COLORADO
Department of Health Care Policy & Financing

Payment Alternatives for Colorado Kids (PACK)
Design Review Team (DRT)
Meeting Minutes
June 12, 2024
5:00 P.M. to 7:00 P.M.

1. Introductions

Suman Mathur called the meeting to order.

The following DRT participants were in attendance: Alison Keesler, Amber Griffin, Andrea Loasby, David Keller, Ealasha Vaughner, Hoke Stapp, Jane Reed, M. Cecile Fraley, Mark Gritz, Cassie Littler, Mike DiTondo, Robert Haywood, Sarrah Knause, and Laura Luzietti.

Other attendees included Devin Kepler (Department of Health Care Policy and Financing [HCPF]), Katie Price (HCPF), Helen Desta-Fraser (HCPF), Nicole Nyberg (HCPF), Zoe Pincus (HCPF), Breelyn Brigola (Stakeholder Engagement (SE) Team), Emily Leung (SE Team), Suman Mathur (SE Team), Andy Wilson (PACK Support Team), The PACK Support Team (PACK Support Team), and The PACK Support Team (PACK Support Team).

2. Meeting 7 Recap

Emily Leung reviewed DRT participant feedback from the DRT 7 Meeting (5/22) on quality target setting with regards to a reward structure for incentive payments. She shared that DRT participants preferred the proposed tiering methodology over the sliding scale due to its predictability, lower burden, and allowance for performance variability. There were also concerns about multi-site practices, small patient populations, data accuracy, and the impact of externalities on performance metrics, suggesting well child visits be weighted more heavily.

- A DRT participant reiterated the group's preference of the current close-the-gap methodology over the tiering and slide scale methodologies expressed in the last DRT session.

Emily then presented DRT Meeting #7 minutes for approval and reminded DRT participants of the PACK North Star Goal. There were no objections to the meeting minutes.

The PACK Support Team framed today's discussion by stating that discussions related to goals/objectives and quality measurement and quality target setting are complete. The PACK Support Team explained that today's payment focus is independent of the previous discussion on reward structures for quality measures tied to payment. The focus of today's discussion is on an additional type of payment, beyond those previously discussed (primary care services and incentive payments), for non-reimbursed activities that are currently provided but not reimbursed under (Fee-For-Service) FFS. The sub-categories of these activities are:

1. Team-Based Care
2. Member and Family Engagement
3. Access
4. Care Coordination

While HCPF may pay for some of these non-reimbursed FFS activities through Department initiatives, it is not consistently paid out to practices. The PACK Support Team stated that this discussion is trying to understand a pediatric perspective of non-reimbursed activities, which may inform future iterations of PACK or other HCPF initiatives. The request to the Joint Budget Committee (JBC) of the 16% additional monies currently funded under Alternative Payment Model (APM) 2 is for a prospective payment model; there are considerations to repurpose the enhanced funding (16%) to better meet the needs of pediatric practices through the PACK program.

- A DRT participant noted that the level setting slide distinguishing between primary care services (FFS payments), incentive payments, and non-reimbursed activities under FFS is a helpful framework. The asked if incentive payments are supplemental to the current base FFS rate, which was confirmed by the PACK Support Team who reiterated that today's, discussion will focus on repurposing the enhanced funding (16%) beyond the base FFS rate.

The PACK Support Team also shared the objectives of today's DRT meeting:

1. Identify and get feedback on activities that pediatric outpatient primary care practices provide and do not receive reimbursement under FFS
2. Understand how these activities may vary across practices and why
3. Discuss the impacts of these activities and their variability on member and family experience, as well as provider experience

3. Discussion: Pediatric Outpatient Primary Care Activities Not Currently Reimbursed Under FFS

The PACK Support Team presented the categories of activities adapted from the Division of Insurance (DOI) Regulation 4-2-96 regarding Primary Care Alternative Payment Model Parameters, emphasizing the need for organization despite potential overlaps. The PACK Support Team acknowledged that the activities for each category are derived from evidenced-based sources, including Massachusetts Sub-Capitation Model, Integrated Practice Assessment Tool, Pediatric Telephone Protocols, the State Innovation Model (SIM) initiative, DOI, Bodenheimer, and research from pediatric APMs existing nationwide. See below for categories and their respective activities:

1. Team Based Care: Activities include:

- Integrated behavioral health*
- Health coaches, care navigators, and community health workers
- Recall system for recommended services

2. Member and Family Engagement: Activities include:

- Health related social needs screening and assistance connecting members/families to resources*
- Health prevention education and counseling
- Member outreach and follow-up
- Gathering patient feedback and experience

3. Access: Activities include:

- Day-time office hours triage and availability of same-day appointments with pediatric- and family-specific expertise*
- After-hours triage with pediatric- and family-specific expertise
- Extended hours appointments
- Physical spaces and services are accessible and responsive to patient needs

4. Care Coordination: Activities include:

- Care coordination*
- Referral tracking and monitoring
- Extended visit time

Dr. Price explained that Team-Based Care pertains to the internal activities within the practice. Member and Family Engagement involves elements that extend into the social ecosystem of the child, while Care Coordination refers to actions that reach beyond the confines of the pediatric practice. She emphasized that while the same staff members might carry out activities in each of these areas, the aim of our discussion today is to define these activities through a pediatric lens.

*Dr. Price noted that the activities that are starred are ones that have a spectrum of activities that will be further discussed in deep dives in the following discussion.

Presentation and Discussion: Team Based Care

Team Based Care: Activities include:

- Integrated behavioral health
- Health coaches, care navigators, and community health workers
- Recall system for recommended services

Overarching Team Based Care Discussion

Dr. Price introduced the concept and activities (listed above) under Team Based Care. She discussed the roles of health coaches, care navigators, and community health workers and defined these team members as individuals responsible for providing culturally relevant support, coordination, referrals, and services tailored to the needs of the member and their family. She highlighted the importance of a recall system for recommended services that is pediatric-specific. She also noted that integrated behavioral health contains a spectrum of activities and will be further explored in today's discussion.

The SE Team facilitated a discussion surrounding Team Based Care with the following discussion questions posed to DRT participants:

- For providers: Are there additional pediatric outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under team-based care?
- For parents/guardians/other stakeholders: Under Team Based Care, what are the types of things your pediatrician office does that positively impacts your child's care?
- Are there specific pediatric considerations for these activities?
- How feasible is it for pediatric practices to implement these activities? Is there variability in how these activities are offered or look like across practices?
- For providers: How well are the Regional Accountable Entity (RAE) payments you're currently receiving for these activities serving your needs?

Questions and feedback from DRT participants are below:

- DRT participants suggested the following activities be added under Team Based Care:
  - Nutrition counseling and support
  - Early childhood or early intervention specialists
  - Lactation consultants
  - Family advocates
- A DRT participant explained that the current Team Based Care category is broad and varies in interpretation. The DRT participant appreciated the 'fire station model' where behavioral health professionals are ready to respond immediately, often requiring at least two staff.
  - In primary care, tasks related to Medicaid, transportation, and early intervention referrals are usually managed by an integrated behavioral team, and so the appearance of integration can differ based on perspectives and setting.
  - Integrated behavioral health teams provide significant behavioral health support and coaching for guardians; this is not fully reflected by Medicaid attribution.
- DRT participants noted that pediatric practices differ from adult primary care in their continuous triage interactions with families and patients, often requiring 1 to 2 full-time equivalent (FTE) roles, like nurses, in busy practices and adds an additional expense not found in adult primary care.
- DRT participants noted that high-quality team-based care involves activities beyond standard patient care, such as regular care management meetings and informal consultations. Many schools and daycares collaborate with teachers regarding student behavior (e.g., tracking National Initiative for Children's Healthcare Quality (NICHQ) Vanderbilt Assessment to make a diagnosis of ADHD) and coordinate with school counselors.

Integrated Behavioral Health Deep Dive

Dr. Price presented the various levels of Integrated Behavioral Health (BH), derived from the Integrated Practice Assessment Tool (IPAT). The model delineates three key elements essential for effective integration: Communication, Physical Proximity, and Practice Change. It spans six levels of collaboration as outlined below:

Coordinated, Key Element: Communication

1. Level 1: Minimal collaboration. Providers communicate sparingly via written or email communication.
2. Level 2: Basic Collaboration at a Distance. Providers communicate regularly to address specific member treatment.

Co-Located, Key Element: Physical Proximity

3. Level 3: Basic Collaboration Onsite. Providers are co-located and work together, but unequally, and primarily through referrals.
4. Level 4: Close Collaboration Onsite with Some Systems Integration: Providers relationships go beyond just increasing referrals; sense of shared member care.

Integrated, Key Element: Practice Change

5. Level 5: Close Collaboration Approaching an Integrated Practice. Providers are equally involved in shared member care in a standardized way.
6. Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice. Providers have shared responsibility and resource allocation amongst all providers in integrated member care.

Dr. Price also shared that PACK is working closely together with the House Bill 22-1302 Integrated Behavioral Health Grant Program team so that payments will not be duplicative but rather complementary.

The SE Team facilitated a discussion about the Integrated Behavioral Health levels with the following discussion questions posed to DRT participants:

- Does this model resonate for integrated behavioral health for pediatric primary care practices?
- How feasible is it for pediatric practices to implement these activities and progress across levels? How does feasibility of progression vary among pediatric practices in Colorado?

Questions and feedback from DRT participants are below:

- DRT participants noted that nearly all pediatric practices have some foundational level of integrated behavioral health happening.
- DRT participants discussed the barriers that prevent reaching higher levels of integrated behavioral health for pediatrics such as:
  1. Low reimbursement rates
  2. Workforce trained in pediatric-specific mental health prevention activities
  3. Office space limitations
  4. Hiring and recruiting necessary staff

5. Varying comfort levels of providers with behavioral health
6. Lack of pediatric-specific integrated behavioral health frameworks

- DRT participants further discussed these barriers (listed above):

1. Low reimbursement rates
    - DRT participants noted that only about 40% to 50% of the cost of delivering integrated care is reimbursable. Therefore transitioning to higher levels of integrated behavioral health would require resources beyond conventional reimbursement, such as grants and other special funding sources
    - DRT participants mentioned a key to allowing their practice to achieve a higher level of integrated behavioral health is due to funding from their RAE and school-based health centers. A DRT participant noted an 8% annual cost increase to maintain these integrated behavioral health resources, with grant funding not keeping pace.
    - A DRT participant mentioned the lack of support from private payers for an Integrated Behavioral Health model.
2. Workforce trained in pediatric-specific mental health prevention activities
    - DRT participants noted the importance of having an appropriate level or mix of behavioral health staff in integrated care, which includes licensed roles such as Mental Health Workers, Child Psychologists, Social Workers, Professional Counselors, Family and Marriage Counselors, and Integrated Behavioral Health Extenders/Community Health Workers.
3. Office space limitations
    - A DRT participant stated that while grant funding might help, there are challenges in locating new office space and indicated that achieving higher levels of integrated care in their practice would be a considerable task, emphasizing the complexities involved in such a transition.
4. Hiring and recruiting necessary staff
    - DRT participants highlighted the concern that an unintended consequence of specialized trainings for pediatric integrated behavioral health staff is that they may leave for private or telemedicine practices for more lucrative positions, which has had an impact on staff retention and payment particularly during the pandemic.
    - DRT participants discussed the role of companies such as Evolved MD, which provide behavioral health staff to offices, handling the responsibilities of hiring and managing these professionals, and even providing psychiatric support for patients requiring higher levels of care or consultation. The DRT participant also highlighted the financial challenges with outsourcing these workforce issues.
5. Varying comfort levels of providers with behavioral health
    - DRT participants shared the utility of the ‘fire station model’ that prioritizes readiness and staff preparedness. A DRT participant explained to prioritize Medicaid and CHP+ patients, their practice is limited to no more than six clients on a weekly basis for their behavioral health providers, approximately one for every three medical providers to sustain this care model.
6. Lack of pediatric-specific integrated behavioral health frameworks

- DRT participant discussed that the IPAT framework may not be helpful for pediatric providers thinking about how to achieve integrated care and expressed concerns about the heavy focus on treatment rather than prevention.
- As an alternative, a DRT participant suggested that the Primary Care Behavioral Health Model, the Collaborative Care Model, and an emerging model which is the combination of the two models (consisting of integrated, embedded paid providers with telehealth access to a psychiatrist) could serve as more practical guides for pediatric practices.

Presentation and Discussion: Member and Family Engagement

Member and Family Engagement: Activities include:

- Health related social needs screening and assistance connecting members/families to resources
- Health prevention education and counseling
- Member outreach and follow-up
- Gathering patient feedback and experience

Overarching Discussion

Transitioning beyond the "Medical/Developmental/Behavioral/Mental" perspective of an individual patient, Dr. Price introduced the concept of Member and Family Engagement to focus on the Social/Family System around a pediatric patient. Activities in this category (listed above) look at the "whole patient" and the "whole system influencing a child's health." She recognized that office staff conducting Team Based Care activities may also perform activities in the Member and Family Engagement category. She stated that there would be further discussion around health related social needs (HRSN) screening and assistance.

The SE Team facilitated a discussion surrounding Member and Family Engagement with the following discussion questions posed to DRT participants:

- For providers: Are there additional pediatric outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under member or family engagement?
- For parents/guardians/other stakeholders: Under member and family engagement, what are the types of things your pediatrician office does that positively impacts your child's care?
- Are there specific pediatric considerations for these activities?
- How feasible is it for pediatric practices to implement these activities? Is there variability in how these activities are offered or look like across practices?
- For providers: How well are the RAE payments you're currently receiving for these activities serving your needs?

Questions and feedback from DRT participants are below:

- DRT participants described the ways in which they have used RAE payments to support member and family engagement, including:
    - Supporting transportation, especially in rural areas
    - Conducting family outreach and follow-up for high-risk patients
    - Gathering patient feedback through structured interviews to gain a deeper understanding of patients' expectations.
- DRT participants indicated that current RAE payments, while helpful, are insufficient in funding the work practices are currently doing due to the underestimation of pediatric member complexity, which results in lower per-member-per-month payments.

Health Related Social Needs (HRSN) Screening and Assistance Deep Dive

Dr. Price presented the various levels of HRSN Screening and Assistance derived from the Massachusetts Primary Care Sub-Capitation Program. The model outlines three progressive levels of support: Foundational, Enhanced, and Advanced – outlined below.

1. *Foundational*
- Administer behavioral health, developmental, social, and other screenings and assessments
- Provide inventory of resources to those with positive screens
2. *Enhanced*
Foundational activities plus:
- Provide members/families assistance with public assistance applications and enrollment (e.g., Supplemental Nutritional Assistance Program (SNAP) and the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC)
3. *Advanced*
- Enhanced activities plus:
- Dedicate full-time educational liaison staff member that serves as resource for families navigating the intersection of the medical and educational systems

Dr. Price noted that as with Integrated Behavioral Health, there is a spectrum of HRSN screening. While the screen is the easy part, the activities and decisions made ("and then what?") following a positive screen can be challenging.

The SE Team facilitated a discussion about the HRSN Screening and Assistance levels with the following discussion questions posed to DRT participants:

- Does this model resonate for health-related social needs screening and assistance for pediatric primary care practices?
- How feasible is it for pediatric practices to implement these activities and progress across levels? How does feasibility of progression vary among pediatric providers in Colorado?

Questions and feedback from DRT participants are below:

- A DRT participant suggested that, in reality, there are often more intermediary steps needed between the "Foundational" and "Enhanced" levels to go from conducting a screening to enrollment in public assistance programs.
    - A DRT participant suggested to define an Enhanced practice by their response to social screens or other positive screenings, like the Patient Health Questionnaire (PHQ 9).
    - A DRT participant pointed out the challenge of collaborating with schools for advanced care integration without being a school-based health center.
- DRT participants highlighted that addressing HRSN is a relatively new concept for many pediatric providers.
- DRT participants mentioned that extra support is needed in practices to help patients with SNAP and WIC benefits management highlighting various barriers, such as language or understanding complex systems, and the absence of enrollment specialists to guide patients.
- DRT participants acknowledged that there is a role for providers in health related social needs, but that the exact delineation in roles between practices, RAEs, and county services is not always clear.
    - DRT participants generally agreed that practices should provide screening and guidance, but that steps beyond that require outside coordination, and may be limited by lack of financial or workforce resources and could be the responsibility of the RAE.
    - DRT participants noted the necessity of substantial funding to reach advanced levels of care, emphasizing the role of navigators and the challenges faced in consistent collaboration with the education system.
    - DRT participants highlighted that families have felt more engaged when they knew the community health navigators were directly affiliated with their practice to support with HRSN.
    - DRT participants highlighted that some communities may not have adequate resources to meet the identified need from screening.
- DRT participants agreed on that integrated behavioral health should be tied to addressing social determinants of health, stressing their combined impact on alleviating stressors for both patients and practices.

Presentation and Discussion: Access

Access: Activities include:

- Day-time office hours triage and availability of same-day appointments with pediatric- and family-specific expertise*
- After-hours triage with pediatric- and family-specific expertise
- Extended hours appointments
- Physical spaces and services are accessible and responsive to patient needs

Overarching Discussion

Dr. Price introduced the concept of Access and explained the pediatric-specific lens for access. Much of outpatient pediatric primary care is preventative care and timely/urgent availability for acute illness and injury. The nature of taking care of

children is much more dynamic than an adult population with often less urgent/more chronic issues. She shared some activities that a practice can provide to address this dynamic nature of caring for children (listed above). She stated that there would be further discussion, or a deep dive, around day-time office hours triage and availability of same-day appointments with pediatric- and family-specific expertise.

The SE Team facilitated a discussion surrounding Access with the following discussion questions posed to DRT participants:

- For providers: Are there additional pediatric outpatient primary care activities that practices currently perform, which are not reimbursed under FFS and fall under access?
- For parents/guardians/other stakeholders: Under access, what are the types of things your pediatrician office does that positively impacts your child's care?
- Are there specific pediatric considerations for these activities?
- How feasible is it for pediatric practices to implement these activities? Is there variability in how these activities are offered or look like across practices?
- What is the role of telemedicine or portal messaging in pediatric outpatient primary care?
- For providers: How well are the RAE payments you're currently receiving for these activities serving your needs?

Questions and feedback from DRT participants are below:

- DRT participants highlighted major differences between adult primary care and pediatric triage, which include:
    - Non-stop triage
    - Additional expense incurred with staffing nurses with pediatric-specific expertise
    - Managing increased workload during high-demand periods, like respiratory seasons
- DRT participants explained how while imperfect, after-hour triage services meet the need to provide after hour access. Weekend, holiday, or after-hours staffing is available to some extent, but requires paying these staff, or even contractors, at higher rates.
    - In addition to exacerbating the financial challenge of paying staff, high patient no-show rates often complicate the task of holding time slots for acute cases or 'fire station model' appointments.
- DRT participants echoed the importance of triage and noted the significant rise in portal messaging, which has substantially increased the volume of patient interactions and workload for nurses and practitioners.
- DRT participants discussed the adaptation of their practices to include telehealth services, emphasizing its utility in addressing challenges related to weather, transportation, and convenience for families. Other use cases of telehealth services as described by DRT participants include chronic disease management, nutrition evaluation, medication management and care coordination for attention-deficit/hyperactivity disorder (ADHD), neurological follow-ups, and addressing school-related challenges.

- DRT participants also discussed despite the benefits of telehealth services (i.e., Teledoc), it poses challenges such as maintaining a comprehensive medical home due to communication gaps and a tendency to overtreat and overprescribe.

Day-Time Office Hours Triage and Same Day Appointment Availability Deep Dive

Dr. Price prefaced the deep dive on day-time office hours triage and same day appointment availability by explaining that it's difficult to define and quantify this spectrum of daytime triage and availability for timely/urgent access for acute illness and injury. The PACK team has attempted to delineate a spectrum, adding in more nuanced availability along it. She recognized that more flexibility comes with more risk to the practice. She presented the various levels of Day-Time Office Hours Triage and Same Day Appointment Availability derived from the "Pediatric Telephone Protocols" by Barton Schmitt, MD. The model is structured into three levels: Foundational, Enhanced, and Advanced – outlined below.

1. *Foundational*
- Limited same day/urgent/walk-in appointments
- Clinical phone triage

2. *Enhanced*
- Seasonally adjusted same day/ urgent/walk-in appointments
- Dedicated clinical phone triage that is pediatric- and family-specific

3. *Advanced*
- Seasonally adjusted to ***meet demand*** same day/urgent/walk-in appointments
- Dedicated clinical phone triage that is ***timely*** and pediatric- and family-specific

The SE Team facilitated a discussion about the day-time office hours triage and same day appointment availability levels with the following discussion questions posed to DRT participants:

- Does this model resonate for day-time office hours triage and availability of same-day appointments with pediatric- and family-specific expertise?
- How feasible is it for pediatric practices to implement these activities and progress across levels? How does feasibility of progression vary among pediatric providers in Colorado?

Questions and feedback from DRT participants are below:

- DRT participants stated foundational activities are essential in pediatrics, with most practices incorporating them as part of their standard business model. However, transitioning to Enhanced and Advanced levels involves significant cost due to the need for well-trained personnel and established procedures, resources not readily available in most practices.
- DRT participants explained that pediatrics experience seasonality in terms of workflow during high respiratory syncytial virus (RSV) and flu seasons, which creates staffing capacity challenges.

  - A DRT participant cautioned that both demand and seasonality are now more difficult to predict, and that behavioral health needs are also not as predictable as respiratory seasons
- A DRT participant noted a trend towards reduced additional availability and changing job expectations among the provider workforce, thus presenting considerations for provider work-life balance. The DRT participant urged the importance of addressing workforce and burnout challenges among new pediatric providers.
- A DRT participant stated that in a non-APM program, finding adequate space in the schedule for well child visits to accommodate increased same-day sick visit availability, results in less FFS payment.
- DRT participants underlined the significance of training and trust-building with nursing staff in managing schedules and ensuring smooth practice operations, with an emphasis on same-day illness management and the use of portals for patient communication.
- DRT participants pointed out the unique aspect of pediatric practice where a significant amount of care, including advice over the phone, is provided free of charge, expressing the desire to maintain this level of service in new models without charging for phone calls.

Presentation and Discussion: Care Coordination

Care Coordination: Activities include:

- Care coordination*
- Referral tracking and monitoring
- Extended visit time

Overarching Discussion

Dr. Price introduced the concept of Care Coordination. Activities for connecting patients beyond the walls of a pediatric practice include care coordination (which she stated would be a deep dive topic); referral tracking and monitoring; and transitions of care. She acknowledged the overlap with some Team Based Care activities, noting that a person could be doing care coordination activities in a team-based care setting. She also highlighted nuances of care coordination work being done by medical practices and other agencies and pointed out the pediatric-specific nature of these activities, in which inpatient to outpatient transitions are very brief (1-2 days) for children, rather than recurrent for adults with chronic conditions. She described that PACK and Accountable Care Collaborative (ACC) programs are working closely together to try and not make payments duplicative but rather complementary.

Care Coordination Deep Dive

Dr. Price presented the various levels of Care Coordination derived from the Colorado State Innovation Model (SIM). The model is structured into three levels: Foundational, Enhanced, and Advanced, illustrating the continuum of practice transformation. At the

Foundational level, a practice employs a care coordinator to facilitate communication among care providers and families and provides educational resources to families for their child's home care management. A practice demonstrating care coordination activities on an Enhanced level performs proactive outreach and facilitates bi-directional communication with other practices to support medical 'specialty care; establishes a system to track referral and intake for specialty services and for follow-up on appointments; and supports care transitions (e.g., emergency department, inpatient hospital). The far end of this spectrum includes Advanced-level activities where a practice performs proactive outreach and facilitates bi-directional communication with other practices and community organizations (historically considered "non-medical" entities) to support whole-person care (e.g., child welfare, schools, juvenile justice).

The SE Team facilitated a discussion about the Care Coordination levels with the following discussion questions posed to DRT participants:

- Does this model resonate for care coordination for pediatric primary care practices?
- How feasible is it for pediatric practices to implement these activities and progress across levels? How does feasibility of progression vary among pediatric providers in Colorado?

Questions and feedback from DRT participants are below:

- A DRT participant expressed disagreement with the RAE 1 tiered definition of children who need advanced care, noting that the tiered definition omits uncommon complexities, but complexities nonetheless, such as children with in-home medical technology, seizures, and cerebral palsy.
- DRT participants listed characteristics of complex patients, including social determinants of health, co-traveling medical issues, and behavioral/mental health concerns.
- A DRT participant suggested adding care conferences to the spectrum of care coordination.
- A DRT participant noted that care coordination levels may look different for rural providers, as they have fewer local external providers to coordinate with. As such, care coordination activities may be more internal facing within practices.
    - Practice-specific examples include TigerText services, a HIPAA compliant texting within Epic.
- DRT participants emphasized that moving to advanced care coordination requires considerable time, specialized staff, and financial resources because of the lack of existing infrastructure to connect different entities that exist today.
- DRT participants cited a lack of technical infrastructure and tools (e.g., consistent use of advanced EHRs) to facilitate increased levels of care coordination.
- DRT participants raised concerns about technical infrastructure barriers and complexities around consent, especially in pediatric patients who cannot legally consent, and the challenges of information exchange within adolescent

care, behavioral health, and with educational institutions due to compliance with laws like FERPA and 42 CFR Part 2. DRT participants noted difficulties in determining the decision maker in cases where parents are separated or divorced, adding another layer of complexity to consent and confidentiality issues.

4. **Looking Ahead**

Suman Mathur provided a list of resources and reminded DRT participants about the next meeting on June 26 from 5-7pm, during which considerations for special provider types and populations will be discussed. Suman then closed the meeting.