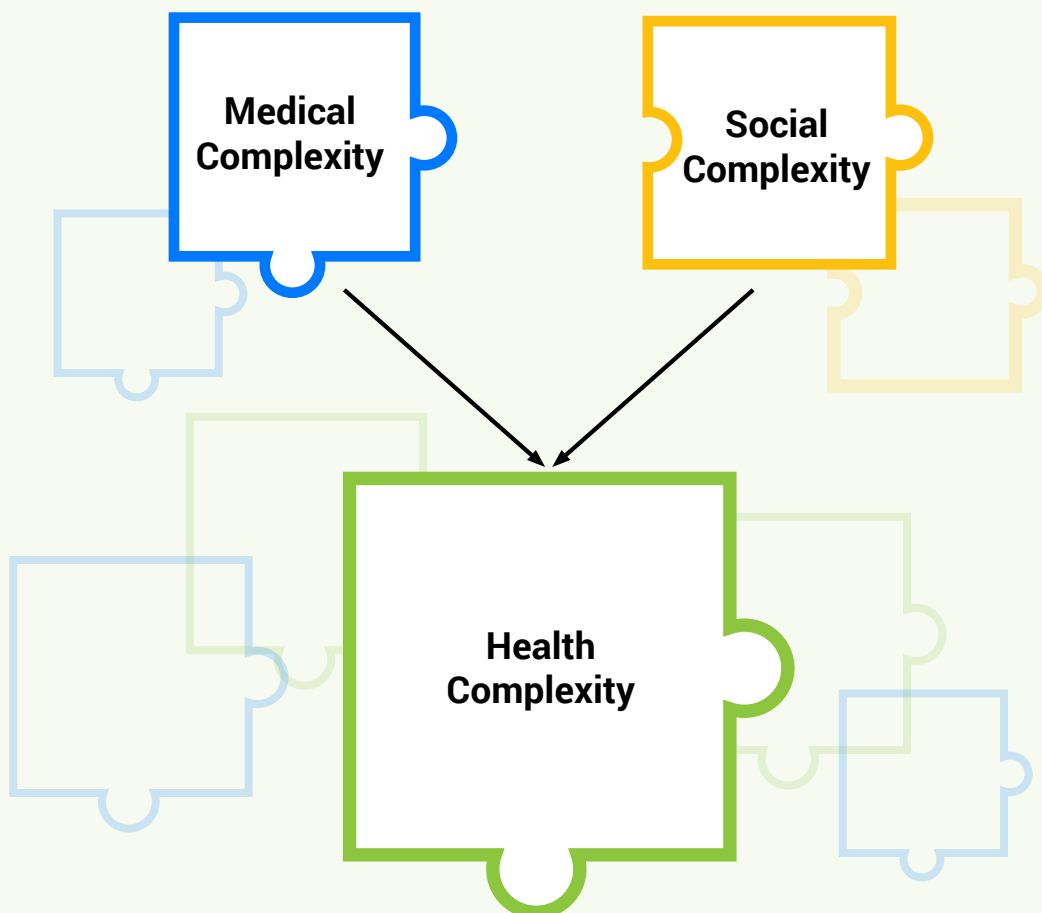OPIP
Oregon Pediatric
Improvement Partnership

Health Systems Strategies to Ensure a Focus on Children with Health Complexity

Oregon Pediatric Improvement Partnership (OPIP)

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About the Oregon Pediatric Improvement Partnership

The Oregon Pediatric Improvement Partnership (OPIP) is a statewide organization focused on improving the health of children and youth in Oregon. OPIP received a grant from the Lucile Packard Foundation for Children's Health titled "Guiding and Informing Policy, System and Practice-Level Efforts Focused on Children with Health Complexity: Supporting and Learning from Efforts in Oregon." This grant funded OPIP to provide technical assistance to the Oregon Health Authority (OHA) to maintain and continue the dissemination of the Child Health Complexity data, to support OHA's use of the health complexity data, and to guide the use of health complexity data by health systems in Oregon. Secondly, the grant supported OPIP to provide technical assistance to six health systems nationwide on the learnings from Oregon's efforts and how components of Oregon's approach could be applied within their own settings.

About Health Complexity

Health complexity is a concept that takes into account both a child's medical and social complexity, described in Maximizing System-Level Data to Address Health and Social Complexity in Children.

Medical + Social Complexity = Health Complexity
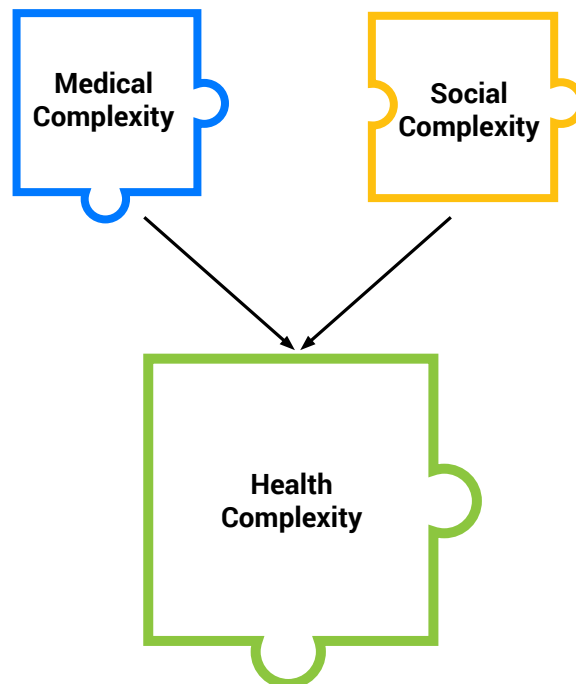
Children with Health Complexity:
An Essential Component of Health Equity

There is an urgent need for health systems to pursue efforts that eliminate health inequities. Childhood experiences impact and predict future health, and inequities experienced in childhood have multi-generational effects. Therefore, if the goal is achieving health equity, there must be an intentional and explicit focus on children, their needs, and their development. Furthermore, when health systems, policies, and payments are designed to meet the needs of the individual but not the family unit, there are missed opportunities to use a dyadic or family approach to care, which evidence shows is the best way to support intergenerational healing. **For health systems, identifying and supporting children with health complexity directly aligns with efforts to eliminate health disparities by putting the most vulnerable in the center of system redesign.** When systems are designed to meet the needs of the most vulnerable, individuals can achieve full health potential and lifelong well-being. By identifying children whose families are likely to face significant barriers, the health complexity data can help fast-track families into programs and services to address their needs before they lead to increased health complexity. Without the right interventions, data indicates that the number of social complexity factors will increase for an individual across the lifespan, and racial, class and other intersectional disparities will persist into adulthood, leading to poor health outcomes and increased healthcare and social service needs. Through OPIP's consultation and improvement work, priority strategies that health systems can use to ensure a focus on children with health complexity have been identified.

Identifying Children with Health Complexity

In order to focus on children with health complexity, health systems must be able to identify individual children in a way that captures information about the child's medical complexity and social complexity. This child-level data allows for the detail, context, and nuance necessary to begin understanding the strengths and needs of individual children with varying degrees of health complexity. The individual child-level data can also be combined to look at specific populations of children with similar levels of health complexity and allow for tailored strategies for each distinct group. Without individual child-level information, health systems cannot identify sub-populations of children that could benefit from different types of interventions or approaches for care. Furthermore, having the child-level data allows for individualized approaches to using the data that are not possible using population-level estimates only. Through OPIP's consultation and improvement work, the priority strategy of identifying children with health complexity has been operationalized and will be described in this brief.

Using the Child-Level Indicators to Improve Health Systems for Children with Health Complexity

Once child-level health complexity indicators have been created and data is available for a group of children, health systems can then use the data to guide improvements and investments that build health and resilience in children, perform assessments of network adequacy, conduct population health management, design care coordination programs, and inform payment models that support primary care providers and community-based providers who serve children with health complexity.

The recommendations and examples provided in this brief are based on technical assistance (TA) OPIP has provided to State Medicaid/CHIP agencies and health systems over the last five years. Different health systems may be able to use their health complexity data to achieve one or more of these options. It is for this reason that four different options are presented, recognizing that some systems may be able to do all four options, while others may be able to only explore one of the options listed below. The examples in the **green boxes** (to represent the combination of both **medical complexity** and **social complexity**) are shared from learnings OPIP has gathered within Oregon and from other states across the country.

Option 1: Enhance Awareness, Analysis, Refinements and Use of Data to Galvanize, Guide and Inform Improvements in Care

Option 2: Ensure the Needs of Children with Health Complexity Are Met

Option 3: Assess for Healthcare Quality for Children with Health Complexity

Option 4: Prioritize Investment that Build Health and Resilience, and Family-Based Approaches to Care

Identifying Children with Health Complexity

A primary and integral way for health systems to ensure and prioritize a focus on children with health complexity is to understand the degree of both medical complexity and social complexity for each individual child and identify this at a child-level. As the adage says, "what is measured is what is focused on." Only when health systems have a way to identify a population with similar levels of health complexity can they ensure quality of care for that population.

Health systems should support data strategies that operationalize data indicators which can help to quantify the degree to which children have health complexity, incorporating feasible indicators related to both medical AND social complexity.

- **Medical complexity** indicators need to be operationalized using models that address the unique needs and characteristics of children, as adult models that capture chronic disease conditions (such as CDPS, the Chronic Disability and Payment System) do not apply to children and significantly underestimate medical complexity in children. Many state Medicaid Agencies and health systems have been able to operationalize the Pediatric Medical Complexity Algorithm using administrative claims data to achieve this goal. In Oregon, the All Payor All Claims database was utilized.

- **Social complexity** factors aligned with the Center of Excellence on Quality of Care Measures for Children with Complex Needs' (COE4CCN) definition of social complexity and related to 18 factors associated with higher health care costs and poor health outcomes is a great place to start when measuring social complexity. Health systems should explore what data elements can be obtained within their databases for their full population of patients (population-level indicators) aligned with the following 18 social complexity factors:

1. Parent domestic violence	10. Parental substance use disorder
2. Parent mental illness	11. Discontinuous insurance coverage
3. Parent physical disability	12. Foster care
4. Child abuse/neglect	13. Parent death
5. Poverty	14. Parent criminal justice involvement
6. Low English proficiency	15. Homelessness
7. Foreign born parent	16. Child mental illness
8. Low parent education attainment	17. Child substance use disorder treatment need
9. Adolescent exposure to intimate partner violence	18. Child criminal justice involvement

Health systems can leverage integrated data systems that combine data from different programs or work with specific agencies to develop data use sharing agreements. **Using these steps, a composite variable that combines and summarizes a child's medical and social complexity can be created to describe the child's health complexity.**

The following is an example of the nine-part health complexity composite categories Oregon used:

Oregon State-Level Health Complexity Categories

Source Variables Related to **Medical** and **Social** Complexity

Legend: **Health Complexity** (green) · **Medical Complexity** (blue) · **Social Complexity** (yellow)

Medical Complexity (3 Categories)	Social Complexity (Total Factors Possible in Preliminary Data Shown Here N=12)		
	3 or More Indicators	**1-2 Indicators**	**None in System-Level Data**
HIGH Medical Complexity (Chronic, Complex PMCA=1)	5.1% (26,650)	3.7% (18,993)	0.9% (4,868)
MODERATE Medical Complexity (Non-Complex, Chronic PMCA=2)	9.2% (47,446)	7.0% (36,454)	2.1% (10,851)
NO MEDICAL COMPLEXITY (PMCA=3)	23.9% (123,764)	27.6% (142,851)	20.5% (106,199) Neither Medically nor Socially Complex

Data Source: ICS Data Warehouse & Medicaid data sourced from Medicaid Management Information System (MMIS).Children publicly insured (Medicaid/CHIP)in Oregon October 2021.

OPIP · Oregon Health Authority · DHS Oregon Department of Human Services

Examples of Innovative Strategies to Identify Population:

- Examples of Oregon's model are described in this brief and provided here. In Oregon, the **Integrated Client Data Warehouse (ICS)** was leveraged to collect data from various state funded programs that contain relevant data. A number of states have similar centralized databases that inform resource allocation and budget forecasting and can be leveraged.

- Colorado Medicaid is utilizing an approach that incorporates the PMCA and social complexity indicators related to ethnicity/race, citizenship and limited English proficiency.

- Kaiser Permanente Northwest utilized information available for their members from clinical encounters, electronic health record and screening data collected at the point of care to operationalize twelve social complexity indicators

Using the Child-Level Indicators to Improve Health Systems for Children with Health Complexity

The power of having data indicators that allow health systems to identify children with health complexity is that they can then use the indicators to prioritize these children in other roles the health systems play, as well as other initiatives and programs they lead. This can include:

• raising awareness about the needs of the children,

• assessing whether health care needs are being met,

• assessing for the quality of care provided to these children, and

• using the data and information about identified gaps in services, access, and quality to prioritize investment and supports that are a best match, build health and resilience, and employ a family-based approach.

The following pages spotlight four specific strategy options that can be used to leverage data that is available for a population of children to create individual child-level data indicators and can ensure a health system focus on children with health complexity.

Learn More

Option 1: Enhance Awareness, Analysis, Refinements and Use of Data to Galvanize, Guide and Inform Improvements in Care

Option 2: Ensure the Needs of Children with Health Complexity Are Met

Option 3: Assess for Healthcare Quality for Children with Health Complexity

Option 4: Prioritize Investment that Build Health and Resilience, and Family-Based Approaches to Care

Option 1. Enhance Awareness, Analysis, Refinements and Use of Data to Galvanize, Guide and Inform Improvements in Care

A powerful way to leverage health complexity data indicators is to ensure that the data is shared in a way that can galvanize, guide and inform improvements in care. Health systems can consider the entities that share a collective responsibility for supporting children with health complexity and think about ways the data can be shared with them to guide and inform their efforts. This can include physical health, behavioral health, public health, and community partners.

It is useful to consider how to stratify the health complexity data into important sub-populations to inform specific efforts for that population. For example, consider showing the data by different age groups (e.g. birth to five, grade-school age, adolescent, young adult), by race and ethnicity, or by primary spoken language to allow for a focus on these subgroups.

Health systems can also analyze the data by primary care practice sites that they may attribute children to within risk-sharing models. If the health systems provide care in multiple regions, they can consider analyzing and showing the data by regions served. In OPIP's efforts, this has often involved examining the data by county, geographic location (e.g. rural, suburban, urban), school district, and zip code.

It is important and powerful to consider how to add the perspective and experience of parents of children with health complexity and young adults with health complexity who are represented in the data. They can provide wisdom about their personal experiences with the health system, and strengths and barriers not captured in the data. Their insight can illuminate the real-world stories of the human beings represented in the data and the improvement opportunities they need to thrive and that this data can inform.

Examples of Innovative Strategies to Enhance Awareness about the Data

- The Oregon Health Authority shares aggregate health complexity data reports annually that display data at the state-level, for each of the 36 counties in Oregon, and by the 16 Coordinated Care Organizations (CCOs) who accept risk to serve children enrolled in Medicaid/CHIP through a global budget. This data is shown overall and by age group. Examples of the data reports can be found here. One area the health complexity reports have created a lot of momentum towards is a specific focus on children birth to five, and how to address health complexity in the first five years of life when health and the foundations of health are being established.

- CCOs in Oregon also receive child-level data related to the medical complexity, social complexity, and health complexity of each of their members birth through 20, blinded to specific social complexity factors. OPIP has worked with CCOs to then analyze and publicly share this data. CCOs have analyzed the data by county they serve, school districts, and provided aggregate data to the primary care medical homes that they contract with and provide value-based payments to.

- In Douglas County, Oregon, with support from the Ford Family Foundation, a cross-sector group of community members used the data to develop a Call to Action for Children with Health Complexity.

- In Marion County, Oregon, the data was used by the collective impact entity Community, Business and Education Leaders (CBEL), which includes health systems, to identify where to prioritize investments for housing that would then also provide dyadic behavioral health supports to children with health complexity and their families. The data provided by OHA and the regional health system was analyzed by zip code to identify where to place the housing.

Option 2. Ensure the Needs of Children with Health Complexity Are Met

States and health systems can use the health complexity indicators to assess whether relevant and meaningful **policy and contractual requirements are equitably fulfilled** for children with health complexity. Gaps in receipt of services for this population can guide and inform improvement efforts that address root cause barriers for these gaps and take into context the roles of medical and/or social complexity.

A basic assessment that health systems can do is to examine whether children with health complexity have received fundamental **recommended physical, behavioral, and oral health care**. This work can align with health systems' assessments of whether services required within the **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** benefit are provided for the targeted population of children with health complexity and prioritize them for provision of care.

Additionally, states and health systems that utilize **managed care are required to ensure that care coordination supports are in place**. Often it is difficult for health systems to know which children should be prioritized for these care coordination supports and to understand how to outreach to these children and families, determine potential needs, and provide best-match care coordination. The health complexity indicators which spotlight children who have both medical and social complexity are invaluable in identifying populations for which family-centered outreach, as well as individualized assessments of their strengths and care coordination needs, are critical. Health systems can examine the degree to which children with health complexity have received any care coordination supports and target this population for improvement efforts. Then, as health systems design best-match care coordination, they can examine the magnitude of children with both medical and social complexity factors to refine and build high quality outreach strategies, supports and connections. **Given that children with health complexity have needs across sectors, a focus on integration of services is particularly important**.

Based on OPIP's experience, it is likely that wide gaps will be identified between what is recommended and what families of children with health complexity are receiving or accessing. OPIP has found that the **improvement solutions needed to address these gaps should be tailored to the health complexity indicators present but must also be informed by direct assessments of the family's strengths and needs**. Important factors to consider in doing these family-centered assessments are described in this complex care brief. Given the limitations of available data sources, which can only provide information from systems and services a child has engaged with, it is crucial that family or young adult assessments inquire directly about their strengths, their priorities, and their needs. The health complexity data helps to illuminate the population and prioritize outreach, but final determinations of specific care plans and strategies must be informed and led by the family, child, and young adult voice and their personal experiences and needs.

OPIP's quality improvement experience has found that best-match supports will vary by the level of health complexity present. For example, the approach and needs of families of children with a complex chronic condition and very high social complexity will be very different than the supports and barriers to receipt of required care for children who have non-complex chronic conditions and one or two social complexity factors. A targeted approach based on individual health complexity indicators would likely be a significant improvement to the families' care experience and help to allocate resources better.

Technical assistance and learning supports will need to be provided to address gaps identified and create safe learning spaces to address root cause barriers. **The aim of the data is to motivate, galvanize and focus improvement efforts on best match solutions** within the context and framework of health complexity, that ensure that both the medical and social complexity factors are taken into consideration together.

Examples of Innovative Strategies to Ensure Needs of Children with Health Complexity Are Met

- All children with health complexity should be receiving routine preventive physical care. Health complexity data indicators can be used to assess whether this population of children with both medical and social complexity are receiving recommended well-child visits.

  - Health systems have used the health complexity indicators to assess specifically whether health complex children are receiving recommended well-child care. Examination of the differences in well-child visit rates for children with varying levels of medical and social complexity has informed better targeted outreach and assessment strategies to support access to preventive care.

  - For example, the data often shows that children with complex medical conditions are accessing specialty care but not preventive care. Furthermore, families of children who are trying to maintain supports for complex conditions and who also have high social complexity often experience a number of other barriers in the health system (examples: stigma, lack of understanding from providers about the impact of poverty on ability to obtain transportation, take time off work, or secure childcare for siblings) or have other issues that parents are managing (example: parental mental health) that can make prioritizing and accessing preventive care for their child difficult. Understanding these factors can help inform a family-centered, strength-based approach to supporting these families.

- Examination of the health complexity data compared to the provision and receipt of Intensive Care Coordination (ICC)/Wraparound services, while looking at additional factors that may impact inequitable access, has been conducted and has illuminated more precise improvement opportunities.

  - For example, examination of the level of receipt of these services by children within specific regions or zip codes compared to the magnitude of children with health complexity seen in population estimates has often illuminated inequities in access by geographic location for health complex children, which may lead to systemic and persistent inequities in health. Furthermore, if descriptive factors related to the population's racial and ethnic backgrounds are overlaid by these gaps, additional inequity is often identified that can inform more precise improvement strategies to address the impact of geographic location and race/ethnicity on ability to access care, and specifically care that is the best match and person-centered.

Option 3. Assess for Healthcare Quality for Children with Health Complexity

Health complexity indicators can be used as a stratification method to assess for healthcare quality for this target population, to prioritize this population in quality assessment and improvement, and to establish benchmarks and incentives specific to this population. Using the health complexity data to stratify when assessing for healthcare quality FOR this population will put the most vulnerable in the center by using data that spotlights and illuminates need for improved healthcare quality.

This is particularly important given the magnitude of missing data related to race/ethnicity currently in most health system data sets. Many health systems are missing race and ethnicity data for more than half of their population of patients. Without this data, health equity efforts cannot be targeted to patients from those specific subgroups. The construct of health complexity is based on data that is available for a majority of children in health system records. 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, the health complexity data allows for a prime opportunity to start action for populations with current and historical injustices for whom other data may not be available.

Examples of Innovative Strategies to Assess for Healthcare Quality for Children with Health Complexity

- As states and health systems move to reporting on the Child Core Set, applicable metrics from the set can be stratified by children with health complexity in order to inform gap analysis and targeted improvement efforts that take into account the context of the child's medical and social complexity.

- Health systems can set improvement benchmarks for metrics specifically FOR children with health complexity. This is an actionable way that health systems can put the most vulnerable children first and align with broader efforts focused on health equity.

- Examine metrics focused on high-cost events specifically for children with health complexity.

  - For example, in Oregon, rates of avoidable emergency department use were examined by the health complexity factors. Children with both medical and social complexity were the most likely to have an avoidable emergency room visit. Children with only social complexity were just as likely, and in some regions more likely, to have an avoidable emergency room visit as children with medical complexity, and much more likely than children with neither social nor medical complexity.

    Examination of the data by contextual factors and potential root drivers of medical and/or social complexity can help to ensure a more informed and tailored approach to reducing avoidable emergency room use.

  - Rates of prolonged hospitalizations (more than 30 days) or repeated hospitalizations (more than one hospitalization in the last year) were examined by the health complexity factors.

    Refinement and examination of hospitalization data by medical complexity and social complexity and other factors that impact discharge planning and successful transitions home (e.g. geographic location from the tertiary center) provided context about the potential factors driving these high-cost events. Eventually, these contextual factors can be used to inform better and more tailored supports and coordination within the hospital and in discharge transitions to home, proactively addressing needs specific to the medical and social complexity factors present and identified through strength-based engagement and assessment of the parent and youth directly.

Option 4. Prioritize Investments that Build Health & Resilience and Support Family-Based Approaches to Care

Empowered with information about the actual needs of children with health complexity, and how their level of medical complexity and specific social complexity factors impact their health and health care use, health systems can then consider investments that focus on building health and resilience for this population.

As health systems explore the important role of **payment models** in incentivizing and compensating for high-quality care, developing **risk adjustment models or payment methodologies that provide financial incentives** to cover the supports that children with health complexity need will be integral. Availability of the data at a population-level can **inform how payment rates** are set and provide an opportunity to include medical and social complexity factors in the rate-setting process. For example, practice sites that have a significantly larger population of patients with high health complexity could get higher rates due to the increased care coordination and other supports these patients and their families will likely need.

Health systems should prioritize **behavioral health resources and investments** for children AND their families given the multi-generational impact lack of services have on the family and communities in which they reside. Investment in **traditional health workers and community health workers**, given the role they play in addressing and supporting the social complexity factors present for some, may be an innovative way to provide best-match supports for children with health complexity.

Health systems should ensure that **appropriate investments are made to provide intensive care coordination and Wraparound services** commensurate with the magnitude of need as indicated by the health complexity data, with a focus on models of care that are best matched to the specific needs and experiences of children and families with varying levels of health complexity. This is particularly important to consider when looking at the kinds of supports and transition-to-home services needed by children with complex medical conditions who receive care in tertiary centers (often located in metropolitan regions), but then need to be transferred and supported in their local communities. Investments are needed to incentivize coordination from these tertiary centers to the community-based providers who play an integral role in addressing ongoing medical and social needs.

Once states and health systems explore how health complexity data indicators can be created for each child they serve, they should also investigate whether a family may have more than one child with health complexity and consider how that will impact the overall services a family may need. I**nvestments in care coordination and supports should factor in the full array of services, needs and barriers for families with multiple children with health complexity.**

States and health systems should explore how they can **link children within the health complexity data to one or both parents** who may also be enrolled in Medicaid/CHIP, or in the same health system, and consider a dyadic approach to addressing care needs of both the child AND the parent. In Oregon, health systems found that a majority of Medicaid/CHIP-enrolled children whose social complexity indicators included parental incarceration, parental substance use disorder services, and/or parental mental health service use (all factors aligned with adverse childhood experiences) had a parent who was ALSO enrolled in Medicaid/CHIP and covered on the same plan. This correlation provides opportunity to explore what physical, behavioral, oral or social supports given to the parent could also positively impact the child's health and functioning and vice versa. Furthermore, particularly for young children, behavioral health interventions or social supports offered together for parent and child, as well as outreach and engagement around the potential need for dyadic behavioral health services focused on parent-child attachment and social-emotional development, may be particularly beneficial for building health and resilience.

Collective Impact Models of Improvement

A powerful yet challenging component of developing health complexity indicators is that it requires cross-sector collaboration with other state agencies that can provide social complexity data and play a role in supporting families of children. The dialogue surrounding sharing of data can be a starting point for conversations around collective impact and population-based improvement efforts that are needed to transform health systems. This transformation will require interacting, integrating, and coordinating with the wide variety of services and agencies that support children and families.

Examples of community partners that have been engaged by Oregon and health systems to develop health complexity indicators, use the data to support population-level advances in care, and work on collective impact models of improvement include: Parent and youth advocacy organizations; Physical care providers (Primary care, Independent practice associations that work with multiple practices, Specialty Providers); Child mental health service providers; Adult mental health service providers; Child substance use disorder (SUD) service providers; Adult SUD service providers; Childcare & Parent Supports; Relief Nurseries; Respite Care; Public Health; Title V; Home Visiting Programs; Department of Human Services, including programs related to Self Sufficiency and Child Welfare; Grief counseling and bereavement programs; Support organizations to people who have recently been incarcerated; Programs and organizations that support non-English speaking clients; Developmental disabilities services; Independent living programs; and Education and Early Intervention/Early Childhood Special Education.

Examples of Innovative Strategies to Prioritize Investments that Build Health and Resilience and Family-Based Approaches to Care

- As part of New Jersey's Integrated Care for Kids (InCK) program, they are implementing the medical complexity component of the health complexity model. Every enrolled Family in the InCK model is being asked to complete a comprehensive needs assessment (called the Health Story). The data from the needs assessment coupled with the medical complexity claims data is used to stratify children and identify priority populations eligible for community-based care management support. A key component of this work is engagement and coordination with community partners in Monmouth and Ocean Counties to identify and support connection to community-based services such as school supports and food pantries.

- Operationalizing an Approach to Addressing Adverse Childhood Experiences Identified in Health Complexity Data. Within Oregon, six of the twelve social complexity factors that are included in the data are directly aligned with adverse childhood experiences (e.g. foster care, child abuse and neglect, parental substance use disorder, parental mental health, parental death, parental incarceration)

  - Recommendations call for assessment of behavioral health needs for children who have experienced adverse childhood experiences. Therefore, the health complexity data has been used to compare current levels of available behavioral health services with the magnitude needed to support the population of health complex children identified through the health complexity data, in an effort to assess provider network adequacy and support investments that address gaps.

  - Outreach strategies by health systems, care coordinators, or providers to engage families, understand their strengths and behavioral or social needs, and connect them to supports should be tailored for children with high social complexity, as traditional phone-based outreach methods are often unsuccessful.

Examples of Innovative Strategies to Prioritize Investments that Build Health and Resilience and Family-Based Approaches to Care *(Continued)*

- Addressing the Social-Emotional Health of Young Children to Support Kindergarten Readiness in Oregon. OPIP and the Children's Institute developed the System-Level Social Emotional Health metric that was in the 2022 Incentive Metric set for Coordinated Care Organizations and will also be included in the 2023 metric set. The four-part attestation metric requires CCOs to conduct and attest to a number of activities, in collaboration with required listening to community partners and parents of young children, that aim to guide and inform action plans created to enhance receipt of social-emotional services by young children.

  - One part of the metric is examination of administrative claims data, which captures the social-emotional services that young children in the CCO have received, stratified by specific social complexity factors. This allows CCOs to examine the degree to which children birth to five who have experienced social complexity factors aligned with adverse childhood experiences have received either a social-emotional screen/assessment or social-emotional intervention therapy aligned with recommendations for building health and resilience.

- Examination of Health Complexity Data by Primary Care Home to Which the Child is Attributed and By Zip code. In Oregon, there is a strong focus on ensuring that children enrolled in Medicaid/CHIP have access to a highly functional primary care medical home, called a Patient Centered Primary Care Home (PCPCH). CCOs are then required to provide value-based payment methodologies that support the PCPCHs in providing high quality care.

  - CCOs have examined the health complexity data by the PCPCH sites that children are attributed to in order to better understand the populations served by the sites. This data can help CCOs consider crucial improvements to payment methodologies and supports for these sites so that they can adequately address the needs of children with health complexity identified by the data. PCPCH sites have requested this data from the CCOs to help them advocate for enhanced care coordination and integrated behavioral health supports to their internal leaders.

  - CCOs have also examined the data by zip code to see if there are specific regions within the area they serve with higher rates of health complexity, which may warrant investments and supports to be placed where these children are located.

In summary, health systems play a critical role in addressing the needs of children with health complexity. What we can identify is what we focus on; therefore, an important and essential first step is to identify the population of children with health complexity that are served by the health system. Identifying populations using the construct of health complexity ensures that the factors that impact a child's health and well-being, their medical and social complexity, are taken into account. This brief provides an array of complementary, but different, options that health systems can use to implement and operationalize strategies that use health complexity indicators to guide and inform improvements in care. The options presented were intentionally designed to span a range of opportunities that health systems have to affect change, from payment and policies, ensuring provider network adequacy and quality of care, providing best-match care coordination and supports, to engaging with the larger group of community partners that can collaboratively work together to improve outcomes for children with health complexity.