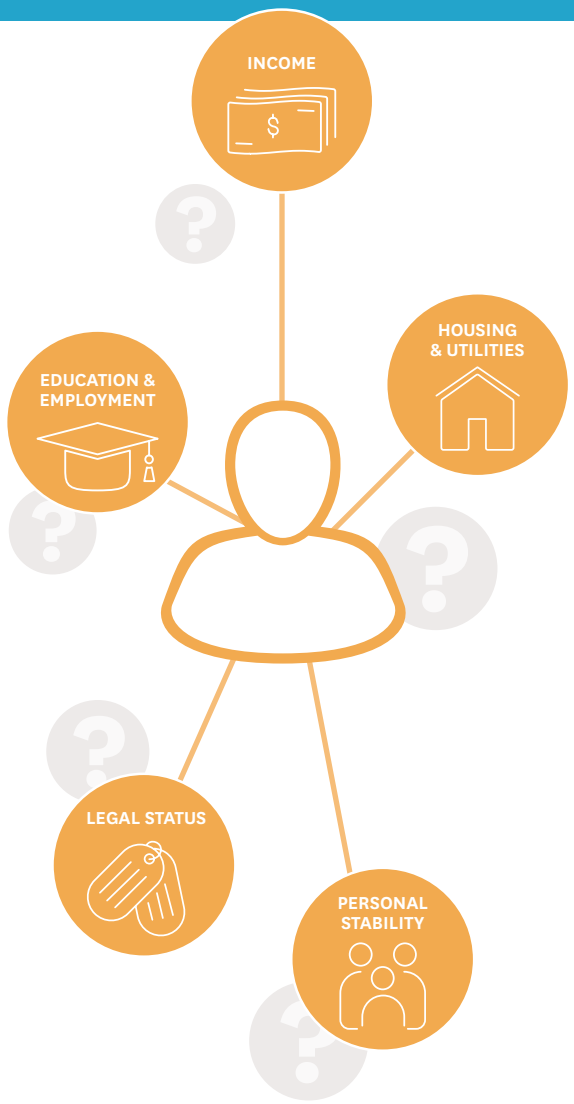
Issue Brief One

SCREENING FOR HEALTH-HARMING LEGAL NEEDS



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The evidence that social and environmental factors outside of the doctor's office have a significant impact on patient health and well-being is well-established.[1] Over the past fifteen years, the concept of medical-legal partnership (MLP) has taken hold as an effective method for addressing those social determinants of health with legal underpinnings that tend to affect the most vulnerable patients. The MLP approach embeds civil legal aid professionals in health care settings to address patient legal needs that are beyond the scope of clinical capacity and expertise. Public benefits, housing issues, and access to adequate education and associated accommodations are just a few of the health-harming issues with legal remedies that MLPs address on a daily basis.

In MLP, one of the most important responsibilities of the health care partner organization is to identify and refer patients who have health-harming legal needs to the legal partner organization. Although the MLP legal partner usually performs its own screening or legal assessment of the patient, this first initial screening by the health care partner is intended to find those patients who might not otherwise have their health-harming legal needs identified or addressed. This initial screening is essentially a gateway from the health care organization to the civil legal aid organization.

1 L. Gottlieb et al., "A Randomized Trial on Screening for Social Determinants of Health: the iScreen Study," Pediatrics 134, no. 6 (2014): e1611-e1618 (discussing findings concerning health effects of adverse social conditions on children) and R. Walker, J. Strom Williams and L. Egede, "Influence of Race, Ethnicity and Social Determinants of Health on Diabetes Outcomes," The American Journal of the Medical Sciences 351, no. 4 (2016): 366-373 (discussing health affects of adverse social conditions on adults).

Medical-legal partnerships use a variety of informal and formal methods to screen patients for health-harming legal needs, at times employing a mix of strategies within a single health care organization. Methods range from using a paper-based or EHR-based screening tool to formally screen a patient at registration, to informal, verbal screening of a patient at point of care. Each MLP sets eligibility criteria for receiving services, which at a minimum include income limits set by federal and state requirements for the provision of civil legal aid. Some MLPs report that they screen all patients, while others target specific conditions or patient populations (e.g. homeless individuals, patients with asthma). Though the health care organization and its providers may embrace the concept of screening patients for social determinants and health-harming legal needs, our data show that screening practices are often inconsistent. This means that for the majority of MLPs, true demand for these services – that is, the number of individuals who actually could benefit from civil legal services – is largely unknown. The National Center for Medical-Legal Partnership recently conducted a survey of more than 200 health care organizations with MLPs and found that only 63 percent have any type of formal screening protocol. Even fewer organizations have consistent protocols that result in all of their patients being screened.

Measurement Pilot Program

In April 2016, the National Center for Medical-Legal Partnership (NCMLP) launched a 4-month pilot program, funded by the Robert Wood Johnson Foundation, to test seven measures of performance in hospital and health center-based MLPs. Thirteen MLPs were selected to participate in the pilot through a competitive application process that, among other characteristics, had the ability to collect and track data related to patients and MLP services. The health care and legal organizations that make up each of the thirteen participating MLPs span the U.S. (see Table 1). These MLPs vary in terms of their age, though most have been operating for less than six years, and also operate in a variety of types of health care organizations. Represented among the participants are general hospitals, children's hospitals, HRSA-funded health centers, one VA medical center, and one primary care association (see Table 2).

TABLE 1. PARTICIPATING ORGANIZATIONS IN THE NCMLP MEASUREMENT PILOT PROGRAM (APRIL – AUGUST 2016)

HEALTH CARE PARTNER	LEGAL PARTNER	STATE
Arkansas Children's Hospital	Legal Aid of Arkansas	Arkansas
Beaumont Health	Legal Aid and Defenders Association, Inc.	Michigan
Cincinnati Children's Hospital Medical Center	Legal Aid Society of Greater Cincinnati	Ohio
East Tennessee State University College of Nursing Community Health Centers	Tennessee Justice Center	Tennessee
Five Rivers Health Centers	Advocates for Basic Legal Equality, Inc.	Ohio
Iowa Primary Care Association	Iowa Legal Aid	Iowa
Lancaster General Hospital	MidPenn Legal Services	Pennsylvania
Rising Sun Health Center, a program of Public Health Management Corporation	Community Legal Services, Inc.	Pennsylvania
Southern Illinois Hospital Services	Land of Lincoln Legal Assistant Foundation	Illinois
The Children's Clinic	Legal Aid Foundation of Los Angeles	California
Veterans Affairs CT Healthcare System, Errera Community Care Center	Connecticut Veterans Legal Center	Connecticut
Yale-New Haven Children's Hospital	Center for Children's Advocacy	Connecticut
Zuckerberg San Francisco General Hospital	Bay Area Legal Aid	California

TABLE 2. NCMLP PILOT PARTICIPANTS BY THE NUMBERS

HEALTH CARE ORGANIZATION TYPES	
HRSA-funded health centers	4
General Hospitals/Hospital Systems	4
Children's Hospitals	3
VA Medical Center	1
Primary Care Association	1
YEARS MLPS HAVE BEEN OPERATIONAL	
Two years or less	4
Five – six years	4
Seven – eight years	3
Ten – fourteen years	2

The participants received $10,000 to participate in a pilot test of seven measures developed by the National Center for Medical-Legal Partnership, which required them to submit monthly data on those measures. One of those measures specifically calculates the screening rate for health-harming legal needs in the health care organization, and is defined as "the percent of patients screened for health-harming legal needs among a given population." In addition to submitting monthly data and attending monthly check-in calls, the 13 participating MLPs described in detail the process they use to screen patients for health-harming legal needs. They also identified one or more goals for improving screening at their organizations. At the conclusion of the pilot, the 13 MLPs also identified a noteworthy aspect of their screening process that might provide a lesson for other MLPs interested in improving their screening protocols and activities.

Below, we identify commonalities and differences in screening processes among the 13 participants, as well as self-described best practices and goals for improvement. We also share observations on the screening measure data collected and implications for the MLP field.

Screening for Health-Harming Legal Needs: Understanding the Process

In order to better understand how health care organizations with robust MLPs operationalize screening for health-harming legal needs, we asked each of the 13 MLPs in the NCMLP Measurement Pilot to map out their process. Through its many interviews with MLPs across the country and knowledge of health care processes, NCMLP defined four basic components of the health care organization screening process, as shown in Figure 1 below.

FIGURE 1. COMPONENTS OF HEALTH CARE ORGANIZATIONS' SCREENING PROCESS FOR HEALTH-HARMING LEGAL NEEDS

1. IDENTIFYING THE PATIENT POPULATION
2. IMPLEMENTING THE SCREENING
3. DOCUMENTATION
4. TRANSFERRING THE SCREENING INFORMATION/REFERRAL

MLPs were asked to describe their screening processes according to these four components (see responses in Table 3 on pages 4-5. Note that organizations have been de-identified). Each of the 13 MLPs refer to their screening tool by a different name. For example, one MLP refers to its screener as a "Social Questionnaire," while another MLP refers to its screener as a "Legal Needs Assessment." Of particular interest was whether MLPs screen broadly for social determinants of health, or if screening focuses more specifically on health-harming legal needs only. While social determinants often have a strong link with conditions that affect health and well-being, screening tools can also be structured to identify health-harming needs that are amenable to legal interventions. Likewise, screening tools can vary in terms of the number of questions asked, with broader social determinants screeners often being lengthier than more focused legal services screening tools. Eight of the 13 MLPs in the pilot screened for social determinants of health beyond health-harming legal needs.

Several trends were observed when examining the four screening components in Figure 1 across the 13 MLPs.

IDENTIFYING THE PATIENT:

- Ambitiously, approximately half of the MLPs set a goal to screen all patients. Others target their screening efforts by location (i.e., a particular clinic) or patient type (i.e., all children or pregnant women).
- More than half of the 13 MLPs begin the screening process when patients enter a waiting room setting. A few start the process at a single point of care or at various points of care, for example, when the patient meets with the physician or the home-health worker.

IMPLEMENTING THE SCREENING:

- Though nearly all of the 13 MLP health care organizations have an electronic health record (EHR), 9 out of the 13 MLPs use a paper-based screening tool.
- When asked where the screening tool is administered, the 13 MLPs responded with a mix of "registration" and "point of care" responses. Some listed various or both locations.
- Five of the 13 MLPs use a tool that can be self-administered. The other MLPs use a range of health care partner professionals to administer the health-harming legal needs screener, including social workers, nurses, medical assistants, home health workers, and physicians. A few MLPs indicated that peer specialists, case managers, and attorneys screened patients for health-harming legal needs at the health care partner site.

DOCUMENTING THE SCREENING:

- Though most of the 13 MLPs use a paper-based screening tool, more than half (8 out of 13) enter the results of the screening into an electronic health record. Others use some sort of tracking tool or scan the results into a database for research use. Two organizations do not document screening at all.

TRANSFERRING THE INFORMATION/REFERRAL:

- About half of the MLPs (7 of 13) use a fax machine as the primary method to transfer screening information from the health care partner to the legal partner. Several MLPs reported using a variety of methods to transmit screening information, such as e-mail, phone, or warm hand-offs. Three out of the 13 MLPs use an EHR at least some of the time for referrals.

TABLE 3. PROCESS FOR SCREENING FOR HEALTH-HARMING LEGAL NEEDS AT 13 HEALTH CARE ORGANIZATIONS

SCREENING FOR HEALTH-HARMING LEGAL NEEDS IN 13 HEALTH CARE ORGANIZATIONS

	IDENTIFY PATIENT POPULATION		IMPLEMENT SCREENING			DOCUMENT THE SCREENING	TRANSFER INFORMATION
	Who receives the screening	**Where the screening is completed in the organization**	**What type of screening tool is used (paper, oral, EHR)**	**When is the screening administered – registration or point of care?**	**Who administers the screening tool**	**How the results of screening are documented**	**How the information [positive screen/ referral] gets to the legal partner**
Institution A	Pediatric patients	Waiting room	Paper	Registration	Self-administered, submitted to nurse at triage	Results entered into tracking tool by data analyst, positive screens entered into EHR	Referral via fax
Institution B	Pediatric patients	Waiting room	Paper	Registration or during meeting with social worker	Registration staff or social worker administers	Results entered into tool sheet by social worker	Referral via fax

SCREENING FOR HEALTH-HARMING LEGAL NEEDS IN 13 HEALTH CARE ORGANIZATIONS

	IDENTIFY PATIENT POPULATION		IMPLEMENT SCREENING			DOCUMENT THE SCREENING	TRANSFER INFORMATION
Institution C	Pediatric patients and pregnant women	Waiting room	Paper	Registration	Self-administered, submitted to patient navigator	Results entered into EHR	Referral via fax or e-mail
Institution D	Pediatric patients	Waiting room and/or point of care	Paper and EHR	Registration and/or point of care	1) Self-administered, submitted to medical assistant; or 2) Provider verbally administers questions listed in EHR	Results entered into EHR	Referral entered into EHR (prints directly to onsite MLP legal partner office)
Institution E	All patients	Waiting room	Paper	Registration	Self-administered, submitted at registration and reviewed by social worker	Does not document screening	Referral via fax or e-mail
Institution F	All patients	Point of care	EHR	Point of care	Nurse or medical assistant administers	Results entered into EHR	1) Referral via phone or e-mail; or 2) Contact info for legal partner provided to patient ; or 3) "Curbside consult": provider calls MLP legal partner while patient is present at clinic
Institution G	High-utilizer patients	Patient's home	EHR	First home visit	Patient care navigator administers	Results entered into EHR	Referral via e-fax
Institution H	All patients	Point of care	EHR	Point of care	Medical assistant administers, reviewed by provider	Results entered into EHR	1) Referral via warm hand-off; or 2) Referral via weekly report to MLP legal partner
Institution I	Cancer patients	Various points	Paper	Various points	Case manager or financial navigator administers	Results entered into EHR	Referral via fax or e-mail
Institution J	All patients	Various points	Verbal	Various points	Provider, social worker, or home health worker administers	Does not document screening	1) Referral via EHR; or 2) Provider gives patient MLP legal partner contact information
Institution K	All new patients	Point of care	Paper	Point of care	Clinician or peer specialist administers	Results scanned for research purposes only	Referral via e-mail, fax, or warm hand-off
Institution L	Pediatric patients	Waiting room	Paper	Registration	Self-administered, submitted to provider	Results entered into EHR	Referral via phone or warm hand-off
Institution M	All patients	Waiting room	Paper	Point of care	Attorney or volunteer administers, submitted at registration	Results entered into EHR	Referral via warm hand-off one afternoon per week

Strengths and Areas for Improvement in the Screening Process

At the beginning of the pilot project, we asked the 13 MLPs to offer their expertise, and to share one strength of the screening process that they built and refined over time. Additionally, we asked each MLP to identify one area for improvement for continued work post-pilot participation. The results, detailed in Table 4 (note that organizations have been de-identified), indicate that the ability to use an EHR to capture and track screening data is viewed as an asset or capability that MLPs desire. Four out of 13 MLPs said that EHR integration or plans for integration is a strength of their screening process. Four out of 13 MLPs also listed integrating the screener or documenting screening information in the EHR as a top area for improvement for their program's screening process.

Additionally, (1) adopting a formalized screening process; and (2) capturing the broadest number of patients and social determinants of health were priority areas for improvement among the MLPs. Three MLPs said that the fact that their screening tool is broad and captures a multitude of social determinant issues is a strength of their program. Three MLPs also set goals of formalizing their screening process and consistently administering their screening tools. Two MLPs believe that their programs should screen more patients by setting a goal to screen all patients at their initial visit and to expand the availability of the staff responsible for administering screening. Lastly, two MLPs believe that a high awareness of social determinants of health among providers is an asset to their organization's screening process.

TABLE 4. SELF-DESCRIBED STRENGTHS AND AREAS FOR IMPROVEMENT IN SCREENING FOR HEALTH-HARMING LEGAL NEEDS AT 13 HEALTH CARE ORGANIZATIONS

INSTITUTION	STRENGTH OF CURRENT SCREENING PROCESS	AREA FOR IMPROVEMENT
Institution 01	Facilitate awareness of social determinants among providers	Formalize screening process by using consistent tools and processes
Institution 02	Facilitate awareness of social determinants among providers	Integrate screening data into the EHR
Institution 03	Use screening tool that captures a breadth of issues	Streamline data collection through various screening processes
Institution 04	Employ an MLP Coordinator to increase efficiency of MLP	Integrate screening data into the EHR
Institution 05	Integrate screening data into the EHR	Formalize screening process by using consistent tools and processes
Institution 06	Integrate screening data into the EHR	Improve communication between providers and lawyers
Institution 07	Capture a breadth of social determinants of health issues	Formalize screening process by using consistent tools and processes
Institution 08	Planning to integrate screening data into the EHR	Integrate screening data into the EHR
Institution 09	Committed to screening process and desire to screen all patients	Screen more patients
Institution 10	Screen all patients for one social determinant	Broaden screening tool to capture additional social determinants of health
Institution 11	Integrate screening data into the EHR	Make screening process efficient by allowing MLP legal partner to have electronic access to referrals
Institution 12	Streamline screening process with face-to-face screening by same staff member	Screen more patients
Institution 13	Capture a breadth of social determinants of health issues	Integrate screening data into the EHR

Measuring and Improving Screening Rates at Health Care Organizations

The 13 MLPs participating in the NCMLP Measurement Pilot submitted monthly data for four months on their screening rates. MLPs were provided with specific instructions and a definition for the screening measure that they reported on. The definition for NCMLP's Screening Measure is as follows:

SCREENING MEASURE CALCULATION*:

Total number of patients in a given population who were screened for HHLN in the past month

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Total number of patients in a given population who were seen at the health care partner in the past month

* More information on how this measure is defined can be found in the NCMLP Performance Measures Handbook.

One limiting factor of this measure is that in the absence of any definition or consensus in the field about the population(s) that should be screened, the measure allows the MLP to define the patient population eligible to be screened. Therefore, a comparison of the results of measure 2 across 13 organizations, with varying policies on who should be screened, provides limited usefulness for the field. At the same time, NCMLP did glean some valuable information from each individual organization's approach to this measure.

During the pilot, participants were tasked first and foremost with submitting accurate data to NCMLP on the assigned measures. They were also encouraged, in the spirit of quality improvement, to use the data to gain new insights into their program operations and to make any changes or improvements that might improve the efficiency and effectiveness of the MLP. Though the pilot was designed to set the groundwork for testing and implementing changes to screening processes; in the process, we observed the seeds of meaningful steps toward data collection and quality measurement.

Four of the 13 MLPs reported a noticeable increase in their screening measure results between the start and end of the pilot. Three of the four MLPs that reported an improvement were in the process of implementing screening for the first time in areas of their organizations that had not previously screened for health-harming legal needs. The fact that these organizations were focusing in new areas may account for the upward trend – training, support, and interest may have been more intensive during this startup phase. At the same time, without data these organizations would not have known if their new screening processes were taking hold in these new areas.

Example from the Field: Implementing a Screening Tool for Health-Harming Legal Needs

Arkansas Children's Hospital attributes its successful screening rates to the thoughtful approach MLP staff took gaining buy-in and input from other health care organization staff prior to implementing its screening process. MLP attorneys and hospital social workers approached the nurse manager of the Circle of Friends Clinic — a general pediatrics clinic that serves as a medical home for many of its patients — early on. Nurses and patient information assistants were trained on how to administer the new screening tool before the tool was implemented. This allowed time for them to provide their feedback and to make any refinements to the tool and the process.

During the first week of administering the screening tool, the schedule was adjusted so that either an MLP attorney or social worker was on hand to answer any questions that the nurses had. Monthly meetings with clinic staff were held to review the data collected on the screening tools, answer questions, and to provide success stories of patients who received critical MLP services as a result of being screened for health-harming legal needs.

"We have heard many examples from nurses where they learned a family had a social need only through the screener (such as a housing issue), that they most likely would not have learned otherwise. There was early pushback from the nurses about the time it takes to follow through with the actions of the screener, but most nurses now see the importance of doing it."

ARKANSAS CHILDREN'S MLP STAFF MEMBER

One participating children's hospital reported a significant increase in the percentage of patients screened in an area of the organization where screening had already been implemented. After seeing less than expected results of their screening data in the first month, the MLP identified "documentation of screening" as a potential weakness of their current process and a possible explanation for the low screening rate. Through additional training of staff, they were able to raise their screening rate from 16 percent in April to 51 percent in July.

Although their screening rates remained steady during the pilot, two of the MLPs used the data obtained from screening as well as referral data to identify potential areas for improvement in their process. One MLP, for example, said that in the past they had focused on increasing referrals to the MLP and did not track individuals who had been referred to the MLP but never made contact with an MLP attorney. The data at the start of the pilot showed that 50 percent of referred patients never made contact with the MLP attorney. Through training, additional screeners, and putting MLP attorneys on call to meet patients when they initially screened positive, the organization adopted a "warm referral" process, and reduced the amount of patients lost to follow up post-screening to 14 percent.

Lessons for the Field

In the absence of formalized and consistent screening for health-harming legal needs, it is impossible for the MLP legal partner to know whether they are reaching all of the people in desperate need of their services. Screening serves several purposes, including identifying true "demand" for civil legal aid services. Likewise, without screening, health care organizations do not have the necessary information to assess the prevalence of health-harming legal needs among their patient populations. Unfortunately, there is little consensus in the MLP or social determinants field about which patients should be screened and how they should be screened. The experiences of the NCMLP Measurement Pilot Program participants provide some insights into the screening process for MLPs. We found that:

1. Most MLPs are committed to screening many or all patients across multiple social determinant of health issues.
2. There is widespread belief among the 13 MLPs that EHR integration has the ability to strengthen and enable consistency in the screening process. Some MLP participants believe that the EHR should have an embedded screening tool electronically accessible for providers to administer. Other MLPs believe that the EHR should at a minimum include the results of the screening process, and should be used to document referrals to the MLP.
3. Although all of the participating MLPs either had a formalized screening process or were in the process of adopting one, tracking data on the effectiveness of their screening process was new to most. This could be due to the lack of resources that many MLPs struggle with, a fear of "opening the floodgates" to more patients than the MLP can handle, or other factors.
4. All 13 MLPs were able to submit monthly data on their screening rates, demonstrating that regularly collecting data on NCMLP's Screening Measure is feasible. For many of the pilot MLPs, having this new screening data meant that they could track whether the screening tool that they had invested in was being administered to patients in their target population. If screening rates were lower than expected, MLP pilot sites honed in on aspects of their screening process to improve or further delineate their process.
5. Many MLPs rely on a variety of clinical and non-clinical staff in health care organizations to support the screening and referral process. MLPs are often supported by a small number of staff at the legal organization, and few if any staff at the health care organization. However, screening patients for health-harming legal needs and other social determinants, and ensuring that they reach the right services often requires a coordinated effort across the health care organization. MLPs appear to design screening processes differently, including who should administer the screening tool, review the results of the screening, document the results, and submit the referral. A few of the pilot participants emphasized that health care staff buy-in and an appreciation for the impact of MLP intervention can have an influence on getting more health care organization staff to see the importance of screening.

In the future, NCMLP plans to use this knowledge to refine its screening performance measure and recommended screening tool. Over the next few years, NCMLP also hopes to seek input from MLPs on what potential standards for screening populations with potential health-harming legal needs could look like. Lastly, NCMLP will continue to identify and collect best practices in screening for social determinants of health, including those with legal implications.

MISSION

The mission of the National Center for Medical-Legal Partnership (NCMLP) is to improve the health and well-being of people and communities by leading health, public health, and legal sectors in an integrated, upstream approach to combating health-harming social conditions. NCMLP leads the research, resource development, and systems change needed to grow medical-legal partnerships across the U.S. and reach communities in need.

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