Unlocking Access: The Connections Between Medical Certifications and Health Equity

Setting the Stage for Cross-Sector Learning & Action
June 19, 2019

Samantha Morton, JD & Baraka Floyd, MD, MSc

1. The Problem

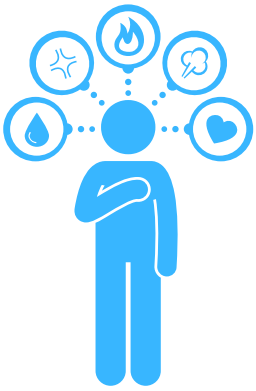
Social, economic, and environmental conditions are well-documented to profoundly influence health and care utilization. Research also shows that these conditions contribute to the rising cost of healthcare. Although these insights are increasingly mainstream, in order to effectively address health-related social needs (HRSN) at a population level, substantial practice transformation and culture change are urgent.

In many federal and state regulatory and policy contexts, consumers cannot access benefits, services, and legal protections for which they are eligible absent a doctor's note. Access to these supports can mitigate the material hardships that drive avoidable care utilization, high total costs of care, and harmful health disparities. Yet often clinicians uniquely "own" responsibility for the paperwork that enables access to timely and stable access to food, heat, and housing.

This is not about a failure to screen for social needs, or a lack of attention to referrals. A barrier to access is providers' well-intentioned but poor-quality preparation of these certifications – or non-responsiveness to people's legitimate requests for this paperwork.

Currently, most health system transformation energy is directed at screening for HRSN and referring people to appropriate community resources. But this ignores a critical reality – "screen and refer" is insufficient to connect people to benefits and services when access to those supports are mediated by care team members. This leaves a gaping hole in care quality, cost management, workforce morale – and slows progress on health equity.

A Typical Scenario

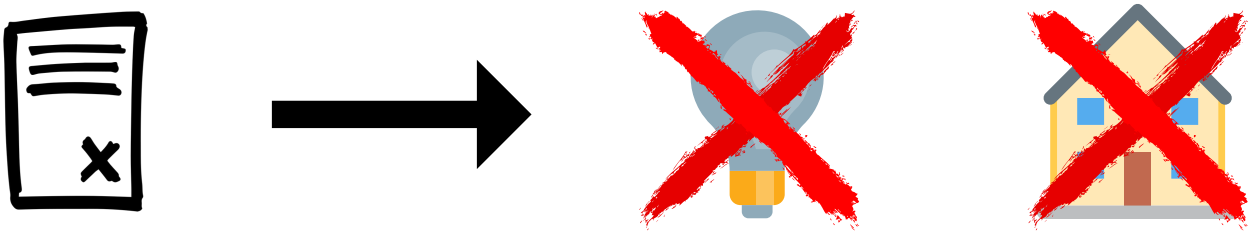


Patient A has multiple chronic medical conditions and mobility impairments, and a long history of avoidable medical utilization. Screens positive for housing instability and energy insecurity, as well as other material hardships.

Dr. B suggests that Patient A apply for **utility shut-off protection** and **reasonable accommodation in housing** (removal of a moldy carpet exacerbating Patient A's asthma) – key "prescriptions" that enable access to healthy housing and safe heating and cooling.

Patient A wants to apply and asks Dr. B for:
(1) **a form** certifying their medical eligibility for utility shut-off protection; and (2) **a letter** attesting to the nexus between the poor housing conditions and the asthma exacerbation.

Dr. B is flummoxed, frustrated, and busy. Dr. B improvises, giving Patient A two poor-quality documents that don't adequately document Patient A's actual dedical eligibility. Both of Patient A's applications for health-promoting benefits and services are denied.



1. The Problem (continued)

Moreover, when a consumer's application for a health-promoting support – like disability benefits – is accompanied by a poorly prepared medical certification, this low-quality application package increases the likelihood of application denial.[1] Such denials can launch the person into an (often multi-year) appeal process with a complex bureaucracy – and while awaiting resolution, they receive none of the benefits or services they need to buy healthy food or pay rent. What could have been a successful, proactive resource connection has converted into an acute, high-stakes, and time-intensive legal process for an individual or family. They, the care team, and multiple systems are now in a downstream problem-solving posture – precisely what healthcare-human service integration transformation seeks to avoid.

It's time to name this problem and point to some solutions in the form of *Unlocking Access.*

2. The Stakes

For Individuals and Families

People generally are not aware of the "secret rules" relating to verification of one's medical eligibility. And lag time in initiation of health-promoting benefits can be a significant source of frustration and material hardship. When a patient makes a legitimate request for a letter from their busy provider, they may be declined or supplied (sometimes late) with a poor-quality document – and each of these scenarios threatens that patient's high-stakes application for a benefit, service, or legal protection. This problem cannot be solved by the dominant HRSN intervention paradigm – screening and referral (even warm referral!) – because public policy authorizes only certain healthcare actors to prepare and sign these certifications.

When a patient with sickle cell disease, respiratory challenges, or multiple sclerosis cannot secure a timely utility shut-off protection certification because their provider doesn't have the time, resources or inclination, this is not a small matter. They are at risk for severe (even life-threatening in the case of sickle cell disease) health consequences when the heat is turned off, with all predictable care utilization and costs repercussions.

[1] Agaronnik, N. D., Pendo, E., Campbell, E. G., Ressalam, J., & Iezzoni, L. I. (2019). Knowledge Of Practicing Physicians About Their Legal Obligations When Caring For Patients With Disability. Health Affairs, 38(4), 545-553. doi:10.1377/hlthaff.2018.05060

For Providers and Care Teams

Clinical providers want to optimize health, and increasingly "meet patients where they are" to respond to their needs. Moreover, providers often have the "power of the pen" to facilitate access to a range of health-promoting benefits and services. But this is easier said than done. While providers are made aware in clinical training and practice of how HRSN can worsen or exacerbate health conditions, they historically have lacked support to systematically address HRSN – even when they have the knowledge, will, and desire to do so.[2] Many clinical providers lack an understanding of the landscape of available benefits, who qualifies for them, and how these benefits are obtained, including their role in the process. Indeed, clinical training encourages clinicians to assess a risk:benefit ratio—and instructs that when the risk outweighs the benefit, the intervention should not be performed. The lack of knowledge makes it impossible to calculate this theoretical ratio, creating uncertainty in whether to even proceed.

Even providers who do engage in good faith with people's requests for "doctor's notes" sometimes:

- draw arbitrary (e.g., age-based) boundaries to try to manage a perceived "floodgate" of requests from patients, [3] and;
- engage with the certification preparation process in a poor-quality manner with devastating consequences for individuals and families.[4],[5]

[2] Barnidge, E., Labarge, G., Krupsky, K., & Arthur, J. (2016). Screening for Food Insecurity in Pediatric Clinical Settings: Opportunities and Barriers. Journal of Community Health, 42(1), 51-57. doi:10.1007/s10900-016-0229-z

[3] Bebinger, "No Tropical Paradise." http://www.wbur.org/commonhealth/2017/07/05/greater-boston-heat-islands (*noting how an FQHC in Chelsea, MA is (a) grappling with a high volume of legitimate requests for reasonable accommodation letters relating to housing conditions, and (b) drawing an arbitrary line between responding to such requests on behalf of medically-eligible children v. medically-eligible adults*)

[4] Saint Louis, "Doctors' Notes for Pregnant Employees Can Backfire, Experts Warn." https://well.blogs.nytimes.com/2015/07/08/doctors-notes-for-pregnant-employees-often-backfire-experts-warn (*describing the perils of poorly drafted doctor's notes on pregnant women seeking reasonable accommodation at work*)

[5] Lisa Bernt, "Opinion | Doctor Notes in Pregnancy - The New York Times." https://www.nytimes.com/2015/07/17/opinion/doctor-notes-in-pregnancy.html (*noting similar risks to disabled persons who need medical certifications to assert reasonable accommodation at work*).

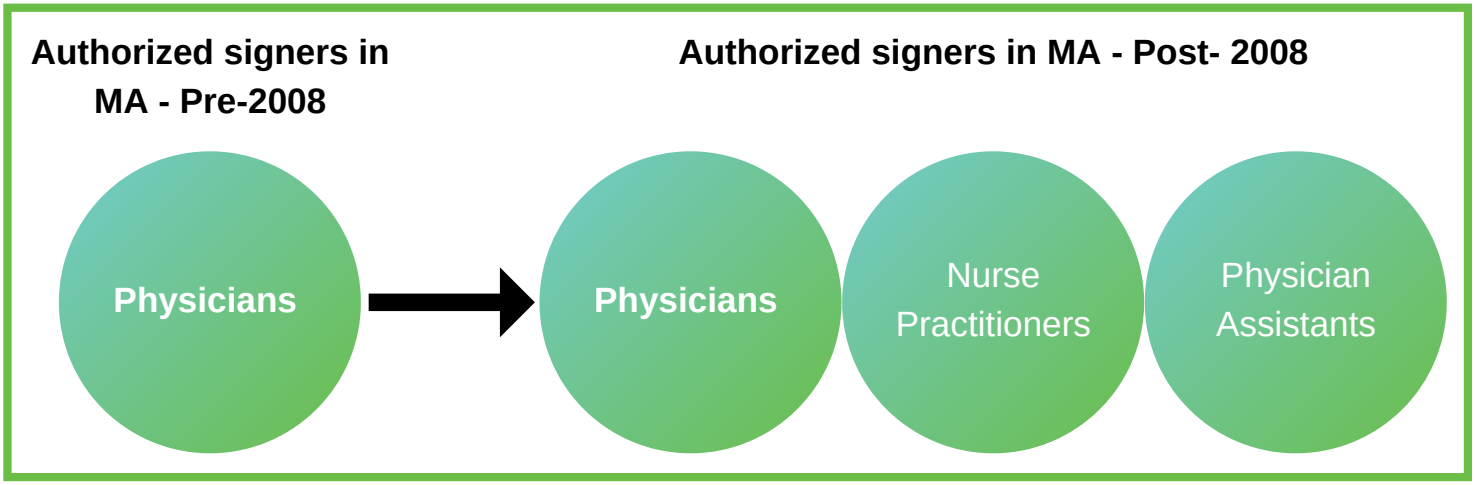
For Healthcare Systems

A person's inability to access sufficient food, stable housing, consistent heat or air conditioning – among many other factors – is a key driver of healthcare system costs. Until these foundational health drivers are addressed, the "math" of healthcare financing reform (e.g., global payments) is not going to add up, and even accountable entities operating under innovative economic frameworks will face financial risks. In the medical certification context, it will be critical to engage quality improvement and risk management teams to assure that communication – about patients' health-related social needs and any care team paperwork that could help meet those needs – is eased among care teams who operate across multiple locations and fragmented data systems.

3. The Opportunity: *Unlocking Access*

Notably, clinicians did not opt into this certification function – it's been vested in healthcare providers and organizations by federal and state regulation for decades, and further complicated by historical silo-ing of healthcare delivery and public health infrastructure. There are opportunities to organize and advocate for revised policies that can re-distribute such responsibility across the evolving healthcare and public health workforce in sound ways (e.g., social workers, community health workers, and new models for well-trained integrated care management teams).

Indeed, in 2008, MLPB (in partnership with the National Consumer Law Center and Dr. Megan Sandel of Boston Medical Center and Children's Health Watch) was instrumental in convincing the Massachusetts Department of Public Utilities to expand the pool of workforce members authorized to complete shut-off protection forms to include not only physicians but also nurse practitioners and physician assistants – relieving some of the significant burden that MA-based physicians had until then shouldered alone.



This work built on a 2007 quality improvement pilot with Boston Medical Center's Department of Pediatrics that focused on provider engagement with utility shut-off protection letters and produced a 300% increase in paperwork completion.[6] That effort not only improved systems and mitigated workflow, but also produced a state-wide policy change that benefited consumers, providers, and healthcare employers.

For the time being, it is largely clinicians (and the health systems in which they work) who have unique power over the fate of patients' applications to safety net programs that carry huge implications for them, their caregivers, and their families, not to mention the quality and cost of U.S. healthcare. Circumstances tied to medical certifications prepared by health professionals are described in Appendix A and include:

- staying housed;
- keeping one's job when dealing with a cancer diagnosis and an intensive chemotherapy regimen;
- keeping the heat and lights on during the winter, and the air conditioning on in the summer;
- putting nutritious food (or any food) on the table;
- accessing appropriate educational opportunity;
- and much more.

The health system transformations currently underway present a meaningful opportunity to embed consumer-oriented practices into new integrated care management workflows. Workforce training and Interprofessional Education (IPE) also are important strategies to support behavioral/habit change on care teams. after participation. *Unlocking Access* will build on these strategies to boost workforce capacity to better navigate requests to verify a person's medically based eligibility for social supports.

This document was generated as part of MLPB's Unlocking Access Special Initiative. The Special Initiative is funded by a grant from the Blue Cross Blue Shield of Massachusetts Foundation. Created in 2001, the mission of the Blue Cross Blue Shield of Massachusetts Foundation is to expand access to health care in Massachusetts through grantmaking and policy initiatives.

[6] Gottlieb, L. M., Tirozzi, K. J., Manchanda, R., Burns, A. R., & Sandel, M. T. (2015). Moving Electronic Medical Records Upstream. American Journal of Preventive Medicine, 48(2), 215-218. doi:10.1016/j.amepre.2014.07.009

Key Health-Promoting Benefits & Services that (May) Require a Type of Medical Certification

Health-Related Social Need Domains	Medical Certification Context
Housing Instability	• Remediation of unhealthy / unsafe housing conditions • Reasonable accommodation of a disability in housing • Priority/preference status in access to subsidized housing
Food insecurity (linked to income & employment insecurity)	• Accessing special formula (enteral nutrition) products (often prohibitively expensive if prior approval delayed or rejected; also complex due to typical classification as DME – durable medical equipment) • ·Medical eligibility for disability benefits like Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
Utility needs	• Medically based utility shut-off protection – gas & electricity • Medically based shut-off protection – telephone service
Transportation needs	• Eligibility for medical transportation services
Interpersonal Safety	• Many survivors of interpersonal violence (IPV, characterized by CMS as “interpersonal safety”) can only access protections in housing, employment, and other critical contexts if they present certification of their IPV/trauma survivorship prepared by designated healthcare or human services workers.
Barriers to employment	• Reasonable accommodation of a disability in the workplace • Family & Medical Leave Act (FMLA) job protections
Barriers to education & learning	• Individualized Education Plans • 504 Plans
Barriers to citizenship faced by some green card holders	• Medically based exemption from the civics test typically required during the naturalization process (securing citizenship is critical to activating eligibility for a range of benefits that enable capacity to pay for food, energy, and housing)