Lawyering as Problem-Solving: Implications of Patient-Centered, Accountable Healthcare for the Legal Profession

healthlawreporter.bbablogs.org/2014/09/06/lawyering-problem-solving-implications-patient-centered-accountable-healthcare-legal-profession/

Posted September 6, 2014

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1. **Introduction**

Health care delivery is rapidly changing in response to a number of new pressures and reform movements, for which the dominant fee-for-service model has proven inadequate to address. Many new organizational structures are converging and spotlight the increased importance of the patient's perspective and lived experience in healthcare delivery redesign. Accountable care organizations (ACOs), with their focus on management of value-based care and total cost risk, have a financial incentive to understand what patients need to become or stay healthy, and to structure care teams, delivery systems, and budgets around those realities.[1] Complementing Massachusetts' 2006 innovation of near-universal access to health insurance, the cost containment legislation signed in 2012 (Chapter 224 of the Acts of 2012, hereinafter referred to as "Chapter 224") explicitly targets health disparities and provides that when setting up new payment structures, the system must engage in thoughtful risk adjustment methodologies to account for variation in the needs of populations that are more vulnerable to those disparities.[2] Moreover, healthcare organizations that seek certification as patient-centered medical homes (PCMHs) must demonstrate that they provide a range of meaningfully consumer-oriented services, such as extended hours, patient-friendly materials, and improved care coordination for patients as they move across the healthcare spectrum.[3] Additionally, several Massachusetts initiatives are pushing healthcare delivery systems to focus on behavioral health as a key driver of costs and to find ways to integrate primary mental healthcare across individual locations and larger health systems.[4]

These developments – especially the economic pressures of new financing methodologies – have triggered a more robust dialogue about the role of the healthcare system in addressing both the biological and social determinants of health.[5],[6] Healthcare providers increasingly are expected to help patients get and stay healthy, as opposed to merely treating patients' diseases. Since the socio-economic context within which people function impacts their health in myriad ways,[7] institutions now disregard complex socio-economic drivers of poor health (and related healthcare costs) at their peril. As presciently noted in Malcolm Gladwell's 2006 article in The New Yorker, *Million Dollar Murray*, a tiny percentage of patients (so-called "superutilizers") generates a disproportionate amount of healthcare costs.[8] Indeed in 2011, one percent of patients in Camden, New Jersey generated one-third of the city's healthcare costs.[9] The high cost of caring for our society's most vulnerable people – combined with the already large and growing costs of care for people with chronic diseases like diabetes, heart failure and kidney failure – demand that health care institutions (a) control costs, but also (b) maintain high quality care, rather than limit care in the short-term and thus create higher costs down the road.[10] It no longer is a sufficient risk stratification strategy to simply identify patients with chronic disease; the delivery system also must assess a range of risk factors – such as food and housing insecurity, interpersonal and community violence, social isolation, and mental illness – that predict complex needs and complex care, if the system is to thwart associated higher costs.[11] These changes have the potential to align healthcare institutions in a new focus on the

multi-dimensional determinants of health and chronic disease management; this kind of alignment could be a major force for health equity among populations that historically have been at highest risk for disparities in coverage, access to care, and health outcomes.[12]

Against this backdrop, attorneys should revisit how the legal profession intersects with the healthcare system. While legal risk management activity in healthcare typically has focused on issues such as medical malpractice, HIPAA compliance, and myriad regulatory obligations, lawyers have an important role to play in helping healthcare stakeholders manage another set of risks that the system is just beginning to confront more systematically. These risks relate to a patient's socio-economic context and increase health disparities, reduce healthcare workforce productivity and efficiency, and trigger high-cost events such as avoidable hospital readmissions.[13] Many of these risk factors can be addressed, and some even prevented, through legal planning, guidance, and interventions.

2. **Socio-Economic Context and Healthcare Delivery: Why Health Reform Matters**

ACOs

The drive to cut overall healthcare costs, exemplified in the federal Affordable Care Act,[14] includes efforts to shift responsibility for increased costs back onto insurers and healthcare institutions via ACO structures. An ACO is a network of physicians and hospitals that shares financial and medical responsibility for providing coordinated, quality care to patients in a cost-effective manner.[15] The underlying concept is that providers in an ACO will take on upside financial risk and/or downside financial risk in relation to defined patient outcome benchmarks.[16] The ACO paradigm creates incentives for providers to develop delivery systems that maintain high quality care and to manage both short-term and long-term costs.[17] Functionally, ACOs are incentivized to recognize the downstream costs of limiting access to prevention, care coordination services, medications, timely follow-up with primary care for acute problems, and behavioral health services.

In this new economic reality, to which payers and institutions are adapting, it will be critical to identify and address a broader range of barriers to care and health. Historically, clinical teams have been best positioned to prioritize internal "process" barriers such as inadequate access to follow-up appointments. However, many barriers to health and care confronted by patients are socio-economic,[18] and the healthcare system is neither accustomed to having to address these complex issues, nor was it built to do so. Indeed, many of the highest-risk and highest-cost patients (so-called "superutilizers")[19] have a preponderance of unresolved, untreated or under-treated mental health diagnoses like depression and addiction.[20] Mental Health Integration, frequently called Behavioral Health Integration (BHI), is now recognized as a crucial component of any successful ACO — with success defined as simultaneous improved health and decreased costs.[21]

Massachusetts has long been a leader in the movement to increase access to healthcare through health insurance, and provides lessons for the rest of the United States in the steps healthcare should take to succeed in this brave new world.[22] Indeed, the Massachusetts coverage expansion movement was sufficiently momentous to spur formation of global payment contracts in the Commonwealth several years ago.[23] However, coverage expansion alone does not guarantee good health or meaningful access to healthcare services. This reality was recognized in Chapter 224:

In developing additional standards for ACO certification, the [Health Policy Commission] shall consider the following goals for ACOs: . . . (4) to promote alternative payment methodologies consistent with the standards developed by the commission and the adoption of payment incentives that improve quality and care coordination, including, but not limited to, incentives to reduce avoidable hospitalizations, avoidable readmissions, adverse events and unnecessary emergency room visits; **incentives to reduce racial, ethnic and linguistic health disparities in the patient population**; and in all cases **ensuring that**

alternative payment methodologies do not create any incentive to deny or limit medically necessary care, especially for patients with high risk factors or multiple health conditions[.][24] *(emphasis added)*

. . .

The office of Medicaid shall ensure that alternative payment methodologies: (i) support the state's efforts to meet the health care cost growth benchmark and to improve health, care delivery and cost-effectiveness; (ii) include incentives for high quality, coordinated care, including wellness services, primary care services and behavioral health services; (iii) include a risk adjustment element based on health status; **(iv) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors**; (v) preserve the use of intergovernmental transfer financing mechanisms by governmental acute public hospitals consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and (vi) recognize the unique circumstances and reimbursement requirements of high Medicaid disproportionate share hospitals and other safety net providers with concentrated care in government programs.[25] *(emphasis added)*

Chapter 224 acknowledges that individuals do not come to the healthcare system on equal footing, even if they all technically are insured. There is a range of other factors that must be accounted for to achieve health equity in the Commonwealth.

There is another reason insurance coverage is not sufficient on its own: the American healthcare system is historically underfinanced in the areas of care that advance prevention and decrease costs (primary care and care coordination) and overfunded in areas that can drive up costs without improving health (sub-specialty care and high-cost, often unnecessary, procedures or tests).[26] In order to avoid a surge in healthcare costs from newly-insured but primary care naïve patients, ACOs in Massachusetts are expanding primary care services in the hope of improving the efficiency and quality of care delivered in primary care settings.[27] These changes are described as the "Patient-Centered Medical Home Model" of care and focus on patients' health needs outside of the traditional "one doctor and one patient in a room together" style of care.[28]

PCMH

The Patient Centered Medical Home (PCMH) describes a care delivery model that is organized with the needs of patients at its center.[29] Concretely, this means:

- Enhanced prevention screenings and careful follow-up on identified risks and problems;
- Making care accessible beyond traditional "banker's hours," either by extending direct patient care into evening and weekend office hours, and/or providing 24 hour access to medical advice by phone or email;
- Generating patient-oriented educational materials regarding chronic disease self-management tips and so forth (accounting for among other things, the needs of low literacy patients and English Language Learners)
- Careful reconciling of patient-reported medication behaviors against what is noted in medical records; and
- Thoughtful care coordination, since no single physician, or even doctor-nurse team, can deliver this type of comprehensive care to a population (panel) of patients.[30]

While the PCMH structure may seem like a one-size-fits-all solution, the complex dance of even a high-functioning PCMH team can quickly come undone by socio-economic factors entirely beyond the team's control. For example, a patient may not be able to keep the necessary appointments due to a lack of

transportation resources; the newest and best asthma medicines simply are not enough to counter the allergens in the substandard housing in which the patient resides; or the patient's abusive partner prohibits him or her from having any further contact with healthcare professionals. Even in the realm of insured patients, those with chronic diseases frequently become overwhelmed by the monthly cost of even "low co-pay" medications; many of these patients either economize by buying medicines every-other-month or choose which ones to buy each month rather than take all of the recommended and necessary doses.[31] Clinicians, understandably, are not equipped to solve these foundational problems.

Notably, the patient profiled in Gladwell's *Million Dollar Murray* article was "non-compliant" because he lacked an apartment to pass out in after a bender, somewhere safe to manage his chronic disease of alcoholism.[32] Housing instability is a key social determinant of health that shadows these highest-cost healthcare consumers.[33] Significantly, health insurers in several states have recently undertaken new initiatives to subsidize affordable housing.[34]

When a medical diagnosis is made, medical treatment teams rush to treat the problem and hopefully resolve the issue. When diagnosis of a socio-economic barrier to care/health[35] is made, the healthcare team's resources are limited. As the healthcare system now grapples with appropriate and feasible treatments for these causes (often root causes) of disease and high healthcare costs, we should consider how the legal profession can support these efforts.

3. Social Determinants of Health (SDH): A New Frontier in Medicine

Physicians and nurses have long been trained to take a patient's medical history. But exploring a patient's social history and context, — beyond tobacco and alcohol use, sexual behavior risk factors, and use of car seats for young children – is a relatively recent development. In fact, systematic clinical screening for domestic violence is a surprisingly recent phenomenon.[36] Not only can conversations on topics such as income, personal safety, and immigration status be challenging, but many providers are understandably reluctant to screen for problemsfor which they may be unable to offer a remedy.[37] However, since institutions no longer can ignore these predictors of poor health and high costs, efforts to develop standardized screening tools and practices for a range of key SDH are underway.[38]

Healthcare institutions that have attempted to build infrastructure to address SDH – generally through increasing their allied health staff – have run up against a core challenge: under the dominant fee-for-service payment model, only clinical services are reimbursable by payers. Therefore, while a hospital could be reimbursed for clinical services provided to a patient by a licensed social worker (such as therapeutic counseling), it could not be paid for social worker efforts to connect patients to resources essential for day-to-day subsistence (such as SNAP benefits, housing subsidies, and more). To offset the costs of providing these additional services, some institutions have received philanthropic grant funding; however, this approach is not sustainable in the long-term.

In the last several years, the community health worker movement has spawned exciting pilot programs that integrate lay, culturally (and often linguistically) congruent outreach workers into healthcare teams to help patients overcome defined barriers to care.[39] In addition, a number of pilots are underway that seek to improve post-discharge care management, including successful leveraging of community-based resources.[40] Massachusetts again is a hotbed of innovation in this area.[41] To date, integration of these new team members has had the most traction in chronic disease managementcontexts (as opposed to primary care), and to the extent this new workforce is helping to eliminate barriers to health insurance coverage.[42] As these initiatives evolve, it will be important to connect the dots between (a) evidence of what exactly patients need to overcome barriers to care and health, (b) funding streams for community health work, and (c) the job description for this important workforce.

4. Big Problems Like SDH Demand Large Toolboxes

Medical institutions and professionals have developed their own unique set of problem-solving tools, which are essential to individual and population health. However, in this time of shifting paradigms, there is a greater recognition that the traditional toolbox is incomplete and collaboration with other disciplines will be important.[43] The legal profession can leverage its long history of tackling some of thorniest challenges confronting our country's most vulnerable people (particularly in the realm of civil rights enforcement) for populations at the highest risk of health disparities: people of color, people with disabilities, English Language Learners, the LGBTQ community, and more. Further, lawyers are trained in a number of distinct strategies – including but going beyond traditional litigation – that solve problems when patients confront health-harming social or environmental conditions. This suite of skill sets will only become more relevant in an accountable care-oriented healthcare landscape:

Preventive law

In healthcare, preventive law[44] typically takes the form of compliance work, and is postured proactively – identifying legal risks before they convert into legal problems for a provider or institution. These same skills can be leveraged, productively, to support low-resource healthcare consumers who often interact with no less than ten powerful decision-makers simultaneously when attempting to access health-promoting benefits and services to which they are legally entitled. These interactions that comprise a person's social ecology – with landlords, abusive partners, government agencies, and so forth – can have a profound impact on a person's health trajectory. The healthcare sector should be fertile ground for proactive legal risk assessments for low-resource patients, since healthcare institutions increasingly will share an interest in anticipating and eliminating barriers to care and health.

Community lawyering

While determining the origins of disease ("pathogenesis") has long been the focus of medicine, understanding and cultivating the origins of health ("salutogenesis") may in fact represent the bigger challenge – and certainly one in which people themselves should be engaged. As healthcare continues an important dialogue about whether its consumers are "people" or "patients", patient-centered care delivery models may ask: what steps will empower people to participate themselves in addressing social determinants of health? Community lawyers have vast experience to share on this subject.

Community lawyering encourages attorneys to meaningfully engage community members in advocacy that affects their lives, and to engage in multiple strategies to achieve their goals (including but not limited to outreach, facilitative leadership, and campaign feasibility exercises).[45] Community lawyers are the legal profession's closest equivalent to community health workers, and the strongest legal community ambassadors for the healthcare notion of "patient engagement." As patient-centered medical homes proliferate and providers operating in ACO environments re-balance expectations with patients regarding responsibility for disease prevention and management, community lawyers could be important allies in supporting patients who have been activated help manage their health.

Negotiation and Mediation

Although negotiation arguably is a critical life skill with which all people should be equipped to succeed, training and support for negotiation capacity largely has been vested in the legal and business professions. Many of the social barriers to care and health that result in a "stuck patient" or repeated avoidable readmissions could be addressed through thoughtful negotiation with a patient's proposed long-term care facility, landlord, state agency worker, or school district. The legal profession has much to offer in this

domain – not merely in serving as negotiators directly, but in helping to build negotiation skills in allied health professionals and patients themselves.

While negotiation involves dispute resolution directly between two or more parties, mediation positions a neutral party as mediator of such as disputes among parties. Again, the legal profession is host to a large supply of active mediators, but also can play a capacity-building role by sharing best practices on mediation techniques with lay and allied communities invested in this form of dispute resolution for people with health-impacting problems.

Litigation

When all else fails, litigators are equipped to challenge rights violations in court proceedings. This can happen on behalf of an individual or a group of similarly situated individuals (class actions). In some contexts (*e.g.*, eviction and imminent homelessness), this strategy functions like a legal "emergency room", since the client is facing severe, life-changing consequences in the near-term. In other contexts (*e.g.*, some consumer class actions), litigation can serve a preventive function, leveraging correction of past harms to ensure no future harm comes to a population going forward.

Policy change

At their best, all of the above strategies can breed changes in public policy and law that are both just and health-promoting. As the socio-economic drivers of poor health are increasingly better documented and understood, the healthcare system may observe opportunities to influence policy domains that have long been considered unrelated to the practice of medicine and healthcare financing. Lawyers sited in healthcare-based general counsel and government relations teams are especially (though not exclusively) well-positioned to examine whether what looks like a "poverty law" issue is in fact a healthcare access and quality problem with damaging consequences not only for patients, but for a healthcare delivery system.

"Reality-checking"

Some socio-economic problems are quickly amenable to the strategies noted above; many are not. When a care coordinator attempts to resolve a patient's difficult barriers to care, s/he quickly will need to know whether or not current law presents a solution. If so, role-appropriate advocacy can begin. If not, this knowledge will allow value-based care teams to allocate their scarce resources wisely in the short-term – and then set long-term policy change agendas on the tougher issues.

4. Lawyering as a Health Intervention: Practical and Cultural Implications for the Profession

Social ecology is a new frontier for healthcare, and it may be useful to step back and look at the big picture. Initiatives designed to address SDH will be most impactful – for patients, for the healthcare system, and for communities – if their design is informed by the following considerations:

- *Re-orienting healthcare teams to patients' total context must start during their education and training.* Would we expect an astronaut to learn a core skill set only after she'd already landed on the moon? **Schools of medicine, nursing, social work, and dentistry** (among others) are key partners in this critical patient-centered, public health-oriented re-alignment. But as the healthcare team expands and diversifies, it's also essential that **community college** graduates heading to myriad careers in healthcare (as physician assistants and more) start their jobs with a comprehensive understanding of what drives a person's health.
- *Tackling SDH may require new workforce skills and role adaptation*. Public policy has long demanded that **clinicians** provide medical certifications and support for patients in a range of high-stakes contexts connected to health inequities: disability benefit applications, utility shut-off

protection letters, requests for health-related reasonable accommodation in housing, employment, and so forth. They've done so for years without much formal guidance, although these time-intensive responsibilities carry with them enormous practical and ethical and implications for both clinicians and their employers – and often "heat-or-eat" implications for the affected patients. The laws, regulations, and policies governing patients' access to a range of health-promoting benefits and programs change frequently. Historically, keeping up with such matters has not been the province, or priority, of healthcare-based offices of **General Counsel**. Perhaps we will see an expansion of the General Counsel domain when it becomes clear that healthcare delivery systems directly benefit from many patients' seemingly external legal claims (to,for example, a housing unit free of asthma triggers to which s/he can be quickly and safely discharged from an emergency room or inpatient ward).Meanwhile, greater emphasis on SDH has put **Social Work** teams under increased pressure to simultaneously differentiate into complex care management and expand their role in routine care management of the usual patient population – generally with no additional financial resources. And the relationship between social work and the community health workforce remains murky – synergistic for sure, but potentially competitive. It will be critical to ensure that existing skill sets and experience are wisely leveraged alongside productive innovation of institutional organizational charts.

- A *successful population health strategy will demand social policy innovation alongside healthcare policy innovation*. As patients' medical and social complexities become more relevant to care delivery and healthcare financing, so do the public policies that drive these complexities. Integration of community health workers (and other allied team members) into specific health centers and hospital departments represents substantial progress, but focuses the intervention at the individual patient level. Perhaps as institutions' interests continue to re-align with the interests of vulnerable patients, we may observe increased engagement among institutions' **Government Relations** teams (often populated by attorneys) on matters that are known to be "root causes" of health inequities, such as the inadequate supply of affordable housing.

If the legal community is to play a different and productive role in the accountable, value-based, patient-centered healthcare landscape, it must:

- Rigorously assess the socio-economic risks confronting low-resource healthcare consumers (often civil rights violations) that simultaneously harm healthcare providers and insurers. These issues extend well beyond access to insurance coverage.
- Learn the healthcare system's values, financing, vocabulary, and culture. We may use different words to describe our goals for patients/clients ("engagement" v. "self-efficacy" v. "empowerment"), but we often are talking about the same thing, and in fact pursuing the same goals.
- Embrace the depth of our lawyer's "toolbox" even if it means adapting our individual lawyering styles and larger practice structures. Healthcare is re-examining whether its practices are truly "patient-centered" – perhaps this process will produce reflections that enhance client-centeredness in the legal profession as well.

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