Mississippi Integrated Community Systems for Children and Youth with Special Health Care Needs and Their Families (MICS)

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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
Prevalence of CYSHCN in Mississippi

About 111,852 children age 0 to 17 years

- 85% Non-CYSHCN
- 15% CYSHCN

2005-06 NS-CSHCN
Age of CYSHCN in Mississippi

Percentage of CYSHCN in Different Age Groups

- 0-5 years old: 34.7%
- 6-11 years old: 33.7%
- 12-17 years old: 31.6%
Gender of CYSHCN in Mississippi

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>49.1</td>
</tr>
<tr>
<td>Female</td>
<td>50.9</td>
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</tbody>
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Race/Ethnicity of CYSHCN in Mississippi

Percentage

- Hispanic
- White, non Hispanic
- Black, non Hispanic
- Multi-racial, non Hispanic
- Other, non Hispanic

44.4%
1.7%
3.3%
49.9%
Income Status of Families with CYSHCN in Mississippi

- 0-99% FPL: 24.7%
- 100-199% FPL: 25.7%
- 200-399% FPL: 29.5%
- 400%+ FPL: 20.2%
National Agenda for CYSHCN

- Provide and promote family-centered, community based, coordinated care for children with special health care needs and
- Facilitate the development of community-based systems of services for such children and their families.

HRSA
Core Outcomes to be Achieved

1. Families are partners in decision making process
2. A "Medical Home" provides coordinated care
3. Families have adequate funding/insurance to pay for services
4. Children receive early and continuous screening
5. Services are organized so families can use them easily and are satisfied
6. Youth receive necessary services to make the transition to adult life
About MICS

• Problems
  Services for CYSHCN are few, fragmented, isolated. Access to the service providers are limited. Families have to adapt their lifestyles to access the services for their children.

• Purpose
  Creating a seamless system of family-centered, community-based, culturally competent services and supports for CYSHCN in Mississippi.
Institute for Disability Studies (IDS) is partnering with the Mississippi State Department of Health Children Medical Program, the MS Chapter of the American Academy of Pediatrics, families, advocates, and other state and community-based stakeholders to identify current system strengths and weaknesses and address barriers to develop a desirable system, which is family-centered, community-based and culturally competent.
MICS’ Focusing Areas

All the identified priorities fit into the Core Outcomes

- Medical Home development
- Early and continuous health and developmental screening
- Youth transition to adult life – Health Care, Work, and Independence
How Can You Help?

- Meet AAP criteria for Medical Home

AAP Medical Home Criteria for CYSHCN:

1. Have a usual place for sick/well care
2. Have a personal doctor or nurse
3. Have no difficulty in obtaining needed referrals
4. Have needed care coordination, and
5. Have family-centered care received.
Percentage of MS CYSHCN Who Receive Coordinated, Ongoing, Comprehensive Care within a Medical Home

![Graph showing the percentage of MS CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home. The national percentage is approximately 47.1%, while the MS percentage is approximately 45%.]
Percentage of CYSHCN Access to Care in MS

<table>
<thead>
<tr>
<th>Category</th>
<th>National %</th>
<th>MS %</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of CYSHCN without any personal doctor or nurse</td>
<td>6.5</td>
<td>8.7</td>
</tr>
<tr>
<td>% of CYSHCN without a usual source of care when sick or who rely on the ER</td>
<td>5.7</td>
<td>6.2</td>
</tr>
<tr>
<td>% of CYSHCN needing a referral who have difficulty getting it</td>
<td>21.1</td>
<td>18.8</td>
</tr>
<tr>
<td>% of CYSHCN without family-centered care</td>
<td>34.5</td>
<td>38.4</td>
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How Can You Help (cont.)

- Tailor your practice to increase screening. Family physicians, regardless of practice location (urban or rural), should tailor their practices to insure early detection and appropriate referral of the developmentally delayed child, thereby minimizing disability and maximizing the child's potential.
Percent of MS CYSHCN Who are Screened Early and Continuously for Special Health Care Needs

- National %: 63.8%
- MS %: 51.4%
How Can You Help? (cont.)

- Enhance the knowledge of youth transition and provide guidance to youth and families
  - Family doctors and pediatricians should be aware that transition is an ongoing process that may begin as early as the time of diagnosis and ends sometime after transfer.
  - Appropriate resources and educational materials should be provided for youth throughout the process of transition.
Percentage of CYSHCN Who Receive the Services Necessary to Make Appropriate Transitions to Adult Health Care, Work, and Independence

- National %: 41.2
- MS %: 30.9
The integrated service system for CYSHCN cannot be established without your efforts!