

Maryland Children and Youth with Special Health Care Needs Outcome #4 CYSHCN who are screened early and continuously for special health care needs

Effective promotion of health and health services for children and youth with special health care needs (CYSHCN) requires a system of care that is integrated, comprehensive, coordinated, family centered and consistent across the life course (or lifespan). Ideally, families of CYSHCN can easily navigate such a system, leading to positive experiences seeking care and interacting with service providers. Advancing integrated care systems for CYSHCN and their families is a national mandate under Public Law 101-239 as well as a priority reflected in the Healthy People goals set forth by the U.S. Department of Health and Human Services from 2000 to 2020. To determine progress toward an integrated system of care for all CYSHCN, the Federal Maternal and Child Health Bureau established the following six core outcomes:

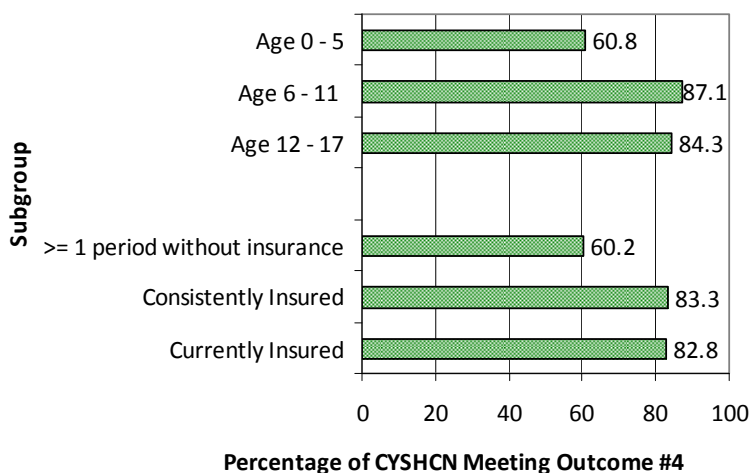
- Partners in Decision-Making
- Medical Home
- Adequate Health Insurance
- Early and Continuous Screening
- Ease of Community-Based Service Use
- Transition to Adulthood

The National Survey of Children with Special Health Care Needs (NS-CSHCN) is designed to provide information on the CYSHCN population and to assist in the measurement of these core outcomes. Since 2001, the NS-CSHCN has been conducted every four years. The NS-CSHCN measures each core outcome with low-threshold criteria. Outcome #4 assesses early and continuous screening for CYSHCN. Early and continuous screening is the precursor to early identification, diagnosis and treatment of special health care needs, which leads to more efficient and comprehensive care. Nationally, only 78.6% of CYSHCN receive early and continuous screening, with states ranging from 64.9% - 89.1%, as measured in the 2009/10 NS-CSHCN. In Maryland, 81.2% of CYSHCN meet this outcome. Maryland ranks 16th in the nation. Assessment of the variation between states and within demographic or other subgroups of CYSHCN is critical to developing appropriate interventions and policy responses.

For CYSHCN to meet Outcome 4, they must have had preventive medical and dental care in the prior 12 months (visits where screening may have occurred). It is based on the following two questions:

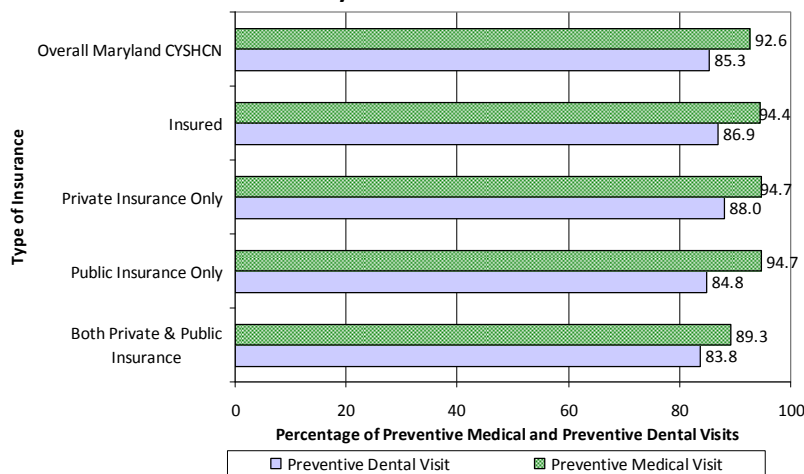
1. [During the past 12 months/ Since [his/her] birth], how many times did [child] receive a well-child check-up, that is general check-up, when [he/she] was not sick or injured?
2. [During the past 12 months / Since [his/her] birth], how many times did [child] see a dentist for preventive dental care, such as check-ups and dental cleanings?

**Figure 1: Prevalence of Outcome #4
by Age and Consistency of Insurance in Maryland for 2009-10**



- Maryland CSHCN ages 0 -5 years of age (60.8%) are less likely to meet Outcome #4, which is due to the low rates of preventive dental visits among CSHCN among that age group.
- Maryland CYSHCN who experience one or more periods without insurance during the past year (60.2%) are least likely to receive one preventive medical visit and one preventive dental visit in the past 12 months.

Figure 2: Breakdown of Outcome #4: Preventive Medical and Preventive Dental Visits in Past 12 months by Insurance Type in Maryland for 2009-10



- The prevalence of the preventive dental visit component of Outcome #4 is lower among the overall Maryland CYSHCN population
- The prevalence of the preventive dental visit component of Outcome #4 is lower among the populations who are insured, those who have public insurance only, private insurance only and those who have both public and private insurance

improve health outcomes
early identification
avoid missed opportunities
timely treatment
identify stressors
minimize negative impact
support
early determinants of lifelong health
maximize assets
minimize negative impact
decrease risk
OUTCOME 4: EARLY AND CONTINUOUS SCREENING
proper care
address concerns
protect future

Using timing as an advantage

Special health care needs arise during different stages of development, from infancy through adolescence. Early and continuous screening allows emerging needs to be identified as early as possible, which is critical to addressing them appropriately and minimizing long term consequences. These ongoing assessments ensure that children receive proper care and support for their existing needs and help prevent secondary conditions. Ongoing assessments also allow each family's strengths to be identified and best utilized. However, many children do not receive this necessary screening. Less than half of CYSHCN living below the federal poverty level meet Outcome 4 and CYSHCN with public insurance are much less likely to than those with private insurance.

Taking it a Step Further:

The following are questions relating to Outcome #4 that cannot be answered by this national survey data but are important to consider when evaluating how early and continuous screening can best work to improve the health and well-being of CYSHCN:

1. Was the child screened for factors related to physical, mental/emotional, and environmental health?
2. Are families included in the screening process and are their concerns addressed during preventive visits?
3. When needs are identified, are proper steps taken for diagnosis, treatment and follow-up?

58.0 Hispanic CYSHCN	78.6 CYSHCN with mother only (no father present)	60.8 CYSHCN 0 – 5 years of age	81.2 All Maryland CYSHCN	86.9 CYSHCN with a Medical Home
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* Child and Adolescent Health Measurement Initiative (CAHMI). 2009-2010 National Survey of Children with Special Health Care Needs Indicator Data Set. Data Resource Center for Child and Adolescent Health. www.childhealthdata.org