

**NDIS**

North Dakota Integrated Services



# Integrated Services for CYSHCN

North Dakota Integrated Services  
Stakeholder Symposium III  
March 2011

# NDIS Overview

- o CYSHCN ages birth to 21 years old
- o Medical Home
- o Healthy Transitions
- o Family Involvement
- o Cultural Competence

# Project Goals

- o Learning Collaboratives
- o Pilot Programs
- o Sustainability



# Goal Progress

## o Learning Collaboratives

- o Medical Home
- o Healthy Transitions
- o Family Involvement/Cultural Competence

## o Learning Session Themes

- o Medical Home
- o Coding
- o Care Coordination
- o State & Local Resources
- o Healthy Transitions
- o Screenings

# Goal Progress

- o Establish Pilot Programs

- o 7 Medical Home pilot sites

- o Monthly Meetings

- o Technical Assistance

- o Changes for Improvement

- o Assessments

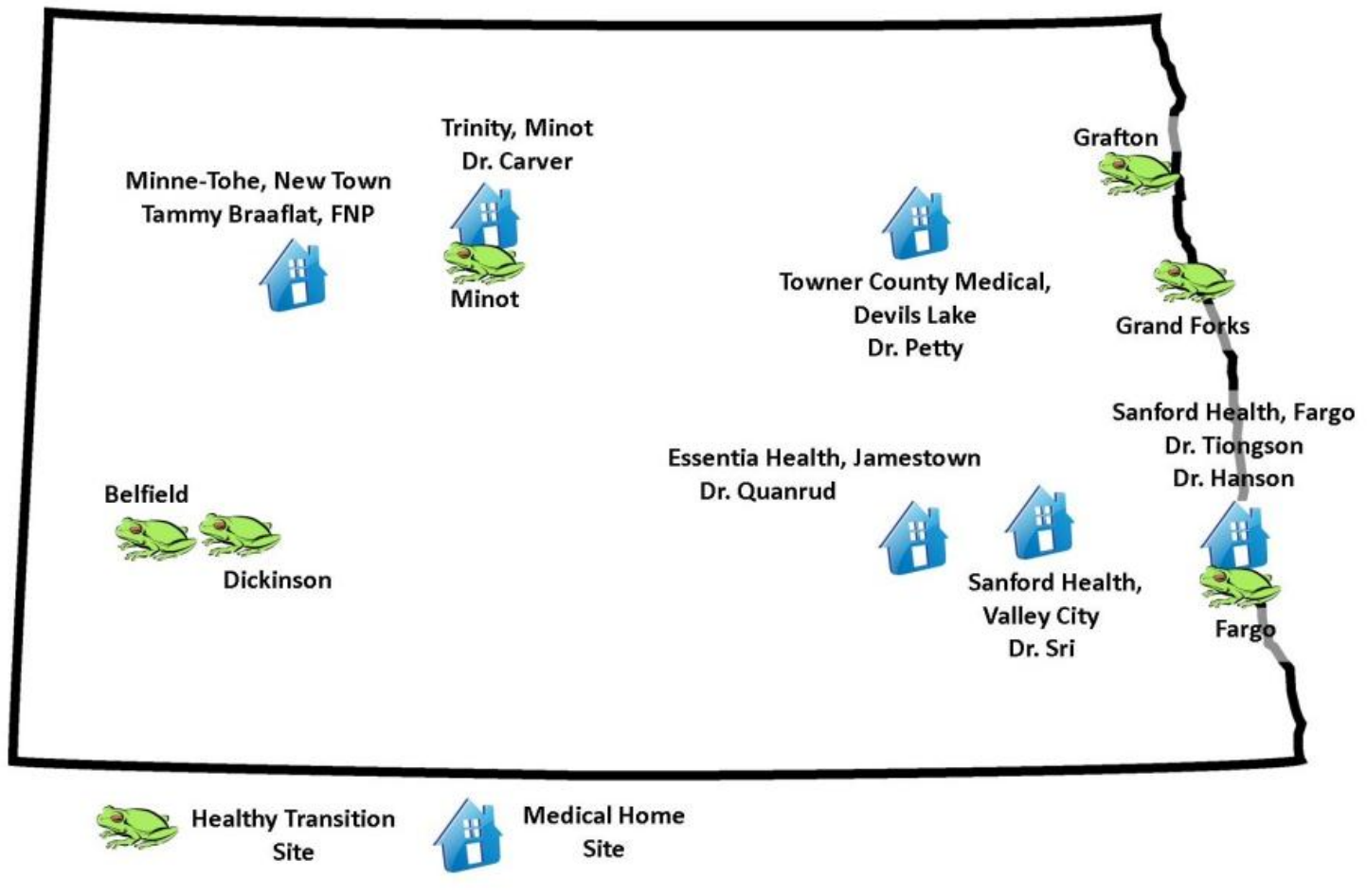
- o 6 Healthy Transition pilot families

- o PDSA Cycles

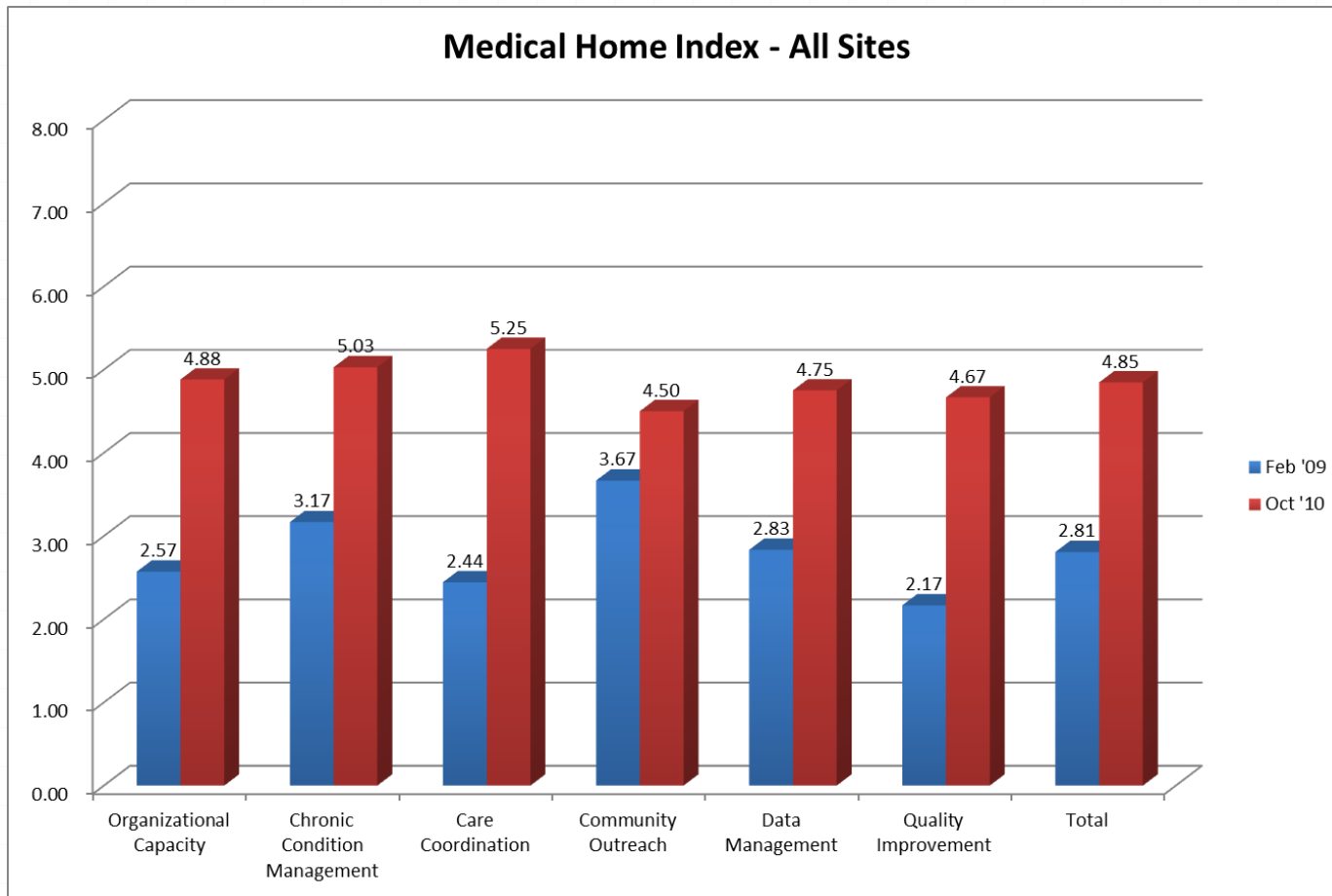
- o Advocacy Folders

- o Interagency Agenda

# NDIS Pilot Programs



# Medical Home Pilots



# Factors Facilitating Improvement

- o Family involvement
- o Productive team meetings
- o Regular screening
- o Resource lists developed
- o Care plan development
- o “Lunch & Learn” meetings
- o Patient follow-up

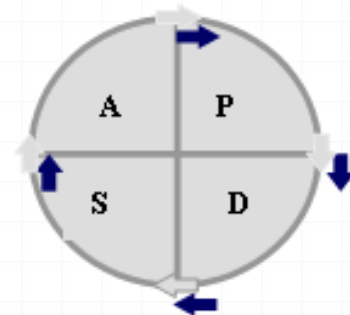
# Medical Home Parent Surveys

- o **85%** currently report they ALWAYS feel their child's provider spends enough time with their child, compared with 60% in November 2009.
- o **88%** 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.
- o **94%** currently report they ALWAYS feel their child's provider is sensitive to their family's values or customs, compared with 75% in November 2009.
- o **94%** currently report they feel comfortable disagreeing with their child's provider, compared to 81% in November 2009.
- o **100%** ALWAYS feel supported by their child's primary provider, presently and in the past.

# Healthy Transitions Pilots

## PDSAs Tested

- o Self-manage health issues
- o Decrease transition anxiety – school
- o Develop independent living skills
- o Transition to adult roles
- o Self-advocate for personal needs
- o Increase social interaction



# Healthy Transitions Interagency Agenda

Agenda item	Person(s) responsible	Timeline
1. <i>Introductions and purpose of the meeting</i>	<i>Facilitator</i>	
2. <i>Review necessary demographic information and update contact information as needed</i>	<i>All</i>	
3. <i>Tell the story (Youth's perspective is preferred)</i>	<i>All</i>	
<p style="text-align: center;"><b>Goals</b></p> <ul style="list-style-type: none"> <li>• Goals for the future               <ul style="list-style-type: none"> <li>○ Short term</li> <li>○ Intermediate</li> <li>○ Long term</li> </ul> </li> </ul>	(Facilitator)	
<p style="text-align: center;"><b>Past</b></p> <ul style="list-style-type: none"> <li>• Medical issues</li> <li>• Diagnoses</li> <li>• Assessments (results, procedures, relevant information)</li> <li>• Social and interpersonal issues</li> </ul>	(Facilitator)	
<p style="text-align: center;"><b>Present</b></p> <ul style="list-style-type: none"> <li>• Present level of academic and functional performance</li> <li>• Current social and interpersonal issues</li> <li>• Manifestation of diagnoses and treatment in all settings</li> </ul>	(Facilitator)	
<p style="text-align: center;"><b>Future</b></p> <ul style="list-style-type: none"> <li>• Activities to reach the goals identified above               <ul style="list-style-type: none"> <li>○ Short term</li> <li>○ Intermediate</li> <li>○ Long term</li> </ul> </li> <li>• Plan development (Each agency identify needs for written plan)</li> <li>• Manifestation of diagnoses and treatment in all settings               <ul style="list-style-type: none"> <li>○ Supports needed (accommodations)</li> <li>○ Changes suggested for the environment (modifications)</li> <li>○ Services needed (related services, referrals, treatments)</li> </ul> </li> </ul>	(Facilitator)	
4. <i>Symptoms, suggested tests, recommendations, intervention plans, things to avoid</i>	<i>(Facilitator)</i>	
5. <i>Supports needed</i>	<i>(Facilitator)</i>	
<b>Item/service</b>	<b>Responsible party</b>	<b>Timeline</b>
Equipment:		
Assistive technology:		
Accommodations:		
Modifications:		
Special needs or requests:		
Other (please explain):		
6. <i>Additional information needed</i>	<i>(Facilitator)</i>	
7. <i>Next meeting</i>	<i>(Facilitator)</i>	
8. <i>Adjourn</i>	<i>(Facilitator)</i>	

# Goal Progress

- Sustainability
  - Stakeholder Symposia
  - Established Partners
  - NDIS Newsletter



**Uniting for a Healthy Future:**  
Integrating Systems for North Dakota's Children,  
Youth, and Young Adults

Monday, May 10th, 2010 · Page 1  
[www.ndcpd.org/ndis](http://www.ndcpd.org/ndis)

**Mark Your Calendar**

**5/15/10**  
Medical Home Teams  
Send in your April Report

**5/19/10**  
Medical Home  
New Teams Training via  
Interactive Video Network (IVN)  
8am - Noon

**5/27/10**  
Medical Home  
Technical Assistance Call  
Primary Care Providers,  
Care Coordinators, and  
Parent Partners  
Noon - 1:00pm

**6/8/10**  
MeritCare Medical Home Patients  
Parent Meeting for  
MeritCare Parents  
Located at MeritCare  
Child Development Center  
6:30pm

**6/9/10**  
All REIMBURSEMENTS  
must be received by our office  
no later than today

**9/20-9/22/10**  
NDIS Learning Collaborative  
Fargo

**11/10/10**  
Stakeholder Symposium  
Bismarck

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North Dakota Integrated Services

## NEWSLETTER

**Moving to Year 3**

This May we are wrapping up our 2nd year on the NDIS project. Looking back at the past 2 years, we are definitely making strides in the right direction for North Dakota. This is what we have all contributed to towards our project goals:

- 7 Medical Home Pilot Sites in ND
- 5 Healthy Transition Pilot Sites in ND
- Development of 2 Curriculum Modules (Care Coordination and State & Local Resources)
- 2 Stakeholder Meetings
- 12 Learning Collaboratives (Medical Home, Healthy Transition, Family Involvement/Cultural Competence combined)
- Development of NDIS newsletter
- 612 Children & Youth with Special Healthcare Needs (CYSHCN) identified
- 52 Care Plans developed
- Contributed to School Plans for 433 Children

As we move ahead into Year 3, we still have many things to accomplish and more excitement to come.

Thank you to everyone on our Advisory Committee, participants in our Learning Collaboratives, our Medical Home and Healthy Transition Pilot Sites, Stakeholder attendees and other supporters for your commitment to improving the quality of life for Children and Youth Special Healthcare Needs in our state.

Sincerely,  
*Kora Dockter*

**Medical Home New Teams Training**

A New Teams Training for Medical Home team members will be held on Wednesday, May 19th from 8am to 12pm through Interactive Video Network (IVN). Sites have been coordinated for your areas. An invitation has been sent to all team members. If you have not received your invitation, please [click here](#) to email Emily or call 800.233.1737 ext. 3546.

All new team members should attend the training. Any team members that have already had the training and would like to attend are more than welcome. RSVP by Wednesday, May 12th. Supplemental materials will be mailed out.

North Dakota Integrated Services is part of the North Dakota Center for Persons with Disabilities at  
North State University · 500 University Ave W · Bismarck ND 58707  
Toll Free: 800.233.1737 · Website: [www.ndcpd.org](http://www.ndcpd.org)

# Stakeholder Symposium I

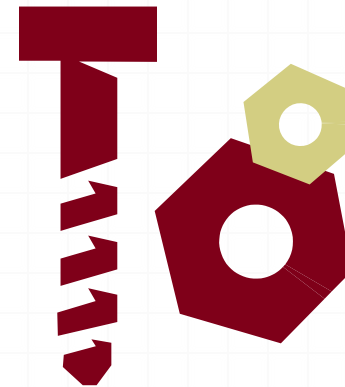
## December 9, 2008

- o Collaborative partnerships identified
- o Prouds and Sorries
- o Top Priorities
  - o Family Involvement
  - o Coordinated Services/ Care Coordination
  - o Healthy Transitions
  - o Medical Home
  - o Health Disparities
  - o Attitudinal Changes

# Stakeholder Symposium II

## March 16, 2010

- o NDIS a state grant
- o Dr. Rich Roberts – Six parts of quality service
- o Nuts & Bolts Activity
  - o 1 Person, 1 Family, 1 Plan
  - o Usual and Unusual Suspects
  - o Current Infrastructure

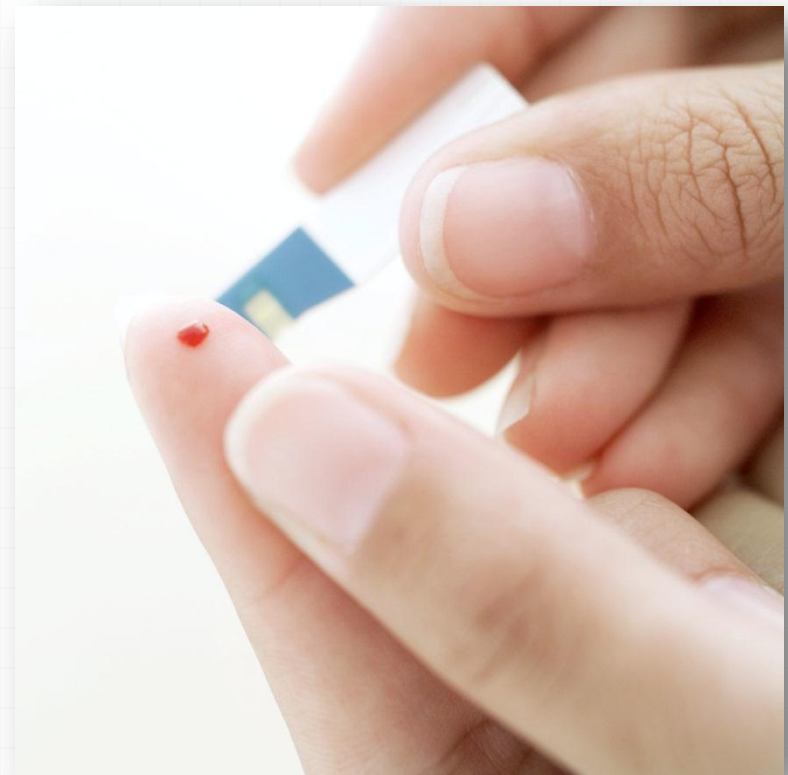


# Statewide Medical Home Activities

- Infrastructure
  - NDAAP
  - CSHS
- Reimbursement and Sustainability
  - Medicaid
- BCBS MediQ Home
- FVND
- Medical Home Workgroup
- ECCS

# BCBS MediQ Home

- o Pilot for diabetes
- o Primary Care Physician
- o Patient-Centered Care
- o MDInsight
- o Benefits



# NDAAP - CSHS

- o Monthly Medical Home calls
- o Care Coordination reimbursement
  - o Family-focused care
  - o Professional collaboration
  - o Program administration
- o Data collection

# FVND

- o Topical calls
- o Education
- o Learning Collaborative participation
- o Shares/gathers Medical Home information



# ND Medical Home Workgroup

- o Data sharing
- o ND Department of Human Services – Medical Services Division
- o Advanced Primary Care
  - o Continuous
  - o Accessible
  - o Comprehensive access
  - o Coordination

# ECCS

- o Medical Home module
- o HNDECA leadership
  - o Health insurance and Medical Home
  - o Mental health and social emotional development
  - o Early care and education and child care
  - o Parent education
  - o Family support

# Medical Home Care Coordination Project

- o Curriculum Development
  - o *Fundamentals for Care coordination*
  - o *State and Local Resources: A How-to Guide*
  - o *Healthy Transitions*
  - o *Health Benefits Counseling*
  - o *Medical Home: A Guide for Professionals (ECCS)*
- o Online Courses
- o CEUs

