A clinical care team is a group of multidisciplinary health care professionals that operate to bridge health care and community. We are currently engaged in facilitating the processes for Minnesota’s social workers, 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 teams and extended care teams members in the community who are offering services and supports which address social needs related to health.

Clinical care teams improve interoperability, allowing for this increased input was invaluable. While there were some issues where parallel processes were shared on repetitive, other responses helped define specific 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.

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’s social workers, 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 teams and extended care teams members in the community who are offering services and supports which address social needs related to health.

**TODD ARCHBOLD, LSH, MBA:** I am a licensed social worker and the Chief Executive Officer at PrairieCare. PrairieCare is a privately-owned clinics led organization providing a partial hospital program (PHP) and important 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, Internal Chief Financial Officer, Chief Development Officer and PrairieCare Medical Group Practice Manager. Todd is also the Executive Director of the state’s Emergency Assistance Line (PAL), offering consultation to primary care providers.

**MAJURI JENNIFER DETERT, PA-C, MAPP, DAAPA, BA, BS CAQ:** ER, has a solo rural emergency medicine practice that serves communities surrounding St. Joseph, Minnesota. This is a physician of the Minnesota Academy of PA (MAPP) and is a retired combat veteran. MAPP’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, the Executive Director of The Minnesota Pharmacists Association (MPhA), a professional association that serves Minnesota pharmacists. The association promotes interdisciplinary collaboration and cooperation between health care professionals from many different specialty areas. Additional work focuses on reversing the trend of physician reimbursement from fee for service to fee for value 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 partnerships with other professional organizations to advance common goals and patient care through collaboration.**

**VIVIANN FISCHER, D.C.,** is the chief clinical officer of Fulcrum Health, an organization dedicated to leveraging physical medicine to transform health care. ChiroCare, the nation’s first chiropractic network launched over 35 years ago is part of the Fulcrum Health network. Dr. Fischer oversees network credentialing, utilization services, and provider support with Fulcrum Health since 2012; she is currently a Board of Trustees member at Northwestern Health Sciences University (NHWSU), and has served as a member on the Board of Directors for the Minnesota Chiropractic Association (MCA).

**JENNIFER P. LUNDLAD, PHD, MBA:** the President and CEO of Stratis Health, an organization dedicated to leveraging physical medicine to transform health care. ChiroCare, the nation’s first chiropractic network launched over 35 years ago is part of the Fulcrum Health network. Dr. Fischer oversees network credentialing, utilization services, and provider support with Fulcrum Health since 2012; she is currently a Board of Trustees member at Northwestern Health Sciences University (NHWSU), and has served as a member on the Board of Directors for the Minnesota Chiropractic Association (MCA).

**JENNIFER D:** 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 specialty areas. This 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.

**JENNIFER D:** A 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 professionals may even 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 the same in the health care setting, providing 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 in 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 help determine interventions and care plans that really work. An example of the benefit of a broad and inclusive care 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 prescribed various medications and therapies which were not as effective 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 diet habits which was used as an intervention to get 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 teams to provide the best possible patient care.

VIVI-ANN: The non-clinical care team refers to the support team assisting the patients 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 while 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 teams consist of health unit coordinators, security, facilities and food service staff, receptions, environmental services workers, information and utilization review. This could be expanded further to include the improvement performance team, administrative support roles, business office and finance personnel and the executive team.

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 connect 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-referrals into daily health care conversations in literature, webinars, remote conference events and other forums. The term catapulted SDOH and e-referral solutions into daily health care conversations. The COVID-19 pandemic and its wide-ranging health and social impacts 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-referrals into daily health care conversations in literature, webinars, remote conference events and other forums. The term catapulted SDOH and e-referral solutions into daily health care conversations.

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 reclusion 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 patient’s pain and managing the patient. 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. For example, over the past two years, we have allowed care team members to perform at the top level of scope and 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.

TODD: One of the obstacles that needed to be overcome in implementing CPS and achieving a reduction in reclusion and restraint involved the large amount of resources needed for educating, engaging and supporting staff through this adoption of philosophy and 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 in managing our staff to be mindful of the physical and psychological effects of stress and trauma on the patients we serve and to find a way to do things differently. As a psychiatric hospital and organization, 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 irritants 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 EHR, bi-directional access of information and accurate and continually updated directories of the CBO information. For payers, an example is a system that produces actionable data at the patient and population levels. Trust and relationships, 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 disciplines engaged in the patient’s care.

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hand-off to other caregivers. Today care 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 been 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 on a visit or already under treatment by 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 on, better yet, the capability to add information to patients’ electronic health records. This collaboration allows the pharmacists to access the necessary lab, 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 pharmacies 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 medical information, including imaging and lab data.

**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 medical information across healthcare organizations provides 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 cardiologist 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. Additional physicians would be involved in the treatment.

**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 our 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 would 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 the overarching 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-eferred 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, driven by COPs, VIVI-ANN, 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. It is critical that EHR vendors are building this capacity within their tools (e.g., Epic). The market is guaranteed to be different by tomorrow.

**JENNIFER L:** EHR is a communication platform that can filter and filter 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 reviewed by the PA – who identifies an abnormal rhythm. The PA supporting data requests clinic staff to contact the on-call cardiologist. The PA allows for knowledge to be shared during clinical planning 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 talent 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 the care team could access the patient’s medications and see the narrative that helps to tell the patient story. 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 should be shared by all stakeholders involved in the care team. It also removed the physician supervision agreement requirement for PAs and removed physician liability for PA practice decisions. Ensuring health care 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 applicable 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 (CIEX) 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 shared 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.

**VIVI-ANN:** All of the steps from developing a patient-centered, best practice pathway that teams can agree upon. Patients would be informed of all of the 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 should be shared by all stakeholders involved in the care team. It also removed the physician supervision agreement requirement for PAs and removed physician liability for PA practice decisions. Ensuring health care bylaws and policies reflect the most up-to-date advancements in state practice laws in an expedited manner will improve care team interoperability.

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

**JENNIFER L:** A racial equity focus is an essential component to our current and future care models. Racial equity refers to removing all medical and social needs referral approach supported by technology in Minnesota. Supporting social needs is an essential element in ensuring equity and reducing health disparities. It is widely recognized that 70%-80% of a person's health is influenced by factors 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. About identifying care team or other communities and also helps identify social needs and gaps taken together to inform policy and decision making.

**Race, ethnicity, and religion have become an increasingly important factor in terms of patient care.**

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VIVI-ANN: 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 the well-being of how cultures influence attitudes, behaviors and inclusion is one of five areas that MPA 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 members, pharmacists, students pharmacists and pharmacy technicians in these efforts.

TODD: In order to address these issues, four core needs will 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.

JENNIFER D: The care team’s interoperability improves when the overarching culture aligns, respects and embraces the diverse perspective all members bring to the team. That a culture 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 is a way for people to increase social power as well. People, especially legislatures, 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 interaction 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 include 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, beliefs, preferences and values. Most support tools can assist in notification of how and when to utilize intercultural 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 coordinates care of the team by chemistry using a tool of Fulcrum’s 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, AscNet and TinTouch, to work as a team when appropriate to meet the patient’s needs.

JENNIFER 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 is the patient voice in the emergency setting, 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 what we do in today’s environment, we set out to identify and understand current priorities and strategies for addressing social determinants of health (SDOH) such as 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 SODIH is the top priority 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 legislators to modernize PA practice statutes to reflect current barriers to ensuring that all participants can effectively voice their needs and meaningfully influence the outcomes in ways that achieve overall goals. The urgency of this effort must be carefully balanced with the time necessary for meaningful engagement and trust.

VIVI-ANN: The majority of clinical in Fulcrum’s network are small independent clinics where the electronic medical record does 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 barriers. Another barrier is costs. Advanced EMR’s are cost-prohibitive for small clinics to obtain and maintain. There is a lack of uniformity among the EMR vendors, used, and 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.

JENNIFER D: Our perspective as Minnesota PAs differs from that of the health care systems top-level management. Per the American Academy of PAs 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 legislators to modernize PA practice statutes to reflect current barriers to ensuring that all participants can effectively voice their needs and meaningfully influence the outcomes in ways that achieve overall goals. The urgency of this effort must be carefully balanced with the time necessary for meaningful engagement and trust.

VIVI-ANN: The completeness of data which reflects the context of a patient’s life. Based on more than 90 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. Interprofessional power balance is critical to ensure that all participants can effectively voice their needs and meaningfully influence the outcomes in ways that achieve overall goals. The urgency of this effort must be carefully balanced with the time necessary for meaningful engagement and trust.

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 provide an individual patient’s care, not just episodes of care. The collection of data can provide health care to patients as they need 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.