North Dakota Behavioral Health Planning Council Meeting Minutes

Date: October 15, 2025

Location: Job Service ND Office – Dakota Room, Bismarck, ND, and Microsoft Teams (Hybrid)

Time: 10:00 AM – 4:00 PM CT

Council Members in Attendance

Brenda Bergsrud *(Family or Consumer Advocacy Organization Representative);* **Dan Cramer** *(HHS Behavioral Health Service Delivery System Representative);***Melanie Gaebe** *(Individual in Recovery – SUD) (Consumer), Chair;* **Denise Harvey** *(Protection and Advocacy Representative);* **Jennifer Henderson** *(Principal State Agency: Housing Representative);* **Andrea Hochhalter** *(Family Member of an Individual in Recovery) (Consumer);* **Megan Indvik** *(Mental Health & Substance Use Advocacy Organization Representative);* **Dr. Melissa Kainz** *(Principal State Agency: Medicaid Representative);* **Kristi Kilen** *(Private Mental Health Provider (Consumer);* **Nancy Maier** *(Principal State Agency: Aging Services Representative);* **Michelle Masset** *(Principal State Agency: Social Services Representative);* **Carlotta McCleary** *(Youth Mental Health & Substance Use Advocacy Organization Representative);* **Amanda Peterson** *(Principal State Agency: Education Representative);* **Emma Quinn** *(Individual in Recovery – Mental Health (Consumer);***Michael Salwei** *(Healthcare Representative (Consumer); M***ark Schaefer** *(Private Substance Use Disorder Treatment Provider (Consumer);* **Rich Smith** *(Family Member of a Veteran (Consumer);* **Phil Sorenson** *(Veteran (Consumer);* **Paul Stroklund** *(Family Member of an Adult with SMI (Consumer);***Tania Zerr** *(Family Member of a Child with SED (Consumer);* **Kelly McGrady** *(Member-at-Large (Consumer);* **Joseph Jahner** *(Individual in Recovery – Mental Health (Consumer);* **Heather Call** *(ND National Guard Representative (Consumer); K***urt Snyder** *(Individual in Recovery – SUD (Consumer).*

Council Members Absent

Glenn Longie *(Tribal Behavioral Health Representative);* **Brad Hawk** *(Indian Affairs Commission Representative);* **Cheryl Hess-Anderson** *(Vocational Rehabilitation Representative);* **Pamela Sagness** *(Principal State Agency: Behavioral Health Representative).*

Call to Order

Chair Melanie Gaebe called the meeting to order at 10:00 AM CT. Roll call was conducted, and a quorum was confirmed.

Approval of Minutes

Motion by Paul Stroklund to approve July 16, 2025, meeting minutes as presented. Seconded by Rich Smith. Motion carried unanimously.

Approval of Agenda

Motion by Carlotta McCleary to approve the meeting agenda. Second is by Denise Harvey. Motion carried unanimously.

BHPC Administrative Updates/Discussion Items:

Membership Updates: Tiffany Pinckney, DHHS BH Administrator, shared she is now the point of contact for the BHPC from the Behavioral Health Division rather than Tami Conrad. This change is due to a shift of responsibilities. Ms. Conrad is still with the division. The Council was informed we continue to have an opening for a consumer member, specifically for a family member of a child with SED. Members were urged to spread the word of the opening.

Final Review of Conflict-of-Interest Policy & Procedure Draft

The Conflict-of-Interest Policy was presented for final consideration following initial review in July. Discussion emphasized the importance of preventing real or perceived conflicts among members who represent organizations or service roles within the behavioral health system. The policy aligns with the North Dakota Ethics Commission Code and reinforces disclosure expectations. Members supported ongoing reminders during new member onboarding and annually.

Motion by Carlotta McCleary to approve the *Conflict-of-Interest Policy* as presented. Seconded by Paul Stroklund. Motion carried unanimously.

Election of Vice Chair Results

Facilitator Regimbal reported the outcome of the electronic vote for Vice Chair. Eleven ballots were submitted, with no write-in nominations. Rich Smith was elected to serve as Vice Chair and as per Policy will transition to Chair following the next leadership rotation. Members expressed appreciation for continued member leadership engagement.

Motion to accept election results as presented was made by Joseph Janher. Seconded by Carlotta McCleary. Motion carried unanimously.

2026 Meeting Calendar Approval

The Council reviewed the proposed 2026 meeting schedule. Due to new scheduling restrictions at our current meeting facilities, meetings will transition to the ND State Capitol's Brynhild Haugland Room.

Motion by Carlotta McCleary to approve the 2026 calendar slate as presented. Seconded by Megan Indvik. Motion carried unanimously.

Connections Update Request

Facilitator Regimbal requested members provide updates to the facilitator as to the various connections they have across the state as it relates to serving on other board or committees that may intersect with the work of the BHPC. An email will be sent to remind members of the request to share as it helps with collaboration around the state strategic plan activities.

Follow Up Discussion Items from July Meeting:

Letters of Support Policy

The Council revisited whether BHPC should issue letters of support for organizations seeking funding. Members noted that the Council's statewide role and alignment with the Behavioral Health Strategic Plan may position it to support initiatives that improve access, expand services, or strengthen recovery and continuity of care.

Concerns included the risk of perceived endorsement of some organizations over others, the potential for requests to exceed the Council's capacity to evaluate proposals, the amount of effort needed to respond to such requests, and the need for consistency and fairness. Members generally agreed that letters should only be considered when an initiative clearly aligns with Council priorities and does not create conflict among service providers.

Motion by Megan Indvik to have the Executive Committee draft a policy for consideration, establishing criteria, request procedures, and with safeguards, with a draft being brought forward at a future meeting that reflects the concerns and desires expressed. Seconded by Paul Stroklund. Motion carried unanimously.

Vision Statement Revision

Members were provided with an opportunity to provide feedback prior to the meeting with a brief poll offering a vote on three possible revision scenarios or an opportunity to offer another version of their own for consideration. Version 3 received the most votes:

Full Vision Statement:
We aspire to a North Dakota where behavioral health is recognized as essential to well-being across the entire lifespan. From childhood through older adulthood, every person is valued and supported through a full continuum of care—delivered at the right time, in the right place, in the right way, and by the right people. Through these services, North Dakotans can thrive—living meaningful, productive, and healthy lives, free from stigma or shame, and sustained by caring, resilient communities.

Tagline:
Supporting behavioral health across the lifespan so every person in North Dakota can thrive within caring, resilient communities.

Motion by Rich Smith to adopt version 3 as presented and as the option with the most support for adoption by members. Seconded by Heather Call. Motion carried unanimously.

Summary Report of ND Behavioral Health Strategic Plan and Future Activities (PPT slides provided)

Bevin Croft of HSRI reported on structural changes being made to the dashboard and to the Aims, specifically there have been changes made to Aim 6,8 and 5. See ppt for specifics. Also, the website now has new wording reflected and the one pager developed during the legislative session is now updated to reflect these changes. The dashboard also has been updated to reflect the consensus ratings stemming from the July BHPC meeting discussions. The items referenced here can be found at this link North Dakota's Behavioral Health Strategic Plan - Human Services Research Institute. Members were encouraged to reach out if they would be interested in being a liaison to any of the Aims, noting we can have more than one member per Aim. Discussion was held on data ideas for the dashboard to better answer the question as to how much progress is being made in the various Aims. Ultimately it was agreed at the July meeting that a goal of 1-2 metrics/Aim would be optimal, yet the difficulty is the Aims are big and there are not always metrics available to address each. Ideas shared via discussion included: penetration rates, gap analysis, qualitative information the CCBHC's will be collecting, to ask each Aims work group to identify a metric, access call

center tracking data on services requested that cannot be fulfilled, and to ask insurers for utilization data. More work will be done to further the identification of and inclusion of metrics into the dashboard.

Peer Support Alliance Update (PPT slides provided)

Andrea Hochhalter, Project Director of the Peer Support Alliance of North Dakota explained they are a young organization that exists to ensure that peer voices are elevated and peers are equipped, connected, and recognized as professionals within the behavioral health system. Their approach is to focus on training, leadership development, and professional standards for building out the capacity of peers across the state. She presented workforce survey findings reflecting both growth and strain within the peer workforce. Discussion highlighted the increasing demand for peer support services across recovery, crisis response, and transitional support settings. Members surveyed emphasized the need for supervision structures, professional development pathways, and retention strategies to avoid burnout and turnover among those in their field. Emma Quinn shared thanks for the leadership Ms. Hochhalter has shown, working tirelessly to help peers have a collective voice. While there has been a team behind the Alliance, she has really spearheaded it. We are fortunate to have her. Members suggested that employers may need help to figure out where peers could fit within their organizations, so the positions do not just exist within peer organizations. Also, questions surrounding funding for peers indicated Medicaid and 3rd party payers are still not reimbursing for these services.

System of Care Update and Learnings (PPT slides provided)

Clinical Administrator Katie Houle (BH Division) reported on North Dakota's SAMHSA System of Care (SOC) grant (FFY 2022–2026; $3M/year; Regions 3 & 7 as learning hubs with statewide intent). The grant's purpose is to expand community-based, culturally responsive services for children/youth with SED/complex needs, build sustainable infrastructure (shared leadership with family/lived experience), and strengthen cross-system coordination (HSCs, child welfare, juvenile justice, DD, schools). Major service lifts include: (1) launching child & adolescent Partial Hospitalization (PHP) at CHI St. Alexius–Bismarck (opened Apr 10, capacity ~12; mixed MH/SUD/co-occurring care; pre-launch cross-system design work on referral/admission/step-down), (2) awarding children's behavioral health service grants (19 of 26 apps implemented), and (3) scaling SPARCS school-based group treatment (23 groups/159 youth last year; expansions in Bismarck/Mandan, Spirit Lake, Devil's Lake area; Spanish-language group in Mandan). Additional efforts include PRTF aftercare care coordination (pilot with Dakota Boys & Girls Ranch; 56 families), Functional

Family Therapy at HSCs, and Parent/Caregiver Peer Support (UConn "PEARLS" model; 33 parents trained; early placement in HSC teams and Juvenile Drug Court).

Key successes: filling critical gaps; measurable school-based trauma skill gains; broadened tribal/rural reach; seeding providers to credential and sustain via reimbursement; and strengthened coalitions/steering committees in both regions (service mapping, 988→mobile response pathway work). Key challenges/learnings: persistent workforce shortages (psychiatry/therapists) delaying launches; transportation/coverage barriers; difficulty serving high-acuity presenting youth (aggression); sustainability risks where salaries were grant-funded (peer/coordination roles); limited capacity and cost of external training; and the need for shared outcomes and a governance structure linking local solutions to policy/funding. SOC data targets are largely on track for training/service delivery, with work remaining on policy and peer support infrastructure needed for long-term sustainment.

Looking ahead, DHHS is prioritizing: embedding SOC values across programs; establishing shared outcome measures; implementing a tiered care-coordination model with High-Fidelity Wraparound (UConn TA; readiness assessed; low care-coord caseloads, cross-system accountability); expanding youth-specific crisis response; and professionalizing parent/youth peers (roles, training, jobs, reimbursement). Given the grant ends Sept 2026, SOC will focus on sustaining those things implemented while monitoring future federal NOFOs.

Q&A highlights: Members raised sustainability of peer support (adult & family) and reimbursement pathways; staff noted ongoing work to amend 1915(i) language and explore Medicaid/State Plan options, but no current Medicaid reimbursement for parent peers. Questions also addressed aligning SOC with CCBHC expansion; DHHS and clinic leadership affirmed strong value alignment and opportunities to embed SOC expectations (e.g., parent-peer requirements) within CCBHC governance/standards. Members encouraged building in-state training capacity over time to replace costly out-of-state vendors.

Opioid Settlement Funding Update (PPT slides provided)

James Knopik, Manager of Addiction and Prevention Programs and Policy and North Dakota's State Opioid Treatment Authority, provided an overview of the opioid settlement funding currently being administered in North Dakota. He noted this was the first time the BHPC had received a detailed briefing on this topic and encouraged questions as needed.

Knopik explained that the opioid settlement funds originate from national legal settlements with opioid manufacturers and distributors for harms associated with the opioid crisis. North Dakota joined these settlements through the Attorney General's Office, and the resulting payments to the state are required to be used directly for prevention, treatment, recovery, and harm reduction, guided by

A statewide Opioid Settlement Advisory Committee, established in statute, is responsible for providing recommendations on spending. The committee includes statewide and local government representatives and a non-voting chair appointed by the Governor. The legislature appropriates a set amount per biennium from the settlement fund to the North Dakota Department of Health and Human Services (HHS), and HHS is responsible for implementing funding decisions. At least 20% of the funding must be directed to prevention, overdose prevention, or workforce development, ensuring upstream strategies remain prioritized alongside treatment system support.

Public listening sessions and also substantial written input submitted by email led to the establishment of six funding priority area used to inform grant awards , including: Increasing access to treatment and recovery in rural communities; Expanding treatment and recovery within jails; Supporting youth and community-based prevention; Strengthening the behavioral health workforce; Supporting syringe services and harm reduction; Increasing services in non-rural areas.

When the first grant application cycle opened in November 2023, the state received more than $50 million in requests across 60 applications, but had only $8 million available, making the process highly competitive. Fourteen projects were awarded, spanning prevention, harm reduction, treatment, and recovery supports. Reported outcomes from the first grant cycle included:

- 17 new Licensed Addiction Counselors statewide (sig. workforce gain)
- 22 new clinical training sites and 31 new clinical supervisors established
- Increased access to treatment and recovery services, including in jails, drug courts, and sober living programs
- Syringe service and naloxone access projects expanded in multiple areas
- 13 of 14 funded projects reported sustainability after grant completion
- Approximately 96% of awarded funds were fully expended, and the required 20% prevention/workforce minimum was met.

Fifteen percent (15%) of overall settlement dollars go directly to local governments (counties and cities). These entities must follow the same allowable-use guidelines, though many are using funds in smaller-scale ways (e.g., naloxone distribution), particularly where funding amounts are modest.

To date $23 million has been received in North Dakota, with investment earnings generating additional resources. While the total settlement amount remains fluid due to ongoing distributions, statewide projections estimate a total of around $60 million over time.

The second biennium grant cycle recently concluded, with 59 applications requesting $31 million; this time, 18 projects were awarded. Priorities remained consistent with the first round. Funded projects include:

- Expansion of opioid treatment and medication support services
- Increased access to treatment and peer support within correctional settings
- Prevention and media awareness campaigns in rural communities
- Sober living and recovery housing supports
- Workforce training expansion through TAP and NDUS prevention programming
- Development of maternal and family-centered treatment models

Knopik noted that outcome data from this second grant cycle will become available over time**,** as awards began in July.

A council member referenced SAMHSAs recently released *Strategic Priorities* document and asked whether the section titled “Ending Crime and Disorder on America’s Streets”—which indicates that SAMHSA will prioritize evidence-based practices and deprioritize harm-reduction strategies perceived as facilitating continued substance use—would affect North Dakota’s current harm reduction and syringe services efforts.

HHS staff clarified that this guidance impacts federally funded State Opioid Response (SOR) dollars, which North Dakota receives annually from SAMHSA (approximately $4 million/year). As a result, the state adjusted its SOR budget to ensure it does not fund materials that could be used to facilitate substance use. Local public health units operating syringe service programs were able to reallocate funds internally and continue providing permitted services, including Naloxone (Narcan) distribution; Fentanyl test strip distribution; and linkage to

treatment and recovery supports. The changes did not result in significant service reductions but reflect a required shift in allowable activities. It was emphasized that Opioid Settlement Funds are not federal funds, and therefore SAMHSA does not have oversight over settlement expenditures. The state may continue to use settlement dollars for harm reduction activities consistent with Exhibit E and state advisory committee priorities, regardless of SAMHSA's strategic adjustments.

Community Example: Oakes Mental Health Coalition

Rebecca Undem, Oakes Mental Health Coalition Member and Executive Director of *Growing Small Towns*, Oakes, along with community partners Sharon Brady, Beth Brademeier; and Josh Gow shared with our group. In 2022, Dickey County Public Health District received a grant requiring creation of a community mental health coalition aligned to the local Community Health Needs Assessment (CHNA). Their top needs were mental health, food scarcity, public transportation). An open community call produced 20+ attendees at the first meeting, signaling strong local interest. After two years the grant ended. Growing Small Towns (501c3) brought the coalition under its organizational umbrella to ensure continuity. The coalition now operates without dedicated funding, meets monthly, and remains volunteer driven.

The group conducted an additional community assessment and hosted licensed therapist engagement events and multiple speakers to reduce stigma, build advocacy, and raise mental health literacy. The 2025 CHNA refresh again identified mental health and substance misuse as top concerns, with access to providers—especially for virtual therapy—a key barrier. The coalition designed Therapy Connect to:

1. Normalize telehealth and show that meaningful therapeutic relationships can form virtually.
2. Directly connect residents/referrers with clinicians who have current openings.
3. Create lasting referral assets (videos/tools) for local providers.

They Invited 10 practitioners (mostly from larger communities; some rural) able to accept new clients via telehealth. It was a well-attended community event; built two durable resources: a recorded Q&A with panelists (usable by medical, school, and social-service referrers); a concise overview video featuring the telehealth providers to shorten the "discovery" phase for first-time therapy seekers.

Barriers addressed & local roles.

- Navigation & tech barriers: Community Health Worker Beth Brademeir (CHI Oakes Clinic) screens all patients for, then hands-on assists residents with telehealth setup, particularly for those without internet/tech comfort.
- Privacy/fit concerns in small towns: Event normalized the idea that local residents can choose non-local virtual therapists if they prefer anonymity, and that therapist–client fit may take a few tries.
- Provider-to-provider bridges: Local therapists and clinic partners (CHI, Sanford) strengthened referral pathways and now have an expanded network of known, trusted colleagues for warm handoffs—reducing mismatches and wait time.

Members commended the innovative “bring the doors to the community” design and asked whether this is building ongoing bridges beyond a one-time event; presenters affirmed that is the explicit intent, supported by the videos and growing networks. Presenters stressed that caregiver support (EMTs, law enforcement, medical staff) is also a coalition priority due to workforce strain and burnout.

Key takeaways for BHPC.

- Community-led solutions first: Encourage and amplify locally designed approaches; what works will vary by community.
- Open communication & idea-sharing: Help circulate models and assets (like Therapy Connect) statewide so communities can adapt, not adopt wholesale.
- Support for navigation roles: Community health workers and similar connectors are critical for converting awareness into successful engagement with care.

Therapy Connect shows how a volunteer rural coalition, sustained under a local 501(c)(3) and without dedicated funding, can normalize telehealth, shorten the path to care, and build durable referral infrastructure—a replicable template for other North Dakota communities.

Consumer Family Network Update (PPT slides provided)

Updates were provided regarding family support programming, outreach activities, and statewide engagement efforts to elevate lived experience in service development.

DHHS Reports (MHBG, SUPTRS, PMHCA- PPT slides provided)

Shauna Eberhardt (Clinical Director, BH Division – Policy) and James Knopik (Manager, Addiction & Prevention Programs & Policy). Provided reports on the block grants with an additional program update from Sara Kapp (PMHCA).

Ms. Eberhardt outlined how North Dakota's 2018 HSRI system study, the Behavioral Health Strategic Plan, and its AIM workgroups inform MHBG (Mental Health Block Grant) and SUPTRS (Substance Use Prevention, Treatment & Recovery Services Block Grant) priorities. Planning integrates: (1) HSRI/Strategic Plan gap data, (2) AIM workgroup inputs across public/private systems, (3) federal requirements (e.g., MHBG focuses on SMI/SED), (4) SAMHSA priorities & federal/State policy changes, and (5) local gap data to drive investments.

Application status: ND submitted the FY2026–2027 MHBG & SUPTRS full application on Aug 29, 2025; annual report due Dec 1. Grants run on a two-year spend; reporting schedules vary by SAMHSA. Priority Areas for 2026–2027 (See PPT slides showing targets newly added in red and were highlighted verbally):

- Prevention & Early Intervention (AIM 2): increase 988 utilization (new).
- Community-Based Services (AIM 3–5): enhance the youth crisis continuum (new).
- Person-Centered Practice (AIM 9 & 11): build provider capacity with evidence-based services for Native American populations (new emphasis).
- Targeted Access (AIM 3–4): expand youth crisis and inpatient behavioral health access; support diversion models (e.g., treatment courts).
- Behavioral Health Workforce (AIM 4 & 7): expand parent/caregiver peer support tied to System of Care (new).

James Koopnik reported on the SUPTRS Block Grant. Annually just over **$7M**. is provided. There is a 5% admin cap (tech/data/salaries). ≥20% must fund primary prevention (ND elects 25% to maintain buffer). Remaining ~70% supports treatment & recovery. Notable initiatives/outcomes**:**

  - New: Providence House (Minot) residential program for pregnant/parenting women now open and taking referrals.
  - Prior pilot ended (Sanford peer support ED pilot) due to capacity.

    - Local prevention via public health & tribal partners (school curricula, community prevention).
    - T21 tobacco compliance (Synar) checks: failure rate improved from ~16% to ~8% year-over-year after outreach and enforcement. Prevention also funds forensic ID scanner training/purchase to curb underage alcohol sales in venues (e.g., Prairie Knights Casino).

Shauna Eberhardt reported on the MHBG. Also has a 5% admin cap. Set-asides: 10% First Episode Psychosis (FEP); 5% Crisis and 80% general investments.

    - FEP programs: two state-operated behavioral health clinics (SE & SC regions) with UND for fidelity, training, and consultation.
    - Crisis set-aside: focus on youth crisis expansion, evidence-based practice uptake, and support for direct-care providers (e.g., CISM grants for first responders/EMS/Highway Patrol).

- General 80% investments (examples):
    - Workforce & competency: Behavioral Health Conference; ongoing Project HEAL (culturally responsive care for Native American populations, trauma-informed).
    - Community Connect previously supported; now increased state general funds = no MHBG set-aside this cycle.
    - Select past supports: Free Through Recovery (now on state GF) and bridge support for Voluntary Treatment in FFY24.
    - New American health & mental health provider supports via ORR collaboration.
    - PRTF (youth) enhancements: materials/EBPs for quality improvement.
    - Rural mental health supports continue.

PMHCA (Pediatric Mental Health Care Access) Program Update was provided by Sara Kapp. A three-year grant was awarded for 2023–2026. $700K base award for Year 3 (2026) with a 20% cost match; pending shutdown-delayed add-on and carryover decisions.

PMHCA contracted partners include Family Voices (intake/care coordination & consult line triage), UND/CRH (ECHO training sessions), CREA (school

supports). Behavioral Health Clinics (consultation lines- Sanford previously staffed consults; interim coverage now via youth clinicians at Human Service Centers.)

Utilization challenge shared are that consult line calls remain low (~12 in 2025); but training engagement is strong. Barriers: provider bandwidth, awareness; some systems (e.g., Sanford) have internal consult lines. Response & next steps to address this include: plan to award community mini-grants to build local awareness/use of consults and strengthen school↔PCP↔BH connections (including rural pilots for **in-school care coordination** without requiring initial PCP consult); Six ECHO sessions scheduled (Oct–Apr) on suicide prevention, trauma/grief, parenting engagement, etc.

HRSA indicated the next PMHCA cycle is more competitive (≈ half of states funded). ND is revising operations and engagement strategy accordingly. They have had positive local feedback on Check & Connect (evidence-based attendance/truancy intervention) supported through PMHCA.

During discussion, multiple members raised urgent sustainability concerns for peer support:

    - Medicaid coverage is critical; reliance on 1915(i) alone is insufficient/complex (administrative burden, billing complexity, limited referral pathways, lower reimbursement vs. care coordination).
    - Agencies struggle to sustain positions absent predictable reimbursement; altruistic/volunteer models are not the chosen path in ND.

- Department stance: BH Division supports professionalized peer support and continues intra-agency work with Medicaid.
- Follow-ups / Actions:
    - Consider Medicaid Medical Advisory agenda submission (deadline announced in meeting).
    - Place peer support funding/coverage as a formal agenda item for the December BHPC meeting to enable focused, solution-oriented discussion (including options beyond 1915(i), e.g., State Plan or alternative coverage models).

- Identify agency/provider voices to inform policy design (billing feasibility, referral mechanics, rate adequacy).

Public Comment

No public comments were offered.

Lightening Round Updates/Announcements from Members

Protection & Advocacy (P&A) Priorities: Denise Harvey announced they are newly released and posted on the P&A website homepage. https://www.ndpanda.org/news/nd-pa-announces-2026-focus-areas

Leadership Transition – Heartview: Kurt Snyder announced his retirement; his successor (incoming CEO) will attend the ND Behavioral Health & Children & Family Services Conference next week and is available for introductions.

Conference Registration Reminder: Council members should have received a free registration link for the annual conference (virtual or in-person). If you didn't receive it or if registration is still open, contact Tiffany for the link.

Homeless Services – Dickinson: Rich Smith reported the homeless shelter proposal was voted down by the City Commission. Stakeholders are continuing to work on codes and alternative pathways to identify a best-fit solution for the Dickinson/western ND area.

Consumer Reimbursements & Honoraria: Tiffany reminded that Consumers attending during work hours may receive an honorarium; submit a brief proof of time off (e.g., screenshot). All reimbursement requests should be sent to Tiffany. Travel reimbursement forms available on request

Follow-Up Inquiry: A member requested confirmation regarding an AIM goal (12.3) reference that Medicaid was added to the State Plan under Medicaid Expansion. Tiffany to follow up with the department contact and report back.

Adjournment

The meeting was adjourned at 3:55 PM CT. The next meeting is scheduled for December 17, 2025. It was noted this was Melanie Gaebe's last meeting as our Chair. She was thanked for serving in that role.

Submitted by: Janell Regimbal, Facilitator of Insight to Solutions