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 panelists more time to reflect on their responses. As a result, some responses helped define specifically unique areas where improvement is needed. The focus was on increasing efficiency and cost-effectiveness in health care for everyone.

SARAH DURR, PharmD, is the Executive Director of the Minnesota Pharmacists Association (MPhA), a professional association that serves Minnesota pharmacists. The association promotes interprofessional collaboration and cooperation between health care professionals from many different specialty areas. Additional work focuses on maximizing access to pharmacy services and patient education to enhance health outcomes. MPhA encourages and promotes networking among pharmacy professionals and partnerships with other professional organizations to advance common goals and initiatives. Pharmacists are involved in all clinical settings: inpatient, outpatient, and community pharmacy. This provided panelists more time to reply to the questions and in some cases consult with colleagues for a more complete 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 panelists did not agree or disagreed on specific issues, other responses helped define specifically unique areas where improvement is needed. It is clear that both the clinical care team and extended care team members must be aware of the issues around the pandemic dictate. Our discussion area about the essential needs of a health care system.

The initial stages of the COVID pandemic, medical information technologies 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 physical needs of the patient. The clinical care team is comprised of physicians, pharmacists, nurses, social workers, respiratory therapists, dietitians, nutritionists, therapists, and others.

JENNIFER D: 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. A clinical care team blends multidisciplinary professionals, allowing several insights and perspectives to offer. Clinical care teams are often used in the remote format, in-clinic, and 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. Clinical care teams operate in all clinical settings: inpatient, outpatient, skilled nursing care facilities, and surgical and specialty care.

The clinical care team is comprised of physicians, pharmacists, nurses, social workers, respiratory therapists, dietitians, nutritionists, therapists, and others, working together to provide the best care for the patient.

TODD ARCHBOLD, LSW, MBA, is a licensed social worker and the Clinical Director at HealthCare. Todd has been a part of PrairieCare since 2006 and has held many roles including Chief Operating Officer, Internal Clinical Financial Officer, Chief Development Officer, and PrairieCare Medical Group Practice Manager. Todd is also the Executive Director of the Minnesota Association for Supportive Employment (MASE), offering consultation to primary care providers.

MAJ(R) JENIFER DETERT, PA-C, MPAS, DEAAP, MA, BS, CAQ: ER, has a solo rural emergency medicine practice that serves communities surrounding St. Joseph, Minnesota. She is a President of the Minnesota Academy of Family Physicians (MAFP) and is a retired combat veteran. MAFP’s mission is to promote the professional and personal development of Minnesota’s ERs through support of 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.

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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 clinical care team.

JENNIFER D: Our perspective is on strengthening the connection between health care and community. We are currently engaged in facilitating the processes for Minnesota youth centers, health systems, community organizations and patients 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, nurses, social workers, respiratory therapists, dietitians, nutritionists, therapists, and others, working together to provide the best care for the patient.

Please define the term non-clinical care team.

JENNIFER 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, manager, clerical, maintenance and environmental staff. Non-clinical care teams 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 technologies 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 physical needs of the patient.
Care teams improve outcomes when utilizing team members at the top of license, experience, competency, education, and training.

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 voices and managing 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 of a few key non-clinical roles, to name a few, that allow care team members to perform at the top of license and scope of practice afforded by the 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 culture of positive change and initiatives that improve safety, decrease inefficiencies and creates a cohesive care team.

TOOD: 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 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 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 hospital, our culture has been one of continuous learning and improvement, and 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 EHR, bi-directional flow of information and accuracy 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 separate access to data for different purposes 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 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 organizations engaged in the process and support. There should be an express approval process before entering a referral in the common platform. This will also assist with HIPAA issues and consent for those for whom the patient does 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 to discuss a challenging medication regimen. 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: There are opportunities to improve care team. One obstacle is the lack of a clear pathway where patient care should begin when they have spine care. This process before entering a referral in the common platform. This will also assist with HIPAA issues and consent for those for whom the patient does 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 to discuss a challenging medication regimen. 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.

JENNER 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 and culture do not allow care team members to perform at the top of license 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 culture of positive change and initiatives that improve safety, decrease inefficiencies and creates a cohesive care team.

TOOD: I perceive the non-clinical care team as comprised of every individual working to deliver high quality care, is provided, but who is not part of a clinical care team. The non-clinical care team essentially provides the pillars to support the delivery of safe, high-quality health care services to patients. These roles consist of health unit coordinators, secretaries, 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.

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

JENIFER 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 community organizations addresses essential elements that were previously missing but are beneficial for good clinical decision making and support. The value of community organizations addresses essential elements that were previously missing but are beneficial for good clinical decision making and support. The value of community organizations addresses essential elements that were previously missing but are beneficial for good clinical decision making and support.
hand-off to other members. 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 platforms that can change. 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. 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 each role, play 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 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 both a hospital and an ambulatory clinic. In this case, it is important that the information is available to both care providers.

**VIVI-ANN:** Much of the discussion around health interoperability centers on the need for progress on sharing data with the patient, health plans and health care providers. Sharing of medical records among health care providers 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 uses an app to share lab results with their cardiologist. This information can be shared with the cardiologist and the patient’s primary care physician. Using such apps can improve patient care.

**TOOD:** 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, to that is so very true. Interoperability for those seeking care starts with a 90-minute in-depth assessment by a master’s prepared intake staff, who then consults with very true. Interoperability for those seeking our care starts with a 90-minute TODD: A critical practice for patients who have been discharged is follow-up care. This is where communication is critical. The information is often fragmented and not available to all health care providers. This can lead to gaps in care, which can have serious consequences. For example, if a patient had a previous adverse reaction (for example a dry cough). Increasing community pharmacist access to electronic health 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?**

**JENIFER L:** A racial equity focus is an essential component to our current health care needs. There are many resources that need 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 and determined outside the traditional health care 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 complex healthcare system. About increasing diversity in health care and communities also helps identify social needs and gaps taken together to inform policy and decision making.

**VIVI-ANN:** The state of Minnesota has a state-level HIE, which is separate from the patient’s primary care facility. Another example is working with the Minnesota Opioid Use Disorder Collaborative, which is a community information exchange. Interoperability is essential for best practice of quality patient care by allowing access to all of a patient’s 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 health information on a daily basis in their practice. Interoperability is the act of computer systems and software 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 both a hospital and an ambulatory clinic. In this case, it is important that the information is available to both care providers.

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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 ensuring equity and reducing health disparities, so our work will be done under 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 for 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 user changes, including direct use by patients or clients. Interconnected power balancing and critical elements are crucial 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.

VIVIAN: The majority of clinics 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 unanswered 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 PA’s 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. AHPA worked with legislative and modern PA practice statutes to facilitate the function and utilization of PAs as 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 asset in supporting social needs and collaborating, licensed to care for patients autonomously without direct physician involvement unless needed by patient care demands.

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 the health of how culture influences attitudes, behaviors and inclusion is one of five areas that HIPAA 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, student pharmacists and pharmacy technicians in these efforts.

TODD: In order to address these issues, four areas 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.

JENNIFER D: The care team’s interoperability improves when the overarchingly cultural system, 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. Taking time to use team 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.

VIVIAN: 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 health, not just episodes of care. From this standpoint, 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 work in today’s environment, we set out to identify and understand current priorities and strategies for addressing social determinants of health (SDOH) in Minnesota. Health plans and state public programs. Stratis Health sent a brief snapshot survey of SDOH strategies and priorities 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 for providers. 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 include hiring or utilizing community health workers and strengthening strategies for addressing social determinants of health among patients.

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.

SARAH: Improving care 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.

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JENNIFER D: We want to remind care team members that PAs are treated 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, adhering to the standards of care, quality measures and credentialing requirements as physicians. PAs are experts at meeting 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.

VIVIAN: 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 allows clinicians to access the medical picture of the patient’s health, not just episodes of care. The collection of data can provide health care providers with access to 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.

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