North Dakota Behavioral Health Planning Council Meeting Minutes

Date: July 15, 2026
Time: 10:00 a.m.–4:00 p.m. CT
Location: Brynhild Haugland Room, North Dakota State Capitol, and Virtual Access**:** Microsoft Teams

Welcome and Call to Order

Vice-Chairperson Rich Smith presided in the absence of Chairperson Tania Zerr. The meeting was called to order at approximately 10:02 a.m. Members were welcomed, and roll call was conducted for those participating in person and virtually. A quorum was established.

Roll Call, Quorum and Approvals

Council Members Present:
Aimee Easton, designee for Cheryl Anderson; Brenda Bergsrud; Heather Call; Dan Cramer; Melanie Gaebe; Denise Harvey; Brad Hawk; Jennifer Henderson; Andrea Hochhalter; Melissa Kainz; Kristi Kilen; Nancy Maier; Carlotta McCleary; Ashley Roulette; Emma Quinn; Rich Smith; Kurt Snyder; Paul Strokland; Patricia "Trish" Camisu; and Michelle Woodcock, designee for Amanda Peterson.

Council Members Absent:
Melanie Flynn; Glenn Longie; Michelle Masset; Kelly McGrady; Pamela Sagness; Michael Salwei; Mark Schaefer; Phil Sorenson; and Tania Zerr.

The Council reviewed the April 15, 2026 meeting minutes.

Motion by Paul Stroklund. Seconded by Melanie Gaebe. Motion carried unanimously.

Approval of Agenda

Members were informed of one change to the agenda. Jared Eagle was unable to participate in the afternoon IMD waiver panel, and Dr. Joy of MHA Recovery Services agreed to participate in his place.

Motion to approve amended agenda by Dr. Dan Cramer. Seconded by Paul Strokland. Motion carried unanimously.

BHPC Administrative Updates

Membership The Council continues to have one vacancy for a consumer or individual in recovery/mental health. The position remains posted on the North Dakota boards and commissions portal, and members were encouraged to identify potential applicants.

Call for Nominations – Vice Chair Members were reminded that the October meeting is the Council's annual meeting and includes officer elections. Under the Council's succession process, Vice-Chairperson Rich Smith will assume the chairperson role following the October meeting. A new vice chair will therefore be elected.

Paul Strokland self-nominated for vice chair. Carlotta McCleary was also nominated and accepted the nomination. Nominations will remain open. Information from the candidates will be distributed before an electronic vote in September, with the result announced at the October meeting. The person elected will assume office following that meeting.

Summary Report of the North Dakota Behavioral Health Strategic Plan and Future Activities

Presenters: Bevin Croft and Vivien Solomon, Human Services Research Institute
(PPT slides provided)

Bevin Croft provided an update on progress across the North Dakota Behavioral Health Strategic Plan. The April dashboard, reflecting activity through the end of March and incorporating the consensus ratings established by the Council in April, is available on the strategic plan website.

Updates across strategic aims included:

- **Aim 3 – Timely Access to Services:** A process was established to reimburse certain health care expenses for people residing in substance use disorder treatment through the SUD voucher program. An additional objective was added to support the transfer of appropriate behavioral health-related 911 calls to 988, with the goal of expanding the process statewide.
- **Aim 4 – Community-Based Services for Adults:** A new goal was added to develop a long-term, structured residential option for individuals with complex mental health and co-occurring substance use needs. Current work includes a needs study and development of a model for possible legislative consideration. A goal is also being developed to support critical incident stress management and behavioral health services for first responders.
- **Aim 5 – Services for Children and Youth:** A partial hospitalization program has opened, and an RFP was issued for a second program. Parent and caregiver peer support was elevated as a distinct goal, beginning with expansion through System of Care regions and public behavioral health clinics.
- **Aim 6 – Justice-Involved Individuals:** Work continues to train, certify, and employ peer specialists within Department of Corrections and Rehabilitation facilities. The

reopening of the Tompkins Rehabilitation and Corrections Center was also incorporated into the plan. Members were invited to consider serving as the Council liaison for Aim 6.

- **Aim 9 – Person-Centered and Culturally Responsive Services:** The Behavioral Health Division policy team completed a person-centered practices self-assessment and identified opportunities related to staff training, contract language, and quality measurement. The Behavioral Health Clinics are beginning a similar assessment. Collaboration among the Behavioral Health Division, Office of Refugee Services, and Community Engagement Unit has resulted in a task force focused on cultural and service barriers to physical and mental health care.
- **Aim 11 – Tribal Partnerships:** Project HEAL was added to reflect education on historical trauma for child-serving professionals and trauma-focused treatment training for clinicians serving American Indian youth.
- **Aim 13 – Data and Quality Infrastructure:** Work continues on electronic health records, data warehouses, data governance, and a broader quality framework.

Vivien Solomon presented a prototype for incorporating system-performance indicators into the strategic plan dashboard. Proposed indicators included suicide mortality, youth alcohol use, 988 calls, texts and chats, public-system penetration rates for adults with serious mental illness and children with serious emotional disturbance, and data related to rural populations.

The presenters emphasized that available data offer only a partial view of the behavioral health system. For example, publicly reported penetration-rate data do not capture services financed through Medicare, private insurance, veterans' benefits, or other systems. The prototype estimated that approximately 13 percent of adults with serious mental illness and 13 percent of children with serious emotional disturbance were receiving services through the publicly funded behavioral health system.

Council members responded positively to the proposed dashboard refinements and found the added information visually useful. A question was raised about whether a federal benchmark or formula previously used to assess the adequacy of public mental health services remains available. Dr. Croft and Dr. Cramer agreed to research the question further. The new indicators will be quality-checked and considered for inclusion in the next dashboard. Members were invited to recommend additional indicators that would help demonstrate whether strategic plan activity is producing measurable system improvements.

Rural Health Transformation Program – Implications for Behavioral Health

Presenter: Pat Traynor, Interim Commissioner, North Dakota Health and Human Services **(PPT slides and handouts provided)**

Commissioner Traynor provided an overview of the Rural Health Transformation Program, describing it as a five-year opportunity to strengthen health and well-being across rural North Dakota. The program includes approximately $199 million annually for five years. Year-one funds must be obligated by the end of September 2026, with an internal target of August to allow sufficient time for contracting and procurement. The proposed year-two budget is also due in August and will support activity beginning November 1.

The program is organized around four broad pillars:

- Prevention and efforts to make North Dakota healthier;
- Workforce development and retention;
- Bringing care closer to home and strengthening the rural safety net; and
- Connecting technology, data, and providers.

Traynor emphasized workforce shortages have reached crisis levels in many communities. Proposed strategies include expanding health-care career pipelines, improving retention in rural and tribal communities, using technology to extend available professionals, supporting critical-access hospitals and rural clinics, strengthening emergency medical services, and using mobile or virtual services to bring care closer to patients.

The prevention pillar includes nutrition, physical activity, social connection, resiliency, and value-based approaches that reward earlier intervention. He highlighted youth suicide data as an urgent call to action and encouraged members to think broadly about how behavioral health, physical health, lifestyle, and community conditions intersect.

The program will also support assessments of critical-access hospitals and help organizations identify sustainable revenue, philanthropic, workforce, service, and technology strategies. Other opportunities may include mobile health services, upgraded emergency medical equipment, data integration, predictive analytics, electronic health records, and other technology intended to improve earlier identification/coordination.

Council discussion focused on how the funding could address behavioral health needs and whether rural communities are meaningfully involved in identifying priorities. Members emphasized:

- The value of sustained early intervention and wraparound services for children with serious emotional disturbance;

- Gaps that occur when early intervention eligibility ends at age three;
- High insurance deductibles and out-of-pocket costs for children's therapies;
- The shortage of dietitians and other specialized providers;
- The importance of placing clinicians and care coordinators within rural communities rather than relying exclusively on centralized or virtual services;
- The need to listen directly to small communities whose needs may differ significantly from one another;
- Limited grant-writing and administrative capacity within small communities and tribal nations; and
- The burden created when providers must submit several narrowly defined applications that could be addressed through a single coordinated initiative.

Commissioner Traynor acknowledged that the accelerated federal timeline and initial grant structure created challenges. He expressed interest in simplifying future applications, improving communication about forthcoming opportunities, supporting proposals that cross multiple program pillars, and reducing redundant reporting. He noted that affordability and insurance coverage are larger issues than the Rural Health Transformation Program alone can resolve, although Federally Qualified Health Centers, sliding-fee programs, and stronger care coordination may help some individuals.

NDCEL Behavioral Health Workshop Recap: Bridging Schools and Communities

Presenters: Keith Harris, Dickinson Public Schools; Patrick Healy, Badlands Behavioral Health Clinic; and Anne Williamson, Central Regional Education Association
(PPT slides provided)

The presenters described the Region 8 "Moonshot" initiative that grew from a previous North Dakota Council of Educational Leaders Behavioral Health Workshop. The work was designed to move beyond discussion and create concrete, community-driven solutions connecting schools, behavioral health providers, youth, families, and other partners.

The initiative began with approximately $25,000 and clearly defined goals. A 42-member working group was organized into four subcommittees, each with an identified leader and responsibility for completing specific work. A leadership group met monthly to monitor progress, resolve barriers, and maintain accountability. Goals were completed in May.

One major product was a regional resource atlas containing behavioral health, crisis, community health, and related services throughout Region 8. The tool allows a resident to

select a county and identify available services, including in the region's most rural communities. The atlas was built from a community resource map developed through Badlands Behavioral Health Clinic and expanded with information supplied by the broader working group. They hope the model could eventually support a statewide resource atlas.

Other goals focused on youth-led activities, relationship building, and creating opportunities for young people and service providers to interact directly. The next phase will focus on connecting the resource information with youth activities so that providers become known, trusted people rather than names on a list.

The June 2026 NDCEL workshop generated interest from other areas of the state in adapting the Region 8 approach. Presenters emphasized that replication should not require every region to use an identical model. Rather, communities should begin with available resources, define manageable goals, assign responsibility, and move discussions into action. Templates and tools from Region 8 may be developed into a roadmap for others.

Dickinson Public Schools also described its tiered approach to student behavioral health. Work has focused on strengthening universal and targeted supports, with increased attention planned for intensive interventions. Schools have leadership teams, professional learning communities, and intervention teams that help teachers identify behavioral skill deficits, implement interventions, and adjust the frequency and intensity of support based on student response. Summer behavior academies and other skill-building opportunities are intended to address unmet needs without treating behavioral intervention as punishment.

Questions and discussion addressed:

- The continued need for formal wraparound care coordination for children/families;
- Connecting behavioral health providers with after-school and summer programs;
- Integrated counseling within schools;
- Support for teacher and administrator well-being;
- Training educators on ADHD, behavioral health needs; and
- Helping educators from feeling solely responsible for resolving every student's needs.

Presenters emphasized the principle that children, families, and educators generally do well when they have the skills and support needed to do so. Members commended the Region 8 partners and noted additional regional and Children's Cabinet efforts.

Public Comment

Public comment was invited before the lunch break. No public comments were received.

Lunch Break

The Council recessed for lunch and reconvened at 1:00 p.m.

Key Update: Behavioral Health Housing Supports

Presenter: Jennifer Henderson, Community Housing and Grants Management Director, North Dakota Housing Finance Agency
(PPT slides provided)

Ms. Henderson provided an update on housing and homelessness, including work by the North Dakota Interagency Council on Homelessness, the Interim Human Services Committee, and the Reentry Housing Task Force.

The Interagency Council on Homelessness was reestablished by Governor Armstrong in January and has met monthly to hear from housing, homelessness, behavioral health, and community partners. Common themes identified through presentations, partner discussions, and a statewide survey include:

- Federal rental-assistance programs are insufficient to meet current demand;
- Most housing authorities maintain waiting lists;
- The aging homeless population is increasing;
- Emergency shelter and homeless-service funding does not meet demand;
- Affordable housing vacancies remain very limited in urban communities;
- Credit history, criminal convictions, application fees, holding fees, and rental prices create significant barriers;
- People experience difficulty applying for and maintaining Medicaid, SNAP, TANF, and child-care assistance; and
- SSI and SSDI applications are lengthy and frequently require appeals.

At the conclusion of the COVID-era North Dakota Rent Help program, approximately $1 million per month was supporting nearly 800 households. By comparison, the North Dakota Homeless Grant currently assists approximately 40 to 60 households per month. The state appropriated $10 million to the Homeless Grant for the biennium, allowing homeless services to be available statewide for the first time. However, a recent funding

round offered approximately $4.5 million while receiving more than $7.8 million in requests.

North Dakota is projected to need approximately 20,000 additional housing units by 2027, and current development is not keeping pace. Renters are much more likely than homeowners to be cost burdened, with particularly high rates among young adults and people age 65 and older. Housing costs also limit the ability of many teachers, nursing assistants, home-health workers, retail employees, and other essential workers to rent or purchase housing in the state's metropolitan communities.

Proposed legislative and administrative priorities include:

- Maintaining or increasing the Housing Incentive Fund;
- Continuing support for emergency shelter operations, short-term rental assistance, and case management;
- Supporting expansion of Certified Community Behavioral Health Clinics;
- Reviewing barriers to accessing and maintaining economic-assistance benefits;
- Increasing landlord engagement and risk-mitigation incentives;
- Developing consistent training and best practices for homeless-service providers;
- Expanding the Recovery Housing Assistance Program; and
- Supporting the Reentry Housing Task Force's work to assess housing stability and barriers for people leaving incarceration.

The Housing Incentive Fund received $25 million during the current biennium, including $5 million for single-family development. All single-family funds were committed during the first year, and the agency could support substantially more qualified development if additional funding were available.

The Recovery Housing Assistance Program used approximately $1.5 million to create 80 beds. Reported outcomes included increases in employment and income and decreases in substance use and intravenous drug use. Regions 6 and 8 are underrepresented because no proposals were received from those areas during the RFP process. Additional funding could support beds in underserved regions.

Discussion addressed federal FHA requirements for older homes, the need to prevent homelessness before people enter shelters, and the increasing number of older adults with limited income who are becoming homeless. Ms. Henderson noted that cultural reluctance

to seek assistance, inadequate retirement resources, increasing rents, all contribute to homelessness among older adults.

Key Update: Crisis Services

Presenter: Dr. Dan Cramer, Clinical Director, Behavioral Health Clinics, North Dakota Health and Human Services
(PPT slides provided)

Dr. Cramer described the crisis continuum as a three-part structure consisting of someone to contact, someone to respond, and a safe place to receive help. In North Dakota, these components include 988, regional mobile-crisis teams, crisis-stabilization units, and drop-in services. The overall objective is to provide a high-quality response that reduces unnecessary hospitalization and legal-system involvement while connecting individuals to continued treatment and support.

From January 2025 through May 2026, 988 handled more than 30,000 calls, texts, and chats, averaging approximately 1,800 interactions per month. Most contacts are resolved through the support provided by 988. When additional intervention is necessary, regional Behavioral Health Clinic teams are available 24 hours a day.

Mobile-crisis requests have increased annually. Effective March 2026, all regional teams were directed to respond to requests throughout their full geographic service areas, regardless of distance. Strategies to support this expectation include cross-regional backup, telehealth support, increased after-hours staffing, peer-support participation, and scheduling based on call-volume data. The period from 6:00 p.m. to midnight is generally the busiest after-hours period. Rural areas may generate crisis requests at rates equal to or higher than urban areas when calculated by population.

Each region now has access to crisis-stabilization beds and a drop-in setting for adults. Drop-in services may provide up to approximately 23 hours of support, including food, hydration, assessment, counseling, and connection to additional services. Crisis-stabilization stays may continue for several days when clinically appropriate. Current facilities serve adults; the state does not yet have comparable youth crisis-stabilization facilities.

Dr. Cramer introduced Mobile Response and Stabilization Services, a specialized youth-crisis model being implemented in North Dakota. The model is designed to respond earlier and more intensively when a child, youth, or caregiver identifies a crisis. Major components include:

- Defining the crisis from the perspective of the youth or caregiver;

- Providing a face-to-face response rather than relying solely on telephone de-escalation;
- Maintaining 24-hour availability;
- Working toward a response within one hour when geography allows;
- Training personnel specifically to work with children, youth, and caregivers; and
- Continuing stabilization and family support for approximately seven to eight days after the initial response.

Readiness and training work is underway, with statewide implementation anticipated in spring 2027. Dr. Cramer acknowledged that the model will require significant workforce and financial resources, particularly in rural areas.

Council discussion emphasized incorporating family and parent peer support, developing trusted relationships with families, addressing transportation and financial burdens when children are placed far from home, and ensuring that parents receive more than another telephone number when requesting help. A Council member with lived experience agreed to participate in future planning discussions. The Federation of Families for Children's Mental Health also offered its parent coordinators and peer-support expertise.

One member shared a personal account of successfully accessing 988, emergency care, crisis stabilization, residential services, and recovery housing. The experience illustrated how effective coordination and warm hand offs can be versus becoming lost between levels of care.

IMD Waiver: Furthering the Discussion

Panelists: Eric Bailly, NorthStar Behavioral Health Advisory; Ty Hegland, Prairie St. John's; and Dr. Joy, MHA Recovery Services
The facilitator explained that the Council currently has a position opposing implementation of an Institution for Mental Diseases waiver. The panel was convened as a learning discussion to test assumptions, hear perspectives from those who support a waiver, and ensure that the Council's position remains informed by current information.

Panelists described the problem they believe an IMD waiver could address as a gap in access to the full behavioral health continuum, particularly for Medicaid recipients who require clinically appropriate residential or inpatient care in facilities with more than 16 beds.

Eric Bailly summarized experiences from other states that have implemented waivers. He reported that states have used waivers to improve access to residential treatment,

medication for opioid use disorder, follow-up after emergency or residential care, and transitions across levels of service. He emphasized that an individual should be able to receive the clinically appropriate level of care without losing access to integrated physical and behavioral health coverage.

Ty Hegland discussed fairness, modernization, and provider sustainability. He noted that the IMD exclusion distinguishes between facilities based on whether they have 16 or more than 16 beds and argued that the exclusion limits Medicaid reimbursement for otherwise clinically appropriate services. He stated that the lack of reimbursement affects the ability of providers to sustain existing services or invest in additional psychiatric and residential capacity, particularly in western North Dakota and for adults with serious mental illness.

Dr. Joy described MHA Recovery Services' development of a culturally grounded continuum that includes withdrawal management, residential treatment, outpatient care, and sober living. She reported that MHA's intake team continues to send members out of state when appropriate treatment is unavailable. At the time of the meeting, approximately 27 MHA members were receiving out-of-state services, including 10 people in Arizona requiring longer-term mental health and substance use treatment. MHA also receives requests from members of other tribes but is not currently able to serve them through its tribally funded system. She emphasized the importance of culturally responsive care and the potential value of traditional-healing services.

The panel discussed the SUD voucher and the requirement that Medicaid coverage be suspended while an individual receives voucher-funded residential treatment in an IMD. Questions focused on how medical care, psychiatric medications, emergency treatment, and ongoing health needs are financed during that period. Members were informed that, effective July 1, 2026, a new state appropriation allows certain Medicaid-equivalent medical expenses to be paid for individuals using the SUD voucher. Approximately $250,000 was appropriated for one year to determine the level of need and inform future funding decisions. Members noted that implementation is new and that additional information is needed regarding the scope and adequacy of the funding.

Council members raised concerns about:

- Protecting investments in outpatient and community-based services;
- Avoiding unnecessary institutionalization;
- Ensuring use of medication for opioid use disorder;
- Maintaining clinical rather than legislatively prescribed lengths of stay;
- Preventing low-quality or profit-driven providers from entering the market;

- Understanding state costs and federal matching funds;
- Monitoring outcomes and continued-stay decisions; and
- Ensuring that an IMD waiver would serve mental health needs as well as substance use treatment.

Panelists responded that medical necessity, licensing, accreditation, individualized treatment plans, utilization review, and continued-stay review can serve as safeguards. They cautioned against establishing a uniform statutory length of stay because individual clinical needs vary. They also suggested that the state could establish ownership, quality, reporting, and outcome requirements to protect against inappropriate expansion.

Members clarified that the Council's position has been based on support for community-based services rather than opposition to residential providers. They noted that earlier presentations had identified mixed evidence and potential risks and requested that future discussion include neutral or opposing perspectives, information from Medicaid and DHHS, updates on the SUD voucher and medical-payment program, and additional evidence regarding outcomes in states with waivers.

Advocacy in Action Planning

The planned 30-minute work session was condensed due to the meeting running behind. The facilitator provided an overview of issues for members to consider before a fuller planning discussion in October.

The Council has historically relied heavily on its Executive Committee to monitor legislative activity, respond to bills, and prepare written or oral testimony. Recent speakers and policymakers have encouraged the full Council to consider a more active advocacy role and to communicate directly with legislators about behavioral health needs.

Members were asked to consider:

- Whether they are interested in meeting individually or in small geographic groups with local legislators;
- Whether a virtual legislative briefing would be useful;
- What information or support members would need beyond the current legislative-priorities document;
- Whether a legislative toolkit would be used;
- How members whose professional roles limit direct advocacy can still contribute expertise;

- Whether a working group should be established to convert discussion into action; and
- How data from the strategic-plan dashboard can strengthen legislative communication.

Potential budget reductions were identified as an important context for the coming session. Members agreed that additional information regarding proposed agency budgets and behavioral health impacts would be more useful in October, when planning is further developed.

The facilitator will distribute preparatory materials before the October meeting and structure a discussion in which members can identify specific activities they are willing to undertake. Members supported moving beyond general discussion toward defined assignments and measurable advocacy work.

Additional advocacy matters included the upcoming Cross-Disability Waiver Advisory Council public-comment opportunity. Members were encouraged to continue advocating for the inclusion of children with mental health conditions.

Members also requested a balanced continuation of the IMD waiver discussion, including speakers with expertise in Medicaid financing, SUD voucher administration, tribal impacts, and research findings.

Update Report Highlights

Pediatric Mental Health Care Access Program

Presenter: Sara Kapp, Program Administrator, Behavioral Health Division

Ms. Kapp reported that the Pediatric Mental Health Care Access Program continues to make psychiatric and psychological consultation available to primary-care and other medical providers treating children and youth. Consultations may address diagnosis, medication management, and other pediatric behavioral health concerns. Behavioral Health Clinic psychiatrists currently staff the consultation service.

Utilization remains extremely low, with no consultation calls during the most recent quarter. To extend the program into communities through other means, the program awarded 12 community grants from more than 20 applications. Nearly $700,000 was distributed, with emphasis on rural and underserved communities.

Funded activities include:

- Collaboration among primary-care providers, behavioral health professionals, and schools;
- Training and consultation for pediatric providers;
- Early identification and intervention;
- Telehealth and rural service expansion;
- Workforce development; and
- Continuation of school behavioral health support during the summer.

The program has also increased advertising to physicians and other providers.

Consumer and Family Network

Presenter: Matthew McCleary, Deputy Director, North Dakota Federation of Families for Children's Mental Health

Mr. McCleary reported that required visits to the state's regional Behavioral Health Clinics were completed. Since the previous Council meeting, visits were conducted with the Southeast, Northwest, Badlands, and Northeast clinics.

Consumer and Family Network call volume continues to vary by region. Calls frequently involve SSI and SSDI applications and increasingly complex coordination among individuals, families, and service providers. Updated promotional materials will be distributed broadly, including through churches, and other faith-community networks.

The annual Consumer and Family Network conference was held June 2 in Mandan. Topics included sleep and mental health, anxiety, advocacy, statewide behavioral health developments, and potential uses of Rural Health Transformation Program funding. Regional representatives were also elected, resulting in a nearly complete statewide membership structure.

Persistent barriers reported include: high private-insurance deductibles; Medicaid and Medicaid Expansion paperwork; limited services in some geographic areas; transportation challenges; rural access barriers; and difficulty navigating multiple programs and eligibility requirements.

Mr. McCleary highlighted care coordinators within the regional Behavioral Health Clinics as a significant system improvement.

Public Comment

Public comment was invited at the conclusion of the meeting. No public comments were received.

Announcements / Lightning Round and Additional Member Discussion

Members discussed information indicating that residential substance use treatment providers report bed availability daily, wondering how that information could better operate such as it does with nursing home beds. Members noted inconsistent information about availability with reports from families and communities describing difficulty obtaining treatment versus bed report information. Possible barriers to accessing available beds were identified as age restrictions, admission criteria, clinical stability requirements, geographic distance, and the absence of a publicly accessible system showing where beds are available. Members suggested that the Council may wish to examine both the accuracy of available-bed data and why individuals are unable to access beds that providers report as open. A similar centralized mechanism for behavioral health treatment beds such as for nursing homes could improve navigation and referral. The topic may be incorporated into the October Advocacy in Action discussion.

A member also reported contacting the chair of the Cross-Disability Waiver Advisory Council for clarification about upcoming public-comment opportunities and agreed to share any response with Council leadership.

Adjournment

The Council adjourned at **4:00 p.m. CT**. No motion was required.

Next Meeting: Wednesday, October 21, 2026
Brynhild Haugland Room, North Dakota State Capitol

Submitted by:

Janell Regimbal
Facilitator, Insight to Solutions