ADDRESSING Child Health Complexity

In Douglas County

In the late fall of 2019, the Oregon Pediatric Improvement Partnership (OPIP), in partnership with The Ford Family Foundation, convened key stakeholders in Douglas County to develop a call to action for creating solutions for children with medical and social needs. That meeting was the beginning of a year-long process, guided by a steering committee of local leaders, that set the foundation for cross-sector collaboration focused on the social and medical needs of children birth to age 21.

The community wide effort established the foundation for transformative partnerships connected to a common goal: support local communities to engage partners, galvanize action, and support improvement efforts focused on children with medical and social needs.

This work builds on previous OPIP efforts to engage health systems and communities in Oregon using data to inform population-based improvement efforts for children with complex health needs.

Why focus on child health complexity?

- Lifelong health and well-being start in early childhood.
- Child health and development are particularly impacted by the social determinants of health and equity.
- Thoughtful and innovative approaches are needed to address children's health complexity and health disparities.
- Provides a targeted approach to addressing Oregon's priorities focused on families.

Medical Complexity

Includes utilization of services, diagnoses, and number of body systems impacted.

Health Complexity

Combining the medical and social complexity factors create a health complexity score.

Social Complexity

Includes individual, family, or community characteristics that impact health outcomes.

In Douglas County

31.2% of publicly insured children 0-21 present with chronic health conditions and **medical complexity**.

28.1% of publicly insured children 0-21 are **health complex**, experiencing both medical and social complexity.

Just under half (**45.9%**) of publicly insured children 0-21 experience high levels of **social complexity** (3 or more indicators). For young children ages 0-5, **34.2%** already have high social complexity.

"Children with complex needs are full of potential and can lead a full life, and our systems can help them do that. Diagnosis does not define the individual."
-Jill Fummerton, FEATT Family network

Reviewing the data and seeking solutions included nearly 70 people from health, education, and community organizations — and parents — that resulted in a call to action with seven themes:

- **Increase Community-level Awareness** About the Health Complexity Data & Leverage Data to Identify Needs.
- **Community Mapping of Available Resources and Services**, Assessment of Capacity and Identifying Priority Gaps.
- **Address Barriers to Access** of Existing Services.
- **Train Providers** to Better Care for Health Complex Children and Their Families.
- **Address Capacity** of and Child and Family Centered Pathways to Behavioral Health.
- **Address Preventive Health & Social Service Needs** of Socially Complex Children.
- **Improve Housing** for Health Complex Children.

Addressing health complexity in Douglas County will require sustained community efforts that are synergistic with local projects. Over the next two years, OPIP will use a population-based improvement approach and collaborate with local partners to move the work forward in two priority areas that encompass many of the themes above:

1. Address capacity of, and child and family centered pathways to, behavioral health: assess resources and build capacity, elevate family voice, examine barriers to services, engage providers, and strengthen referrals and care coordination.
2. Collaborate with Umpqua Health Alliance (UHA) to increase awareness and use of the health complexity data to identify gaps in care and inform improvement efforts.

This work will focus on the areas deemed highest priority by local partners. The steering committee intends to further galvanize action across all seven themes by identifying opportunities in their own work and collaborating with initiatives such as Network of Care, Community Health Improvement Plan, and Umpqua Health Alliance's CCO 2.0 efforts.

Steering Committee Members

Alison Hinson, Douglas Education Service District
Amanda Rigsby, Umpqua Health Alliance
Brian Mahoney, Public Health Network
Jessica Hunter, Dept. of Human Services Child Welfare
Jill Fummerton, FEATT Family Network
Gillian Wesenberg, South Central Early Learning Hub
Kat Cooper, Umpqua Health Alliance
Lee Ann Grogan, Health Care Coalition of Southern Oregon
Lisa Platt, Mercy Foundation
Rob McAdam, Umpqua Health Alliance
Robin Hill Dunbar, The Ford Family Foundation
Ruth Galster, Network of Care
Sondra Williams, Early Intervention/Early Childhood Special Education
Tracy Livingston, Dept. of Human Services Child Welfare

This project is dedicated to Cory Lyn Ortega for her role on the steering committee and her professional dedication to support children with medical and social needs and their families.