

North Dakota Integrated Services

Uniting for a Healthier Future for Children and Youth with Special Healthcare Needs

NDIS OVERVIEW

North Dakota Integrated Services (NDIS) 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. The NDIS project assists state agencies, local medical providers, and families of Children and Youth with Special Healthcare Needs (CYSHCN) ages birth to 21 years to develop the knowledge and infrastructure to assure that all children and youth receive the coordinated care they need.

GOALS

- 1) Establish a network of Learning Collaboratives that integrate the six components of quality services for CYSHCN focusing on Medical Home, Family Involvement and Cultural Competence and Healthy Transitions to adult life.
- 2) Medical Home and Healthy Transition Pilot Programs
- 3) Develop a comprehensive plan for systemic implementation of an integrated services system for CYSHCN.

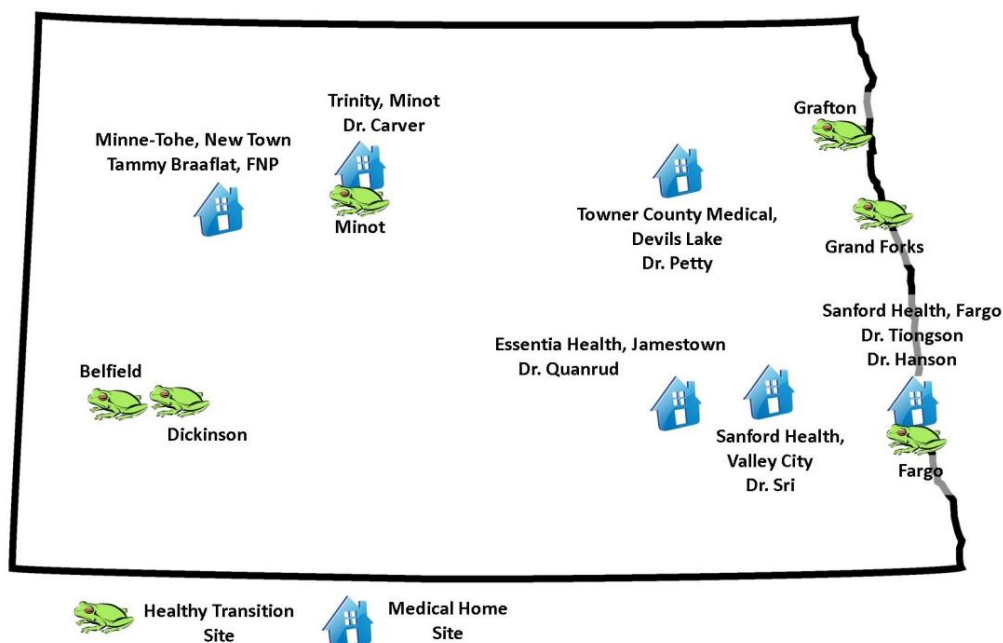
MEDICAL HOME PILOTS

Through the North Dakota Integrated Services (NDIS) project, Medical Home pilot sites have been established at different practices throughout the state. Each pilot site has a team that consists of a primary care provider, a care coordinator, and two family partners. The teams meet at least one time per month to develop quality improvement strategies and implement Medical Home concepts into the practice.

HEALTHY TRANSITION PILOT SITES

NDIS works directly with families of CYSHCN that will be transitioning to adulthood in the near future. Each site works on various tests of change to develop Best Practices for healthy transitions in North Dakota.

ND PILOT SITE LOCATIONS



Contact: Emily Rodacker, Medical Home Project Coordinator at emily.rodacker@minotstateu.edu or call 800.233.1737 ext. 3546.

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BY THE NUMBERS*

946: The number of CYSHCN identified with mild to complex special healthcare needs.

77: The number of CYSHCN with complex special healthcare needs that have a Medical Home.

640: The number of school plans for CYSHCN that Medical Home providers have contributed.

CHANGES FOR IMPROVEMENT*

- Regular screening of patients to identify CYSHCN
- Practices develop comprehensive resource lists to better serve patients and families.
- Development of care plans to be used in Electronic Health Records
- Organize “Lunch and Learn” meetings with other support agencies/community resources to coordinate efforts
- Medical Home Parent Partners conducted informational meeting on Medical Home to parents of CYSHCN
- Implementation of pre-visit phone calls to determine changes, needs and concerns

TESTIMONIAL BY THE NUMBERS**

79% currently report they ALWAYS feel their child’s provider spends enough time with their child, compared with 60% in November 2009.

84% currently report they ALWAYS feel their child’s provider made them feel like a partner in their child’s care, compared with 80% in November 2009.

84% currently report they ALWAYS feel their child’s provider is sensitive to their family’s values or customs, compared with 75% in November 2009.

87% currently report they feel comfortable disagreeing with their child’s provider, compared to 81% in November 2009.

100% ALWAYS feel supported by their child’s primary provider, presently and in the past.

TESTIMONIAL BY THE FAMILIES**

“We now have a medical home action plan. I also have “I” nurse that I call when we need something. “I” makes it so nice that she knows us and our history.”

“...Medical home has been a great item for us-it is a relief to have everything together, we get into appointments easier-makes doctoring easier to handle.”

“Don't need to run to Fargo now when Dr. [Q] can stay in contact with her other doctors.”

“I'm not on the phone all day stressing out about care for my child. I am able to put more focus on my children and family.”

**As reported by ND Medical Home Pilot Sites*

***As reported by parents in the Parent Perception Surveys conducted semiannually by ND Medical Home Pilot Sites.*

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