

North Dakota Center for Persons with Disabilities · Minot State University

North Dakota Integrated Services Project Stakeholder Position Paper

Submitted by the North Dakota Integrated Services Project, February 2011



NDIS Project Overview

The North Dakota Integrated Services (NDIS) project is a three year grant project funded by the U.S. Department of Health and Human Services-Maternal and Child Health Bureau to the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. 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 in developing the knowledge and infrastructure to assure that children and youth receive coordinated care within the Medical Home (patient-centered care) model.

NDIS PROJECT GOALS

- 1) North Dakota will establish a network of learning collaboratives that integrate the six key components of quality services for children and youth with special healthcare needs (CYSHCN). To achieve this goal, the NDIS project will:
 - Establish an individual Learning Collaborative Model for Medical Home, Family Involvement/Cultural Competence, and Healthy Transitions to adulthood,
 - Establish functional networking systems to integrate the topic-specific learning collaboratives' work,
 - Host ongoing learning collaborative events throughout the year for team members, and
 - Increase cultural competence and family involvement through the learning collaboratives.
- 2) North Dakota 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 reach this goal, the NDIS project will:
 - Establish five to eight Medical Home model pilot sites and
 - Increase the number of CYSHCN who have adequate health insurance that meets their needs.
- 3) North Dakota will have a comprehensive plan for systemic implementation of an integrated services system for CYSHCN. To accomplish this goal, the NDIS project will:
 - Implement an annual stakeholder symposium to create top level buy-in to an integrated health service system and
 - Work with existing and future partners to promote regulations, funding, and systemic changes to increase knowledge and access to improved systems of care in the state.

NDIS GOAL PROGRESS

North Dakota (ND) has conducted eight learning collaboratives that integrated the six components of quality services for CYSHCN. The Learning Collaborative Model has provided significant education, training, and opportunities for primary care providers, care coordinators, families, and state and community partners. The learning collaboratives focused on the core areas of Medical Home, Family Involvement/Cultural Competence, and Healthy Transitions to adulthood. Each collaborative had a different theme, including the Six Goals of CYSHCN (family involvement, medical home, adequate insurance, early and continuous screening, community services organized and transition to adult life), Coding for Medical Home services, Care Coordination, State and Local Resources, Transition, and Screenings. A final collaborative, themed around Sustainability, will take place April 15th, 2011. NDIS project staff developed a periodic newsletter to keep collaborative participants and stakeholders connected to the project between meetings. The newsletter contains information about upcoming events, recaps of previous meetings, and links to other resources.

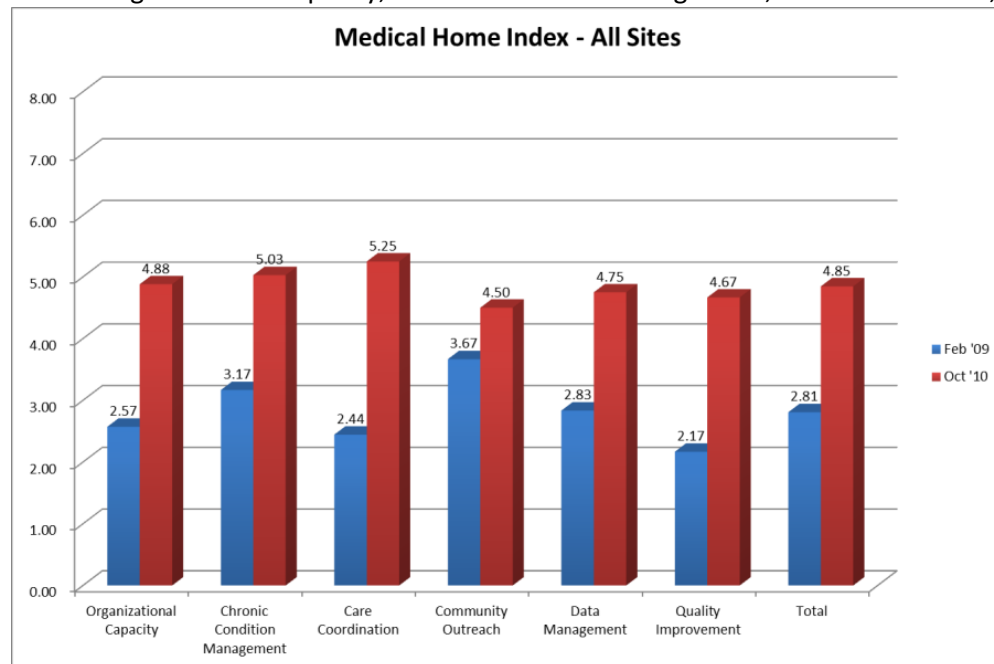
ND has increased positive outcomes for children and families through the work done at the established pilot sites testing the Medical Home model. During the implementation phase and throughout the project, NDIS has partnered with stakeholders and primary care providers in both urban and rural communities. There are seven Medical Home and six Healthy Transitions pilot sites. The Medical Home pilot sites submit monthly reports detailing the number of CYSHCN identified, the number of care plans developed, and summaries of changes tested by the site. Medical Home pilot sites also conduct self-assessments and parent surveys that are submitted back to NDIS project staff for analysis. The information collected throughout the NDIS project has been shared with insurance companies and other state systems. This led to the identification of opportunities to educate ND residents/youth on various health care options.

ND is developing a comprehensive plan for systemic implementation of an integrated services system for CYSHCN. The NDIS project has coordinated annual stakeholder symposia to create awareness and gather support for the continued Medical Home model, Healthy Transition strategies, and Family Involvement/Cultural Competence practices. Input from culturally diverse participants and information about culturally competent practices have been shared to affect long-term change in care coordination and practice. NDIS evaluated and disseminated best practice information as it became available to influence system change.

MEDICAL HOME PILOTS

Through the NDIS project, Medical Home pilot sites have been established at different medical 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 once per month to develop quality improvement strategies and implement Medical Home concepts into the practice. The sites receive a monthly stipend for their participation and demonstration of Medical Home activity.

To measure the “medical homeness” of the pilot sites, each site conducts semiannual surveys. The Medical Home Index is a self-assessment that focuses on the main components of a Medical Home and helps the sites determine where they currently rank and where improvement is needed. Categories include organizational capacity, chronic condition management, care coordination, community



outreach, data management, and quality improvement. Overall scores of the Medical Home Index have improved significantly. Figure 1 shows the comparison of Medical Home Index results from February 2009 to October 2010. The scores are averaged from all seven pilot sites.

Figure 1

The Parent-Perception Survey is administered to families of CYSHCN in each practice and solicits their opinions. The survey is mostly multiple choices, but does offer several opportunities for families to comment. The survey provides both valuable quantitative and qualitative data for the sites to use in identifying areas for improvement.

NDIS project staff provides technical assistance to Medical Home pilot sites through site visits, phone calls, and email. Project staff provides site-specific technical assistance during the team meetings either in person or via conference call. Medical Home team members from each site also participate in a monthly technical assistance phone call to receive additional training, to address challenges and successes, and to provide a regular networking opportunity for the pilot sites. The monthly parent calls are co-facilitated by Family Voices of North Dakota.

Each Medical Home site makes it a priority to continuously screen for CYSHCN and to develop care plans for their patients. Once a patient has a completed care plan, they are an official Medical Home patient. A care plan is a document that contains pertinent information about the child ranging from medical diagnosis and lab results to the unique needs of the individual. The care plan is meant to travel with the patient so that when the patient must see another provider, they will receive the same quality of care they get in their Medical Home. This document also reduces the need for families to tell and retell their backstory time and again.

The Medical Home pilot sites are committed to providing coordinated care. Many sites host “lunch and learn” meetings periodically, inviting a local agency representative to a team meeting to discover how the agency and practice can best work together to increase positive outcomes for CYSHCN. The teams also dedicate their efforts to familiarizing themselves with resources available in their communities so they can be a valuable resource to CYSHCN and their families.

HEALTHY TRANSITION PILOT SITES

The NDIS project also recruited and established six families of CYSHCN to be involved in the project as Healthy Transitions pilot families. During their involvement in the project, NDIS staff consults with the families about the goals of their CYSHCN and the methods necessary to achieve them. NDIS staff introduced Plan-Do-Study-Act (PDSA) cycles to the families as a way to achieve goals by incorporating small tests of change into their everyday lives. Some PDSA cycles families have tested include

- Independently managing health issues
- Decreasing anxiety of transition from middle school to high school
 - Become familiar with school buildings
 - Identify opportunities to get to know new staff and personnel
 - Find a student mentor
- Independent livings skills
- Transitioning to adult roles
 - Medication management/independence
 - Organization of personal belongings
- Self-advocacy for personal needs
- Increasing access to social interaction

“As a parent of a child transitioning to college, I have many concerns to making the transition successful so that he can become independent. Through the NDIS project I am able to have input from several professionals and families that will help my son through this transition. I strongly believe it takes a community to raise a child, and I am honored to be a part of the NDIS community.”
–Healthy Transitions Parent Partner

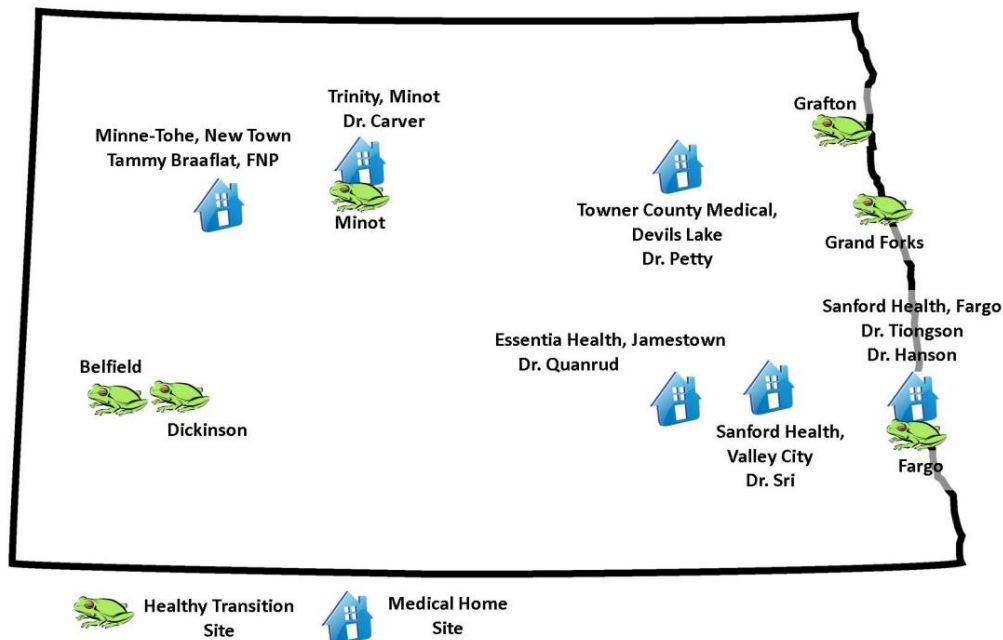
The Health Transition Community of Practice was established in ND by the State Transition Community of Practice through the Department of Public Instruction in partnership with the NDIS project. Work was done at the state and national level to educate about the needs of Healthy Transitions.

NDIS staff also assists the families in identifying state and local resources that could be used to enhance the transition of the CYSHCN to adulthood. One family commented that because of this project, they have been able to find resources available in ND. An offer was extended by the Community of Practice to an NDIS Healthy Transitions youth to join the Community of Practice State Advisory Committee and the Youth Leadership subcommittee. Through these positions, the youth will provide self-advocacy and self-awareness training, as well as participate in leadership opportunities across the state.

NDIS project staff in collaboration with partner agencies developed advocacy folders. The folders are designed for use by transitioning youth to encourage self-advocacy. Within the folders are different tabs and forms that can be used to organize and document critical information needed by the CYSHCN. There are compartments and documents specifically tailored to house personal, medical, education, career, and money management materials. Having CYSHCN build the advocacy folder encourages them to think about planning for their future and the activities that significantly impact their quality of life. The folders were presented at the January 2011 collaborative to the Healthy Transitions collaborative and were very well received.

Another priority is the creation of an “interagency agenda” that can be used by CYSHCN and their families. The agenda is not another form to fill out, but rather a guide for conducting an interagency meeting. When actively transitioning, there are often several meetings the family and youth must attend, telling and retelling their story again, but to different people, organizations, or agencies. An interagency agenda would permit all stakeholders in the youth’s life to attend one meeting, gather the needed information, and collaborate to improve the outcomes for the youth. NDIS staff is working with several different agencies and the pilot families to put this document in action.

ND PILOT SITE LOCATIONS



BY THE NUMBERS

This information reported by ND Medical Home pilot sites.

1065: The number of CYSHCN identified with mild to complex special healthcare needs.

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

676: The number of school plans for CYSHCN that Medical Home providers have given input.

TESTIMONIAL BY THE NUMBERS

This information is family opinion gathered from Parent Perception Surveys conducted semiannually by ND Medical Home pilot sites. Current data is from October 2010.

85% currently report they ALWAYS feel their child's provider spends enough time with their child, compared with 60% in November 2009.

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.

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.

94% 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.

CHANGES FOR IMPROVEMENT

This information reported by ND Medical Home pilot sites.

- 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 conduct informational meeting on Medical Home to parents of CYSHCN
- Implementation of pre-visit phone calls to determine changes, needs, and concerns

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."

Summary of Stakeholder Symposiums

DECEMBER 9, 2008

The first NDIS Stakeholder Symposium was held in Bismarck on December 9, 2008. The purpose of this meeting was to develop collaborative partnerships for creating integrated, family-centered and culturally competent systems of care so that CYSHCN have an equal opportunity to thrive in body, mind and spirit. At this meeting, the foundation for developing a collaborative leadership and humane systems of care was established.

Representatives from several different agencies and organizations throughout ND participated in this meeting. Activities during the day included planning for the future by identifying trends affecting CYSHCN and their families, sharing “prouds and sorries” regarding CYSHCN in ND, and prioritizing specific areas that everyone was willing to work on together. The group agreed that family involvement, coordinated services, smooth transitions for all ages, service providers trained in Medical Home, reduction in health disparities, care coordination, and attitudinal changes were the most important. Based on these priorities, five committees were formed. The committees were to determine a committee name, establish a chair, maintain contact with Ms. Kora Dockter, develop meeting schedules, determine committee goals to meet the needs of the Integrated Services grant, and share goals among other committees to avoid duplication. Committees formed were:

- 1) Family-Centered/Family Involvement
- 2) Coordinated Services/Care Coordination
- 3) Smooth Transitions at All Ages
- 4) Medical Home – Trained Service Providers
- 5) Health Disparities/attitudinal Changes

MARCH 16, 2010

The second NDIS Stakeholder Symposium was held in Bismarck on March 16, 2009. This meeting emphasized that the NDIS project was not an NDCPD grant but a state grant. Participants included representatives from a variety of agencies, organizations, and families. Participants were excited about the concepts of integrated services and moving forward with the project’s goals related to their respective agencies.

Keynote speaker Dr. Rich Roberts presented the six interactive parts of quality service. Dr. Roberts led the group in a discussion with stressing the importance of celebrating successes and to reach out to the “unusual suspects”. Examples of “unusual suspects” included teachers, coaches, clergy, mentors, and business owners. Participants also planned for the future by breaking into groups and working on the “Nuts & Bolts” group activity (see below). Discussion included “How do we change *buts* and *ifs* into *yes we cans*?” Dr. Roberts encouraged participants to move thoughts and ideas into actions.

Step 1 – Inspiring a Vision and Mission: Agency mission statements were shared to identify common themes. Participants were asked who they would bring to the discussion on building a community-based service system. Groups were also asked to think about how their current mission statements reflected support for CYSHCN and a community-based service system. What would they change? From this discussion, the concept of “1 person, 1 family, 1 plan” was born; the idea that a system-wide approach is needed to improve outcomes for CYSHCN.

Step 2 – Engage Other Partners: The groups generated a list of “usual and unusual suspects” who should be at the table during these discussions. This list included administration, public nursing staff, pediatricians, family practice providers, information technology, school, parents, Head Start,

Benefits Coordinators, legislators, DD case managers, people you have done it before, Independent Living Centers and other community providers.

Step 3 – Assess Your Community Infrastructure: The groups discussed how communities could be defined by either public health regions, geographical regions, or whole state. Information that already exists about the state include Medicaid claims, Children’s Health Insurance Program (CHIP) data, family surveys, Behavioral Risk Factor Surveillance System (BRFSS), National Longitudinal Transition Study (NLTS), Kids Count, Family Voices data and parent stories. The groups identified ways to engage communities and bring “ambassadors” together through health tech and trade fairs, organizations, Doc Talks, radio shows, topical calls, learning collaboratives, marketing and education.

Step 4 – Develop a Plan and Budget: The groups discussed strengths of the communities which included awareness of available resources in each region, programs already in place, functioning committees, economic advantages, small town feel, and interagency meetings through the counties. Some challenges identified were cultural competence, geography, resistance to change, rural vs. urban, access, not enough time, making contacts in tribal communities, and disparity of services. Considering strengths and weaknesses, the groups did generate ideas for implementation strategies including, care coordination in partnership with medical homes, referral and outreach, interagency collaboration, family leaders, and funding opportunities. Groups were also asked to identify factors driving the systems change effort which included correspondence from NDIS project staff, identified needs, a goal to keep youth here, and money.

Step 5 – Implementation: Groups talked about implementing these new ideas into program structure. Services would have to integrate training in strategies, communication needs to be open and clear, and a shift from being in charge to providing support needs to occur. This will cause an increase in budgets initially, but eventually will save money because of prevention efforts.

Ms. Dockter provided an overview of the NDIS project, project goals, and project progress. Updates on Medical Home and Healthy Transitions pilot sites and efforts focused Family Involvement and Cultural Competence were discussed. Ms. Dockter also introduced the care coordination curriculum concept to the group.

North Dakota Statewide Medical Home Activities

INFRASTRUCTURE

NDIS has been funding monthly phone calls, which are facilitated by the AAP Medical Home Liaison for state level partners, to discuss current and future needs of the Medical Home project. NDIS Medical Home pilot sites have been supported by AAP-NDAAP with a grant that has been made available through the ND Department of Health Children's Special Services Division to support care coordination activities in pilot sites.

REIMBURSEMENT AND SUSTAINABILITY

A representative from NDIS has been working with the Medicaid Medical Advisory group in the planning process for potential implementation of Medical Home to support Medicaid clients. Additional data is needed to identify funding options to support Medical Homes for Medicaid clients. An optional adjustment request (OAR) was submitted by Medicaid but was not funded in the 2011 Governor's Budget. The representative from NDIS will work with partners to set up a meeting with the Department of Human Services leadership to identify areas of potential funding, if needed.

BLUE CROSS/BLEU SHIELD MEDIQ HOME

In a MediQ Home, the primary doctor and clinic become the patient's Medical Home where all care is coordinated and where the patient has access to credible information about his or her health. The goal is to involve the patient in medical decisions and provide easy access to clinical staff beyond regular doctor appointments. This improved medical collaboration is made possible by a sophisticated electronic backbone, MDinsight, which keeps everyone informed.

For now, the program is especially helpful to those with chronic conditions such as diabetes, coronary artery disease, hypertension, asthma, and chronic heart failure. It also benefits a wider group by tracking pediatric and adult immunizations, attention deficit hyperactivity disorder (ADHD), colon cancer screening, cervical cancer screening, and breast cancer screening. When healthcare providers work together through MediQHome, diagnosis is faster and conditions can be better managed earlier on. In fact, this model often prevents problems from occurring in the first place. This kind of collaboration not only gives patients a better quality of life, it also helps hold down the cost of medical care.

In a MediQHome three-year pilot project for diabetes, costs for care were not only less than expected, but they actually dropped. Those cost reductions saved more than a quarter million dollars in just two years. This model of care is endorsed by all four major medical credentialing groups: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association.

If the primary care physician participates in MediQHome and the patient has been diagnosed with a chronic condition, the patient is automatically eligible to participate. For patients without a chronic disease, the doctor will ensure all appropriate screenings, immunizations, and preventive care is provided at the right time.

MediQHome allows providers to focus on their patients' health outcomes through the use of MDinsight, a free, web-based, interactive decision support tool. MDinsight helps the provider identify care opportunities by organizing all available patient clinical data to create patient-specific clinical summaries and quality reports. MDinsight stores patient information in one place that is easily accessible to the provider at the point of care, allowing the provider to spend more time treating patients and less time

searching for information. For example, if a diabetic patient has not had a dilated eye exam in over a year, MDinsight identifies the missing test. The provider and patient can then discuss what needs to be done and decide on the best option. Having this information allows the provider to identify current and missed care opportunities in individual patients or groups of patients with specific chronic conditions. Providers who participate in MediQHome have access to MDinsight that provides the following benefits:

- Actionable patient data at the point of care
- Improved decision support
- Accurate tracking of patient adherence
- Better patient outcomes
- Elimination of manual chart reviews
- Greater patient satisfaction
- Pay for efforts that are traditionally not reimbursed

Statistics show this model of care improves the effectiveness of healthcare while driving down costs. That's a combination that benefits everyone, including:

Patients

MediQHome is a model of care that is completely focused on the patient – especially those patients with chronic conditions. Together, the patient and doctor build treatment plans, schedule follow-up appointments, and develop a long-term relationship. By keeping the treatment plan on track, the patient will feel better and live a healthier life. When symptoms do occur, they can be better controlled and the chance of severe side effects from leaving the disease untreated drops dramatically. In the end, the patient is living healthier and holding down healthcare costs.

Doctors

Doctors go into medicine to care for people; MediQHome helps meet that objective. The program provides the tools and financial resources that allow the doctor to focus on a strong relationship with the patient and his or her care. Through MediQHome, the doctor also establishes better collaboration with other caregivers through MDinsight. Through this tool, caregivers can interact and share information about the patient's condition, treatment goals, and progress.

Employers

Since this program helps control chronic conditions, it not only helps patients live healthier, it helps their employers as well. When employees are healthy, they're more productive, more focused, and take fewer sick days. Keeping employees healthy also helps contain healthcare costs and keeps premiums down.

The overarching goal of MediQHome is to provide the right care at the right time for the right reason, resulting in a healthier North Dakota. Specifically, it will:

- Improve the quality of patient care
- Promote collaborative decision making between patients and doctors
- Create better doctor-patient relationships
- Provide clear treatment plans for patients to follow
- Enable a better quality of life
- Create more cost-effective care

BCBSND's MediQHome Adult and Pediatric Quality Advisory Committees provide a forum for collaboration and communication about improving the quality of healthcare in ND. The committees have broad representation including patients, consumers, and physicians. The committee members help determine quality measurements, metrics, and performance standards for the MediQHome program. An NDIS representative has joined the BCBS MediQ Home advisory board.

The committees are comprised of BCBSND executive staff, ND providers, and physician representatives from various specialty societies that endorse the Patient-Centered Medical Home (PCMH) concept. The specialty societies include the American Board of Family Medicine, American Board of Pediatrics, American Board of Internal Medicine, and ND Medical Association. In addition, the committees include a consumer member to provide representation of our consumers' needs and expectations and a process improvement administrative representative from participating entities.

David Hanekom M.D., BCBSND's chief medical officer, or his designee, chairs the committees. Appropriate BCBSND staff is available for ongoing support. The Blue Cross Blue Shield MediQ Home project has a Quality Advisory Committee made up of a Department of Health representative, Quality Improvement representatives, Employer/ Consumer representatives, Provider representatives, and a Community ad hoc member. For program questions, contact Petrice Balkan at BCBSND: Petrice.balkan@bcbsnd.com or 701-227-2336.

NDIS is in the process of collaborating with BCBSND and Medicaid to collect and review claims data and complete a qualitative survey on the Medical Home teams and patients to determine both financial and personal benefits for patients and families who have participated in the NDIS Medical Home Project.

NORTH DAKOTA AMERICAN ACADEMY OF PEDIATRICS

ND Children's Special Health Services' grant funds are used to support infrastructure in Medical Home sites piloted by the NDIS project. Data regarding the types of activities provided by the pilot sites is tracked and will be reported when the grant period ends June 30, 2011. The goal of data collection is to provide justification and research to approach Medicaid and Blue Cross/Blue Shield for reimbursement. Data being tracked includes:

- For 11 weeks, the hours spent in each site are defined as:
 - Family-focused care
 - Professional collaboration
 - Program administration
- For two consecutive weeks of the quarter, the recorded activity is more detailed:
 - Family-focused care
 - Assess child/family needs
 - Care plan development/review/revision
 - Child/family support: face to face or via technology
 - Education: disease process, transition
 - Other
 - Professional collaboration
 - Coordinate appointments and ancillary activities
 - Coordinate referrals to agencies and support
 - Coordinate benefits (equipment, prescriptions)
 - Participation in outside agency planning, IEP, IFSP, etc.
 - Other

- Program administration
 - Program infrastructure including meetings with administration, recruiting families
 - Team/ meeting coordination
 - Documentation
 - Education to include learning collaborative, conference calls, web-based
 - Program outreach
 - Other

FAMILY VOICES OF NORTH DAKOTA (FVND)

Family Voices aims to achieve family-centered care for all children and youth with special healthcare needs and/or disabilities. Through this national network, Family Voices provides families tools to make informed decisions, advocates for improved public and private policies, builds partnerships among professionals and families, and serves as a trusted resource on healthcare issues. FVND has advocated for the Medical Home approach to care delivery for CYSHCN. Some of the activities that FVND has sponsored, participated, or partnered in to increase Medical Home awareness are as follows:

- Sponsored topical calls to families and providers on Medical Home
- Educated nursing students in Fergus Falls, MN about basic Medical Home practices
- Participated in monthly calls with the Medical Home team
- Participated in other Medical Home committees such as HNDECA
- Assisted with monthly family calls to support family Medical Home team members
- Participated in Learning Collaboratives
- Provided Medical Home information in weekly e-news, publications, and the snail mail newsletter, *The Navigator*
- Participated in other states' Medical Home processes to stay current on initiatives across the U.S.
- List fact sheets and brochures on the FVND website
- Included regular Medical Home information in ND's Family Leadership Institute

NORTH DAKOTA MEDICAL HOME WORKGROUP

The purpose of the Medical Home Workgroup is to assist and advise through data sharing and discussion in support of the development of the Medicaid Medical Home model within the ND Department of Human Services, Medical Services Division.

The workgroup defines Medical Home as an advanced primary care practice and as a qualified healthcare practice that ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, preventive healthcare, mental healthcare, and oral healthcare and related services. All advanced primary care practices will ensure, at a minimum, the following:

- Health maintenance and preventive care
- Anticipatory guidance and health education
- Acute and Chronic illness care
- Coordination of medications, specialists and therapies
- Provider participation in hospital care, and
- Twenty-four hour telephonic care.

EARLY CHILD COMPREHENSIVE SYSTEMS (ECCS)

Recognizing the necessity of educating professionals on care coordination, the ECCS program provided funding for a care coordination module titled *Medical Home: A Guide for Professionals*. Effective care coordination will provide prompt and consistent access to services, along with individualized support based on the family's needs and strengths. Lack of training and skills have been identified as a barrier to effective care coordination in ND by care coordinators, parents, and Title V directors (AAP, 2000; Anonymous, 2000; Title V Directors Survey, 2001). CYSHCN in ND are likely to lack adequate care coordination in the area of communication between their doctors/other providers and schools or other programs. It is estimated that nearly half of CYSHCN in ND who needed healthcare providers to communicate with schools and other programs did not receive the level of coordination needs. Training will enable children and youth with developmental disabilities and special healthcare needs in ND to benefit from trained care coordinators.

ECCS also created the Healthy North Dakota Early Childhood Alliance (HNDECA) to help achieve its goals. HNDECA's vision is to support families and communities in their development of healthy children who are ready to learn. HNDECA has a steering committee and five subcommittees:

- 1) Family Support,
- 2) Early Care & Education,
- 3) Mental Health,
- 4) Health Insurance & Medical Home, and
- 5) Parent Education.

Medical Home Workgroup

The group discussed the qualifications for a PCMH and what type of practitioner could provide Medical Home services, such as a family practice physician, specialty physician, nurse practitioner, or physician's assistant. More discussion is needed to confirm who would best serve as a provider in the ND Medical Home. The group did discuss some criteria or services that could be included in the PCMH, including:

- Offers health maintenance and preventive care,
- Provides guidance and health education,
- Serves the needs of individuals with acute and chronic health conditions,
- Coordinates referrals to specialists and therapies,
- Offers 24-hour telephonic care to eligible recipients,
- Maintains current medication lists for recipients,
- Has a patient tracking system, and
- Promotes continuity of care.

WORK GROUP MEMBER AFFILIATION

A multidisciplinary group of stakeholders across the state of ND have had periodic meetings to discuss the Medical Home approach. Groups that have been represented at the workgroup meetings have been staff from Department of Health, Department of Human Services, ND Medical Association NDIS, ND State Hospital, American Academy of Nurse Practitioners, Sanford Health Systems, and Community Health Association.

TARGET POPULATION

The group discussed with which population the Medical Home work could begin. Some suggestions were all Medicaid recipients, CYSHCN, high risk individuals, or individuals in a high cost category. Currently, ND Medicaid does work with a disease management program that targets Medicaid recipients with chronic conditions. The group discussed methods for identifying a target population, such as review of claims data by primary care provider, a standardized screening tool for recipient identification, or looking to other states for guidance on population identification.

DELIVERY MODEL

There are various models for delivering patient-centered care. The National Committee for Quality Assurance (NCQA) has a rigorous set of standards for delivering patient-centered care that would require all the providers in a clinic setting to meet the standards even if the practice is not part of the Medical Home concept, which may not be realistic as a starting point for most practices. With the different options for implementing Medical Home, the group had not confirmed which method would be best for ND. In review of Minnesota, the Medical Home project has adopted standards that are more rigorous than the NCQA standards but are more family focused. The method for delivering patient-centered care in a Medical Home setting can be implemented in various ways for different populations and payer sources.

REIMBURSEMENT FOR MEDICAL HOME ACTIVITIES

ND does not have an established method for reimbursing Medical Home practices. Through the NDIS project, the seven Medical Home pilot sites can claim a \$200 to \$400 stipend per month for participating as a pilot site. This funding will not be available after May 2011. The sustainability plan for the participating clinics has not been confirmed. Other options of payment include reviewing codes for care coordination from the private payer side. Other reimbursement options discussed were the tiered

payment system practices by Minnesota or the per-member per-month (PMPM) option that has been used in the Enhanced PCCM program funded by ND Medicaid.

BARRIERS AND CHALLENGES

The group discussed how the medical field as a whole needs to change. The need for significant incentives for the primary care practitioner as well as a shift from traditional fee for services to outcome based reimbursement.

Medical Home Care Coordination Project

The Medical Home Care Coordination Project is a two-year project, ending in October of 2011 that is funded by the ND Development Disabilities Foundation. The purpose of the grant is to develop instructional modules to educate care coordinators and families in different areas of Medical Home. In Year 1 of this project, NDCPD staff developed four instructional modules covering the following content: *Fundamentals of Care Coordination*; *State and Local Resources: A How To Guide*; *Healthy Transitions*; and *Health Benefits Counseling*. A fifth module entitled *Medical Home: A Guide for Professionals* was developed with funding from the ND Early Childhood Comprehensive Systems (ECCS) group.

For Year 2 of the grant, necessary revisions were made to the paper curricula in order to put the courses online through the MSU WebCT online course system. The courses will then be offered to targeted audiences, including care coordinators, physicians, nurses, and families of children with developmental disabilities and special healthcare needs. The online courses will be offered to participants at no charge during grant Year 2 because the cost of taking the course was included in the funding for the year. In addition to taking the course, the course participants may be eligible to receive continuing medical education credits (CME's) or continuing education credits (CEU's) at no charge. The final component of grant Year 2 will focus on sustainability of the online Medical Home courses. A sustainability plan will be developed in collaboration with state partners.

National News on Medical Home

NASHP and The Commonwealth Fund are pleased to announce the release of a new report, *Leading the Way: State Innovations in Primary and Chronic Care Delivery*. Drawing on case studies from Colorado, Michigan, North Carolina, Oklahoma, Pennsylvania, and Vermont, the report details how states can help small practices offer more efficient and effective care, and become Medical Homes. To read the report, please visit: <http://www.nashp.org/state-innovations-transform-link-small-practices>

An archived version of last week's webcast, "New Tactics for Building Medical Homes in State Medicaid and CHIP Programs," is now available online at <http://www.nashp.org/webinars/new-tactics-building-medical-homes-state-medicaid-CHIP-programs>. Speakers' slides are also available at that site.

During the "New Tactics" webcast, Dr. Engebretsen of Iowa referred to several materials related to Iowa's new Medical Home program for low-income, childless adults. These materials are now available at the bottom of this page, under IowaCare Medical Home Links: <http://www.ime.state.ia.us/IowaCare/index.html>

Melinda Abrams of The Commonwealth Fund referenced a new issue brief from the PCPCC during last week's webcast. That brief, entitled "Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States" is available online at: http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

The Safety Net Medical Home Initiative, a project of The Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute, have released another Medical Home Digest dedicated to promoting patient-centered interactions. Please see the attached e-mail or follow this link: <http://ghmedicalhome.org/safety-net/patientcenteredinteractions.cfm#Guide>

ND Parent Opinion of Medical Home

“The Medical Home approach to providing healthcare to children with special healthcare needs has been beneficial to patients and families in North Dakota. A mother of a special needs child in North Dakota stated that since her son is part of a Medical Home, “the nurse knows me” and usually calls back within an hour to either schedule an appointment or answer questions. When the child is scheduled for a clinic visit, he is “roomed” right away and doesn’t have to sit in the waiting area. The Medical Home approach has been beneficial in coordinating care thru out the continuum by having information available that can be shared with the pediatrician, pediatric cardiologist and pediatric surgeon. In addition, the care coordinator in the pediatric setting is able to answer questions and assist the family with the transition process. As this youngster approaches his 3rd birthday, discussion and planning has been occurring to transition from in home respite care to private day care. Without having a Medical Home, care would not be as coordinated and timely.”

–Medical Home Parent Partner

“It is reassuring to see a doctor who cares enough to go the extra steps for our child.”

–Parent of a Medical Home Patient

“We received a card to show the receptionist to “Room patient Right Away”. So my immune-compromised daughter does not have to wait in the waiting room with ill children. This service is greatly appreciated.”

–Parent of a Medical Home Patient

“When our daughter gets sick, Dr. “x” starts her on medicine right away so she gets better faster, back to school, and I don’t miss work.”

–Parent of a Medical Home Patient

“Decreases the amount of time to explain the care my child needs.”

–Parent of a Medical Home Patient

“This program is wonderful for families with kids with special needs. We have a lot of info to organize and Medical Home allows this.”

–Parent of a Medical Home Patient

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

–Parent of a Medical Home Patient

“Now I don't have to call so many other clinics for info.”

–Parent of a Medical Home Patient