HRSA
Health Resources & Services Administration

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

Housekeeping

- Attendees are muted throughout the webinar.

- Type questions into Questions & Answers pane.

- To activate captions, select "Live Transcript" and "Show Subtitle."

- This webinar will be recorded and shared at medical-legalpartnership.org/resources/

- Send a chat to the Hosts & Panelists for help.
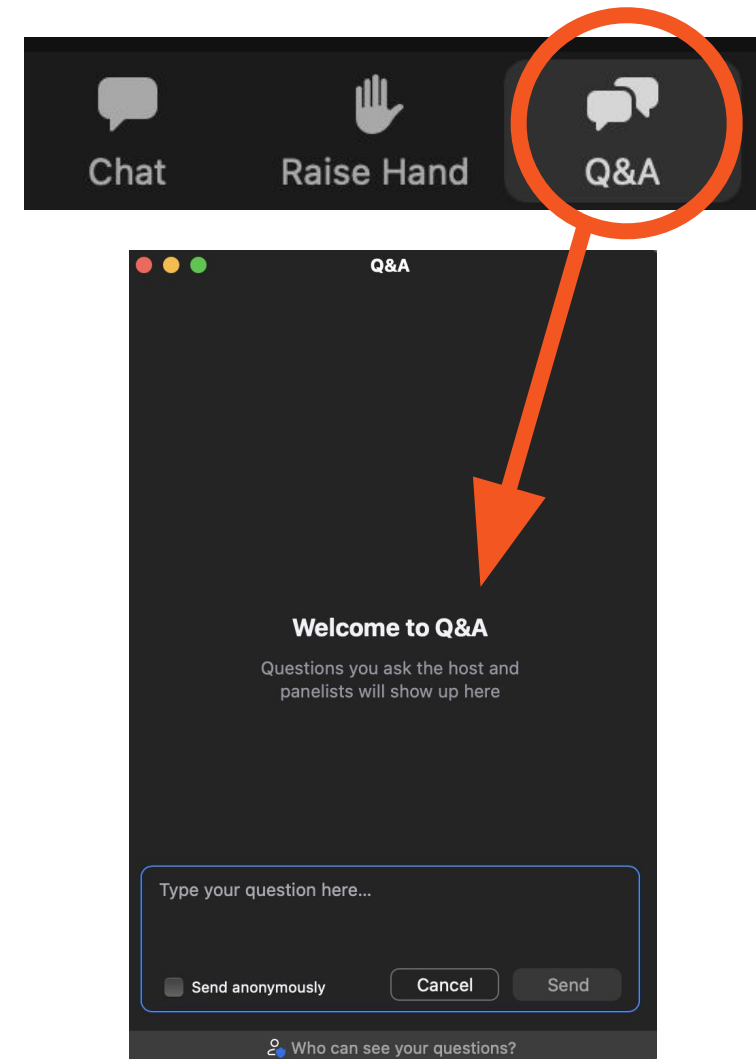
Icebreaker | Poll Questions #1 and #2:

1. Tell us who you are:

- – FQHC or Look-Alike
- – Legal Services Organization
- – Hospital
- – PCA
- – HCCN
- – Academic Institution
- – Other (Let us know in the chat!)

2. Do you have a medical-legal partnership (MLP)?

- - Yes
- - No
- - I don't know
- - I am developing an MLP

The Health Center MLP Toolkit

Webinar Series:

- Understanding the Current Social Needs of Health Center Patients
- **Screening, Referral, and Service Delivery Workflows**
- Workforce Development | Training Staff to Identify the Health-Harming Legal Needs of Patients
- Patients-to-Policy Initiatives
- Evaluation and Sustainability for MLPs

Access the toolkit:
medical-legalpartnership.org/mlp-resources/health-center-toolkit/

OCTOBER 2020

Bringing lawyers onto the health center care team to promote patient & community health

A planning, implementation, and practice guide for building and sustaining a health center-based medical-legal partnership

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

Objectives

- Describe how PRAPARE® enables health centers and MLPs to better understand patient complexity, address social needs/risks, and demonstrate value.
- Explore risk stratification principles and how PRAPARE® is used within risk stratification efforts.
- Understand how to design a standardized workflow for MLP screenings, referrals, and service delivery.

MLPs embed lawyers as members of the health care team, creating:

- Healthier patients
- Stronger health center workforce
- Improved health equity

Legal Assistance

to address patients' social needs & help the health center workforce operate at "top of license"

Training

to build knowledge, capacity, & skills that strengthen the health center workforce's response to SDOH

Clinic-Level Changes

that leverage legal expertise to shape clinical practices to address many patients' needs at once

Policy Change Strategies

that advance healthy regulatory, administrative, & legislative policy solutions for whole communities

Today's Panelists

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Co-Director

National Center for Medical-Legal Partnership

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Deputy Director, Social Drivers of Health

National Association of Community Health Centers

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KEEGAN WARREN

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Poll Question #3: Screening Data

3. How are you using your social needs screening data? To:

- make referrals to address those needs
- identify and stratify risks
- improve my care quality and delivery model
- identify staffing needs
- *all of the above*

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MEDICAL-LEGAL PARTNERSHIP is an intervention where legal and health care professionals collaborate to help patients resolve **SOCIAL, ECONOMIC & ENVIRONMENTAL FACTORS** that contribute to **HEALTH DISPARITIES** and have a remedy in civil law.

NĀLANI TARRANT & YURIKO DE LA CRUZ

NACHC

Developing Screening, Referral, and Service Delivery Workflows for MLPs

Overview of PRAPARE® and how it relates to MLPs

National Center for Medical-Legal Partnership
October 18, 2022

PRAPARE™
Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

Longstanding PRAPARE Partnership

Session Presenters

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Who's in the room?

- Poll 1 – Is your health center/MLP currently collecting social needs data?
  - Yes, using PRAPARE
  - Yes, using another screening tool
  - No, not collecting social risk data
  - Not sure

- Poll 2 – What is your level of understanding with the social drivers of health?
  - New/ not knowledgeable
  - Beginner/ somewhat knowledgeable
  - Intermediate/ knowledgeable
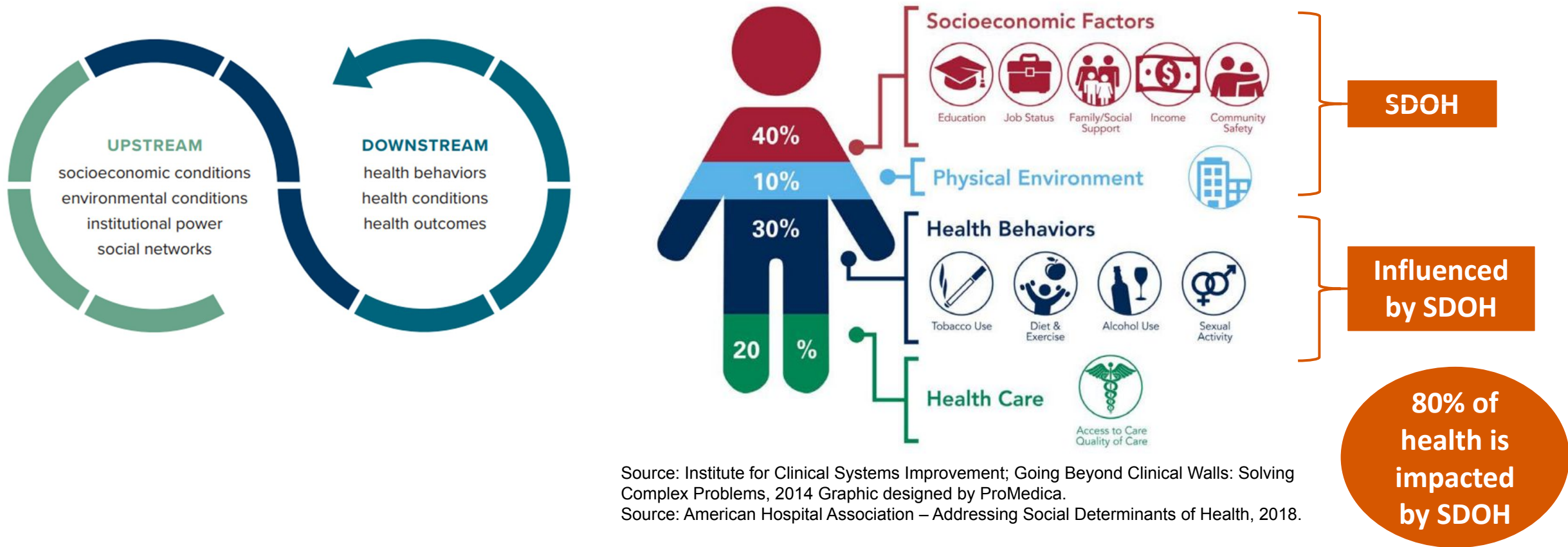 - Advanced/ very knowledgeable

Definitions

1. **Social drivers (determinants) of health:** the conditions in which people are born, grow, live, work, and age. These conditions are shaped by the distribution of money, power, and resources.

2. **Social risk factors:** specific adverse social conditions that are associated with poor health.

3. **Social needs:** patient's role in identifying and prioritizing social interventions.

4. **Population health:** the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Source: AAFP https://www.aafp.org/news/practice-professional-issues/20190610sdohterms.html
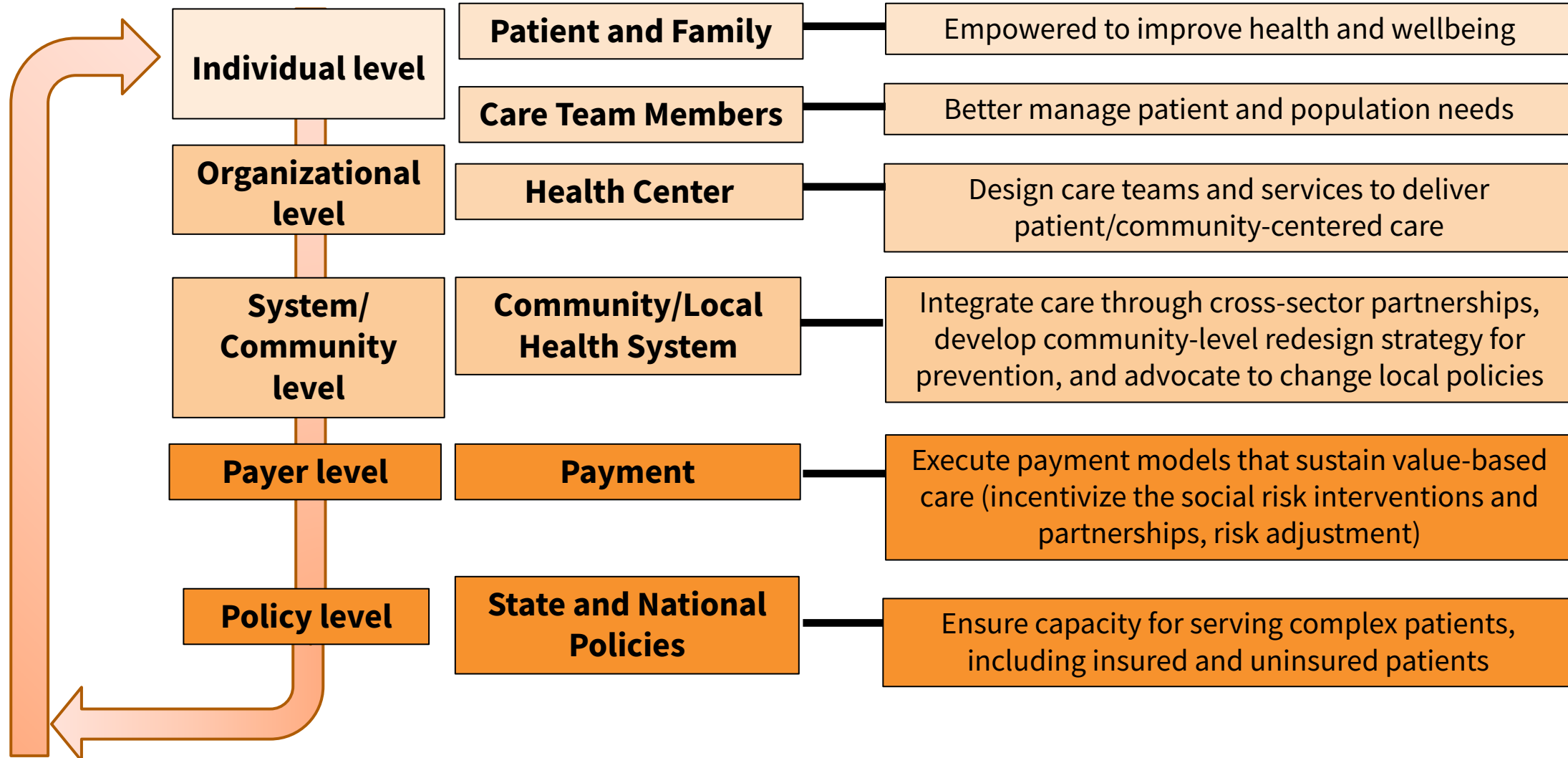
Knowledge Check: SDOH

1. Social Drivers of Health include which of the following?

- The conditions in which we live
- The conditions in which we work
- The conditions in which we play
- All of the above

2. What percentage of a person's health is impacted by SDOH?

- 20%
- 40%
- 60%
- 80%

Why Collect Standardized Data on SDOH?

Individual level

| Patient and Family | Empowered to improve health and wellbeing |

| Care Team Members | Better manage patient and population needs |

Organizational level

| Health Center | Design care teams and services to deliver patient/community-centered care |

System/ Community level

| Community/Local Health System | Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies |

Payer level

| Payment | Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment) |

Policy level

| State and National Policies | Ensure capacity for serving complex patients, including insured and uninsured patients |

Building Capacity to Respond to SDOH Needs

What is PRAPARE?

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

A national **standardized** patient risk assessment **tool** designed to **engage patients** in assessing and addressing social drivers of health

What does PRAPARE Measure?

PRAPARE™
Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

Core

1. Race*	10. Education
2. Ethnicity*	11. Employment
3. Veteran Status*	12. Material Security
4. Farmworker Status*	13. Social Isolation
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

Optional

1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

* UDS measures are automatically populated into PRAPARE EHR templates.

Find the tool at www.prapare.org

Knowledge check: PRAPARE

3. "PRAPARE" stands for which of the following:
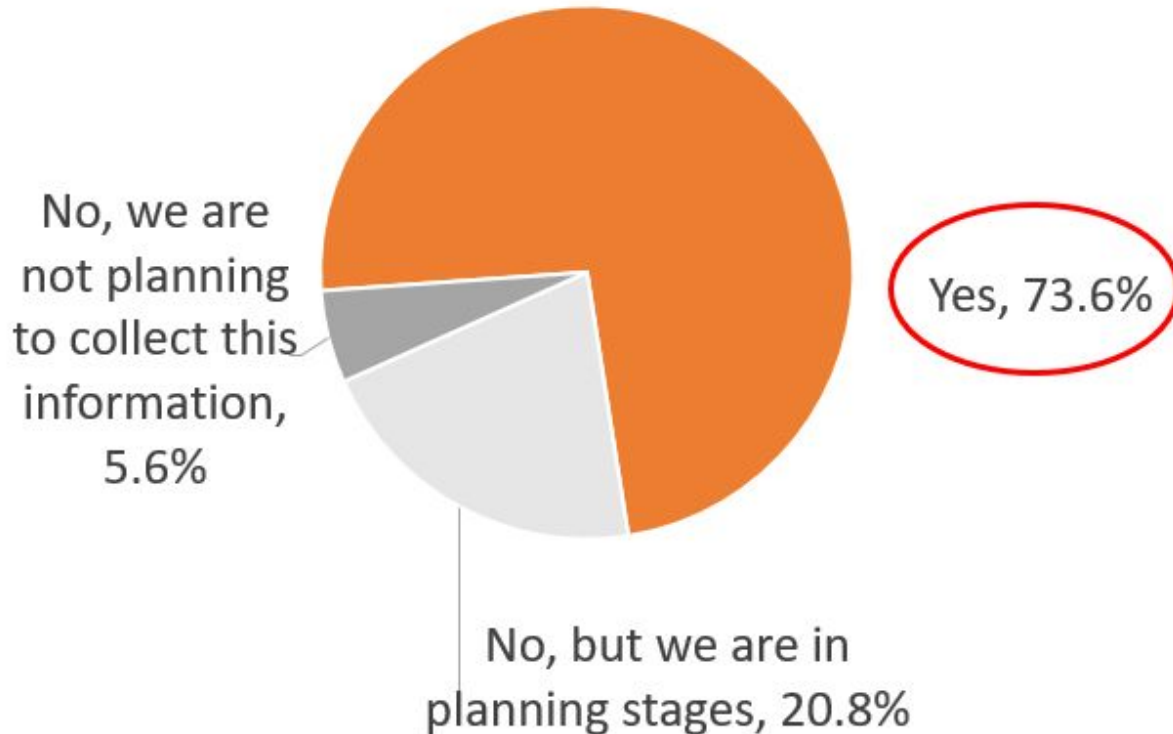
- The Plan for Researching and Advising Patients' Actions, Rewards, and Experiences
- The Project to Reduce and Assist Patients with Adverse Risk Experiences
- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
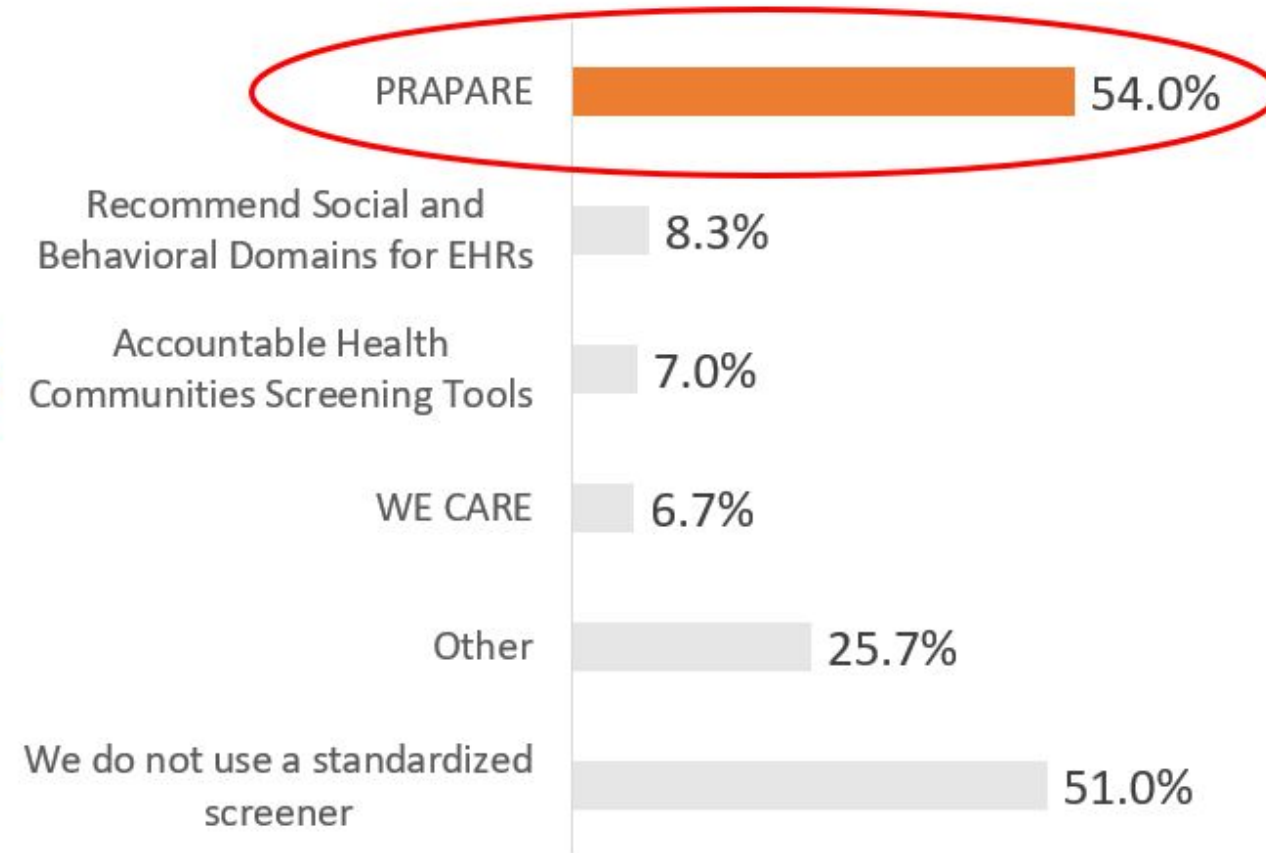- None of the above

4. True or False:
   PRAPARE data can be used for change at the patient level, population level, and community level.

National SDOH Screening 2021-UDS

Does your health center collect data on individual patients social risk factors, outside of the data reportable in the UDS?

No, we are not planning to collect this information, 5.6%

Yes, 73.6%

No, but we are in planning stages, 20.8%

Which standardized screener(s) for social risk factors, if any, do you use?

PRAPARE — 54.0%

Recommend Social and Behavioral Domains for EHRs — 8.3%

Accountable Health Communities Screening Tools — 7.0%

WE CARE — 6.7%

Other — 25.7%

We do not use a standardized screener — 51.0%

www.prapare.org

PRAPARE Reach

PRAPARE Use Among Federally Funded Health Centers, 2019
0% — 97%

PRAPARE Use Among Federally Funded Health Centers, 2020
0% — 100%

PRAPARE Use Among Federally Funded Health Centers, 2021
0.0% — 109.1%

Note: Percentages reflect PRAPARE use among federally funded health centers that report screening for social risk. Excludes Health Center Program Look-Alikes and may underestimate the true volume of federally funded health centers using PRAPARE. For example, data may not capture all health centers accessing PRAPARE through some Electronic Health Records or other Health Information Technology platforms and does not capture health centers using parts of PRAPARE.

Why use PRAPARE to collect SDOH?

 ACTIONABLE

 STANDARDIZED and WIDELY USED

 EVIDENCE-BASED and STAKEHOLDER-DRIVEN

 DESIGNED TO ACCELERATE SYSTEMIC CHANGE

 PATIENT-CENTERED

Opportunities to Leverage PRAPARE

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Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

Delivery System Transformation Activities (VBP, Shared Savings, etc.)

Payment Reform Efforts

Payers Interested in Social Determinants Data Collection (e.g., Medicaid, private, etc.)

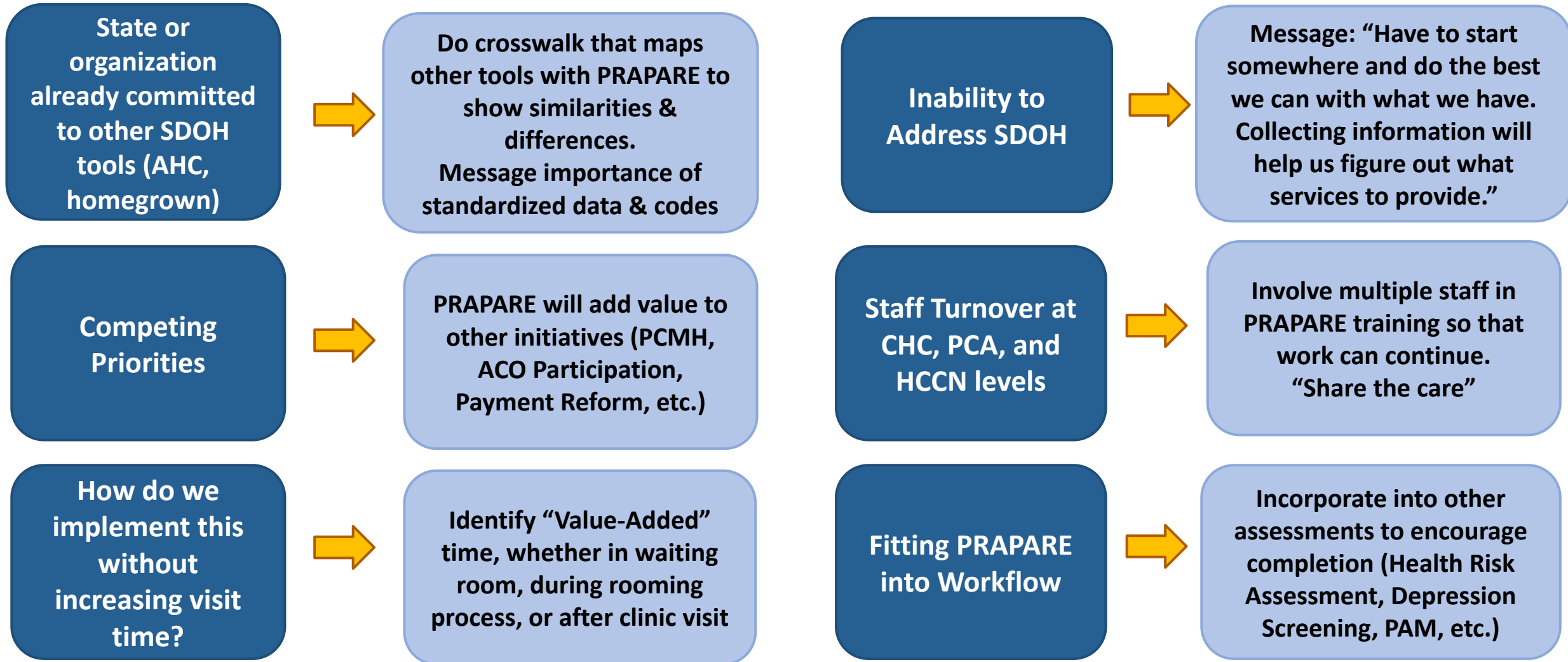State Foundation Interests in Social Determinants or Related Topics (Opioids, etc.)

PCMH and QI Initiatives

Quality Incentives that Reward for Social Determinant Data Collection

Data Sharing and Aggregation Opportunities (e.g., HIE, CIE, etc.)

Community Health Worker Initiatives

Common Challenges and Messaging Solutions

PRAPARE™
Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

Challenge	Solution
State or organization already committed to other SDOH tools (AHC, homegrown)	Do crosswalk that maps other tools with PRAPARE to show similarities & differences. Message importance of standardized data & codes
Competing Priorities	PRAPARE will add value to other initiatives (PCMH, ACO Participation, Payment Reform, etc.)
How do we implement this without increasing visit time?	Identify "Value-Added" time, whether in waiting room, during rooming process, or after clinic visit
Inability to Address SDOH	Message: "Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide."
Staff Turnover at CHC, PCA, and HCCN levels	Involve multiple staff in PRAPARE training so that work can continue. "Share the care"
Fitting PRAPARE into Workflow	Incorporate into other assessments to encourage completion (Health Risk Assessment, Depression Screening, PAM, etc.)

What Workflow to Use to Implement PRAPARE

The Five Rights Framework

How are we collecting this information?

Where are we collecting this information?

THE RIGHT INFORMATION
WHAT

What information in PRAPARE do you already routinely collect?

IN THE RIGHT FORMAT
HOW

WITH THE RIGHT PEOPLE
WHO

Who will collect the data? Who will respond to needs identified?

VIA THE RIGHT CHANNELS
WHERE

AT THE RIGHT TIMES
WHEN

When is the right time to collect this information?

Building a Data Strategy

1. Outline PRAPARE Data Goals
2. Assess PRAPARE Data Capacity and Infrastructure
3. Develop and Implement PRAPARE Data Roadmap
4. Conduct PRAPARE Data Analysis
5. Identify/Prioritize Actions based on PRAPARE Findings
6. Act on PRAPARE Data
7. Evaluate Outcomes and Restart as Needed

Definitions

> **"Risk Stratification is an intentional, planned and proactive process carried out at the practice-level to effectively target clinic services to patients."**

Risk stratification: process or tool for identifying—and predicting—which patients are at high risk—or likely to be at high risk—and prioritizing the management of their care in order to prevent worse outcomes (care team, clinic level)

Risk adjustment: method to offset the cost of providing health insurance for individuals who represent a relatively high risk to insurers (policy, payment level)
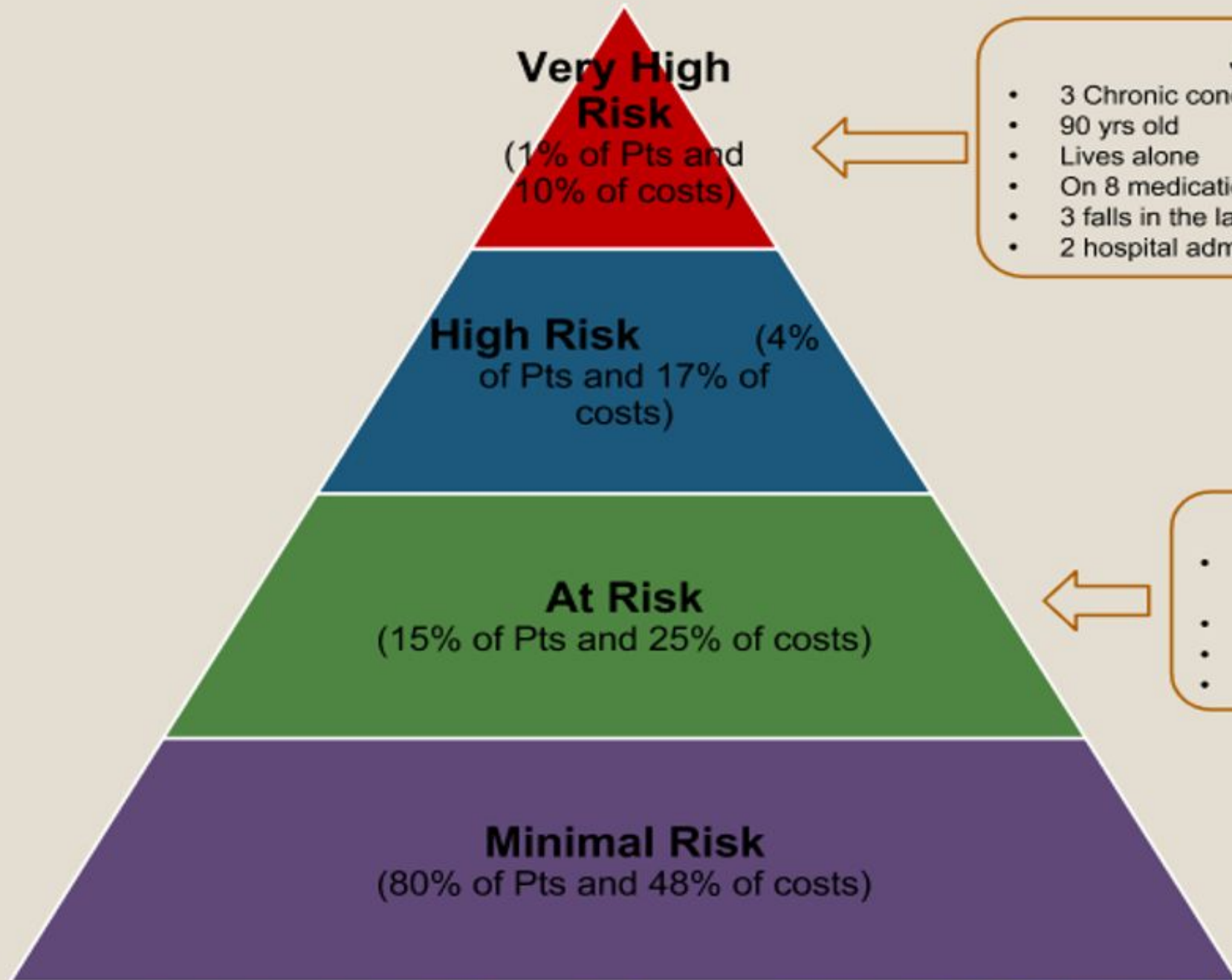
5% of the population accounts for 50% of the cost

Source: Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services– January 2019

Slide from Hardin, Trumbo & Murray Presentation - November 2019

Communication
Monitoring
Planning

Very High Risk
(1% of Pts and 10% of costs)

High Risk (4% of Pts and 17% of costs)

At Risk
(15% of Pts and 25% of costs)

Minimal Risk
(80% of Pts and 48% of costs)

Joe
- 3 Chronic conditions
- 90 yrs old
- Lives alone
- On 8 medications
- 3 falls in the last year
- 2 hospital admissions in the last year

Jen
- Recently diagnosed w/ Type II Diabetes
- 55 years old
- Has mild cognitive impairment
- On 3 medications

Adapted from Risk Stratification Oct 2014 https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0015/253005/Risk_Stratification_discussion_paper.PDF

Why Risk Stratification?

- Prioritize care for sickest patients, reduce costs, and improve care

- Make care management decisions, such as providing greater access and resources to patients in higher risk levels

- Examples:
  - Select patients for intensive vs non-intensive care management
  - Select patients for working with limited staff such as behavioral health
  - Prioritize patients for long term care management
  - Schedule patients for longer visit times
  - Prioritize resources for those who need them most

Risk Stratification incorporating SDOH Positions Health Centers For Sustainability

PRAPARE™
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

- Funders and stakeholders hold health centers accountable

- More shifts towards value-based payment

- Greater demands for evidence of impact

- Growing competition

- Health centers' unique model of care positions them to address SDOH

  ✔ Stratify patients by social risks

  ✔ Document patient complexity and demonstrate value

Principles for Risk Stratification Model

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Patients' Assets, Risks, and Experiences

Intended **to inform but not replace clinic care team judgment**

Encourage use of a hybrid approach using **quantitative data** for risk algorithm **and qualitative data** from clinic staff judgment

Social risk stratification **does NOT replace social risk screening**

Use of a **national standardized numeric score** is important for policy and comparison with other providers

Localization of risk group cutoffs is important for informing care and targeting interventions at the clinic level

Risk factors organized in categories to better understand aspects of each component for each patient to target appropriate care

Use a point system to be useful at the point of care

Higher score = higher risk patient

Range is 0 to 25, 5 for each component

Benefits of Using a Risk Stratification Model

PRAPARE™
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Improve Care Management and Interventions	Standardization and National Comparison	Demonstrate Complexity of Patients
Inform Value-based Care and Cost Savings	**Qualify for PCMH and Quality Incentives**	**Inform Payment and Policy and Advocate for Risk Adjustment**

Publication pending. Do not quote or distribute without permission from NACHC, AAPCHO, or OPCA.

Questions & Discussion

Twitter: @prapare_sdoh
Join our Listserv
Email: prapare@nachc.org

For more information, visit www.prapare.org

Poll Questions #4 and #5: Tools

4. Does your medical-legal partnership (MLP) use standardized tools for screenings and referrals?

- Yes
- No
- I don't know
- I don't work with an MLP

5. If yes *(your MLP uses standardized screenings and referrals tools)*, are these tools standardized in your MLP's service delivery workflow?

- Yes
- No
- I don't know
- My MLP does not use standardized tools/I don't work with an MLP

KEEGAN WARREN

Health Management Associates

How Legal Services Help Health Care Address the Social Determinants of Health

Common SDOH	How Legal Services Can Help	Impact of Legal Services on Health / Health Care
INCOME & INSURANCE Resources to meet daily basic needs	• Appeal denials of food stamps, health insurance, cash benefits, and disability benefits	• Increasing someone's income means s/he makes fewer trade-offs between affording food and health care, including medications. • Being able to afford enough healthy food helps people manage chronic diseases and helps children grow and develop.
HOUSING & UTILITIES A healthy physical environment	• Secure housing subsidies • Improve substandard conditions • Prevent evictions • Protect against utility shut-off	• A stable, decent, affordable home helps a person avoid costly emergency room visits related to homelessness. • Consistent housing, heat and electricity helps people follow their medical treatment plans.
EDUCATION & EMPLOYMENT Quality educational and job opportunities	• Secure specialized education services • Prevent and remedy employment discrimination • Enforce workplace rights	• A quality education is the single greatest predictor of a person's adult health. • Consistent employment helps provide money for food and safe housing, which also helps avoid costly emergency health care services. • Access to health insurance is often linked to employment.
LEGAL STATUS Access to jobs	• Resolve veteran discharge status • Clear criminal / credit histories • Assist with asylum applications	• Clearing a person's criminal history or helping a veteran change their discharge status helps make consistent employment and access to public benefits possible. • Consistent employment provides money for food and safe housing, which helps people avoid costly emergency health care services.
PERSONAL & FAMILY STABILITY Safe homes and social support	• Secure restraining orders for domestic violence • Secure adoption, custody and guardianship for children	• Less violence at home means less need for costly emergency health care services. • Stable family relationships significantly reduce stress and allow for better decision-making, including decisions related to health care.

Where do legal services fit within a health center's response to SDOH?

SOCIAL DETERMINANTS OF HEALTH

are broadly defined by the World Health Organization as the conditions in which people are born, grow, work, live, and age. These circumstances are shaped by economic and social policies, political systems, and social norms, and they contribute significantly to health disparities.

SOCIAL NEEDS

are the more immediate, individual needs that patients enter the health center with every day as a result of social determinants of health.

LEGAL NEEDS

are, simply put, the subset of social needs that have legal solutions. The distinction in this guide is made to help health centers understand where lawyers can be helpful*

FOR EXAMPLE

A food desert

A family's need for fresh produce today

A family's need to file an appeal after their SNAP benefits are incorrectly cut

How different team members address social needs while working at "top of license"

A FAMILY OF 4

is struggling to make rent after one Mom is unable to work during her cancer treatment

A Community Health Worker

can help the patient fill out applications, pull documents together, an may go to benefits office with her.

A Case Manager / Social Worker

may work with the patient to determine what housing, disability, insurance, and food benefits she is eligible for. They write support letters and gather medical documentation as needed.

A Lawyer

may advise the patient about the Family Medical Leave Act and job protections to help ensure her job is waiting for her after treatment. They can help CHWs and case managers understand benefit eligibility and problem-solve as needed. They may assist the patient with appeals if benefits are denied.

MLP is one of the only interventions that tackles individual needs AND underlying policies

Training activities and direct legal services help health centers address individuals' legal needs.

When a landlord refuses to make improvements to an apartment with mold, an MLP lawyer can enforce safe housing laws to get the mold removed.
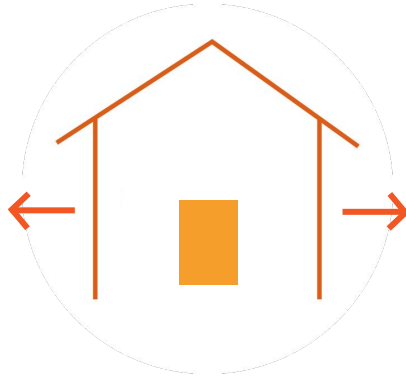
By detecting patterns in patients' needs and using upstream strategies to target unhealthy policies, MLPs prevent future problems and advance health equity.

An MLP team works together to change their city's lead ordinance to prevent children from being lead poisoned at home.

HEALTH MANAGEMENT ASSOCIATES

Screening, Workflow, and Care for Health-Harming Legal Needs
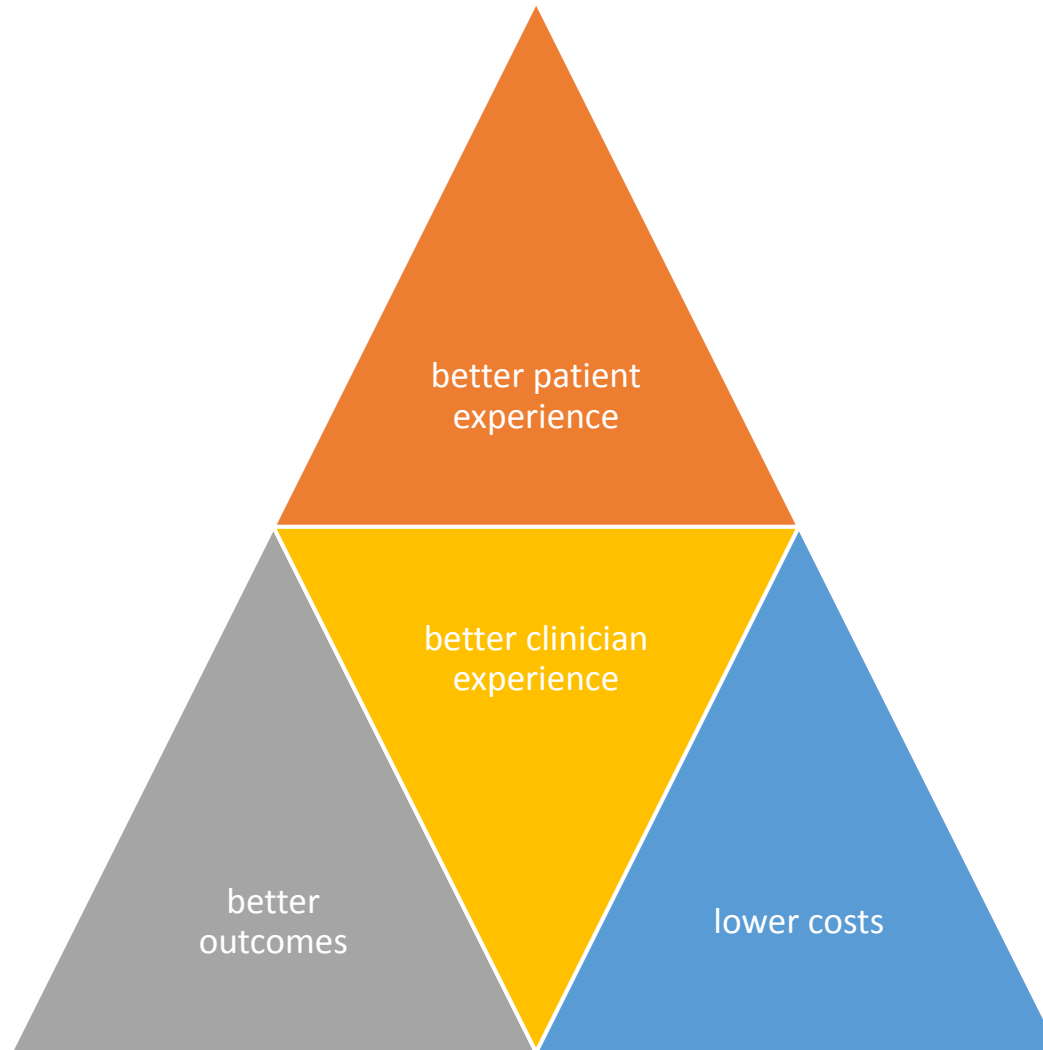
By Keegan D. Warren, JD, LLM

HMA

A Quick Overview of the Changing View of Value in Health Policy
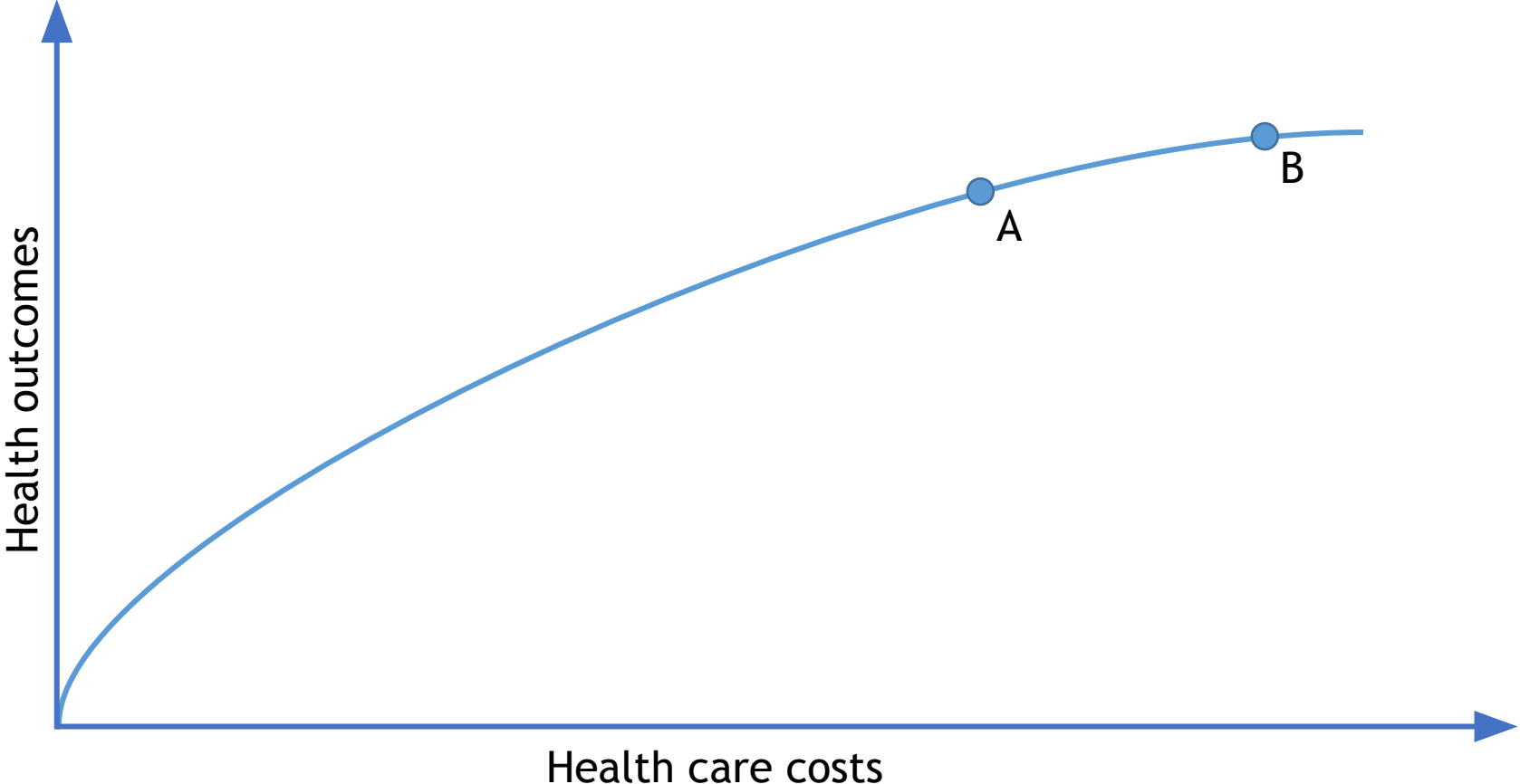
HEALTH MANAGEMENT ASSOCIATES

THE TRIPLE AIM → THE QUADRUPLE AIM

VALUE-BASED CARE: A TO B IS COSTLY

Source: Bodenheimer & Grumbach (2020)

VALUE-BASED CARE: BETTER OUTCOMES AT COST
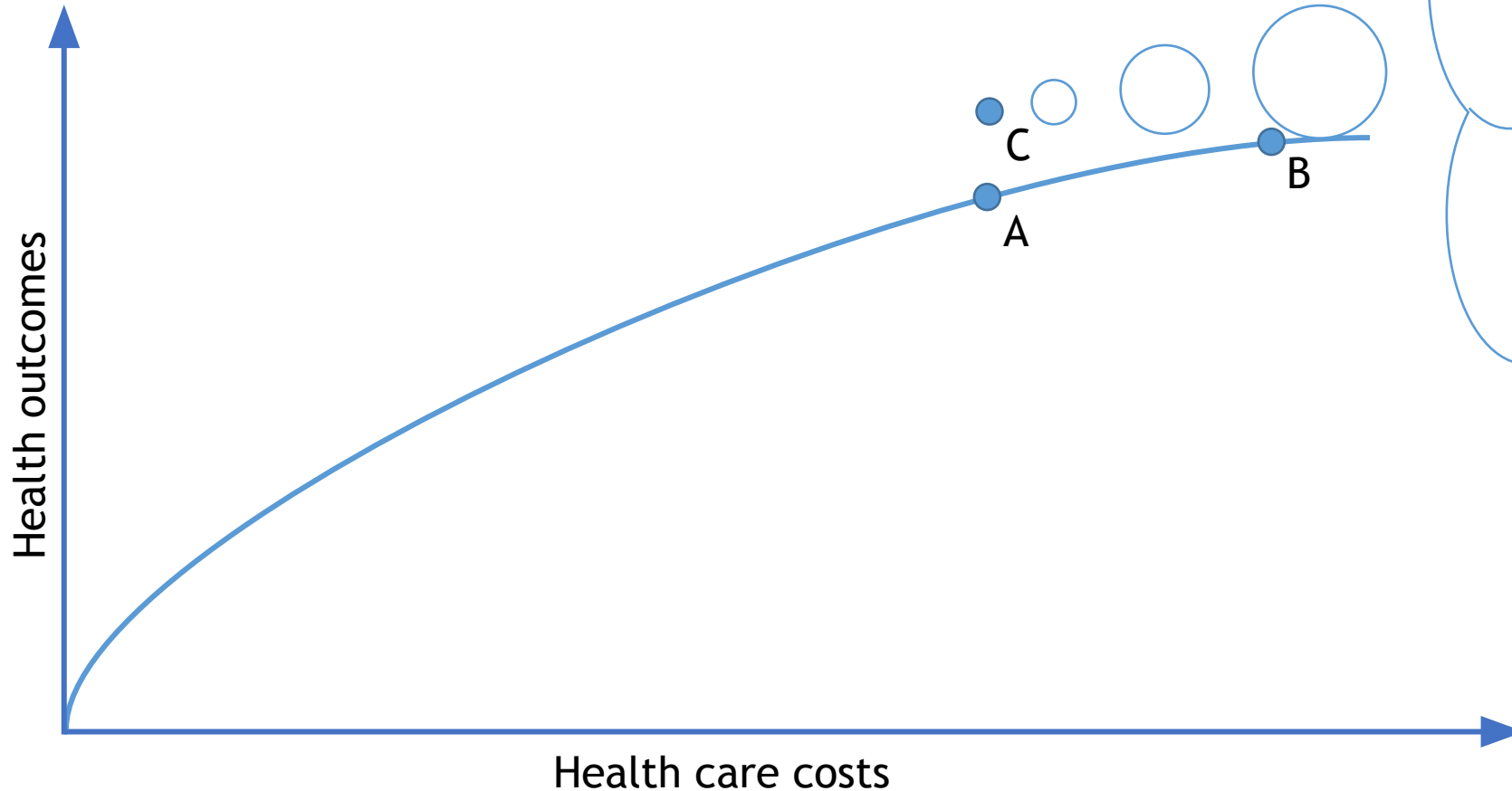
Better Health?
- Improved longevity and quality of life
- Reduced mortality and morbidity rates from specific diseases
- Relief of pain and suffering
- Enhanced ability to function independently for those with chronic illnesses
- Reduction in fear of illness and death
- Increasing health equity

Source: Bodenheimer & Grumbach (2020)

VALUE-BASED CARE: C IS EFFICIENT, HIGHER-VALUE CARE

Source: Bodenheimer & Grumbach (2020)

HEALTH MANAGEMENT ASSOCIATES
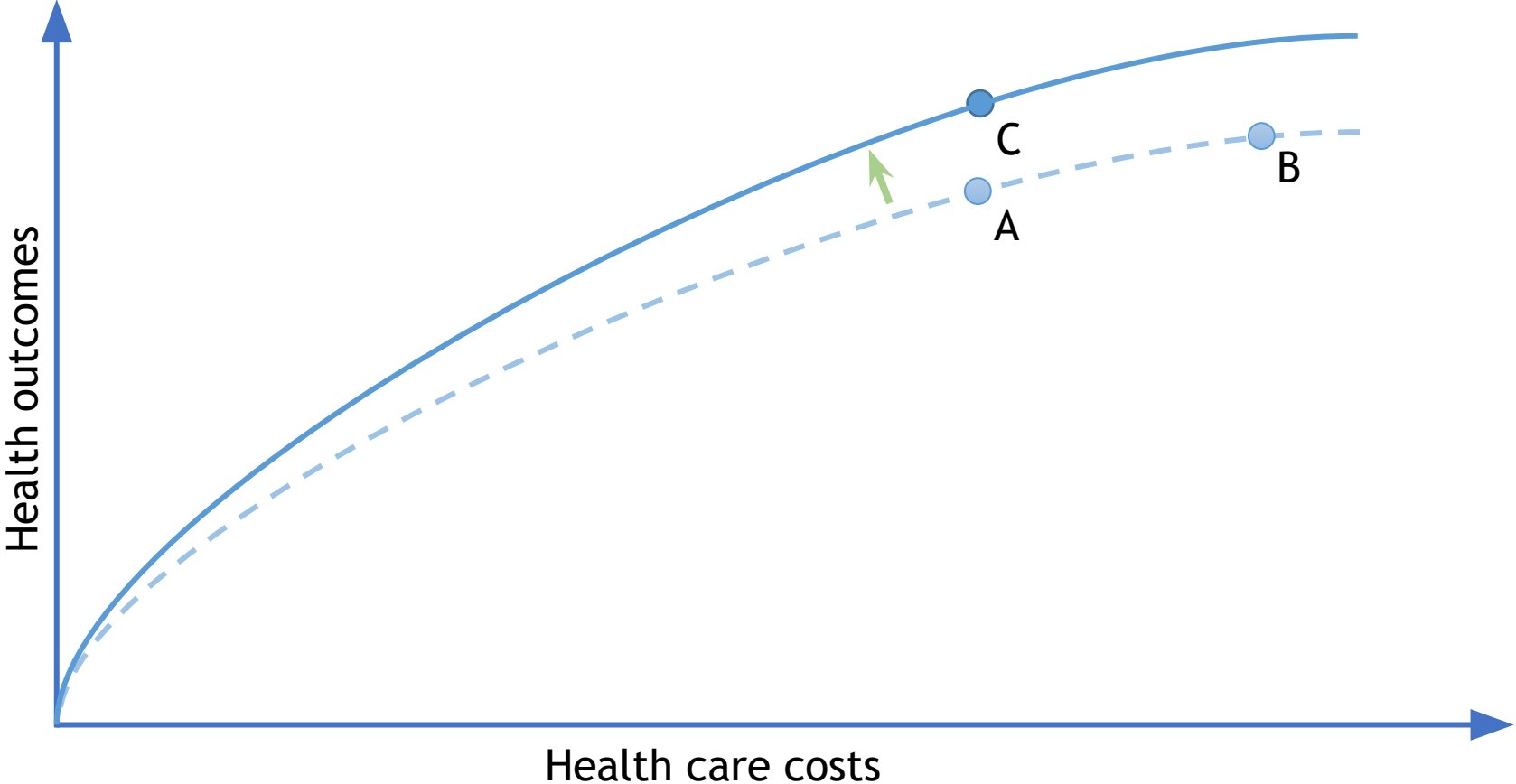
OTHER KEY "VALUE" TERMS IN HEALTHCARE THAT ALL MLP LEGAL TEAMS SHOULD RECOGNIZE AND USE

Patient panel

Encounter

Billing/invoicing

Reimbursement

- Prospective Payment System
- Fee-For-Service
- Per Member Per Month
- Capitation

FIRST PRINCIPLES IN EQUITY

"Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation)."

-World Health Organization

Screening and Workflow Key Themes

» The purpose of screening is to identify patients with unmet social needs that could be resolved through some level of MLP intervention.

» The quality of the workflows put in place and how well they are communicated to staff plays a major role in the volume and quality of patients whose health-harming legal needs are met.

» Formalized approaches facilitate continuous quality improvement for MLP professionals, systemic change for patients and communities, and help ensure sustainability.
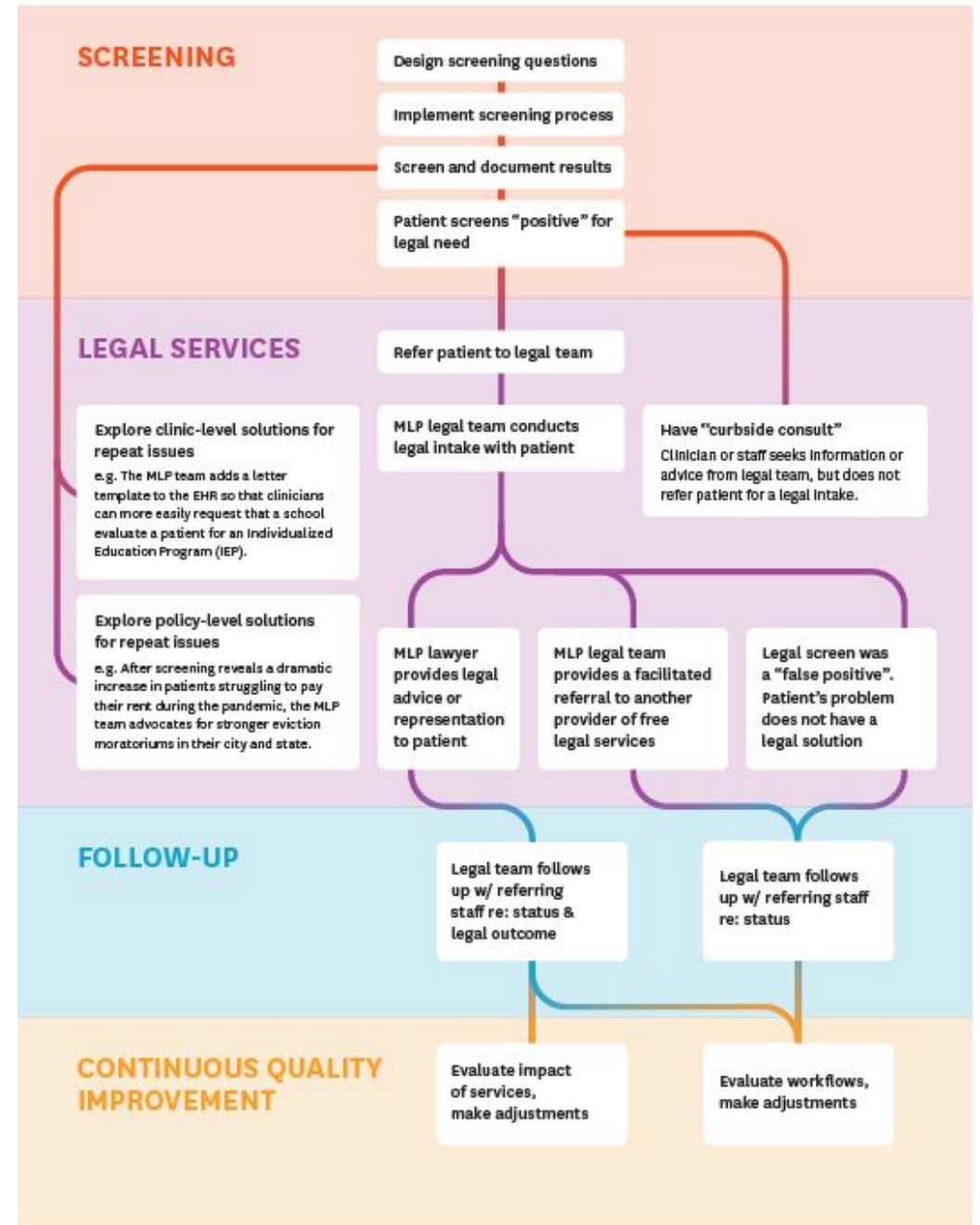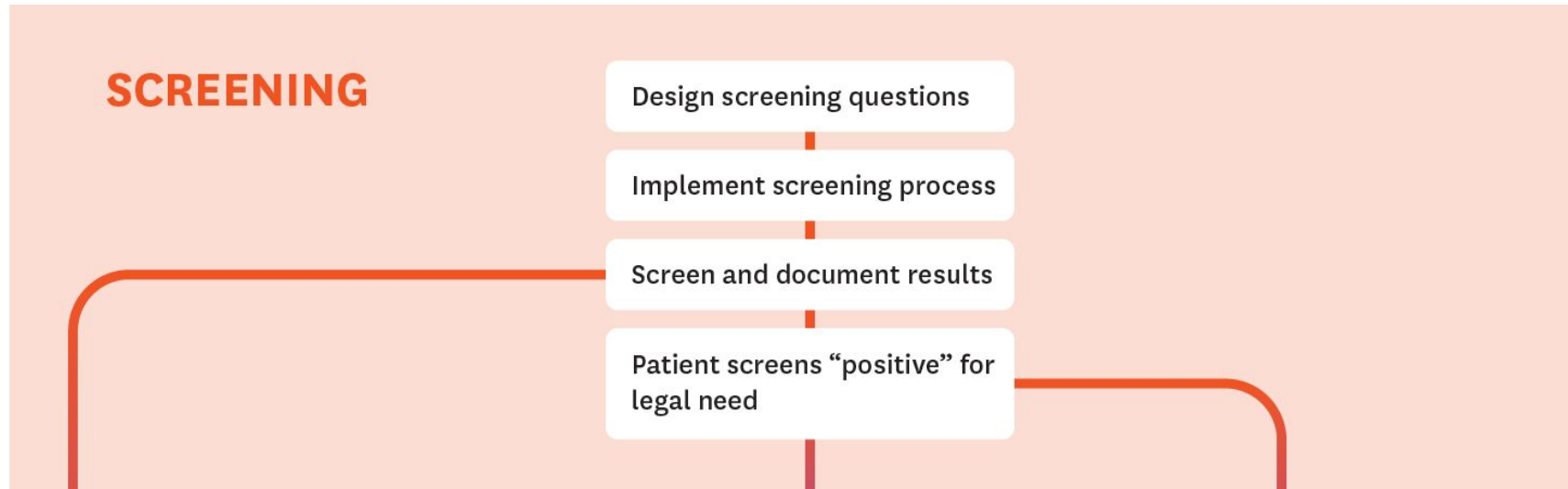
Integrated Care: Screening for Health-Harming Legal Needs

HEALTH MANAGEMENT ASSOCIATES

FORMAL SCREENING FOR HEALTH-HARMING LEGAL NEEDS

SCREENING

- Design screening questions
- Implement screening process
- Screen and document results
- Patient screens "positive" for legal need

» Social care screening questions should be authored by structural experts (including the MLP legal team), be trauma-informed, avoid redundancy with other patient forms, and be linguistically and culturally appropriate.

» Screening tools should reflect professional workflow and patient flow.

» Screening helps legal services become a routine part of care delivery.

» Documentation of positive screens facilitates continuous quality improvement and health equity.

ALGORITHMIC SCREENING

Excerpt from Interventions List

Think about the place you live. Do you have problems with any of the following?

	losing your housing	MA will ask if problem with Financial Assistance, Eviction, Mobile Home, or Foreclosure and give appropriate HANDOUT(S) (Financial Assistance is 2 handouts). Also ORDER a referral to Austin MLP if there is a court date or letter of notice.
	water leaks or mold	MA will ask if Renter and, if so, give 1 appropriate HANDOUT (Right to Repairs). ORDER a referral to Austin Tenant's Council or Austin MLP (see flowchart to determine which) if patient wants help.
	broken or no smoke detectors	
	broken heat or air conditioning	
	lead paint/pipes	
	unclean water	
	bugs or rodents	MA will ask if Renter and, if so, give 1 appropriate HANDOUT (Right to Repairs or Bed Bugs). Also ORDER a referral to Austin Tenant's Council or Austin MLP (see flowchart to determine which) if patient wants help.
	changes to make your home safer (like wheelchair ramps, shower bars, etc.)	No HANDOUT. ORDER a referral to Austin Tenant's Council or Austin MLP (see flowchart to determine which) if patient wants help.
	I don't problems with any of these things.	NONE

PEOPLE'S COMMUNITY CLINIC

Name_____

Date of birth_____

We care about you and your family. Your answers can help us know you better and build new partnerships in our community to help meet our patients' needs. You can skip questions or stop at any time. Whether you do this survey or not, our clinic will continue to care for you with dignity and respect.
CHECK ALL BOXES THAT APPLY TO YOU AND YOUR FAMILY.

Think about your future. Do you need help getting any of the following?
- ☐ checking/savings bank account
- ☐ job or job training
- ☐ a GED
- ☐ high-speed internet
- ☐ preschool for your 3- to 5-year-old child
- ☐ English classes for you or a family member
- ☐ financial aid for college
- ☐ I don't need help getting any of these things.

Think about your groceries. In the past year, have you worried that you would run out of food?
- ☐ yes
- ☐ no
- ☐ We don't have enough food right now.

Think about the place you live. Do you have problems with any of the following?
- ☐ losing your housing
- ☐ mold or water leaks
- ☐ lead paint/pipes
- ☐ bugs or rodents
- ☐ unclean water
- ☐ broken or no smoke detectors
- ☐ broken heat or air conditioning
- ☐ I don't have problems with any of these things.

Think about your utilities (gas, water, electric). In the past year, have you had trouble paying your bill?
- ☐ yes
- ☐ no
- ☐ My gas, water, or electric is shut off right now.

Think about your money. Do you need help getting any of the following?
- ☐ food stamps (SNAP)
- ☐ WIC
- ☐ welfare/cash assistance (TANF)
- ☐ veterans' benefits (VA)
- ☐ free tax help, especially if you work or have kids
- ☐ lowering your debt/improving your credit score
- ☐ I was recently denied one of these and want help.
- ☐ I don't need help getting any of these things.

Think about your transportation. Do you miss medical appointments because you have no way to get there or because it is hard to get there?
- ☐ yes
- ☐ no

Think about your neighborhood. Do you feel unsafe doing any of the following?
- ☐ being in your yard/on your sidewalks
- ☐ using your local park
- ☐ visiting your local library
- ☐ calling the police
- ☐ shopping at your grocery store
- ☐ going to your school or your child's school
- ☐ waiting at your local bus stop
- ☐ I feel safe doing all of these things.

Think about your community. Would you like information about any of the following?
- ☐ voting (registering, where to go, etc.)
- ☐ volunteering
- ☐ getting an ID
- ☐ joining affordable sports activities (☐ youth ☐ adult)
- ☐ joining social clubs (☐ youth ☐ adult ☐ senior)
- ☐ I don't need information about these things.

FOR ADMIN. USE ONLY

Provider Signature_____
☐ well visit ☐ acute visit   Date Signed_____

Adapted from CMS AHC, Health Begins, Health Leads, and PRAPARE
Rev. 9/18

"ORGANIC" SCREENING

OTHER MEANS FOR SPOTTING HEALTH-HARMING LEGAL NEEDS

» **Complex case conferences** are interprofessional clinical staffing sessions that should include MLP structural expertise.

» E.g., chronic pain management best practices are to complement medication with naturopathic and social care (https://healthpolicy.duke.edu/publications/exemplary-integrated-pain-management-programs-peoples-community-clinic-integrative)

» **Group medical visits** offer patients with similar health needs the opportunity to have facilitated discussion that can lead to self-diagnosis of a health-harming legal need.

» E.g., group prenatal visits led by a nurse-midwife, health educator, and attorney (https://texaslawhelp.org/article/prenatal-legal-checkup)

» **Legal clinics** are targeted educational sessions put on by attorneys or attorney/clinician teams for patients or community, often with an en masse pro bono legal component.

» E.g., transgender community members and advocates trained by an MLP attorney on the legal process for name-and-gender-marker change (https://www.austinchronicle.com/daily/qmmunity/2019-02-18/local-orgs-help-identify-medical-and-legal-support-for-trans-residents/)

» **Segmentation** is examination of a patient dataset to determine likelihood of presence of a health-harming legal need and, sometimes, likelihood of efficacy of intervention.

» E.g., neuroatypical 17-year-olds may be routinely provided legal information or referred for care and decision-making planning (https://medical-legalpartnership.org/wp-content/uploads/2020/07/Austin-PCC-Transition-Packet.pdf)
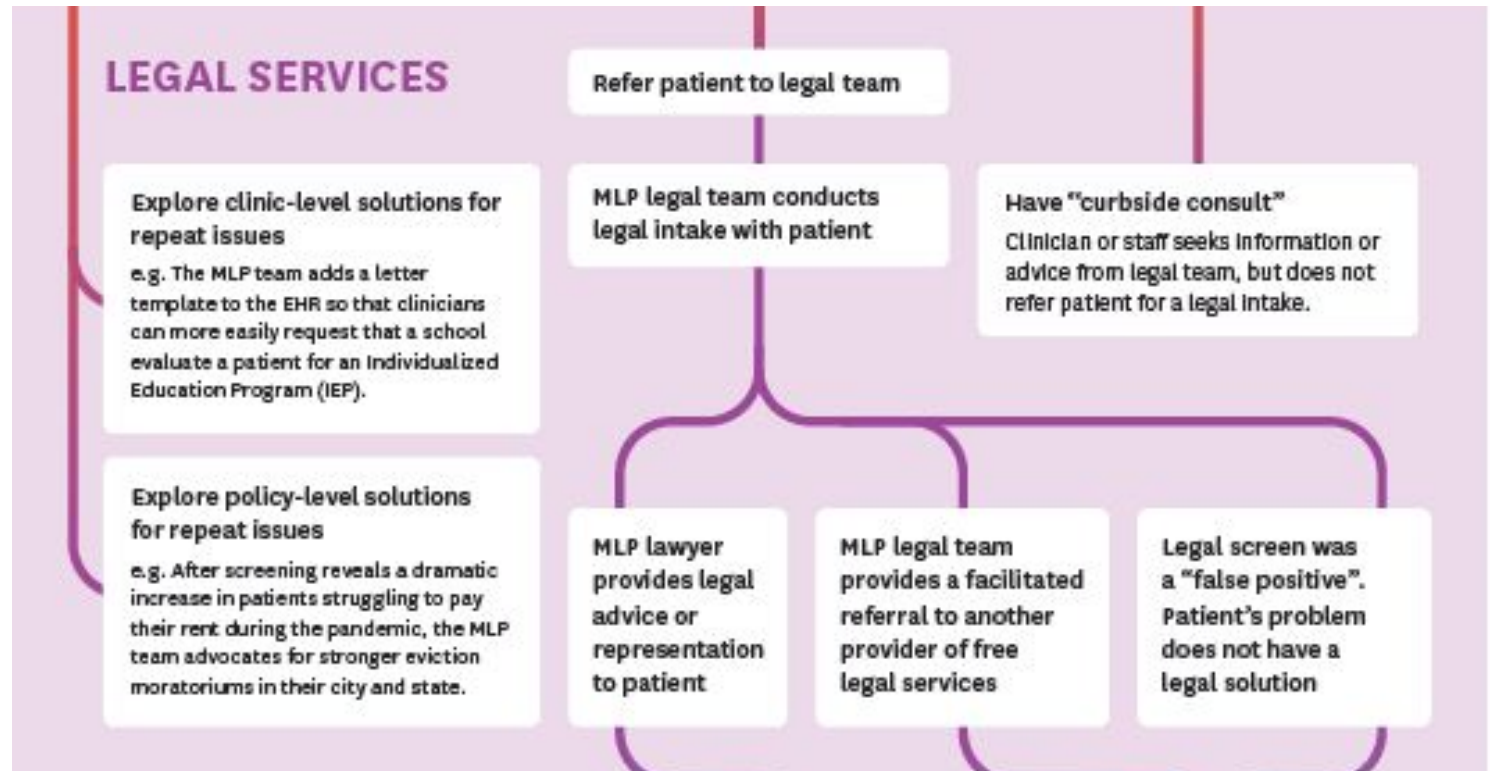
HEALTH MANAGEMENT ASSOCIATES

Integrated Care: Legal Care Workflow

LEGAL REFERRAL ORDERS

» Legal care includes curbside consultations, institutional change, and direct and referral professional services.

» MLP Legal Referral Orders may be electronic or paper-based.

» Should include basic information, including reason for referral and any relevant physical or behavioral health information.

» A trauma-informed practice is for the legal team to use the information provided to minimize redundancy in intake.

LEGAL SERVICES

Refer patient to legal team

Explore clinic-level solutions for repeat issues
e.g. The MLP team adds a letter template to the EHR so that clinicians can more easily request that a school evaluate a patient for an Individualized Education Program (IEP).

MLP legal team conducts legal intake with patient

Have "curbside consult"
Clinician or staff seeks information or advice from legal team, but does not refer patient for a legal intake.

Explore policy-level solutions for repeat issues
e.g. After screening reveals a dramatic increase in patients struggling to pay their rent during the pandemic, the MLP team advocates for stronger eviction moratoriums in their city and state.

MLP lawyer provides legal advice or representation to patient

MLP legal team provides a facilitated referral to another provider of free legal services

Legal screen was a "false positive". Patient's problem does not have a legal solution

DEVELOPING AN EFFICIENT AND MEANINGFUL LEGAL REFERRAL ORDER

Convene an interdisciplinary team, including representation from all clinical departments, legal team, social care team, information technology, and others.

Review current approaches to making other specialty referrals, to screening and tracking health-related social needs, to legal intake, and to health equity.

Identify information needed to further these approaches and add it to the backend tables of the referral order.

Prepare an accessible how-to for clinicians and other patient-facing staff.

Train clinicians and other patient-facing staff.

Launch the referral order.

Solicit and obtain feedback, and modify accordingly.

Create and run reports to measure legal care provided, stratify patient panels, and improve health equity.

HMA

Integrated Care: Follow-up and Continuous Quality Improvement

CLOSING THE LOOP

» End-of-care reporting makes legal services consistent with other types of professional specialty healthcare.

» Status updates and, especially, case-closing information should be provided for every consenting patient to build relationships, close the loop, and further health equity.

FOLLOW-UP

Legal team follows up w/ referring staff re: status & legal outcome

Legal team follows up w/ referring staff re: status

IMPACT ASSESSMENT

» CQI enables care efficiencies for professionals and patients, and it assures deployment of best practices.

» Referrals and loop-closures should be reviewed routinely by MLP champions team for opportunities for collaborative training, institutional change, or systemic solution.

» Monthly patient panel reports should aggregate helpful information for systems change, such as diagnosed medical and legal needs, indicated acuity level of each type of need, and main benefit of the legal intervention.

CONTINUOUS QUALITY IMPROVEMENT

Evaluate impact of services, make adjustments

Evaluate workflows, make adjustments

LEVERAGE MLP DATA TO HELP ASSURE SUSTAINABILITY

HEALTH CENTER DATA

- The number of patients screened
- The number of referrals made to the MLP legal team
- The types of legal issues that were referred
- The health conditions for which patients were referred
- Where referrals came from at the health center and from whom
- Demographics of patients who were referred

LEGAL TEAM DATA

- The number and types of curbside consults completed
- The number of patients who had a lawyer added to the care team
- The number and types of legal issues addressed for patients
- The acuity level of service provided patients
- Legal outcomes
- Dollar value of any benefits obtained or financial liabilities avoided for patients
- Dollars recovered for health center through successful appeals of health insurance denials
- The dollar value of the direct, referral, and pro bono legal services provided had they been billed at the prevailing market rate
- Trainings, clinical policies, and systemic change, etc.

Questions

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QUESTIONS

Please put questions in the Q&A Panel.

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

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THE MLP IN HEALTH CENTERS SERIES

PART 3

PROMISING TRAINING PRACTICES TO MEET THE NEEDS OF PROVIDERS & PATIENTS

NOVEMBER 1, 2022
1-2:30 PM ET

National Center for Medical ◯ Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

"NO WRONG DOOR" FOR VETERANS

VETERAN CULTURAL COMPETENCY TRAINING FOR MLP TEAMS

NOVEMBER 9, 2022 • 2-3:30 PM ET

WITH

| EMILY EDWARDS | LARA EILHARDT | MADOLYN GINGELL |

FROM THE
DEPARTMENT OF VETERANS AFFAIRS

National Center for Medical ◯ Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

Please feel free to email
ncmlp@gwu.edu
with any further questions.

THANK YOU!

Please take a moment to complete our survey. Link is in the chat.