A Collaborative Approach to Building Mississippi's Integrated Community Systems for Children and Youth with Special Health Care Needs (CYSHCN)

Who are CYSHCN?
Children/Youth with Special Health Care Needs (CYSHCN) are those who have or who are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

McPherson et al., 1998

Methodology
MICS is utilizing existing internal resources and partnering with the Mississippi State Department of Health’s Children’s Medical Program, Mississippi’s Title V implementation agency, as well as other state-wide, e.g., the Division of Medicaid, the Head Start Collaboration Office, the Mississippi Chapter of the American Academy of Pediatrics, the Mississippi Department of Human Services, and the Division of Children’s Medical Services. Conduct surveys among health care providers on staff, methods and materials used for children developmental screening to ensure the quality of the practice.

Six National Core Outcomes
1. Increase the number of primary care providers in Mississippi that meet American Academy of Pediatrics (AAP) criteria for medical home.
2. Increase the number of children in Mississippi that receive an annual health and developmental screening.
3. Increase the number of families in Mississippi who are competent partners in making decisions about health care services and supports for CYSHCN.
4. Increase the number of transition-age CYSHCN who participate in person-centered planning (PCP) that addresses the individual’s ongoing healthcare, educational, and occupational needs.
5. Ensure the quality and sustainability of project activities through the use of evidence based practices, continuous quality improvement, and participation in training on the learning collaborative model.
6. Collect data from families, providers, and community-based organizations and services to identify barriers in developing integrated community systems for Mississippi’s CYSHCN and evaluate the impact of system changes.

Assessment
Collect data from focus groups of parents and family members of CYSHCN and assess the preference and effectiveness of existing services.

Conduct surveys among health care providers on staff, methods and materials used for children developmental screening to ensure the quality of the practice.

Host telephone survey of families with CYSHCN to assess the level of satisfaction from the families from the services they received.

Partnering with CYSHCN and their families will be established.

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Partnership, Collaboration and Networking
Work with the Family-to-Family Health Information and Education Center project at IDS to enhance effectiveness and reduce the duplication of effort.

Conduct partnership meetings among public and private stakeholders across the state including families and youth to address the importance of working collaboratively to effectively deliver services.

Establish networking tools and a data base to provide assistance in advocacy to health care providers and communities on family involvement of decision-making process.

Education
Provide educational training on transition from youth to adulthood in health care, employment, and independent living to YSHCN, parents, and health care providers.

Conduct cultural and linguistic competence training to health care providers and communities.

Advocate the concept of “Medical Home” by providing technical assistance to stakeholders including health care providers.

Provide educational information to primary health care providers on early childhood and continuous developmental screening.

Conclusion
Partnerships and a collaborative approach in building an integrated service system for CYSHCN and their families could be an effective and efficient way to erase work performed in silos among involved organizations. The positive impact of the collaborative approach may be enhanced by increasing shared information and resources, as well as reducing the duplication of effort.