



Doernbecher  
Children's Hospital

School of Medicine  
Division of General Pediatrics

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Dr. Hargunani and Mr. Schroeder:

I am writing to voice my strong support for the continued maintenance and provision of the child health complexity data by the Oregon Health Authority. This would include annual updates to health complexity aggregate reports provided at the state level, at the Coordinated Care Organization level, and at the county level, and supplemented by child-level files sent annually to CCOs for their attributed population from birth to 21 years of age.

Since 2018, Oregon has led the nation in the development and dissemination of system-level data to understand and quantify the degree to which Oregon's publicly-insured children experience both medical and social complexity, a concept called health complexity. This novel and transformative work is now slated to end due to lack of funding for a proposed Child Health Team within OHA. Yet, health disparities for children have been illuminated and exacerbated by the pandemic and the call for health equity, that goes beyond just health care coverage and policies around service coverage, has never been more urgent.

In direct alignment with OHA's health equity goals, the health complexity data identifies children who have experienced medical and/or social challenges that lead to disadvantage, such as disability, poverty, language barrier, parental incarceration, parental death, foster care, or child abuse. Recognizing that children with health complexity have often been disproportionately impacted by the intersections of race & ethnicity, language, disability status, gender, gender identity, sexual orientation and social class, this data allows for a prime opportunity to start action for populations with current and historical injustices for whom other data is not available. Without the right interventions, my data tells us that the number of social complexity factors will increase across the lifespan, and that racial, class and other intersectional disparities within will persist. Without supports, the disadvantages for many of these children and families will continue to grow and significantly impact their health and future. As Director of the Oregon Center for Children and Youth with Special Health Needs (OPCCYSHN), which is our state's Title V Public Health agency for that population, I see the this issue as especially urgent and important.

The publicly available data and CCO-level child-level data has galvanized efforts across the state focused on children at risk for poor health outcomes, child welfare involvement, and/or low success in school. Efforts have also included children with special health care needs and have spotlighted specific roles that health care needs to play in supporting the most vulnerable children and their families.

These efforts include leveraging data for our work in OCCYSHN work, as well as inclusion of the data in the System-Level Social-Emotional Health Incentive Metric for Coordinated Care Organizations, and several improvement projects grounded in the data:

- Health Share of Oregon - the largest CCO which serves the most publicly insured children in the state and the largest share of Medicaid/CHIP insured





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children of color is implementing multiple efforts using the data

- Care Oregon has developed a new equity dashboard that includes these data
- Douglas County – the county with the highest rate of children who experience social complexity in the state – targeted behavioral health improvements for socially complex children are being implemented
- A public/private partnership in Marion County used the data to inform housing supports for families and co-location of behavioral health services.

If these data are no longer available, these efforts and future efforts focused on social impacts on health will not have the data needed to stimulate action. Communities that have engaged cross-sector partners and listened to families of children with health complexity will not be able to fulfill their commitment to the child-level efforts that they have invested in to improve health outcomes for these children.

The data allow for quantifiable metrics to assess whether programs and policies intended to prioritize children with experiences that impact and predict future health actually meet the needs of these children. This is crucial as failure to address these inequities experienced in childhood have multi-generational effects. Being able to track, assess and prioritize efforts for the most vulnerable children is critical as OHA plans to meaningfully implement efforts focused on the 1115 Waiver, health care coverage for young children and young adults with special health care needs, ESPDT implementation, Title V priorities, and addressing behavioral health work force priorities.

I urge you to maintain development and dissemination of the child health complexity data. This is an issue of equity and justice for children and communities.

Sincerely,

A handwritten signature in black ink, appearing to be "Benjamin Hoffman".

Benjamin Hoffman MD CPST-I FAAP