Minnesota Health Care Roundtable 53RD SESSION

Clinical and Non-clinical Care Teams

Improving interoperability

The 53rd session of the Minnesota Health Care Roundtable continued in the remote format. This provided panelists more time to reply to the questions and in some cases consult with colleagues for a response that represented consensus from within their organizations. In consideration of our focus, improving care team interoperability, allowing for this increased input was invaluable. While there were some issues where panelist responses bordered on repetitive, other responses helped define specifically unique areas where improvement is both clearly needed and a manageable challenge to address systemwide. We extend our special thanks to the participants and sponsors for their commitments of time and expertise in bringing you this report. In April we will publish the 54th session of the Minnesota Health Care Roundtable on the topic "Care Transitions, improving the safety net." Consideration of issues around the pandemic dictate that we must continue with the remote format. We welcome comments and suggestions.

TODD ARCHBOLD, LSW, MBA, is a licensed social worker and the Chief Executive Officer at PrairieCare. PrairieCare is a privately-owned clinician led organization providing a partial hospital program (PHP) and inpatient mental health services in several Minnesota locations. Todd has been a part of PrairieCare since 2006 and has held many roles including Chief Operating Officer, Interim Chief Financial Officer, Chief Development Officer and PrairieCare Medical Group Practice Manager. Todd is also the Executive Director of the statewide Psychiatric Assistance Line (PAL), offering consultation to primary care providers.

MAJ(R) JENIFER DETERT, PA-C, MPAS, DFAAPA, BA, BS CAQ: ER, has a solo rural emergency medicine practice that serves communities surrounding St. Joseph, Minnesota. She is President of the Minnesota Academy of PAs (MAPA) and is a retired combat veteran. MAPA's mission is to promote the professional and personal development of Minnesota PAs, through representation at the local, state, and national levels, advocacy, educational opportunities, and public relations, with the goal to promote quality and cost-effective, accessible health care for every person.

SARAH DURR, PharmD, is the Executive Director of The Minnesota Pharmacists Association (MPhA). a professional association that serves Minnesota pharmacist providers. The association promotes inter-professional collaboration and cooperation between health care professionals from many different specialty areas. Additional work focuses on maintaining a strong economic environment for pharmacy practice and engagement in advocacy efforts to ensure that laws and regulations keep pace with the evolution of the profession. MPhA encourages and promotes networking among pharmacy professionals and partnership with other professional organizations to advance common goals and patient care through collaboration.

VIVI-ANN FISCHER, D.C, is the chief clinical officer of Fulcrum Health, an organization dedicated to leveraging physical medicine to transform health care. ChiroCare, the nations first chiropractic network founded over 35 years ago is part of the Fulcrum Health network. Dr. Fischer oversees network credentialing, utilization services, and provider services. She has been with Fulcrum Health since 2012, is currently a Board of Trustees member at Northwestern Health Sciences University (NWHSU), and has served as a member on the Board of Directors for the Minnesota Chiropractic Association (MCA).

JENNIFER P. LUNDBLAD, PHD, MBA is the President and CEO of Stratis Health, an independent non-profit organization that leads collaboration and innovation in healthcare quality and safety. Stratis Health improves health care quality and patient safety – locally and nationally – at the clinician, organization, and community levels and across the full continuum of care. Established as the Foundation for Health Care Evaluation in 1971, this year Stratis marked its 50th anniversary, celebrating its mission to embrace new and emerging improvement methodologies and deepening its work to bridge health care and community.

Please define the term clinical care team.

JENNIFER L: Our perspective is focused on strengthening the connection between health care and community. We are currently engaged in facilitating the processes for Minnesota stakeholders (health systems, community organizations and payers) to co-design a common approach to sharing social needs resource referrals between health care organizations and community organizations. So, for the purposes of our responses here, the care team is broadly inclusive of the clinical care team and extended care team members in the community who are offering services and supports which address social needs related to health.

TODD: A clinical care team is a group of health care professionals that operate on the front lines of patient care. For us, the clinical care team consists of physicians, pharmacists, physician assistants, advanced practice nurses, therapists, registered nurses, social workers, spiritual care coordinators, recreational therapists, occupational therapists, art therapists, psychiatric technicians and residential counselors. All work collaboratively to either direct, coordinate or assist in carrying out the patient's plan of care.

VIVI-ANN: A clinical care team is a group of multidisciplinary health care professionals, working together to determine the most appropriate care plan for the patient, based on the family and patient's needs and preferences. The team may include physicians, doctors of chiropractic, physical therapists, nurses, massage therapists and acupuncturists. The goal of a care team is to improve safety, outcomes, efficiency and affordability by delivering the right care at the right time and providing care coordination between team members. In high-functioning teams, patients are members of the health care team and assist with decision making.

SARAH: A clinical care team is a team composed of health care professionals who work collaboratively to provide the best care for the patient. This team may be composed of physicians, physician assistants, nurses, pharmacists, dentists, physical or occupational therapists, dietitians, nutritionists, social workers, respiratory therapists, behavioral health workers, technicians, etc. Each member of the clinical care team brings a unique perspective to patient care, which is why it is important to maintain a diverse clinical care team. Clinical care teams can span different practice sites. For example, a pharmacist may work in the community pharmacy, work closely with a clinic who employs a physician, nurse practitioner and physician assistant, and also a hospital. It is important to note that all members of a clinical care team do not have to be part of one health system or one location.

JENIFER D: A clinical care team blends multidisciplinary professionals, allowing several insights and perspectives to offer health care, delivered in a holistic, high-value manner and completing various clinical tasks to serve the needs of patients. The clinical care teams operate in all clinical settings: inpatient, outpatient, skilled nursing care facilities and surgical and clinical specialty care. Clinical care team members are called to fill the needs of a patient from all levels and specialties in nursing, laboratory and radiology technicians, speech, occupational and physical therapists, pharmacists, nutritionists/dietitians, mental health psychologists and counselors, often by the referral or request from a primary care clinician/provider, such as a physician assistant, advanced practice RN/NP, or physician.

> Interoperability is not only important within one individual healthcare episode, but it is important and imperative to provide continuity of care.
>
> —Todd Archbold

Please define the term non-clinical care team.

JENIFER D: The non-clinical care team encompasses members, without direct patient care responsibilities, vital in performing tasks and supporting the essential needs of a health care system. Non-clinical care teams represent a wide range of education, background, experience and competencies from personnel representing the behind-the-scenes essential work force: high-level executives, administrators and billing and coding specialists, along with financial, human resource, managerial, clerical, maintenance and environmental staff. Non-clinical team members ensure the clinical team has optimal support to allow safe, effective, efficient high-quality clinical care to every patient. During the initial stages of the COVID pandemic, medical information technologists were instrumental in pivoting patient care from bedside to virtual. Clinical and non-clinical care teams are incomplete without the supporting role of family, friends, significant others and caregivers who extend beyond clinical and non-clinical duties advocating for and supporting the personal, spiritual, emotional and best interests of the patient.

JENNIFER L: The non-clinical care team broadly includes the clinic staff and/or members from community organizations providing services and supports necessary for health care. Some health care organizations opt to employ social workers and community health workers (CHWs) so they are more closely connected to the clinical care team in supporting and transitioning patients, have the data available within the practice, and are known and trusted by the clinical care team. Alternatively, clinical care teams can rely on community organizations which embed such staff, enabling the social workers and CHWs from local communities to do visits in the home that provide a more comprehensive context of that person's and family's life–the patient's lived experience. There are advantages to both approaches, and we are observing carefully as our approaches evolve and are studied. Regardless of what approach is taken, it is essential for clinical care teams to have the contextual information about their patient's lives which helps determine interventions and care plans that really work. An example of the benefit of a broad and inclusive care team is when a patient presents in a clinic or hospital (including behavioral health services), the context of that person's day-to-day health risks can be considered. One physician described a patient diagnosed with asthma. She had been prescribing various medications and therapies which were not as effectual as they should have been. A social needs screening was done at the clinic, which triggered a community health worker to do a visit to the home and identified unhealthy air quality in the home as a potential contributor in getting the patient's asthma under control. The community health worker was able to connect with a local housing organization to find more appropriate housing. The

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referral and follow-up action were linked back to the clinic's electronic health record for the clinical care team to incorporate into the care plan.

SARAH: A non-clinical care team would include team members who do not provide clinical care to a patient. These members are essential to coordinating patient care and making clinical care possible. Members on this team include the following personnel: administrators, schedulers, IT, front of store operations and call center staff, environmental services, etc. The non-clinical care team is essential to supporting the clinical care team to provide the best possible patient care.

VIVI-ANN: The non-clinical care team refers to the support team assisting the patient and health care professionals such as the office manager, medical billers, care coordinator, coaches and community health workers. Studies demonstrate many care and care-coordination activities have been successful when provided by nonphysician members of a care team.

TODD: I perceive the non-clinical care team as comprised of every individual working where health care is provided, but who is not part of a clinical care team. The non-clinical team essentially provides the pillars to support the delivery of safe, high-quality health care services to patients. These positions consist of health unit coordinators, security, facilities and food service staff, receptionists, environmental services workers, information management and utilization review. This could be expanded further to include the performance improvement team, administrative support roles, business office and finance personnel and the executive team.

> Care teams improve outcomes when utilizing team members at the top of license, experience, competency, education, and training.
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> —Jenifer Detert

What are some examples of how care teams improve outcomes?

JENNIFER L: Team-based care has been shown to be effective in health care. Adding team members such as social workers and community health workers who can assess social needs and make referrals and connections to community organizations addresses essential elements that were previously missing but are beneficial for good clinical decision making and support. The value of identifying social needs and connecting patients to social services such as those provided by community-based organizations (CBOs) has existed and been a focus long before SDOH emerged locally and nationally as a priority in health care. The COVID-19 pandemic and its wide-ranging health and social impacts catapulted SDOH and e-referral solutions into daily health care conversations in literature, webinars, remote conference events and other forums. The term e-referral describes social needs electronic referrals. E-referrals are the approach to assessing a patient's social needs by a health care organization, identifying services that can meet those needs, and conveying the referral electronically to CBOs that provide services and support to meet those needs.

TODD: One example of how care teams have improved outcomes within our organization is through the adoption and implementation of the Collaborative Problem Solving (CPS) philosophy and associated techniques for response to escalated patients. All members of the clinical care team have been trained in CPS, and all disciplines are now using a shared language, philosophy and techniques for de-escalation and management of patient behaviors. Consequently, we have experienced a 61% reduction in seclusion and restraint episodes over the past two years.

SARAH: There are many ways care teams improve outcomes. In a retail pharmacy, non-clinical staff availability to check out customers or direct them to a specific item assists in patient care by providing more time for the clinical staff to spend with patients. Pharmacists improve outcomes in the dispensing setting by ensuring medications are safely dosed, with no major drug-drug interactions, and financially accessible for the patient. In a clinic (primary care or specialty care) setting, pharmacists are able to improve patient outcomes and free up provider time by engaging in their own patient visits and managing complex medication regimens. Non-clinical team members are able to free up clinical pharmacist time, in turn, by scheduling patients and ensuring appropriate outreach. In a hospital, pharmacists may work with respiratory therapists, speech-language pathologists and nurses to ensure patients are receiving the correct medication type, dosage and frequency. These are only a few examples; there are so many others they can't all be addressed in a short response. Additionally, it is imperative that the clinical care team work collaboratively to provide the patient with the best possible outcomes. For example, the pharmacist in the community setting contacts the clinic or hospital if there is a question on a medication that the patient is taking. In turn, the clinic may contact a community pharmacist to discuss a challenging medication regiment. In the clinic setting, often pharmacists will discuss medication regimens and disease state concerns and medications face-to-face with physicians, physician assistants and nurse practitioners.

VIVI-ANN: Care teams improve outcomes when utilizing a navigator who assists with finding the right team member at the right time. Non-clinical care team members demonstrate improved care and care coordination by reducing the fragmentation of repetitive services and engage patients by focusing on the patient needs and preferences. The care team provides seamless communications and transitions among health care professionals. For example, a patient hurts their low back, and the navigator suggests to start care with a chiropractor. The chiropractor determines if this case can be treated conservatively and if x-rays are needed. If the patient is a conservative care candidate, care can begin with a non-pharma option. If the patient is not a conservative care candidate, the care team expands as needed with more specialists, each offering the patient options to achieve maximum quality of life goals.

JENIFER D: Care teams improve outcomes when utilizing team members at the top of license, experience, competency, education and training. Assigning a non-clinical team to health maintenance, prevention and care gaps improves the health of the patient population and allows the clinical team to focus on medical decisions required to treat acute and complex disease management. Utilizing teams in this manner may decrease the risk of illness, disease progression and hospitalization, thus improving outcomes. Multiple evidence-based studies have proven that including physical assistants (PAs) within the care team results in improved quality outcomes. The trauma surgeon-PA team model resulted in a 13% decrease in overall length of stay and a 33% decrease in neurotrauma intensive care length of stay. A primary care best practice study showed evidence that working with PAs and utilizing PAs to the full extent of education and experience ranked the highest in care delivery. A cohesive care team culture instills trust and reassures patient and family, emboldening them to ask questions, follow treatment recommendations and speak up about concerns. This culture thus reduces medical errors, increases patient safety and improves overall health care delivery and outcomes.

What are the primary obstacles to creating this improvement?

JENIFER D: Obstacles arise when a clinical care team is assigned non-clinically relevant work. For example, administrative paperwork and burdensome documentation requirements limit the care team's time dedicated to patient care. Obstacles arise when a health care system's policies, bylaws, leadership and culture do not allow care team members to perform at the top of licensing and scope of practice afforded by state laws. These unnecessary restrictions create inefficiencies and undermine the trust and culture of the care team. When team members are granted more autonomy, respect and trust, it encourages opportunities for them to seek out and speak up. This cultivates positive changes and initiatives that improve safety, decrease inefficiencies and creates a cohesive care team.

> Increasing community pharmacist access to patient's health care records would improve patient care.
>
> —Sarah Durr

TODD: One of the obstacles that needed to be overcome in implementing CPS and achieving a reduction in seclusion and restraint involved the large amount of resources needed for engaging, educating and supporting staff through adoption of this philosophy and the resulting culture change. We were able to sustain implementation of the initiative, despite also having to navigate the ever-changing and challenging environment of a global pandemic, and at times, civil unrest. The killing of George Floyd in May of 2020 challenged our leadership team and our staff to be mindful of the physical and psychological effects of seclusion and restraint on the patients we serve and to find a way to do things differently. As a psychiatric health organization, and for so many right reasons, PrairieCare felt compelled to go all in on this initiative. I am proud of how we embraced so many challenges, and our metrics reflect that our patients and staff are experiencing the benefits of a CPS culture.

JENNIFER L: Key interests and considerations for improvement come from multiple stakeholder groups. For CBOs, improvements include a system that is simple and generates reports and actionable information, to be fairly reimbursed for the value of their services, a better understanding of models and technology, and trust. In health care organizations, an example is a system that is integrated with EHRs, bi-directionality of information and accurate and continually undated directories of the CBO information. For payers, an example is a system that produces actionable data at the patient and population levels. Trust and trustworthiness, as well as cultural responsiveness, are factors that become obstacles if they are not addressed. Also, transparency about who has access to data and strong walls that prevent access by outside groups or agencies are important for community organizations (e.g., no ICE access for immigration enforcement). There is an obstacle to improvement if it is not made clear to patients and clients that they can consent to or refuse referrals. When a referral is being made, it should be communicated to the patient or client that the information will be seen and may be followed up by other providers engaged in the person's care and support. There should be an express approval process before entering a referral in the common platform. This will also assist with HIPPA issues and is an easy opt-out button for those who do not want to be followed. It is important to accurately match cultural needs with responsive service and to recognize community organizations' language and cultural attributes so that people from one culture are not referred to services from another culture, particularly where there are language differences. For example, the platform must be able to record and recognize patient or client names in ways that are different from dominant culture approaches, such as the use of two last names.

VIVI-ANN: There are opportunities to improve team care. One obstacle is the lack of a clear pathway where patient care should begin when they have spine or joint pain. This absence of clarity creates confusion for the patient and may involve many team members when only one or a few are necessary. Many physicians are holding on to outdated pathways rather than first following non-pharmacological care for spine care. Another obstacle is the understanding by care team members of each other's roles and responsibilities and appropriate

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hand-offs to other members. Care today is often siloed, and there is a lack of communication and transitions among health care professionals. Ease of communication among the care team members is a common obstacle. The EMRs were not created to communicate with other systems, and there is a need for platform changes. Standards are being developed via the Fast Healthcare Interoperability Resource (FHIR), which allows for the secure exchange of clinical, administrative and other healthcare information.

SARAH: Communication is the first obstacle, especially in the community pharmacy when you do not have direct face-to-face contact with prescribers or other team members at the clinic or hospital. Understanding of each person's role on the team can also be confusing if it has not specifically laid out the skills, education and role of each person on the team. This can be improved by creating job descriptions for each team member. Another obstacle is when certain team members are out of sight and are often not thought to be included in clinical decisions. Health care outcomes can be improved when team members respect each other, recognize the role each plays and are comfortable asking for help or offering assistance when needed.

What are some examples of care team interoperability?

SARAH: Interoperability is the act of computer systems and software applications exchanging information. This transfer of information needs to be diligently protected since it involves private patient information. One example may be the need to link information across health care systems if a patient is seen while on a vacation or only able to reach a specific health care system that is separate from the patient's primary care facility. Another example is working closely with the community pharmacy to provide, at a minimum, read only or, better yet, the capability to add information to patients' electronic health records. This collaboration allows the pharmacists to access the necessary labs, diagnostic information and other medical information to ensure that all medications are indicated, safe, effective and accessible to the patient. It is important to note that pharmacists are HIPAA trained and protect patient health information on a daily basis in their practice. Interoperability is essential for best practice of quality patient care by allowing access to all of a patient's data to allow for the safest and most effective treatment plan.

VIVI-ANN: Much of the discussion around health interoperability centers on the need for progress on sharing data with the patient, health plans and healthcare professionals. Sharing of medical records among healthcare professionals allows for significant efficiency and cost savings while avoiding redundant testing, and sharing with patients increases their engagement and understanding. An ideal example is when a patient sees a chiropractor for back pain and is referred to an acupuncturist to address other health care concerns, and the acupuncturist can see the medical history along with prior exams and tests, which allows for a quicker diagnosis and care plan development. The records from the chiropractor and the acupuncturist would be visible to the patient's primary care or other care team members which may impact their care plan development. The patient would receive treatment by both practitioners with alignment of the care plan.

TODD: Care team interoperability may look much different in a mental health or substance abuse setting than it does in a medical one. We all know the saying ,"It takes a village," and in child and adolescent mental health, that is so very true. Interoperability for those seeking our care starts with a 90-minute in-depth assessment by a master's prepared intake staff, who then consults with a psychiatrist to determine an appropriate level of care. This starting point could be likened to an X-ray or other diagnostic procedure in a medical setting that would set in motion a plan of care for a patient. Upon admit, the clinical care team is assigned, and interoperability begins to take shape. Each care team member has a unique set of skills and expertise they use to contribute to the patient's overall care and outcomes. A typical inpatient plan of care consists of medication management and education, individual therapy, family therapy, psychosocial groups, safety assessments, illness education, development of coping skills, leisure and recreational activities, milieu management, discharge planning and collaboration with outside agencies. To achieve optimal outcomes, all care is provided based upon an underlying foundation of the principles of CPS, Trauma Informed Care, Patient and Family Centered Care and Relationship Based Care.

JENNIFER L: There are three viable models for a common approach to electronically sharing social needs information between health care organizations and community-based organization: a single e-referral vendor, an integrated model; and an interoperable connectivity model (network of networks). There are a few examples of these models underway in other states and regions of the country that we are learning from. The social needs e-referral landscape continues to be a rapidly changing and dynamic one, accelerated by COVID-19 and its socioeconomic effects, which have elevated the intensity of social needs throughout the nation and Minnesota, including urban and rural environments. There are currently three predominant national vendors serving health care organizations in Minnesota in the social needs e-referral vendor marketplace: Aunt Bertha, NowPow, and UniteUs. This is an emerging and dynamic environment. For example, UniteUs recently purchased NowPow as well as Carrot Health, a social determinants of health predictive analytics company. Products are developing rapidly, and HER vendors are building this capacity within their tools (e.g., Epic). The market is guaranteed to be different by tomorrow.

JENIFER D: EHR is a communication platform that can filter and relay patient information allowing care team visibility and accountability. For example, a primary care office visit is scheduled with a PA for preventative care. The patient offers no concerns or symptoms. However, during the clinical exam, an irregular heartbeat is identified. The Medical Assistant performs an EKG - ordered, supervised and read by the PA –who identifies an abnormal rhythm. The PA with supporting data requests clinic staff to contact the on-call cardiologist. The EHR allows for knowledge to be shared during clinical consultation and for plan of care to increase patient safety and decrease heart risk. The care coordinator uses EHR to facilitate a prompt appointment with the consulting cardiologist. Utilizing and focusing EHR with care team education, training, background and talents allows for increased interoperability.

What are some examples of how care team interoperability could be improved?

TODD: One thing that could improve care team interoperability would be an EHR where charting would occur by all disciplines in one continuous form that provides sequential details from admission to discharge. Most EHRs were designed for notes to be entered in a modular or segmented way, which means information is separated out by disciplines. Important information has the potential to get lost or buried in different places within numerous notes from multiple staff. In this case, the information is fragmented, and we lose the narrative that helps to tell the patient story.

JENIFER D: Care team interoperability can be improved exponentially when well-intended but unnecessary barriers on team members are removed. This would involve seeking out and removing barriers in bylaws, policies, procedures and accepted practice arrangements that impose restrictions on care team members' ability to function autonomously and are not supported by state practice law. The Minnesota state legislature passed a bill that modernized PA practice that allows a PA's clinical practice to be determined within the care team. It also removed the physician supervision agreement requirement for PAs and removed physician liability for PAs practice decisions. Ensuring health system bylaws and policies reflect the most up-to-date advancements in state practice laws in an expedited manner will improve care team interoperability.

JENNIFER L: At the national level, there has been a long-term movement by stakeholders in government, vendor solutions, health care systems and other entities to promote interoperability and the use of standards-based data exchange. These standards and interoperability solutions are replicable and applicable to the emerging e-referral marketplace without reinvention of technical standards. Relevant strategies and standards for e-referral systems include the use of application programming interfaces (APIs) and the ability to query and request specific discrete sets of clinical information through the Fast Healthcare Interoperability Resources (FHIR) standard. E-referral vendors, their customers and stakeholders are coming together to build similar networks of exchange at the community level– known as community information exchanges (CIEs) and often collaborate with those entities. Just as Minnesota is building a network of networks for health care data exchange, we should also endeavor to create interoperable networks to assist and solve social needs and join the larger HIE network of networks. While Minnesota does not have a state-level HIE, many states and regions with a varied EHR vendor landscape (like Minnesota) can effectively exchange patient data. Health care systems in this environment can cooperate in the context of patient health data exchange.

> Race, ethnicity, and religion have become an increasingly important factor in terms of patient care.
>
> —Vivi-Ann Fischer

VIVI-ANN: One of the first steps is developing a patient-centered, best practice pathway that teams can agree upon. Patients would be informed as to their options regarding provider types and be given recommendations and choices of where to initiate care. This will create clarity of how the patient should progress on the care pathway and when additional care team members should be added. The pathway creates efficiency of both number of services provided and number of members seen along with saving the patient's time. Engaging the patient and supporting self-management instructions improves care. Having resources, such as consumer-facing apps, as part of the seamless patient experience would support team messaging and care plan decision making while alerting the team if the patient is experiencing positive or negative outcomes. Data collected from remote patient monitoring and patient records could be used for machine learning and artificial intelligence to predict good and bad outcomes and provide early intervention when indicated.

SARAH: Within pharmacy practice, there are many times when access to information is not available to pharmacists. The primary example is in regard to community pharmacies that have limited or no access to patient health care records that would otherwise be essential to assure the patient's medications are indicated, effective, safe and accessible. This access can also eliminate duplicate questions to prescribers in regard to whether the patient has tried a medication in the past when we are looking at their drug therapy. Often, in different disease states, the patient may need to try and fail multiple medications before moving to another option. The access also eliminates the need for the pharmacist to reach out and ask why the patient is on a particular medication (for example an ARB) rather than another (for example an ACE inhibitor) because we can see they have had a previous adverse reaction (for example a dry cough). Increasing community pharmacist access to patient's health care records would improve patient care.

What are some examples of how improved care team interoperability can address issues in health care that involve diversity, equity and inclusion?

JENNIFER L: A racial equity focus is an essential component to our current effort to co-create a common statewide social needs referral approach supported by technology in Minnesota. Supporting social needs is an essential element in assuring equity and reducing health disparities. It is widely recognized that 70%-80% of a person's health is influenced or determined outside the traditional health care service delivery walls of clinics, hospitals, long-term care and other health care settings. By cataloging needs and connecting patients to CBOs in an automated fashion to address health-related social needs, we are helping streamline an often disconnected and cumbersome process. Collecting data about individuals and communities also helps identify social needs and gaps taken together to inform policy and decision making.

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SARAH Addressing diversity, equity and inclusion is an important aspect of healthcare, especially as we have a very diverse population in Minnesota. Additional collaboration in access to the electronic record will improve patient care as pharmacists and the health care team address specific concerns that may impact certain populations more than others. Diversity, equity and inclusion is one of five areas that MPhA is addressing in their strategic plan this year (June 2021 to May 2022). Our exact plan is not fully formulated, but we are looking at this from both an association standpoint and ways in which we can support our member pharmacists, student pharmacists and pharmacy technicians in these efforts.

TODD: In order to address these issues, they first need to be identified. Inclusion of various members on a care team who come from diverse backgrounds and have different life experiences contributes positively to an increased diversity, equity and inclusion care perspective. As each member brings a unique lens from which to view the patient's story, there are opportunities to discover and explore possible underlying DEI issues and how to provide care that minimizes gaps and is most supportive to individual patient needs.

JENIFER D: The care team's interoperability improves when the overarching culture honors, respects and embraces the diverse perspective all members bring to the team. A team that cultivates a culture of curiosity, transparency and humility can help identify bias among themselves and within the health care system and work toward inclusion. Even seemingly small acts, such as allowing a nursing assistant interested in a career as a provider to shadow the provider and care team for a few days, can help increase inclusion in health care. Leveraging the collective or individual social collateral and privilege of the team and its members can go a long way to closing the gaps in diversity, equity and inclusion within health care. The care team has inherent social power as well. People, especially legislators, generally trust the experience of the care team. Capitalizing on opportunities to support legislation that improves health equity, diversity and inclusion is another tool we can use to make progress in these areas.

VIVI-ANN: For providers to promote health equity through their practice, they need to understand the complexity of the intersection of these factors and how they impact treatment outcomes. In the health care sector, race, ethnicity and religion have become an increasingly important factor in terms of patient care due to an increasingly diverse population. Effective interoperability can support not only the sharing of records between clinics, but also the resources that match the needs and preferences of the diverse population groups. This may increase understanding of how culture influences attitudes, behaviors and expectations related to health, medications, treatment regimens, health care and health care providers. Support tools for providers can offer insight to aspects of diverse cultures, such as languages, religions, spiritual practices, traditions, customs, beliefs, preferences and values. Also, support tools can assist in notification of how and when to utilize interpreter services and address confidentiality concerns.

What are some examples of care team interoperability within your organization?

VIVI-ANN: Fulcrum Health's physical medicine networks address spine and joint conditions, a common condition that 80% of us will experience in our lifetime. However, patients are not sure where to begin care. To address this problem, Fulcrum created Care Connections by Fulcrum Health, which provides coordination of the care team by use of a Fulcrum navigator to support patients in finding the right care at the right time. The Care Connections navigator connects the patient to a provider close to their home or work and matches the provider with the patient's needs and preferences. This service removes the burden of self-navigation while enabling choice and customization. Fulcrum also supports team-based care with our online provider directory. This tool allows patients and providers to search for providers by profession type and location. We encourage our Fulcrum network, which consists of ChiroCare, AcuNet and TruTouch, to work as a team when appropriate to meet the patient's needs.

JENIFER D: After the 2020 passage of Modernization law, PAs are fully licensed to care for patients autonomously within a care team. PAs can be the identified Primary Care Provider, making clinical decisions in accordance with collaborative practice agreements. In rural and urban emergency rooms, PAs perform all necessary care and treatment, but lack of resources compel them to seek consultation, admission or a higher level of care. The PA contacts the specialist, hospitalist or transferring facility without the need of physician oversight, supervision or permission. A clinical PA evaluates a patient with fatigue and exercise intolerance, noting abnormal rhythm on an office-based EKG and consults a cardiologist. This process is seamless due to the respect granted to care team members. Both examples demonstrate how care team interoperability in a clinical setting encourages individuals to function at the highest level with increased responsibility and engagement.

JENNIFER L: Stratis Health has a long history of addressing health disparities and improving health equity in Minnesota. To advance that work in today's environment, we set out to identify and understand current priorities and strategies for addressing social determinants of health (SDOH) among Minnesota health plans and state public programs. Stratis Health sent a brief snapshot survey of SDOH priorities and strategies to nine health plans based in Minnesota, as well as to the Minnesota Department of Human Services (DHS) public programs. All nine health plans responded, as did DHS. In addition, Stratis Health reviewed the current SDOH priorities for the 28 individual Minnesota Medicaid Integrated Health Partnerships (IHPs). Based on the information gathered and reviewed, Stratis Health offered several key findings. We found that SODH is the top priority.

There is a consistency of focus statewide, especially in looking at mental health issues, food insecurity and housing instability. Many intervention strategies were similar in health plans, DHS public programs and IHPs. These included hiring or utilizing community health workers and strengthening partnerships with community-based organizations. It was also important to support providers in implementing and utilizing screening tools to identify SODH risk areas and needs.

What are the most important aspects of care team interoperability facing your organization?

TODD: Many of our child and adolescent patients transfer between different levels of care within PrairieCare. From this standpoint, care team interoperability is not only important within one individual health care episode, but it is important and imperative to provide continuity of care across all programs and all touchpoints within the organization. To achieve the best patient experience and the best outcomes, interoperability is not only needed within a specific care team, but throughout care teams at different sites and different levels of care as well.

JENNIFER L: The completeness of data which reflects the context of a patient's life. Based on more than 80 interviews with stakeholders, our work is guided by a set of principles that reflect the most important aspects of care team interoperability. Supporting social needs is an essential element in assuring equity and reducing health disparities, so our work will be done using an equity lens. Authentic community engagement and leadership are necessary for success, guiding us toward community-led processes and solutions. The process and recommendations will be relevant statewide, inclusive of urban and rural needs, preferences and considerations. Cross-sector communication and collaboration are imperative to pave the way to action. Another element is design for the future—this is not a short-term solution and needs to be created to flexibly adapt as the environment, technology and users change, including direct use by patients or clients. Intentional power balancing processes are critical to ensure that all participants can effectively voice their needs and meaningfully influence the outcome in ways that achieve overall goals. The urgency of this effort must be carefully balanced with the time necessary for meaningful engagement and trust.

> Supporting social needs is an essential element in assuring equity and reducing health disparities.
>
> —Jennifer Lundblad

VIVI-ANN: The majority of clinics in Fulcrum's network are small independent clinics where the electronic medical records do not communicate with larger clinics and/or hospital groups. Although information can be shared by fax, this creates a time delay, and often information ends up unshared due to administrative burden. Another barrier is costs. Advanced EMRs are cost-prohibitive for small clinics to obtain and maintain. There is a lack of uniformity among the EMR vendors used, and it is difficult to migrate clinical records to competing EHR platforms. The third barrier is protecting patient privacy. Securing data access and mitigating the risk of breaches are paramount for moving to a digital-based health care system.

JENIFER D: Our perspective as Minnesota PAs differs from that of the health care system's top-level management. Per the American Academy of PA's guidelines for state regulations, care team goals are reminiscent of Optimal Team Practice (OTP). OTP occurs when care team members work together to provide quality care without burdensome administrative and clinical practice constraints. MAPA worked with legislatures to modernize PA practice statutes to reflect the function and utilization of PAs in all aspects of health care delivery. The PA Modernization Act took effect in August 2020. The most important aspect facing care team interoperability for Minnesota PAs is for health care systems to adopt the PA Modernization Act. Marginalizing, restricting and limiting the practice capacity of team members beyond licensing and practice laws is counterproductive to care team interoperability. PAs are a trusted associates and collaborators, licensed to care for patients autonomously without direct physician involvement unless needed by patient care demands.

Is there anything else about care team interoperability that you would like to discuss?

JENIFER D: We want to remind care team members that PAs are trusted partners in the medical care of the population. PAs are educated and trained in the medical model, similar to physicians, but with an intentional clinical focus that emphasizes team-based care. PAs are held to the same standards of care, quality measures and credentialing requirements as physicians. PAs are experts at adapting to meet patient care delivery needs in any setting or specialty, and they share the goals of expanding access to high-quality, safe and cost-effective care.

VIVI-ANN: The vision of interoperability is exciting. It offers the ability to put the patient at the center of their care, allow providers seamless ability to securely access and use health information from different sources and offers a longitudinal picture of the patient's health, not just episodes of care. The collection of data can provide health care to apply rapid learning and deliver cutting edge treatments. A number of benefits can be realized for exchange of health care information, including: care coordination, improving administrative processes, and increased patient safety and satisfaction.

SARAH: Interoperability is key to patient care and all health care providers need to be included: physicians, physician assistants, nursing, nurse practitioners, pharmacists, occupational therapists, physical therapists, etc.

TODD: Care team interoperability is complex, yet critical, to effective outcomes in creating a positive patient experience. When performed well, few people notice. However, when interoperability is compromised or otherwise short-circuited, the effects can be amplified and create risk for the patient. The impact of interoperability is especially important within mental health care, where such a large variety of staff participate in assessment, treatment planning and care delivery.

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