

NDIS is recruiting individuals willing to be a part of a diverse, interdisciplinary team. Team members will participate in Learning Collaboratives and may be selected to be a part of one of the six Pilot programs. If you would like to be involved, call 1.800.233.1737.

Interdisciplinary Team includes:

- Youth (ages 15-25) with special health care needs
- Family members of CYSHCN
- Family advocacy groups
- Representatives from programs supporting diverse populations in ND
- Primary care physicians
- Hospital and clinic administrators/staff
- School health professionals
- Care coordinators/case managers/service coordinators
- Health insurance groups
- Social Services and social workers
- Representatives from adult transition programs
- Representatives from work incentive/employment programs
- College/University student support staff
- Policy makers

Project Staff

PRINCIPAL INVESTIGATOR

BRENT A. ASKVIG, PHD

PROJECT DIRECTOR

KORA DOCKTER, RN BNSC

PROJECT COORDINATORS

JANET GREEN, MS

FOR MORE INFORMATION CONTACT THE
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PROJECT STAFF AT:



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www.ndcpd.org

North Dakota Integrated Services Project



The North Dakota Integrated Services (NDIS) project is a three year grant funded by the US Department of Health and Human Service-Maternal and Child Health Bureau to the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. The NDIS project will assist state agencies, local medical providers, and families of children and youth with special health care needs (CYSHCN) ages birth to 21 years of age to develop the knowledge and infrastructure to assure that all children and youth receive the coordinated care they need.



Components of Quality Services

In Partnership With:

- Family Voices of North Dakota — Health Information & Education Center
- North Dakota Dept of Insurance
- North Dakota American Academy of Pediatrics
- North Dakota Health Disparity Grant
- Children with Special Health Care Needs — Minnesota Dept of Health
- Children's Special Health Services Division — North Dakota Dept of Health
- MeritCare Health Systems
- Head Start — State Collaboration Children and Family Services Division North Dakota Dept of Human Services
- Early Childhood Comprehensive Systems
- North Dakota Dept of Public Instruction

Project Goals

NETWORK OF LEARNING COLLABORATIVES

North Dakota (ND) will have a network of Learning Collaboratives that integrate the six components of quality services for CYSHCN.

Using a Learning Collaborative Model, ND will provide significant education, training, and opportunities to collaborate for primary care providers, families and other important partners in coordinated care. These Collaboratives will focus on three core areas: medical home, family involvement and cultural competence, and healthy transitions to adult life.



PILOT PROGRAMS

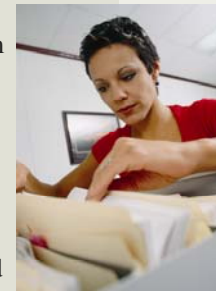
ND will increase positive outcomes for children and families through the establishment of pilot programs that build the capacity of communities and the state to

provide effective integrated health services to CYSHCN. Several ND community primary care providers will work as demonstration sites to pilot test the Medical Home

Concept in urban, rural, and American Indian communities. NDIS will support implementation of a cost effective statewide plan that cross shares information about services and insurance with partners and state systems.

COMPREHENSIVE PLAN

ND will have a comprehensive plan for systemic implementation of an integrated services system for CYSHCN. The NDIS will coordinate an annual stakeholder symposium to create top level buy-in to an integrated system. Input from culturally diverse families and information about culturally competent practices will be shared to effect long-term change in care coordination and practice. NDIS will evaluate and disseminate best practice features of the models to influence system changes.



- Families of CYSHCN are partners in decision making at all levels and are satisfied with the services they receive.
- CYSHCN receive coordinated, ongoing, comprehensive care within a medical home.
- Families of CYSHCN have adequate private and/or public insurance to pay for the services they need.
- CYSHCN are screened early and continuously for special health care needs.
- Services are organized in ways that families can use them easily.
- Youth with special health care needs receive the services necessary to make appropriate transitions to adult health care, work, and independence.