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Tackling Social Needs through Screening and Medical-Legal Partnership Referrals in a Primary Health Care Clinic

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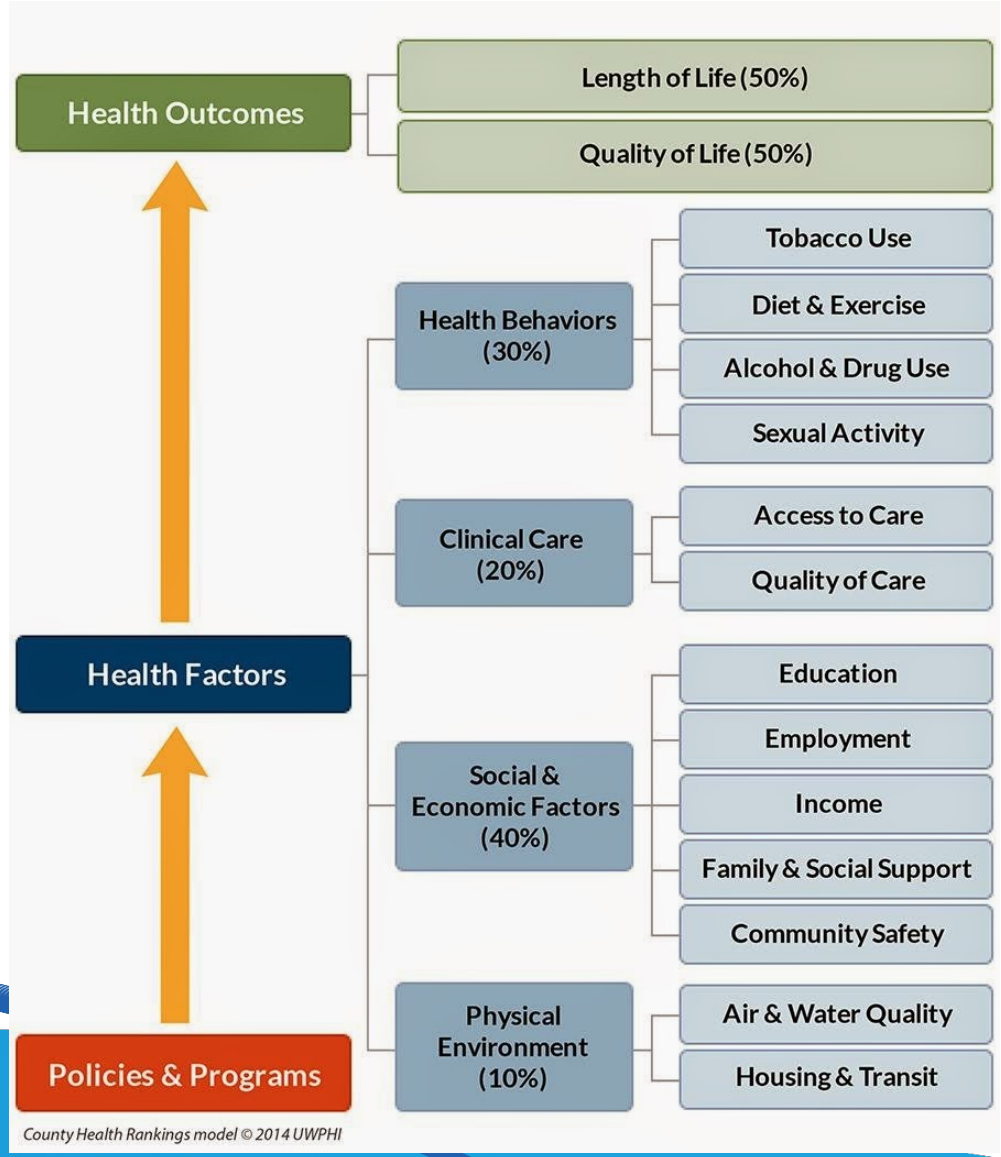
Health Care not Sick Care



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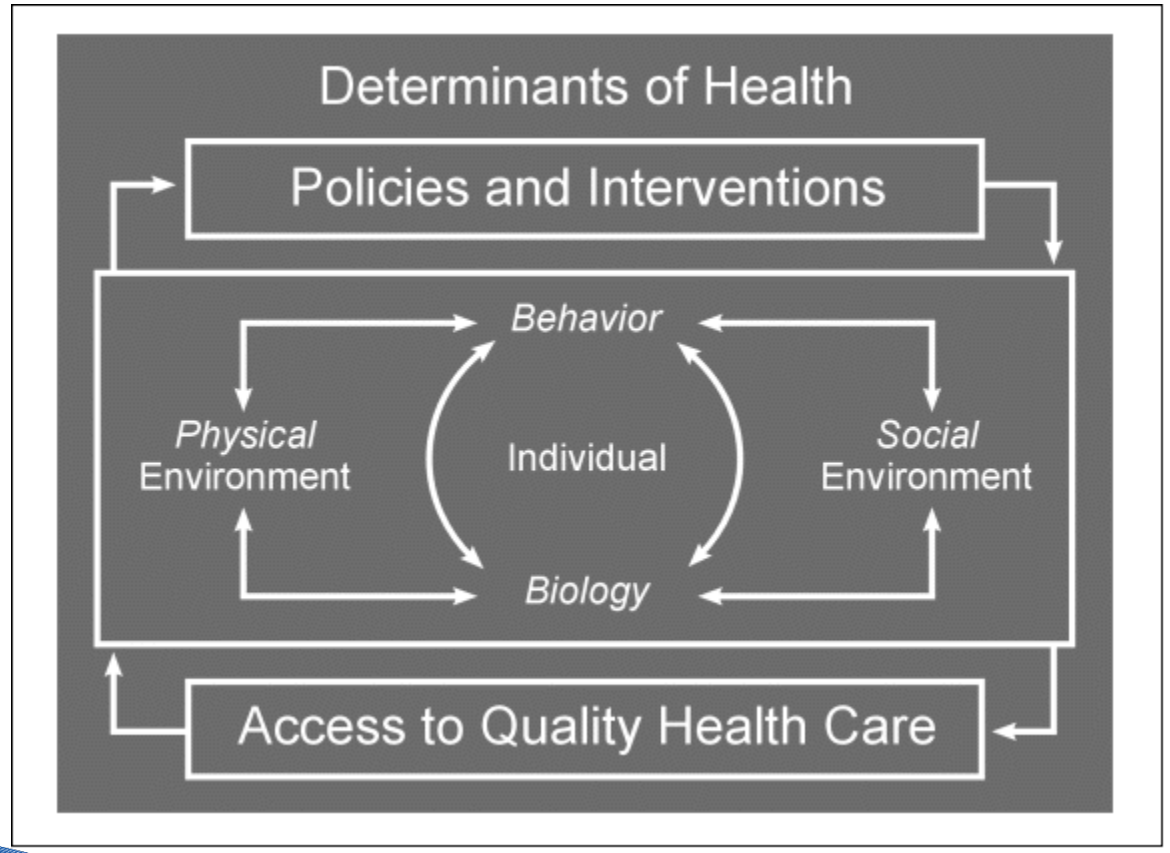
Population Health



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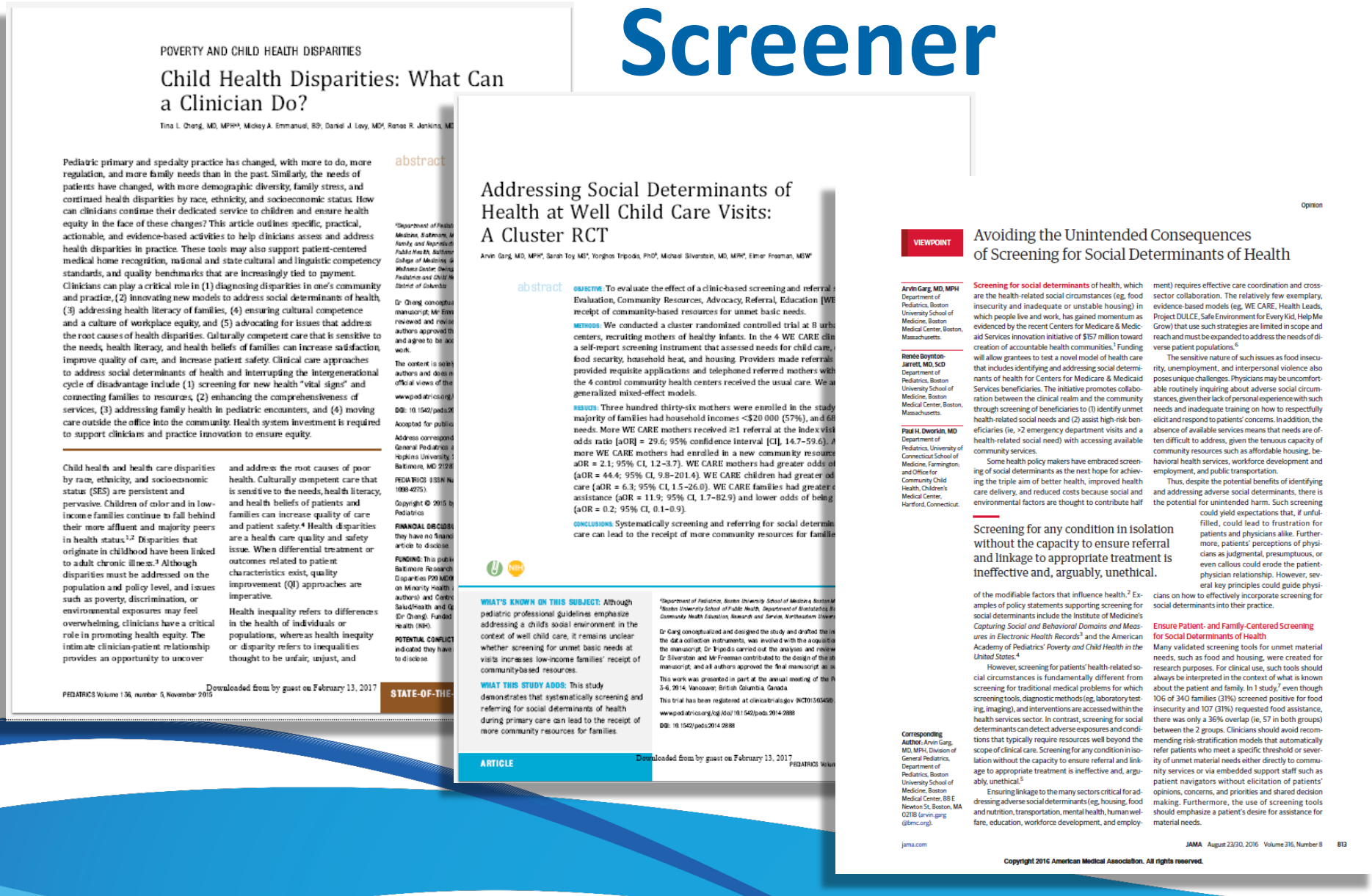
Evidence-Base for Social Health Screener



POVERTY AND CHILD HEALTH DISPARITIES

Child Health Disparities: What Can a Clinician Do?

Tina L. Cheng, MD, MPH[a], Mickey A. Emmanuel, BS[a], Daniel J. Levy, MD[a], Renee R. Jenkins, MD

abstract

Pediatric primary and specialty practice has changed, with more to do, more regulation, and more family needs than in the past. Similarly, the needs of patients have changed, with more demographic diversity, family stress, and continued health disparities by race, ethnicity, and socioeconomic status. How can clinicians continue their dedicated service to children and ensure health equity in the face of these changes? This article outlines specific, practical, actionable, and evidence-based activities to help clinicians assess and address health disparities in practice. These tools may also support patient-centered medical home recognition, national and state cultural and linguistic competency standards, and quality benchmarks that are increasingly tied to payment. Clinicians can play a critical role in (1) diagnosing disparities in one's community and practice, (2) innovating new models to address social determinants of health, (3) addressing health literacy of families, (4) ensuring cultural competence and a culture of workplace equity, and (5) advocating for issues that address the root causes of health disparities. Culturally competent care that is sensitive to the needs, health literacy, and health beliefs of families can increase satisfaction, improve quality of care, and increase patient safety. Clinical care approaches to address social determinants of health and interrupting the intergenerational cycle of disadvantage include (1) screening for new health "vital signs" and connecting families to resources, (2) enhancing the comprehensiveness of services, (3) addressing family health in pediatric encounters, and (4) moving care outside the office into the community. Health system investment is required to support clinicians and practice innovation to ensure equity.

Child health and health care disparities by race, ethnicity, and socioeconomic status (SES) are persistent and pervasive. Children of color and in low-income families continue to fall behind their more affluent and majority peers in health status.[1,2] Disparities that originate in childhood have been linked to adult chronic illness.[3] Although disparities must be addressed on the population and policy level, and issues such as poverty, discrimination, or environmental exposures may feel overwhelming, clinicians have a critical role in promoting health equity. The intimate clinician-patient relationship provides an opportunity to uncover and address the root causes of poor health. Culturally competent care that is sensitive to the needs, health literacy, and health beliefs of patients and families can increase quality of care and patient safety.[4] Health disparities are a health care quality and safety issue. When differential treatment or outcomes related to patient characteristics exist, quality improvement (QI) approaches are imperative.

Health inequality refers to differences in the health of individuals or populations, whereas health inequity or disparity refers to inequalities thought to be unfair, unjust, and

STATE-OF-THE-

Addressing Social Determinants of Health at Well Child Care Visits: A Cluster RCT

Arvin Garg, MD, MPH[a], Sarah Toy, MS[a], Yonghos Tripodis, PhD[b], Michael Silverstein, MD, MPH[c], Elmer Freeman, MSW[a]

abstract

OBJECTIVE: To evaluate the effect of a clinic-based screening and referral [...] Evaluation, Community Resources, Advocacy, Referral, Education [WE] receipt of community-based resources for unmet basic needs.

METHODS: We conducted a cluster randomized controlled trial at 8 urb[an] centers, recruiting mothers of healthy infants. In the 4 WE CARE clin[ics] a self-report screening instrument that assessed needs for child care, [...] food security, household heat, and housing. Providers made referrals [...] provided requisite applications and telephoned referred mothers with [...] the 4 control community health centers received the usual care. We a[...] generalized mixed-effect models.

RESULTS: Three hundred thirty-six mothers were enrolled in the study [...] majority of families had household incomes <$20 000 (57%), and 68 [...] needs. More WE CARE mothers received ≥1 referral at the index visi[t] odds ratio [aOR] = 29.6; 95% confidence interval [CI], 14.7–59.6). [...] more WE CARE mothers had enrolled in a new community resource [...] aOR = 2.1; 95% CI, 1.2–3.7). WE CARE mothers had greater odds o[f] (aOR = 44.4; 95% CI, 9.8–201.4). WE CARE children had greater od[ds] care (aOR = 6.3; 95% CI, 1.5–26.0). WE CARE families had greater [...] assistance (aOR = 11.9; 95% CI, 1.7–82.9) and lower odds of being [...] (aOR = 0.2; 95% CI, 0.1–0.9).

CONCLUSIONS: Systematically screening and referring for social determin[ants] care can lead to the receipt of more community resources for familie[s]

WHAT'S KNOWN ON THIS SUBJECT: Although pediatric professional guidelines emphasize addressing a child's social environment in the context of well child care, it remains unclear whether screening for unmet basic needs at visits increases low-income families' receipt of community-based resources.

WHAT THIS STUDY ADDS: This study demonstrates that systematically screening and referring for social determinants of health during primary care can lead to the receipt of more community resources for families.

ARTICLE

VIEWPOINT

Avoiding the Unintended Consequences of Screening for Social Determinants of Health

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Screening for social determinants of health, which are the health-related social circumstances (eg, food insecurity and inadequate or unstable housing) in which people live and work, has gained momentum as evidenced by the recent Centers for Medicare & Medicaid Services innovation initiative of $157 million toward creation of accountable health communities.[1] Funding will allow grantees to test a novel model of health care that includes identifying and addressing social determinants of health for Centers for Medicare & Medicaid Services beneficiaries. The initiative promotes collaboration between the clinical realm and the community through screening of beneficiaries to (1) identify unmet health-related social needs and (2) assist high-risk beneficiaries (ie, >2 emergency department visits and a health-related social need) with accessing available community services.

Some health policy makers have embraced screening of social determinants as the next hope for achieving the triple aim of better health, improved health care delivery, and reduced costs because social and environmental factors are thought to contribute half of the modifiable factors that influence health.[2] Examples of policy statements supporting screening for social determinants include the Institute of Medicine's *Capturing Social and Behavioral Domains and Measures in Electronic Health Records*[3] and the American Academy of Pediatrics' *Poverty and Child Health in the United States*.[4]

> Screening for any condition in isolation without the capacity to ensure referral and linkage to appropriate treatment is ineffective and, arguably, unethical.

However, screening for patients' health-related social circumstances is fundamentally different from screening for traditional medical problems for which screening tools, diagnostic methods (eg, laboratory testing, imaging), and interventions are accessed within the health services sector. In contrast, screening for social determinants can detect adverse exposures and conditions that typically require resources well beyond the scope of clinical care. Screening for any condition in isolation without the capacity to ensure referral and linkage to appropriate treatment is ineffective and, arguably, unethical.[5]

Ensuring linkage to the many sectors critical for addressing adverse social determinants (eg, housing, food and nutrition, transportation, mental health, human welfare, education, workforce development, and employment) requires effective care coordination and cross-sector collaboration. The relatively few exemplary, evidence-based models (eg, WE CARE, Health Leads, Project DULCE, Safe Environment for Every Kid, Help Me Grow) that use such strategies are limited in scope and reach and must be expanded to address the needs of diverse patient populations.[6]

The sensitive nature of such issues as food insecurity, unemployment, and interpersonal violence also poses unique challenges. Physicians may be uncomfortable routinely inquiring about adverse social circumstances, given their lack of personal experience with such needs and inadequate training on how to respectfully elicit and respond to patients' concerns. In addition, the absence of available services means that needs are often difficult to address, given the tenuous capacity of community resources such as affordable housing, behavioral health services, workforce development and employment, and public transportation.

Thus, despite the potential benefits of identifying and addressing adverse social determinants, there is the potential for unintended harm. Such screening could yield expectations that, if unfulfilled, could lead to frustration for patients and physicians alike. Furthermore, patients' perceptions of physicians as judgmental, presumptuous, or even callous could erode the patient-physician relationship. However, several key principles could guide physicians on how to effectively incorporate screening for social determinants into their practice.

Ensure Patient- and Family-Centered Screening for Social Determinants of Health

Many validated screening tools for unmet material needs, such as food and housing, were created for research purposes. For clinical use, such tools should always be interpreted in the context of what is known about the patient and family. In 1 study,[7] even though 106 of 340 families (31%) screened positive for food insecurity and 107 (31%) requested food assistance, there was only a 36% overlap (ie, 57 in both groups) between the 2 groups. Clinicians should avoid recommending risk-stratification models that automatically refer patients who meet a specific threshold or severity of unmet material needs either directly to community services or via embedded support staff such as patient navigators without elicitation of patients' opinions, concerns, and priorities and shared decision making. Furthermore, the use of screening tools should emphasize a patient's desire for assistance for material needs.

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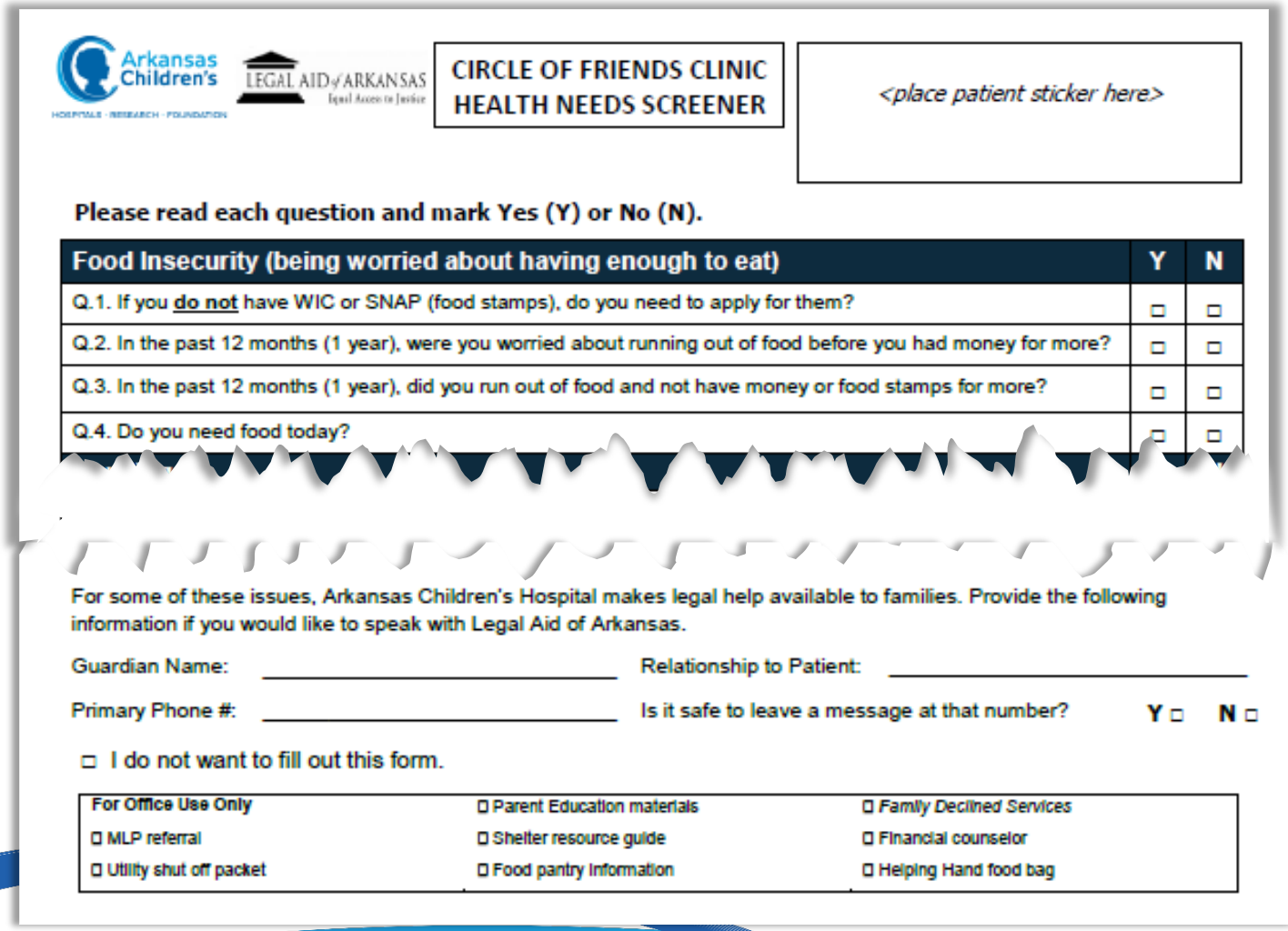
Social Determinants of Health Screener



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LEGAL AID of ARKANSAS Equal Access to Justice

CIRCLE OF FRIENDS CLINIC HEALTH NEEDS SCREENER

<place patient sticker here>

Please read each question and mark Yes (Y) or No (N).

Food Insecurity (being worried about having enough to eat)	Y	N
Q.1. If you **do not** have WIC or SNAP (food stamps), do you need to apply for them?	☐	☐
Q.2. In the past 12 months (1 year), were you worried about running out of food before you had money for more?	☐	☐
Q.3. In the past 12 months (1 year), did you run out of food and not have money or food stamps for more?	☐	☐
Q.4. Do you need food today?	☐	☐

For some of these issues, Arkansas Children's Hospital makes legal help available to families. Provide the following information if you would like to speak with Legal Aid of Arkansas.

Guardian Name: _____ Relationship to Patient: _____

Primary Phone #: _____ Is it safe to leave a message at that number? Y ☐ N ☐

☐ I do not want to fill out this form.

For Office Use Only	☐ Parent Education materials	☐ *Family Declined Services*
☐ MLP referral	☐ Shelter resource guide	☐ Financial counselor
☐ Utility shut off packet	☐ Food pantry information	☐ Helping Hand food bag

- Created based on evidence-based, patient-family needs, and bridging of stakeholder groups
- Focus areas:
  - Food insecurity
  - Housing
  - Education
  - Health Insurance
  - Parent Education
- Started April 2016 in COF clinic – currently in 3 clinics with plans to expand

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Arkansas Children's Screener Planning/Process

Why is the screener bright green?

- Selecting the questions
  - Pilot evaluation program with National Center for Medical-Legal Partnership
  - Previous food insecurity screening questions
  - Literature on social determinants of health

- "PDSA" cycles
  - Start small (one clinic hallway) with frequent feedback and revisions

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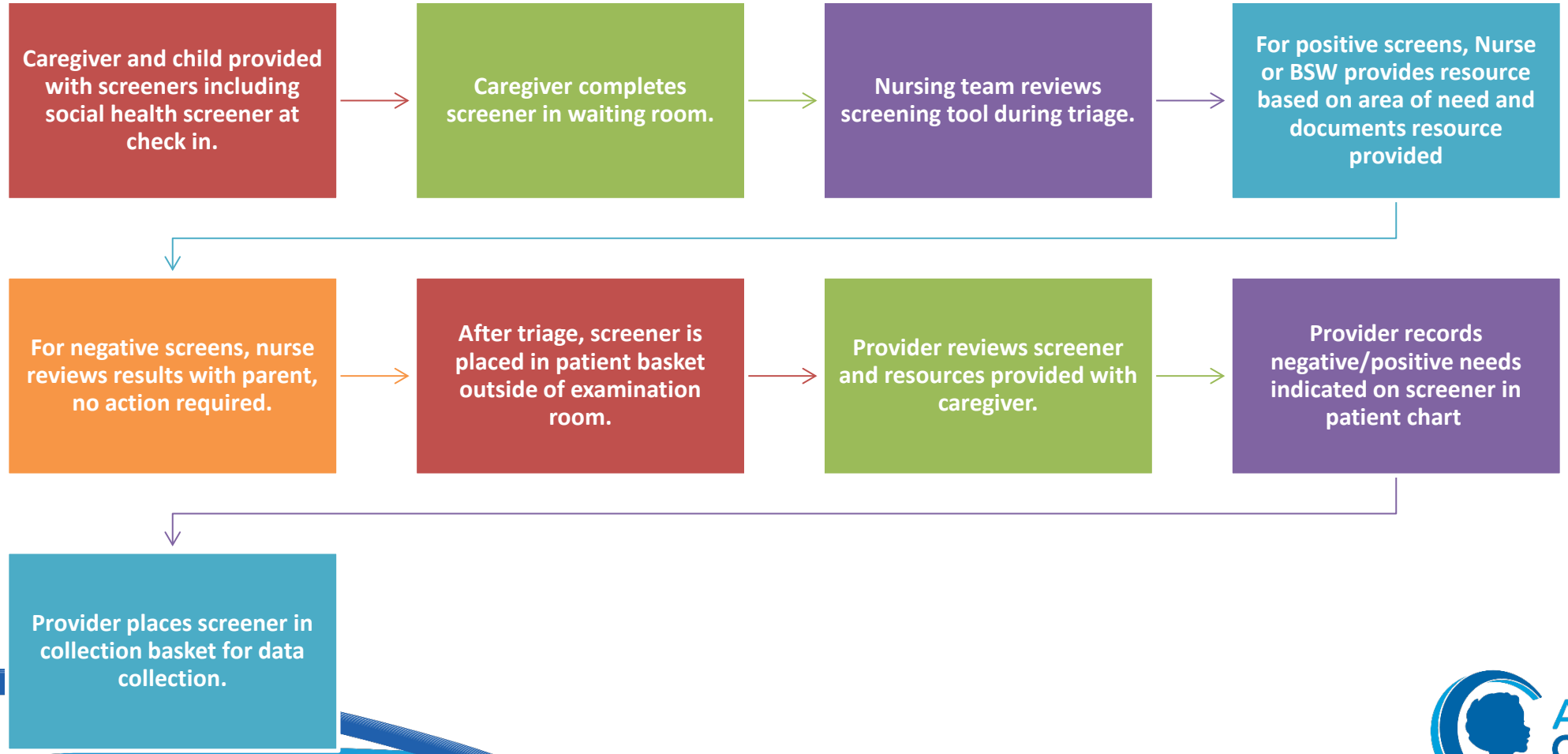
Arkansas Children's Screener Process: Nurse-driven



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Social Health Screener Interventions

Food Security

- SNAP and WIC
- Food Pantry List
- Groceries to take home

Housing

- Eviction MLP Referral
- Homelessness shelter resource guide
- Utility shut off packet and letters of medical necessity

Education

- MLP Special Education fellow, all + screens for education are automatic MLP referral.
- -Developing self-help tools for caregivers

Arkansas Children's Screening Tool - Challenges

- Response to push back
- Culture change
- Buy-In v. Ownership
  - PIA taking ownership of copying/printing the screener
  - Nursing staff taking charge of SNAP/WIC application need
  - Nurses advocating for more food resources
  - Participation in quality improvement project
- Manage expectations
  - Moving forward, we model behavior so clinic staff becomes more comfortable with owning and directing the process

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Medical-Legal Partnership

- Arkansas Children's has a partnership with Legal Aid of Arkansas and Walmart Legal.
- Attorneys are specialists on the healthcare team providing "diagnosis" and "treatment" of legal issues that are impacting health.

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Referrals to Medical-Legal Partnership

- MLP receives referrals from 3 sources:
  - Screener
  - Local Champion
  - Self-Referrals
- MLP provides training to healthcare team about legal issues faced by client population, screening tool, referral process
- PROCESS:

Referral → Eligibility Intake → Legal Interview → Legal Services → Provider Feedback (closed loop referral)

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Case Example

- Client was referred to the Medical-Legal partnership because her landlord had denied her reasonable accommodation request. He two year old son had a condition necessitating use of a wheel chair. The issue was that the client lived on the third floor of her apartment complex. This caused her to have to carry the child and the wheelchair up over thirty stairs in order to access her apartment. She repeatedly asked for a first-floor unit and even provided medical documentation, but her requests were ignored for months.

  Legal Aid intervened and made contact with the landlord. We were able to get her a full release from her lease so that she could move into a more suitable unit.

MLP Successes

- In 2017, the MLP provided a financial benefit of **$162,682** for Arkansas Children's patient/families
- Won 2017 Outstanding MLP Award from the National Center for Medical-Legal Partnership (NCMLP)
- Arkansas Children's MLP was one of two MLPs nationally to be chosen for an evaluation project with the NCMLP

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MLP Summit

- June 8, 2018
- Children's Hall, Arkansas Children's Hospital
- Information about MLP, including
  - Why MLP works
  - How to start an MLP
  - Proposed statewide MLP network
  - Proposed MLP collaboration

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Social Determinants of Health Screening Data

COF Social Needs Screener Data April 2016- March 2018	# Responses	%
At least 1 positive need on screener	6864	44.3%
% with at least 1 positive need on screener		
Food Insecure Families	4372	28.2%
% of Food Insecure Families by Month		
At least 1 Housing Need	2348	15.2%
% with at least 1 positive housing need on screener		
At least 1 Education Need (school-age children)	1080	17.1%
% with at least one Education need (school-age children)		
At least 1 Medicaid need (started August 2017)	364	9.6%
% with at least 1 positive Medicaid need on screener		
Information on GED/ESL classes requested (started August 2017)	316	8.4%

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Screener Data and Program Successes April 2016-March 2018

Total patients screened:	**28,180**
Resource Provided	# of resources
Utility Shut Off packet given	1187
Parent Education Materials	135
Shelter resource guide given	302
Food pantry information given	3491
Family Declined Services	121
Financial Counselor Information given	1259
Helping Hand Food Bag given	1803
MLP Referrals	1117

*Based on checkboxes marked on screener – this has been an underestimate of actual resources provided

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Future plans for screener and MLP

- Expansion to other clinics and NWA hospital
- Continued work on Community Resource Directory- universal resource guide for patient/family/providers
- Integration of screener and referrals (including MLP, financial counselor, and community referrals) into Epic medical record system

Questions?

Thank you. Questions? Contact:

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