2017. Services eligible for the voucher program include only those services recognized as effective by the American society of addiction medicine, specifically ASAM Critieria Assessments, outpatient treatment (Low and high intensity)

Attach #2
SB 2045
02/03/2015
J# 23085

Testimony of Elizabeth Faust

S.B. 2045

Human Services Committee

February 3, 2015

Madam Chair and committee members, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota (BCBSND). I have been asked to provide information to the Committee about the American Society of Addiction Medicine (ASAM) Criteria Software as it relates to a proposed amendment to SB 2045 appropriating funds to the Department of Human Services for a voucher system for addiction treatment services. My goal today is to provide some straightforward information for you about what the ASAM Criteria and Software are and to explain the unique opportunity I believe they may represent for North Dakota at this time.

The ASAM Criteria, now in its third edition, represents 20 years of work on the part of ASAM to lift addiction diagnosis and treatment out of the "black hole of subjective unmeasurability". As you may know, the historical roots of addiction treatment came from the recovery community of lay persons, and the mainstream medical community did not recognize addiction as a disease early on. The American Society of Addiction Medicine brought science and medicine to the field in working to marry the "science" with the "art" already established by the 12-step and peer recovery models working in the field. It is worth emphasizing that there is not a competition between the medical model and the abstinence-based recovery models.

2.2

These are the guiding principles of the ASAM Criteria:

*Moving from one-dimensional to **multidimensional assessment**
*Moving from program-driven to **clinically-driven and outcomes-driven treatment**
*Moving from fixed length of service to **variable length of service**
*Moving from a limited number of discrete levels of care to a **broad and flexible continuum of care**
*Identifying **adolescent-specific needs**
***Clarifying the goals of treatment**
***Moving away from using previous "treatment failure"** as an admission prerequisite
*Moving toward an **interdisciplinary, team approach to care**
***Clarifying the role of physicians**
***Focusing on treatment outcomes**
*Engaging with **"Informed Consent"**
*Clarifying **"Medical Necessity"**
***Incorporating ASAM's definition of addiction**

There are two foundational halves of the ASAM Criteria that are important for you to understand. The first half is the assessment of individuals. Humans are messy and complicated, and the disease of addiction, like other kinds of brain-based disorders, are diseases of behavior, insight and physical health. Trying to assess and juggle the physical, emotional and social parts of a person's addiction all in a limited amount of assessment time has challenged clinicians from the beginning. The ASAM model takes all of the complicated information from the assessment of an individual and organizes it into 6 domains, or dimensions. Why six? Because humans are complex and it takes six to capture it all. The model forces us to remember and value all of the elements that are important in understanding each individual and their needs, and to describe it in the same way every other clinician describes it. It helps us assign risk in each dimension and helps us to not forget any important aspects. Every clinician can and should address each of these dimensions when doing evaluations, regardless of their training background or the location in which they see

patients or clients.

Once you have a thorough picture of an individual's unique needs, the second half of the ASAM Criteria come into play. What kind of care does a person need and in what setting?

The ASAM Criteria defines levels of care that represent intensities of service. Just as assessments need to be done in a standard way so clinicians are speaking a common language, the elements of levels of service need to be defined in a standard way. How do you assure that inpatient programs in the eastern part of the state offer the same capability for services and support that those in the western part of the state, or another state? A lay person's example might be the difference between food vendor stands, restaurants and restaurants with bars. Each has specific criteria that must be met in order to appropriately offer the advertised services.

The criteria define objective elements of care delivery that must be available in order for a program to be called by a specific description. This is where you will hear the terminology: "Partial Hospital Program, ASAM Level 2.5", etc. The purpose for this second component defining levels of care is again to create a common definition so that every program and clinician is talking about the same thing when we talk about where to match patients to appropriate services and levels of care.

This has been the hard work for ASAM of pulling addiction assessment and treatment out of the "black hole of subjective unmeasurability". If you can't measure it, you can't manage and improve it. This is where cancer treatment was 15-20 years ago. This is not someone's "good idea of the month". The development of the ASAM Criteria has been done using evidence-

2.4

based research, and every new edition of the criteria has been done based on the clinical consensus of the best experts in the field of addiction medicine. The model has gained more and more acceptance over the past two decades, and 38 states now endorse the ASAM Criteria. North Dakota is one of those states. We have statute language describing some of the treatment program elements according to an early version of ASAM, as well as administrative language setting expectations that assessments will reflect the ASAM multi-dimensional model. However, there is a gap between intent and reality and it would only be accurate at this point in time to say that North Dakota uses pieces of ASAM definitions.

That represents major progress and we are like many other states having marched forward in our effort to treat addiction more effectively. However, humans are complicated and multi-dimensional assessment is challenging to do objectively and consistently. Some might say that ASAM is just too complicated. Actually, it's humans who are complicated and the model simply reflects that. Current data shows that when you assess people with the ASAM Criteria using fidelity to the model, they have better outcomes and lower relapse rates.

The ASAM editors are evolving with us in addressing our challenges. Assessment is hard to do consistently and objectively. ASAM obtained a $1 million grant from SAMHSA (U.S. Substance Abuse and Mental Health Services Administration) and developed the ASAM Criteria Software, which is a standardized version of the adult criteria for open-source release. The software provides a structured interview to guide assessment and calculate suggested levels of care for patients. It uses the power of a computer algorithm to help us objectively and consistently organize the complexity of human beings into a coherent, understandable framework and guides clinicians in recommending levels of service intensity. It has demonstrated excellent

acceptance by patients and clinicians. Those clinicians who have used other structured interviews such as the ASI (Addiction Severity Index) indicate preference for the ASAM interview as giving them better quality clinical information.

The ASAM Criteria Software is now being launched nationally after extensive testing in Norway and the U.S. I have included a handout from ASAM with details of the research and Software commercial launch. In order to support widespread dissemination, SAMHSA is expecting ASAM to distribute the Software at cost. The only element necessary for providers is internet access. Providers do not have to have EHRs (electronic health records) in order to use the Software. However, the computer algorithm can be incorporated into EHRs and ASAM has already obtained agreements from 75% of behavioral health EHR companies to incorporate the software into their systems. Requirements for privacy, including HIPAA and 42-CFR, have been accommodated.

Engaging the use of the ASAM Criteria Software will allow us better objective assessments and guidance in clinical decision making as clinicians, provider facilities and payers. Blue Cross Blue Shield North Dakota is committed to engaging with our providers to implement the use of the Software. We believe it will allow a level playing field between the provider and payer. It will facilitate objective conversations and decisions about how to deliver best care and to best spread resources in order to serve our members affordably and effectively.

But this can do so much more. I am going to move now to explanation of the opportunity this can represent for North Dakota. One of the findings of the Schulte Behavioral Health Planning Report in July 2014 was that we lack a coherent method for capturing data about behavioral

2.6

health needs in North Dakota. This statement is made in the executive summary:

"Drug use is on the rise and is seen as a critical issue in the West. Data to measure needs in the state is incomplete with collection only within the public sector. Legacy services, not data driven with proven outcomes, are being used state wide making it difficult to fight for additional funding in the legislature. Sky-rocketing bad debt at hospitals is a reality throughout the state."

If we made a decision to implement the Software-supported ASAM assessment and patient placement across the board in our state, public and private alike, we would unquestionably take giant steps toward improving the quality of all addiction assessments. We would facilitate continuity and collaboration, reduce duplication, and improve matching of consumers with the services they need.

But in addition, we would be stepping into the best available data measurement system for addictive disorders available in the U.S. On a macro level, our data would become part of the ASAM national work to continue developing outcomes-based best practice for treating addiction. On a micro level, our data would be available to us as providers for measuring quality of care and clinician competence. It would be available for the state to develop needs assessment analyses and to identify and quantify gaps in the care delivery continuum. It would allow the state to measure provider outcomes with one another. It would allow legislators to make rational decisions about allocation of resource based on accurate and believable data across both public and private sector. It is another step forward in the process of moving addiction treatment out of the "black hole of subjective unmeasurability" and into the mainstream of health care delivery. We've done it for cancer, and we need to do it for addiction.

In conclusion, I am recommending that you adopt the proposed amendment to SB2045 to include the expectation that all substance abuse treatment programs licensed in North Dakota implement, utilize and maintain program and clinical fidelity with the most current version of the ASAM Criteria and utilize the ASAM Criteria Software in assessment and treatment planning. It is a great step that the private providers have indicated willingness to work with BCBSND in developing the use of the Software in their work with our members. It will be even more beneficial if you expand this to include all private providers involved in care delivery within the voucher and best of all if you include all providers, public and private. That will power our ability to capture data and drive forward improvements like nothing else. In the words of David Gastfriend, M.D., the chief software architect and one of the chief editors for the ASAM Criteria, "If we get this off the ground, North Dakota will be one of the national leaders in this process."

I have included additional information and detail in my written testimony below labeled as Attachment 1, as well as the information regarding the ASAM Criteria Software launch. I am happy to answer any questions you might have.

2.8

Attachment 1:

American Society of Addiction Medicine
ASAM Criteria Software-Proposal for implementation in North Dakota
February 2015
Elizabeth Faust, MD
BCBSND

Definitions:

ASAM Criteria Software- A standardized version of the adult ASAM Criteria for open-source release, funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA). The software provides a structured interview to guide assessment and calculate suggested levels of care for adult patients.

ASAM Criteria-Clinical guidelines designed by the American Society of Addiction Medicine for the purpose of multidimensional assessment to develop patient-centered service plans and to guide clinicians in making objective decisions about patient admission, continuing care, and transfer/discharge for various levels of care for addictive, substance-related and co-occurring mental health/substance abuse conditions. The ASAM Criteria text delineates dimensions, requirements, and decision rules that comprise ASAM's criteria. The text serves as a companion to the ASAM Criteria Software. The text contains adolescent-specific content regarding service planning and considerations relevant to adolescent populations.

The ASAM Criteria text and the ASAM Criteria Software are companion text and application. The text delineates the dimensions, levels of care and decision rules that comprise the ASAM criteria. The software provides the approved structured interview to guide the adult assessment and calculate the complex decision tree to yield suggested levels of care. To assure effective, reliable treatment planning, the text and the software should be used in tandem, the text to provide the background and guidance for proper use of the software, and the software to enable comprehensive, standardized evaluation. Note that services specifically tailored to adolescents are addressed throughout the ASAM Criteria but are not included in the ASAM Criteria Software at this time.

Features:

1) Incentive-neutral assessment system: the ASAM Criteria Software coupled with ASAM Criteria is designed to assure comprehensive, standardized evaluation and treatment placement decisions. Potential bias related to financial incentives is removed from the decision-making process. It creates a level playing field between payers and providers-one on which consumers get the best care with the most efficient use of society's resources.

2) Documentation of exceptions: providers administer the computer-based assessment, report the findings (electronically and instantly) and place the consumer in services according to ASAM. Discrepant placements are documented and the software gathers justification for discrepancies. These can occur for reasons such as lack of program availability, client refusal, or counselor disagreement. Data can be analyzed for algorithm problems or counselor bias and creates opportunity for program improvement, provider education or software enhancement.

3) Evidence-based practice: the ASAM Criteria has been developed over 20 years and represents the expert consensus of addiction treatment leaders regarding assessment, service planning and treatment delivery for substance abuse. Widespread use of the ASAM Criteria Software will accelerate the collection of quantitative, empirical data and move the field to outcome-based treatment guidelines to provide high quality, affordable care to the largest number of consumers possible.

4) Consumer choice and patient-centered care: satisfaction studies of the ASAM Criteria Software assessment process indicate that consumers liked the greater depth and personalization of the branched assessment, and were more likely to accept their placements as a result of their increased

2.10

awareness of their range of needs illustrated in the software assessment, as compared to conventional assessment.

5) Standardized assessment-the Software algorithm creates a common assessment and clinical decision making algorithm for all providers. This will dramatically improve consistency among providers in consumer assessment, reduce duplication of evaluation and enhance communication between provider facilities in care transitions. Providers will see improved interface with payers. Programs using the Software consistently report that it speeds up the managed care review process and improves successful level of care decisions.

6) Outcome measurement-the ASAM Software will allow researchers, providers and payers throughout the field to speak the same language and arrive at the same level of care determinations. The software will facilitate aggregate analyses of patient placements, service utilizations and clinical outcomes. Treatment programs will be able to understand their utilization patterns and needs and research centers will be able to objectify and validate the ASAM Criteria. The result will be that North Dakota will contribute to and benefit from the development of evidence-based, outcomes-driven substance abuse treatment services.

7) Application to adolescent assessment and treatment-the ASAM Criteria has an embedded set of criteria especially designed for assessing and recommending treatment according to the unique needs of adolescents. Accordingly, the ASAM Criteria is evidence-based for use with adolescents. At this time, the software algorithm has not been expanded to include the additional unique elements of adolescents. Funding for that development has not been available to this point, but is on the future work plan for the software development. Nonetheless, the Software can still be used for adolescent assessment because it allows for counselor customization of decision making.

2.11

American Society of Addiction Medicine

The ASAM Criteria Software

National Launch – Jan 2015 – Contact your EHR Vendor or State/County

DATE: November 25, 2014
REPORT: To Participants in the ASAM Criteria Software National Demonstration Project And Other Interested Parties

NOTE: The Software will be re-launched this January: at-cost, i.e., $65/user/month (see below)

Results from the 2014 National Demonstration Project:
In all, 20 systems completed all training and patient privacy authorizations and used the Software.

Previously, alpha testing had been completed in 10 Norwegian programs by the Central Norway Health Trust. This confirmed the prior evidence-basis of the Software, including convergent and predictive validity. Please see the following 3 data papers accepted into the scientific peer-reviewed literature:

- Stallvik M, Gastfriend DR. Predictive and convergent validity of the ASAM criteria software in Norway. Addiction Research and Theory 2014. 22(6):515-523 (doi:10.3109/16066359.2014.910512)
- Stallvik M, Gastfriend DR, Nordahl HM. Matching patients with substance use disorder to optimal level of care with the ASAM Criteria software. J Substance Abuse. Posted online July 8, 2014. (doi:10.3109/14659891.2014.934305)
- Stallvik M, Nordahl HM. Convergent Validity of the ASAM Criteria in Co-Occurring Disorders. J of Dual Diagnosis 2014. 10(2):68-78. DOI:10.1080/15504263.2014.906812

The beta testing was completed over 6 months in Central Intake units of Milwaukee County.

In the National Demonstration Project, 387 patients underwent assessments. Among the participating programs/systems were those directed by ASAM leaders Drs. John Femino (Meadows Edge Recovery Center, RI), Ramsey Farrah (Phoenix Health Center, MD) and Ken Roy (Addiction Recovery Resources, LA). Large county- and state-wide systems included Janus of Santa Cruz CA, and the Washington State Division of Behavioral Health and Recovery. Other large multi-level systems included 12&12 Treatment Center of Oklahoma and the parole and probation network of ManageAttendance, LLC. Programs participated from Norway to Alaska and Hawaii. The Demo was a substantial success in many ways.

FEASIBILITY: In general, the Software demonstrated good feasibility. Many early adopters were able to see their first patient using the Software with only a minimum of training (a single 45-minute online video eLearning Orientation Module). In order to succeed in rolling out *staff-wide mandated use* of the Software, however, one system invested additional effort, 8-20 hours of in-service training, primarily on the meaning and method of the ASAM Criteria (rather than on the use of the Software itself).

Overall, across all systems that participated in the Demo, over 60% of patient assessments were conducted to completion. The remainder consisted of practice sessions, abbreviated sessions (e.g., partial evaluation for placement in withdrawal management / detox) or follow-up evaluations.

Programs that got past the learning curve reported that the time for an average assessment was under two hours and closer to 60-90 minutes. Small, single-level programs with few staff found it more difficult to adapt to even starting to use the Software, and did not get started on this learning curve. Some programs billed for this as an Extended Evaluation, which provided a higher reimbursement.

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CLINICAL BENEFIT: Programs reported that, with the Software, intake clinicians believed that they were getting more and better quality clinical understanding of their patients. This was true even among programs that had previously used the Addiction Severity Index (ASI) as their assessment tool. Another finding was that patients liked the greater depth and personalization of the branched assessment, and were more likely to accept their placements as a result of their increased awareness of their range of needs, compared to conventional assessment.

MANAGED CARE BENEFIT: Programs that used the Software consistently reported that it speeds up the managed care review process. They also reported better luck getting managed care authorizations for reimbursement. This happened with both private commercial insurance managed care AND with public sector (e.g., managed Medicaid) managed care. This was reported to be a great benefit, including financially, of the Software.

IMPROVEMENTS:
Programs generated numerous suggestions, a number of which are being promoted for development:

- Create a printable report of all questions and answers *[Will be in the new release!]*
- List full names of Dimensions and Levels-of-Care *[Will be in the new release!]*
- Provide a delete button for erroneous or practice cases *[In development]*
- Provide a full biopsychosocial narrative report for the chart *[In development]*
- Integrate with a program's EHR *[Available upon request from your EHR vendor!]*
- Obtain Meaningful Use Certification (MUC) and related rebates from the federal government *[Available upon request from your EHR vendor!]*
- Satisfy Probation and Parole CMS funding requirements to qualify for Medicaid administrative costs and targeted case management programs *[Available upon request from an EHR vendor!]*
- Spanish translation *[Under consideration, pending funding]*
- Addition of a module for SAMHSA's ATR Recovery Support Services (RSS) Needs Assessment *[Under consideration, pending funding]*

Market Release Plan:
So far, ASAM has received 18 agreements out of the ~25 currently active, identifiable behavioral health EHR companies that have been contacted and offered the opportunity to obtain a license from ASAM to join in the national commercial launch of the Software beginning this January (*see list below). This is a high level of endorsement of ASAM's commercial launch strategy. These vendors will sell the ASAM Software AT COST, i.e., $65 per intake clinician per month, for unlimited read-write uses. Discounts will be available, based on volume (i.e., numbers of users). Vendors are being invited to develop new derivative products for you, their customers (analyses, reports, EHR integration, Meaningful Use Certification linkage, etc.). It is ASAM's great hope that this approach will succeed in upgrading the health IT functionality of the U.S. addiction treatment field.

Other potential resources:
Other potential resources to help explain and educate programs about the national launch may include: The Treatment Research Institute (TRI; "home" of the ASI), researchers who participate in the Addiction Health Services Research Conference (AHSR), some of the 14 SAMHSA-NIDA funded Addiction Technology Transfer Centers (ATTCs), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

Public Licensing:
ASAM will also license the Software to states, counties and large municipalities for subsequent dissemination to their treatment systems. Please contact them directly for more information.

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Currently participating behavioral EHR commercial vendors:

BestNotes	Foothold Technology	Sigmund Software
Brain Resource.com	Lauris / Integrated Imaging	Smart
Compulink	ManageAttendance	Stratus EMR
Computalogic's MethodOne	Orion Systems	The ECHO Group
DocuTrak	Qualifacts	TenEleven Group
eHana	Ramsell	Welligent

Also: States that currently participate in the WITS data program are also eligible to receive the ASAM Criteria Software, potentially with WITS data field integration, through FEi Systems.

For information: David R Gastfriend MD, at gastfriend@gmail.com or 617.283.6495

American Society of Addiction Medicine
4601 North Park Avenue, Upper Arcade Suite 101, Chevy Chase, MD 20815-4520
Phone: (301) 656-3920 • Facsimile: (301) 656-3815
Website: HTTP://WWW.ASAM.ORG

2.14

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Attach #3
02/03/05
SB2045
J#23085

SB 2045

Substance Use Disorder Voucher Program for Substance Abuse Licensed Private Providers

Goals of Voucher:

1) Improve access to services (rural areas, private providers, avoid waitlists, etc.)
2) Allow for client choice of providers

Client Eligibility:

1) Adults (age 18+)
2) Self-pay individuals at all levels of care (ASAM 1, 2.1, 2.5, 3.1, 3.5).
3) Individuals with Medicaid for 2.5, 3.1, 3.5 levels of care (ASAM).

Voucher is considered payment of last resort (Medicaid, Medicaid expansion, marketplace, etc.)

Provider Eligibility:

1) Providers must hold a valid ND substance abuse program license.
2) Programs must provide services following ASAM Criteria (as required in administrative rule).
3) Programs must comply with all documentation standards as identified in administrative rule.

Oversight:

The Department of Human Services, Mental Health & Substance Abuse Division will administer the voucher program. Administrative rules will be developed that ensure programs are research-based, ensure providers collect and report both process and outcome measures, and to develop authorization guidance and process. The Division will utilize the data reported to move toward an outcome-based substance use disorder system of care.

The group developing and review this proposal includes members from across the state representing the following:

DHS Mental Health & Substance Abuse Division
ND Treatment Providers Coalition
ND Addiction Counselors Association
Large Private Provider
Small Private Provider
ND Substance Abuse Training Consortium
ND Board of Addiction Counseling Examiners
DHS Field Services Division
Department of Corrections and Rehabilitation

Attach#1
SB 2045
J# 23117
02/03/2015

SB 2045 ADDITIONAL AMENDMENT (February 05, 2015)

SECTION 2. The department of human services shall report to an interim legislative committee before July 1, 2016, the rules the department has adopted for the voucher system.

2-11-15
SB2045
#1
Subcom
JH 23678

SB 2045

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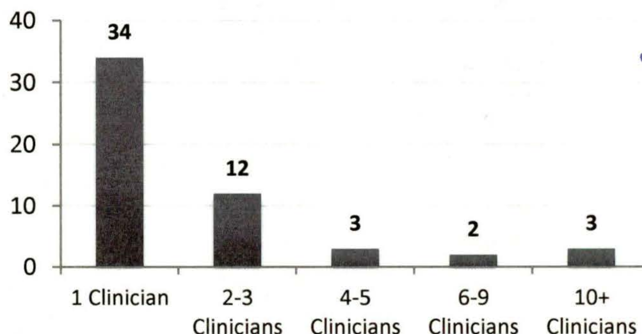
Department of Corrections and Rehabilitation

#2
SB 2045
Subcom
2-11-15
J# 23678

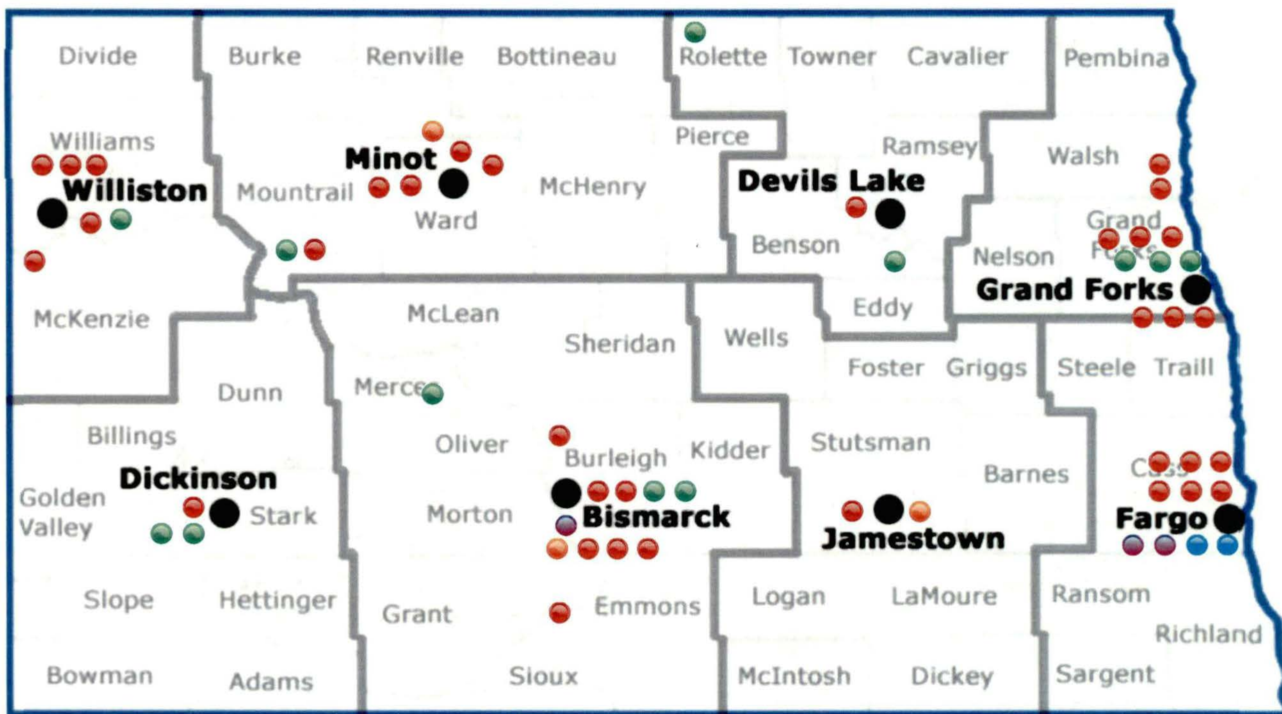
NORTH DAKOTA
Licensed Private Substance Abuse Treatment Programs

Total Number of Licensed Private Programs* = 54

- 34 Licensed Programs have 1 Clinician
- 12 Licensed Programs have 2-3 Clinicians
- 3 Licensed Programs have 4-5 Clinicians
- 2 Licensed Programs have 6-9 Clinicians
- 3 Licensed Programs have 10+ Clinicians



Location and Number of Clinicians per Program



LEGEND
- 1 Clinician
- 2-3 Clinicians
- 4-5 Clinicians
- 6-9 Clinicians
- 10+ Clinicians

Licensed Substance Abuse Treatment Programs are required to follow the levels of care based on the DSM and ASAM patient placement criteria and policies for client admission.

*Does not include DUI providers

2.2

List of Programs by Region

Region 1 (Williston)

Programs with 1 Clinician

- **ADAPT, Inc.** - Williston
- **Native American Resource Center** - Trenton
- **Choice Recovery Counseling** - Williston
- **Weishoff Alcohol & Drug** - Williston
- **Montgomery Counseling Services** - Wiliston

Programs with 2-3 Clinicians

- **Montgomery Counseling Services** – Williston

Region 3 (Devils Lake)

Programs with 1 Clinician

- **ADAPT, Inc.** - Devils Lake

Programs with 2-3 Clinicians

- **5th Generation** - Belcourt
- **Spirit Lake Nation Recovery & Wellness Program** - Fort Totten

Region 5 (Fargo)

Programs with 1 Clinician

- **ADAPT, Inc.** - Fargo
- **Shiaro, Chris Counseling Services** - Fargo
- **Simon Chemical Dependency Services** - Fargo
- **McGrath, Claudia Counseling** - Fargo
- **Discovery Counseling** - Fargo
- **Fargo VA Medical and Regional Office Center Substance Abuse Treatment Program** - Fargo

Programs with 6-9 Clinicians

- **First Step Recovery, a program of The Village Family Service Center** - Fargo
- **Drake Counseling Services, Inc. - Fargo**

Programs with 10+ Clinicians

- **PSJ Acquisitions, LLC d/b/a Prairie St. John's** - Fargo
- **ShareHouse, Inc.** - Fargo

Region 7 (Bismarck)

Programs with 1 Clinician

- **Prairie Learning Center** - Raleigh
- **Pathway to Freedom** - Wilton
- **Basaraba, Rose Counseling Service** - Bismarck
- **Be Free Counseling Services** - Bismarck
- **Chambers and Blohm Psychological Services, PC** - Bismarck
- **Kazmierczak, Audrey Counseling Service** - Bismarck
- **One 80 Programs, Dakota Institute of Trauma Therapy, PC** - Bismarck

Programs with 2-3 Clinicians

- **St. Alexius Medical Center/PHP Dual Diagnosis Program** - Bismarck
- **Coal Country Substance Abuse Services** - Beulah
- **ADAPT, Inc.** - Bismarck

Programs with 4-5 Clinicians

- **New Freedom Center, Inc.** - Bismarck

Programs with 10+ Clinicians

- **Heartview Foundation** - Bismarck

Region 2 (Minot)

Programs with 1 Clinician

- **ADAPT, Inc.** - Minot
- **Bob Hayes Addiction Services** - Minot
- **Cornerstone Addiction Services** - Minot
- **Goodman Addiction Services** - Minot
- **Parshall Resource Center** - Parshall

Programs with 2-3 Clinicians

- **Circle of Life Alcohol Program** - New Town

Programs with 4-5 Clinicians

- **Trinity Hospitals** - Minot

Region 4 (Grand Forks)

Programs with 1 Clinician

- **ADAPT, Inc.** - Grand Forks
- **MAB Addiction Counseling Services** - Grafton
- **Quinn DUI/MIP/Evaluations** - Grafton
- **Alcohol & Drug Services, Inc** - Grand Forks
- **Foley, Don Counseling** - Grand Forks
- **Northland Christian Counseling Center** - Grand Forks
- **Stadter, Richard P. Psychiatric Center - Chemical Dependency** - Grand Forks
- **Start Somewhere Counseling Services** - Grand Forks

Programs with 2-3 Clinicians

- **Agassiz Associates, PLLC** - Grand Forks
- **UND Counseling Center Substance Abuse Program** - Grand Forks
- **Drake Counseling Services - Grand Forks**

Region 6 (Jamestown)

Programs with 1 Clinician

- **Dockter-Evjen Recovery Choice** - Jamestown

Programs with 4-5 Clinicians

- **Addiction & Counseling Services** - Jamestown

Region 8 (Dickinson)

Programs with 1 Clinician

- **ADAPT, Inc.** - Dickinson

Programs with 2-3 Clinicians

- **Heart River Alcohol & Drug Abuse Services** - Dickinson
- **Sacajawea Substance Abuse Counseling** - Dickinson

January 2015

NORTH DAKOTA

Licensed Private Substance Abuse Treatment Programs... by ASAM Level of Care

#3
SB2045
2-11-15
Sub. JH 23678

EDUCATIONAL DUI SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
0.5	4	3	5	9	10	4	21	3	59

ADULT SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
I	5	7	4	10	13	2	9	3	**53**
II.1	2	4	3	3	8	1	5	2	**28**
II.5		2	1	2	5		5	1	**16**
III.1		2	3		2		2		**9**
III.5		1	1	1	2		1		**6**
III.7		1		1	1				**3**

ADOLESCENT SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
I	1	4	2	6	7	1	6	2	**29**
II.1		2	2	2	3		1		**10**
II.5		1		1	2		1		**5**
III.1		1			1		1		**3**
III.5		1		1	1		1		**4**
III.7		1		1	1				**3**

WITHDRAWAL MANAGEMENT (DETOX) SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
III.2D		1	1		3		1		6

north dakota department of human services

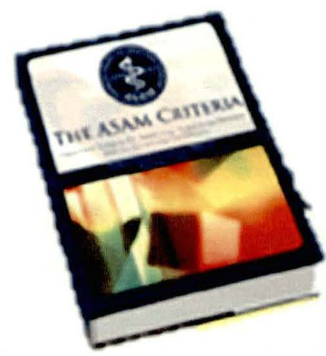
HOW THE ASAM CRITERIA WORKS

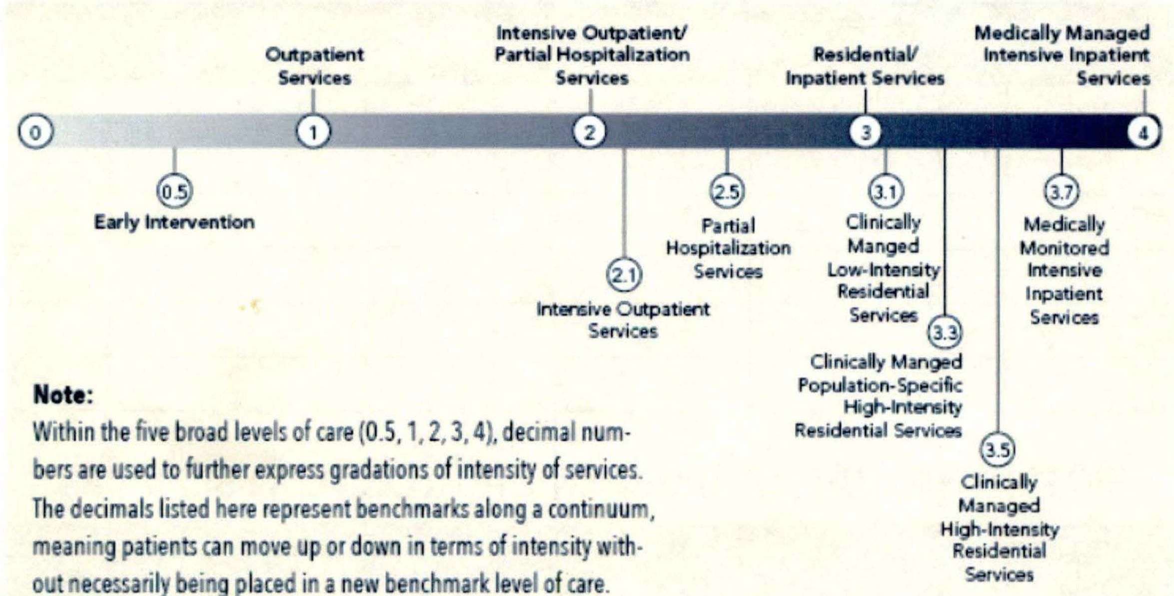
The ASAM criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1 DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2 DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3 DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
4 DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
5 DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
6 DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things





http://www.asam.org/publications/the-asam-criteria/about/

SB 2045
2-17-15
#1

15.0178.03001
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
February 6, 2015

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2045

Page 1, line 2, after "services" insert "; and to provide for a report to the legislative management"

Page 1, after line 16, insert:

"**SECTION 2. DEPARTMENT OF HUMAN SERVICES REPORT TO LEGISLATIVE MANAGEMENT.** The department of human services shall provide a report to the legislative management or a committee designated by the legislative management before July 1, 2016, regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs as provided in section 1 of this Act."

Renumber accordingly

15.0178.03002
Title.

Prepared by the Legislative Council staff for
Senator Erbele
February 18, 2015

#1
SB 2045
2-18-15

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2045

Page 1, line 2, after "services" insert "; and to provide for a report to the legislative management"

Page 1, line 5, replace "$2,000,000" with "$1,000,000"

Page 1, after line 16, insert:

"**SECTION 2. DEPARTMENT OF HUMAN SERVICES REPORT TO LEGISLATIVE MANAGEMENT.** The department of human services shall provide a report to the legislative management or a committee designated by the legislative management before July 1, 2016, regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs as provided in section 1 of this Act."

Renumber accordingly

/

#1
SB 2045
3-9-15

Testimony in support of
SB 2045
March 9
By Kathy Hogan, Rep. District 21

Chairman Weisz and members of the House Human Service Committee, my name is Kathy Hogan, I represent District 21 and I am a member of the Behavioral Health Stakeholder group.

The primary objective of SB 2045 is to expand available substance abuse services through the establishment of a voucher system. This system would address several of the interim committee recommendations, particularly the expansion of available services, greater consumer choice and more rural accessibility.

Following the interim committee, the Behavioral Health Care Stakeholders Committee continued to meet. During the meetings, it was discovered the Addiction Society of American (ASAM) has just established a standardized computerized assessment system that is now available. The ASAM criteria and standards are well established and agreed upon protocols. This new assessment offers ND an opportunity to unify the public and private system that will identify unmet needs, collect data on current resources and build a more unified system of care. The ASAM Criteria Software encourages individualized treatment planning and helps provide accountability for consistent stewardship of resources, maximizing the efficient use of substance abuse treatment dollars.

Attached is a copy of an amendment to this bill that the Behavioral Health Stakeholders would encourage you to consider as ND moves to a more integrated public/private partnership in assuring access to services.

Thank you for your consideration of this amendment. I am more than willing to answer any questions.

SB 2045 part of #1

15.0178.04001
Title.

Prepared by the Legislative Council staff for
Representative Hogan
March 9, 2015

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2045

Page 1, line 1, after the first "to" insert "create and enact a new section to chapter 50-31 of the North Dakota Century Code, relating to regulation of substance abuse programs; to"

Page 1, after line 4, insert:

"**SECTION 1.** A new section to chapter 50-31 of the North Dakota Century Code is created and enacted as follows:

Treatment criteria - Rules.

1. The department shall adopt by rule a comprehensive set of guidelines for placement, continued stay, transfer, and discharge of patients with addiction and co-occurring conditions which is based on the American society of addiction medicine's criteria. The guidelines may include use of American society of addiction medicine's criteria clinical decision software and for adults the use of the related software algorithms.

2. A substance abuse treatment program licensed under this chapter shall comply with the rules adopted under this section. This section and the rules adopted under this section apply regardless of whether the substance abuse treatment program's services are privately or publicly funded.

3. The department of human services shall identify by rules the edition of the American psychiatric association's diagnostic and statistical manual of mental disorders a licensed substance abuse treatment program shall utilize in describing co-occurring mental health conditions."

Page 1, line 16, replace "Act" with "section"

Page 1, line 17, replace "Act" with "section"

Page 1, line 23, replace "1" with "2"

Renumber accordingly

#2

SB 2045

MARCH 9, 2015

Substance Use Disorder Voucher Program for Substance Abuse Licensed Private Providers

Goals of Voucher:

1) Improve access to services (rural areas, private providers, avoid waitlists, etc.)
2) Allow for client choice of providers

Client Eligibility:

1) Adults (age 18+)
2) Self-pay individuals at all levels of care (ASAM 1, 2.1, 2.5, 3.1, 3.5).
3) Individuals with Medicaid for 2.5, 3.1, 3.5 levels of care (ASAM).

Voucher is considered payment of last resort (Medicaid, Medicaid expansion, marketplace, etc.)

Provider Eligibility:

1) Providers must hold a valid ND substance abuse program license.
2) Programs must provide services following ASAM Criteria (as required in administrative rule).
3) Programs must comply with all documentation standards as identified in administrative rule.

Oversight:

The Department of Human Services, Mental Health & Substance Abuse Division will administer the voucher program. Administrative rules will be developed that ensure programs are research-based, ensure providers collect and report both process and outcome measures, and to develop authorization guidance and process. The Division will utilize the data reported to move toward an outcome-based substance use disorder system of care.

The group that developed this proposal includes members from across the state representing the following:

DHS Mental Health & Substance Abuse Division
ND Treatment Providers Coalition
ND Addiction Counselors Association
Large Private Provider
Small Private Provider
ND Substance Abuse Training Consortium
ND Board of Addiction Counseling Examiners
DHS Field Services Division
Department of Corrections and Rehabilitation

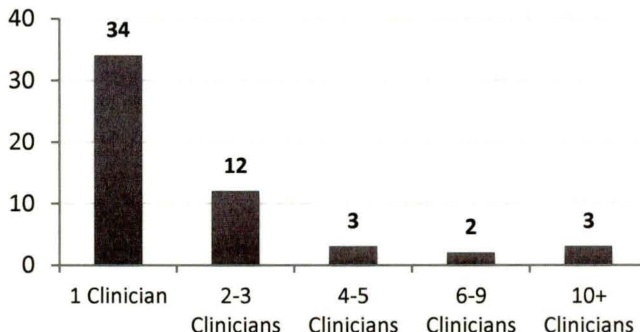
SB 2045 #3
3/9/2015

February 2015

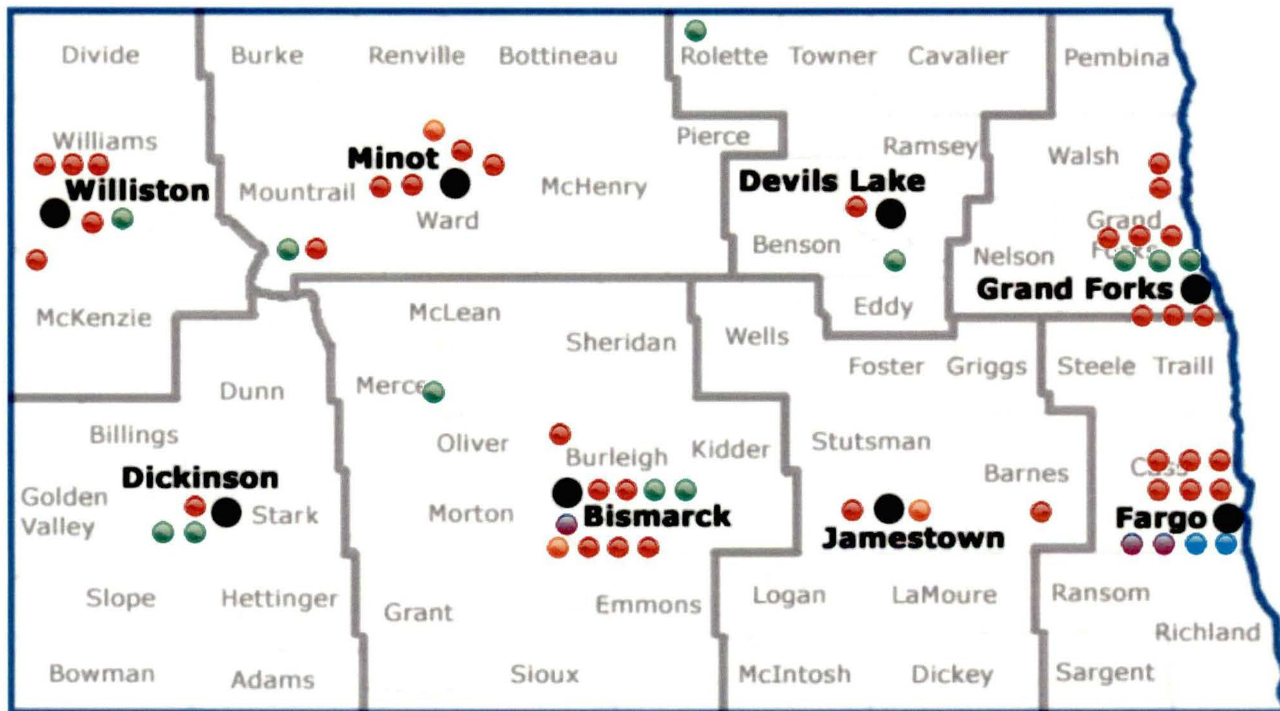
NORTH DAKOTA
Licensed Private Adult Substance Abuse Treatment Programs

Total Number of Licensed Private Programs* = 54

- 34 Licensed Programs have 1 Clinician
- 12 Licensed Programs have 2-3 Clinicians
- 3 Licensed Programs have 4-5 Clinicians
- 2 Licensed Programs have 6-9 Clinicians
- 3 Licensed Programs have 10+ Clinicians



Location and Number of Clinicians per Program



LEGEND

- 1 Clinician
- 2-3 Clinicians
- 4-5 Clinicians
- 6-9 Clinicians
- 10+ Clinicians

Licensed Substance Abuse Treatment Programs are required to follow the levels of care based on the DSM and ASAM patient placement criteria and policies for client admission.

*Does not include DUI, adolescent only, or public providers (DHS/DOCR)

List of Programs by Region**

Region 1 (Williston)

Programs with 1 Clinician

- **ADAPT, Inc.** - Williston
- **Native American Resource Center** - Trenton
- **Choice Recovery Counseling** - Williston
- **Weishoff Alcohol & Drug** - Williston
- **Montgomery Counseling Services** - Wiliston

Programs with 2-3 Clinicians

- **Montgomery Counseling Services** – Williston

Region 3 (Devils Lake)

Programs with 1 Clinician

- **ADAPT, Inc.** - Devils Lake

Programs with 2-3 Clinicians

- **5th Generation** - Belcourt
- **Spirit Lake Nation Recovery & Wellness Program** - Fort Totten

Region 5 (Fargo)

Programs with 1 Clinician

- **ADAPT, Inc.** - Fargo
- **Shiaro, Chris Counseling Services** - Fargo
- **Simon Chemical Dependency Services** - Fargo
- **McGrath, Claudia Counseling** - Fargo
- **Discovery Counseling** - Fargo
- **Fargo VA Medical and Regional Office Center Substance Abuse Treatment Program** - Fargo

Programs with 6-9 Clinicians

- **First Step Recovery, a program of The Village Family Service Center** - Fargo
- **Drake Counseling Services, Inc. - Fargo**

Programs with 10+ Clinicians

- **PSJ Acquisitions, LLC d/b/a Prairie St. John's** - Fargo
- **ShareHouse, Inc.** - Fargo

Region 7 (Bismarck)

Programs with 1 Clinician

- **Pathway to Freedom** - Wilton
- **Basaraba, Rose Counseling Service** - Bismarck
- **Be Free Counseling Services** - Bismarck
- **Chambers and Blohm Psychological Services, PC** - Bismarck
- **Kazmierczak, Audrey Counseling Service** - Bismarck
- **One 80 Programs, Dakota Institute of Trauma Therapy, PC** - Bismarck

Programs with 2-3 Clinicians

- **St. Alexius Medical Center/PHP Dual Diagnosis Program** - Bismarck
- **Coal Country Substance Abuse Services** - Beulah
- **ADAPT, Inc.** - Bismarck

Programs with 4-5 Clinicians

- **New Freedom Center, Inc.** - Bismarck

Programs with 10+ Clinicians

- **Heartview Foundation** - Bismarck

Region 2 (Minot)

Programs with 1 Clinician

- **ADAPT, Inc.** - Minot
- **Bob Hayes Addiction Services** - Minot
- **Cornerstone Addiction Services** - Minot
- **Goodman Addiction Services** - Minot
- **Parshall Resource Center** - Parshall

Programs with 2-3 Clinicians

- **Circle of Life Alcohol Program** - New Town

Programs with 4-5 Clinicians

- **Trinity Hospitals** - Minot

Region 4 (Grand Forks)

Programs with 1 Clinician

- **ADAPT, Inc.** - Grand Forks
- **MAB Addiction Counseling Services** - Grafton
- **Quinn DUI/MIP/Evaluations** - Grafton
- **Alcohol & Drug Services, Inc** - Grand Forks
- **Foley, Don Counseling** - Grand Forks
- **Northland Christian Counseling Center** - Grand Forks
- **Stadter, Richard P. Psychiatric Center - Chemical Dependency** - Grand Forks
- **Start Somewhere Counseling Services** - Grand Forks

Programs with 2-3 Clinicians

- **Agassiz Associates, PLLC** - Grand Forks
- **UND Counseling Center Substance Abuse Program** - Grand Forks
- **Drake Counseling Services - Grand Forks**

Region 6 (Jamestown)

Programs with 1 Clinician

- **Dockter-Evjen Recovery Choice** – Jamestown
- **Creative Therapy, PLLC** – Valley City

Programs with 4-5 Clinicians

- **Addiction & Counseling Services** - Jamestown

Region 8 (Dickinson)

Programs with 1 Clinician

- **ADAPT, Inc.** - Dickinson

Programs with 2-3 Clinicians

- **Heart River Alcohol & Drug Abuse Services** - Dickinson
- **Sacajawea Substance Abuse Counseling** - Dickinson

**Programs in red have a Medicaid provider number.

SB 2045 #4
3/9/15

January 2015

NORTH DAKOTA

Licensed Private Substance Abuse Treatment Programs... by ASAM Level of Care

EDUCATIONAL DUI SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
0.5	4	3	5	9	10	4	21	3	59

ADULT SERVICES

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I	5	7	4	10	13	2	9	3	53
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III.5		1	1	1	2		1		6
III.7		1		1	1				3

ADOLESCENT SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
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II.1		2	2	2	3		1		10
II.5		1		1	2		1		5
III.1		1			1		1		3
III.5		1		1	1		1		4
III.7		1		1	1				3

WITHDRAWAL MANAGEMENT (DETOX) SERVICES

ASAM LEVEL OF CARE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	TOTAL
III.2D		1	1		3		1		6

HOW THE ASAM CRITERIA WORKS

The ASAM criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

	Dimension	Description
1	DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
3	DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
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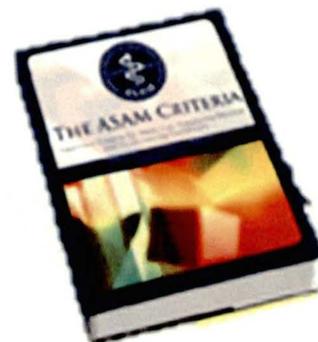
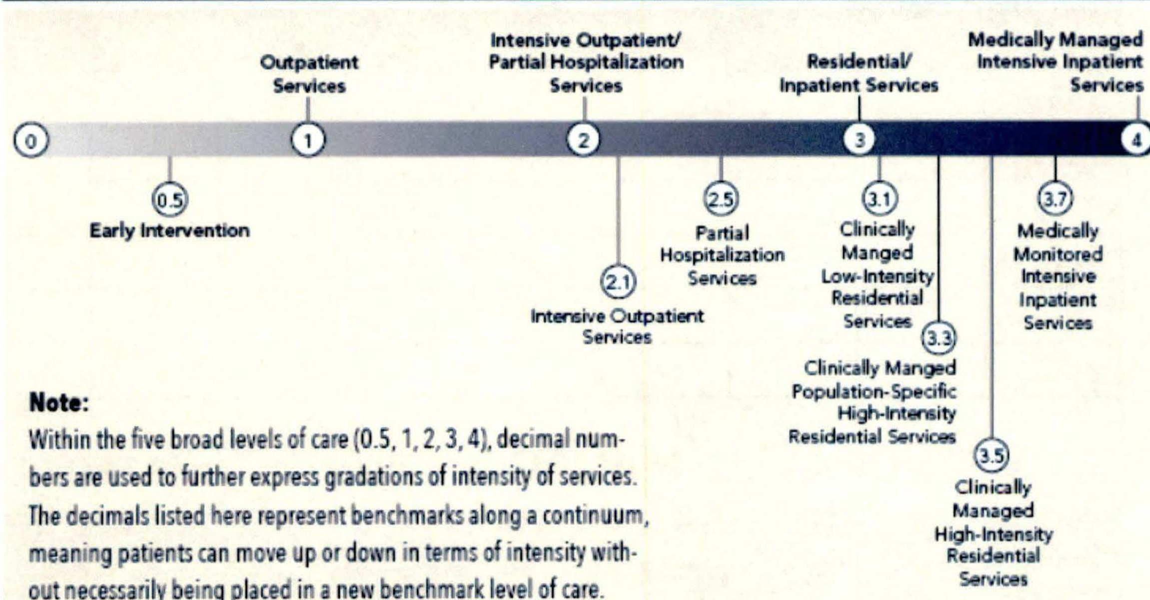


REFLECTING A CONTINUUM OF CARE



http://www.asam.org/publications/the-asam-criteria/about/

north dakota department of human services

2

#5
SB 2045
3-9-15

Testimony of Elizabeth Faust

S.B. 2045

House Human Services Committee

March 9, 2015

Chairman Weisz and committee members, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota (BCBSND). I am submitting testimony to the Committee about the American Society of Addiction Medicine (ASAM) Criteria Software as it relates to a proposed amendment to SB 2045 appropriating funds to the Department of Human Services for a voucher system for addiction treatment services. My goal today is to provide some straightforward information for you about what the ASAM Criteria and Software are and to explain the unique opportunity I believe they may represent for North Dakota at this time.

The ASAM Criteria, now in its third edition, represents 20 years of work on the part of ASAM to lift addiction diagnosis and treatment out of the "black hole of subjective unmeasurability". As you may know, the historical roots of addiction treatment came from the recovery community of lay persons, and the mainstream medical community did not recognize addiction as a disease early on. The American Society of Addiction Medicine brought science and medicine to the field in working to marry the "science" with the "art" already established by the 12-step and peer recovery models working in the field. It is worth emphasizing that there is not a competition between the medical model and the abstinence-based recovery models.

These are the guiding principles of the ASAM Criteria:

*Moving from one-dimensional to **multidimensional assessment**
*Moving from program-driven to **clinically-driven and outcomes-driven treatment**
*Moving from fixed length of service to **variable length of service**
*Moving from a limited number of discrete levels of care to a **broad and flexible continuum of care**
*Identifying **adolescent-specific needs**
***Clarifying the goals of treatment**
***Moving away from using previous "treatment failure"** as an admission prerequisite
*Moving toward an **interdisciplinary, team approach to care**
***Clarifying the role of physicians**
***Focusing on treatment outcomes**
*Engaging with **"Informed Consent"**
*Clarifying **"Medical Necessity"**
***Incorporating ASAM's definition of addiction**

There are two foundational halves of the ASAM Criteria that are important for you to understand. The first half is the assessment of individuals. Humans are messy and complicated, and the disease of addiction, like other kinds of brain-based disorders, are diseases of behavior, insight and physical health. Trying to assess and juggle the physical, emotional and social parts of a person's addiction all in a limited amount of assessment time has challenged clinicians from the beginning. The ASAM model takes all of the complicated information from the assessment of an individual and organizes it into 6 domains, or dimensions. Why six? Because humans are complex and it takes six to capture it all. The model forces us to remember and value all of the elements that are important in understanding each individual and their needs, and to describe it in the same way every other clinician describes it. It helps us assign risk in each dimension and helps us to not forget any important aspects. Every clinician can and should address each of these dimensions when doing evaluations, regardless of their training background or the location in which they see

patients or clients.

Once you have a thorough picture of an individual's unique needs, the second half of the ASAM Criteria come into play. What kind of care does a person need and in what setting?

The ASAM Criteria defines levels of care that represent intensities of service. Just as assessments need to be done in a standard way so clinicians are speaking a common language, the elements of levels of service need to be defined in a standard way. How do you assure that inpatient programs in the eastern part of the state offer the same capability for services and support that those in the western part of the state, or another state? A lay person's example might be the difference between food vendor stands, restaurants and restaurants with bars. Each has specific criteria that must be met in order to appropriately offer the advertised services.

The criteria define objective elements of care delivery that must be available in order for a program to be called by a specific description. This is where you will hear the terminology: "Partial Hospital Program, ASAM Level 2.5", etc. The purpose for this second component defining levels of care is again to create a common definition so that every program and clinician is talking about the same thing when we talk about where to match patients to appropriate services and levels of care.

This has been the hard work for ASAM of pulling addiction assessment and treatment out of the "black hole of subjective unmeasurability". If you can't measure it, you can't manage and improve it. This is where cancer treatment was 15-20 years ago. This is not someone's "good idea of the month". The development of the ASAM Criteria has been done using evidence-

based research, and every new edition of the criteria has been done based on the clinical consensus of the best experts in the field of addiction medicine. The model has gained more and more acceptance over the past two decades, and 38 states now endorse the ASAM Criteria. North Dakota is one of those states. We have statute language describing some of the treatment program elements according to an early version of ASAM, as well as administrative language setting expectations that assessments will reflect the ASAM multi-dimensional model. However, there is a gap between intent and reality and it would only be accurate at this point in time to say that North Dakota uses pieces of ASAM definitions.

That represents major progress and we are like many other states having marched forward in our effort to treat addiction more effectively. However, humans are complicated and multi-dimensional assessment is challenging to do objectively and consistently. Some might say that ASAM is just too complicated. Actually, it's humans who are complicated and the model simply reflects that. Current data shows that when you assess people with the ASAM Criteria using fidelity to the model, they have better outcomes and lower relapse rates.

The ASAM editors are evolving with us in addressing our challenges. Assessment is hard to do consistently and objectively. ASAM obtained a $1 million grant from SAMHSA (U.S. Substance Abuse and Mental Health Services Administration) and developed the ASAM Criteria Software, which is a standardized version of the adult criteria for open-source release. The software provides a structured interview to guide assessment and calculate suggested levels of care for patients. It uses the power of a computer algorithm to help us objectively and consistently organize the complexity of human beings into a coherent, understandable framework and guides clinicians in recommending levels of service intensity. It has demonstrated excellent

acceptance by patients and clinicians. Those clinicians who have used other structured interviews such as the ASI (Addiction Severity Index) indicate preference for the ASAM interview as giving them better quality clinical information.

The ASAM Criteria Software is now being launched nationally after extensive testing in Norway and the U.S. I have included a handout from ASAM with details of the research and Software commercial launch. In order to support widespread dissemination, SAMHSA is expecting ASAM to distribute the Software at cost. The only element necessary for providers is internet access. Providers do not have to have EHRs (electronic health records) in order to use the Software. However, the computer algorithm can be incorporated into EHRs and ASAM has already obtained agreements from 75% of behavioral health EHR companies to incorporate the software into their systems. Requirements for privacy, including HIPAA and 42-CFR, have been accommodated.

Engaging the use of the ASAM Criteria Software will allow us better objective assessments and guidance in clinical decision making as clinicians, provider facilities and payers. Blue Cross Blue Shield North Dakota is committed to engaging with our providers to implement the use of the Software. We believe it will allow a level playing field between the provider and payer. It will facilitate objective conversations and decisions about how to deliver best care and to best spread resources in order to serve our members affordably and effectively.

But this can do so much more. I am going to move now to explanation of the opportunity this can represent for North Dakota. One of the findings of the Schulte Behavioral Health Planning Report in July 2014 was that we lack a coherent method for capturing data about behavioral

health needs in North Dakota. This statement is made in the executive summary:

"Drug use is on the rise and is seen as a critical issue in the West. Data to measure needs in the state is incomplete with collection only within the public sector. Legacy services, not data driven with proven outcomes, are being used state wide making it difficult to fight for additional funding in the legislature. Sky-rocketing bad debt at hospitals is a reality throughout the state."

If we made a decision to implement the Software-supported ASAM assessment and patient placement across the board in our state, public and private alike, we would unquestionably take giant steps toward improving the quality of all addiction assessments. We would facilitate continuity and collaboration, reduce duplication, and improve matching of consumers with the services they need.

But in addition, we would be stepping into the best available data measurement system for addictive disorders available in the U.S. On a macro level, our data would become part of the ASAM national work to continue developing outcomes-based best practice for treating addiction. On a micro level, our data would be available to us as providers for measuring quality of care and clinician competence. It would be available for the state to develop needs assessment analyses and to identify and quantify gaps in the care delivery continuum. It would allow the state to measure provider outcomes with one another. It would allow legislators to make rational decisions about allocation of resource based on accurate and believable data across both public and private sector. It is another step forward in the process of moving addiction treatment out of the "black hole of subjective unmeasurability" and into the mainstream of health care delivery. We've done it for cancer, and we need to do it for addiction.

In conclusion, I am recommending that you adopt the proposed amendment to SB2045 to include the expectation that all substance abuse treatment programs licensed in North Dakota implement, utilize and maintain program and clinical fidelity with the most current version of the ASAM Criteria and utilize the ASAM Criteria Software in assessment and treatment planning. It is a great step that the private providers have indicated willingness to work with BCBSND in developing the use of the Software in their work with our members. It will be even more beneficial if you expand this to include all private providers involved in care delivery within the voucher and best of all if you include all providers, public and private. That will power our ability to capture data and drive forward improvements like nothing else. In the words of David Gastfriend, M.D., the chief software architect and one of the chief editors for the ASAM Criteria, "If we get this off the ground, North Dakota will be one of the national leaders in this process."

I have included additional information and detail in my written testimony below labeled as Attachment 1. I am happy to answer any questions you might have and can be reached at: Elizabeth.faust@bcbsnd.com or 701-277-2477. Thank you very much for your time and attention.

Elizabeth Faust, MD

Attachment 1:

American Society of Addiction Medicine
ASAM Criteria Software-Proposal for implementation in North Dakota
February 2015
Elizabeth Faust, MD
BCBSND

Definitions:

ASAM Criteria Software- A standardized version of the adult ASAM Criteria for open-source release, funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA). The software provides a structured interview to guide assessment and calculate suggested levels of care for adult patients.

ASAM Criteria-Clinical guidelines designed by the American Society of Addiction Medicine for the purpose of multidimensional assessment to develop patient-centered service plans and to guide clinicians in making objective decisions about patient admission, continuing care, and transfer/discharge for various levels of care for addictive, substance-related and co-occurring mental health/substance abuse conditions. The ASAM Criteria text delineates dimensions, requirements, and decision rules that comprise ASAM's criteria. The text serves as a companion to the ASAM Criteria Software. The text contains adolescent-specific content regarding service planning and considerations relevant to adolescent populations.

The ASAM Criteria text and the ASAM Criteria Software are companion text and application. The text delineates the dimensions, levels of care and decision rules that comprise the ASAM criteria. The software provides the approved structured interview to guide the adult assessment and calculate the complex decision tree to yield suggested levels of care. To assure effective, reliable treatment planning, the text and the software should be used in tandem, the text to provide the background and guidance for proper use of the software, and the software to

enable comprehensive, standardized evaluation. Note that services specifically tailored to adolescents are addressed throughout the ASAM Criteria but are not included in the ASAM Criteria Software at this time.

Features:

1) Incentive-neutral assessment system: the ASAM Criteria Software coupled with ASAM Criteria is designed to assure comprehensive, standardized evaluation and treatment placement decisions. Potential bias related to financial incentives is removed from the decision-making process. It creates a level playing field between payers and providers-one on which consumers get the best care with the most efficient use of society's resources.

2) Documentation of exceptions: providers administer the computer-based assessment, report the findings (electronically and instantly) and place the consumer in services according to ASAM. Discrepant placements are documented and the software gathers justification for discrepancies. These can occur for reasons such as lack of program availability, client refusal, or counselor disagreement. Data can be analyzed for algorithm problems or counselor bias and creates opportunity for program improvement, provider education or software enhancement.

3) Evidence-based practice: the ASAM Criteria has been developed over 20 years and represents the expert consensus of addiction treatment leaders regarding assessment, service planning and treatment delivery for substance abuse. Widespread use of the ASAM Criteria Software will accelerate the collection of quantitative, empirical data and move the field to outcome-based treatment guidelines to provide high quality, affordable care to the largest number of consumers possible.

4) Consumer choice and patient-centered care: satisfaction studies of the ASAM Criteria Software assessment process indicate that consumers liked the greater depth and personalization of the branched assessment, and were more likely to accept their placements as a result of their increased awareness of their range of needs illustrated in the software assessment, as compared to conventional assessment.

5) Standardized assessment-the Software algorithm creates a common assessment and clinical decision making algorithm for all providers. This will dramatically improve consistency among providers in consumer assessment, reduce duplication of evaluation and enhance communication between provider facilities in care transitions. Providers will see improved interface with payers. Programs using the Software consistently report that it speeds up the managed care review process and improves successful level of care decisions.

6) Outcome measurement-the ASAM Software will allow researchers, providers and payers throughout the field to speak the same language and arrive at the same level of care determinations. The software will facilitate aggregate analyses of patient placements, service utilizations and clinical outcomes. Treatment programs will be able to understand their utilization patterns and needs and research centers will be able to objectify and validate the ASAM Criteria. The result will be that North Dakota will contribute to and benefit from the development of evidence-based, outcomes-driven substance abuse treatment services.

7) Application to adolescent assessment and treatment-the ASAM Criteria has an embedded set of criteria especially designed for assessing and recommending treatment according to the unique needs of adolescents. Accordingly, the ASAM Criteria is evidence-based for use with adolescents. At this time, the software algorithm has not been expanded to include the additional unique elements of adolescents. Funding for that development

has not been available to this point, but is on the future work plan for the software development. Nonetheless, the Software can still be used for adolescent assessment because it allows for counselor customization of decision making.