SB 5525 Supporting the Needs of Children with Health Complexity

Committee Co-Chairs Senator Campos and Representative Valderrama, and Members of the Joint Committee on Ways and Means, Subcommittee on Human Services

I am a professor of pediatrics and director of the Division of General Pediatrics at OHSU Doernbecher Children's Hospital. I am a board member of the Oregon Pediatric Society, the Oregon state chapter of the American Academy of Pediatrics. I am also the District VIII Vice Chair for the national American Academy of Pediatrics. This role allows me to assist 12 state chapters of the AAP west of Colorado (except California), the Uniformed Services West Chapter, and 2 Canadian Provence chapters.

I will keep my written testimony rather short and not repeat what Dr. Ben Hoffman or the state AAP Chapter, the Oregon Pediatric Society testimony makes clear. Instead I will highlight that Oregon's ability to bring together social determinant of health (SDOH) and medical complexity data (Pediatric Medical Complexity PMCA) creating the pediatric Health Complexity Data shared in aggregate to work on population health efforts has come up at several meetings of the board of directors of the AAP. Oregon truly is the envy of the nation in our ability to look at compiled health complexity data via marriage of social determinant of health and the medical complexity of children enrolled on OHP.

This effort has allowed rich conversations at the state, CCO and clinic level of consideration of differential approaches to care of children with different needs based on social determinants and levels of medical complexity. This effort must be continued and in fact should lead to further thoughts of differential programs and funding for those with high health complexity and/or due to added SDOH complexity. As a practicing pediatrician my concern for children who fail to make an appoint can be quite different based on their SDOH, medical complexity and/or when combined health complexity. If the child has no SDOH, no medical complexity, one can likely generally rely upon the family to reschedule follow up. If on the other hand, high SDOH and or High medical complexity, care management is likely needed. Different forms of care management and make up of a practice may be needed in an FQHC with very high SDOH compared to a tertiary children's hospital with standard SDOH but very high medical complexity. A private practice with small amounts of either may not require as intense services. Eventually this data could allow planning and thought toward a better way to consider both services and payment of services. Essentially while not fully realized this could provide important information for OHP/OHA and risk stratification when more fully mature,

Currently as the division head of the clinic with the highest medical complexity of children in the state of Oregon, the thought of loosing this data would be horrible. While we generally do not use the data at the individual level, in aggregate it should determine what types of services and what additional levels or reimbursement may be needed in each primary care medical home practice in Oregon that serves children. We are a long way from that endeavor but elimination of the data would be the wrong direction to pursue.

Children are no longer the base of a population pyramid, but have become the bottom of a population square. With falls in infant/child mortality and with the increased ability of life

saving care and technology, plus the aging of the Baby Boomers –children are now only about 20% of overall US population, and 10-15 cents of the health care dollar. Despite that we know that they are 100% of our future and have the highest ROI. Currently in the US, about 50% of children are from racial, ethnic and language minorities; 50% are on OHP at some point and finally overall <50% get their recommended care.

Children by definition are vulnerable (in natural disasters, in poverty and frankly in health care and system decisions.) Parents know that children are not cheap to raise, and health care costs for kids are lower than other total costs of child rearing; however, if things go awry— we know from the Adverse Childhood Events studies that all outcomes (including health, financial) are worse when they become adults. Suffering can begin at birth and may last a lifetime. Investment in skill building has a huge ROI and like compounding interest, they expand over time.

This is not the time to reverse course and reduce investment in a core system that helps us understand the needs of children in Oregon. Please continue support for this data stream that is the envy of every state in the nation.

Respectfully

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