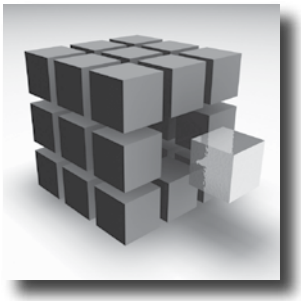

Medical-Legal Partnerships: From Surgery to Prevention?

By Ellen M. Lawton, Esq., Executive Director[1]
Medical-Legal Partnership for Children at Boston Medical Center/
Boston University School of Medicine

Injury is the leading cause of childhood morbidity, hospital admissions and mortality in the United States. Even so, few communities and fewer trauma centers have mounted efforts to prevent this significant health problem. Moreover, hospital administrators rarely accept responsibility for either improving community health or preventing injuries.

But in the 1990s in the world of trauma surgery, there was a revolution; trauma surgeons, especially pediatric trauma surgeons, had grown frustrated seeing children in their emergency rooms and operating rooms with traumatic injuries that resulted from unsafe homes and communities. Children who suffered traumatic brain injury, from falling out of apartment windows, burns from uncovered radiators or lacerations from unsafe playgrounds all experienced preventable injuries.

After a study revealed that childhood injury rates in Harlem were substantially higher than national rates, as well as rates in most other New York City communities, Barbara Barlow, M.D., Director of Pediatric Surgical Services at Harlem Hospital and Professor of Surgery at the College of Physicians and Surgeons of Columbia University, had a vision to change this.

"If the majority of your work is trauma surgery, the fact that all trauma is preventable means that to not develop a program to prevent injuries is not doing your job as a doctor — it's almost immoral," Dr. Barbara Barlow, Director of Surgery at Harlem Hospital Center in New York City, and Executive Director of the Injury Free Coalition for Kids (Vassar Quarterly, 1993). (see *www.injuryfree.org*).

Working with pediatricians, pediatric trauma surgeons and pediatric emergency medicine doctors alongside community groups, business leaders and local and national foundations, Dr. Barlow fostered a movement toward prevention by experts skilled in *responding* to crisis, not preventing it. As it turned out, trauma surgeons became an important credible voice for change in community safety efforts, by sharing their tragic clinical experiences and their agenda to change the trajectory of tragedy in low-income communities.[2]

Surgery = Litigation?

At the Medical-Legal Partnership for Children (MLPC) at Boston Medical Center (BMC), the injury prevention trend is a powerful analogy for our work in the legal world. BMC's patient population is overwhelmingly low-income. As the largest safety net hospital in the northeast, over 60% of the patients earn below 200% of the poverty level, and over 50% are immigrant and refugee families.

At MLPC, we run a small legal aid office within the Department of Pediatrics, where our mission is to create a culture of advocacy in the Department, and ensure that pediatric patients and their families basic needs — for food, housing, health care, safety and stability, and education — are met. Our core activities include *training for front-line health care staff, direct legal assistance* for patient-families and *systemic advocacy* in partnership with doctors and other clinicians.

Like all legal services providers, we constantly witness the impact of a broken "safety net" on the lives of the families who receive their pediatric care at BMC, and our unique vantage point allows us to see not just the families in medical crisis, but those in "social" crisis – facing eviction, domestic violence or lack of income. But our view from pediatrics also allows us to spot the crisis before it happens, and to train the clinicians we work with to act as surveillance for us, to understand that if a family has a child with a chronic illness, that probably has impacted wage-earning in the family and created a trickle if not a cascade of legal issues ranging from healthy housing access to income supports to education access. We view the clinical setting as the

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gateway to *preventive law* for the legal services population, so that families can get access to the legal help they need *before* the crisis of eviction or job loss that would typically lead them to legal services.

The Roots of Medical-Legal Partnership

Since the advent of the AIDS crisis in the early 1980s, models of partnership between lawyers and healthcare providers have been emerging.[3] At the same time, health care providers and social workers concerned about child abuse and neglect also began working more closely with lawyers. In the late 1980s, Harvard Law professor and legal aid visionary Gary Bellow teamed with a local internist at Boston's Brigham & Women's Hospital to bring legal assistance to the clinical setting for vulnerable adult patients. Finally, informal and formal medical-legal collaborations have emanated from a range of disease-specific and geriatric clinical settings.

MLPC's groundbreaking innovation was to create a medical-legal partnership with a committed vision of shifting legal resources to a prevention model. Pediatricians are uniquely situated to intervene when children's basic needs are not being met, because children are seen regularly in the pediatric setting, especially in the first five years of life. These ongoing visits lead to the development of trusting relationships between pediatric providers and families. In pediatrics, the ethos of preventive medicine is well-accepted, and lends itself particularly well to identifying non-medical determinants of child health, since families are encouraged to seek out preventive care.

Nevertheless, while pediatricians are usually taught to consider the family and social context of their patients, they often do not have the specific knowledge or resources to effectively intervene in these arenas.[4] Pediatricians' training and experience is generally limited to addressing the biological causes of illness. As a result, they are reticent to ask families about housing conditions, violence, or access to adequate food, since they are unsure what to do with the response. Thus, pediatricians and other health care providers often find themselves in the difficult situation of recognizing the effect of social factors on the health of their vulnerable young patients, while feeling helpless to address them. Indeed, even highly skilled social workers do not have the training to address complicated questions about family eligibility for public benefits, especially where there is an immigration component.

Children with poorly managed health and mental health conditions miss school, fall behind their classmates, and experience preventable health consequences. Their illness affects their family wellbeing because repeated emergency room visits, doctor's office visits, and hospitalizations place their low-income parents' low wage jobs at risk. As it turns out, legal advocacy is the best medicine for the social determinants of health. (**See Figure 1**.)

From Local Service to National Model

MLPC started as a partnership between Greater Boston Legal Services and BMC in 1993, but quickly became a small independent program in the legal services community. Funded with small grants and philanthropy developed through the hospital, the program grew slowly.

Shortly after an article about MLPC appeared in the *New York Times* in 2001, we began fielding dozens of requests for technical assistance from nascent sites all over the country, and started running annual conferences. From 2001 to 2005, we ran annual conferences, published a how-to manual and provided hundreds of hours of technical assistance on a shoestring, since we did not have dedicated national funding to support this effort. A remarkable thing was transpiring in the legal aid and pediatric communities across the country: people were passionate to create a partnership in their own communities to help vulnerable children and families. Despite a lack of significant research data supporting outcomes, and without major dedicated funding, programs nevertheless began to crop up, thanks to intrepid Equal Justice Works and Skadden Fellows, visionary legal services attorneys and directors, and dedicated pediatricians, nurses and social workers. The result? Over 50 programs across the country now identify themselves to us as medical-legal partnerships.

In late 2005, acknowledging the national demand for technical assistance and funding, and recognizing the passionate commitment of the partnerships that were forming, the W. K. Kellogg and Robert Wood Johnson Foundations awarded MLPC $2.7 million over five years to create a national center for medical-legal partnership. The response in the legal aid and clinical communities has been astounding. In April 2006, MLPC issued its first request for proposals for small (up to $25K) grants with a required 2:1 match. We received thirty proposals and in November 2006, awarded $400,000 in grant funds to fifteen sites.

MLPC's central goal, through the provision of

technical assistance and funding to active and nascent sites, is to transform the practice of pediatrics and the delivery of legal services by introducing preventive law to the clinical setting. By drawing on the strength of two powerful professions, community resources can be leveraged, and children and families can realize the promise of integrated, preventive services that promote health and well-being. A secondary goal is to use the powerful alliance of doctors and lawyers to catalyze change in the community and national systems and in policies that impact our most vulnerable children and their families.

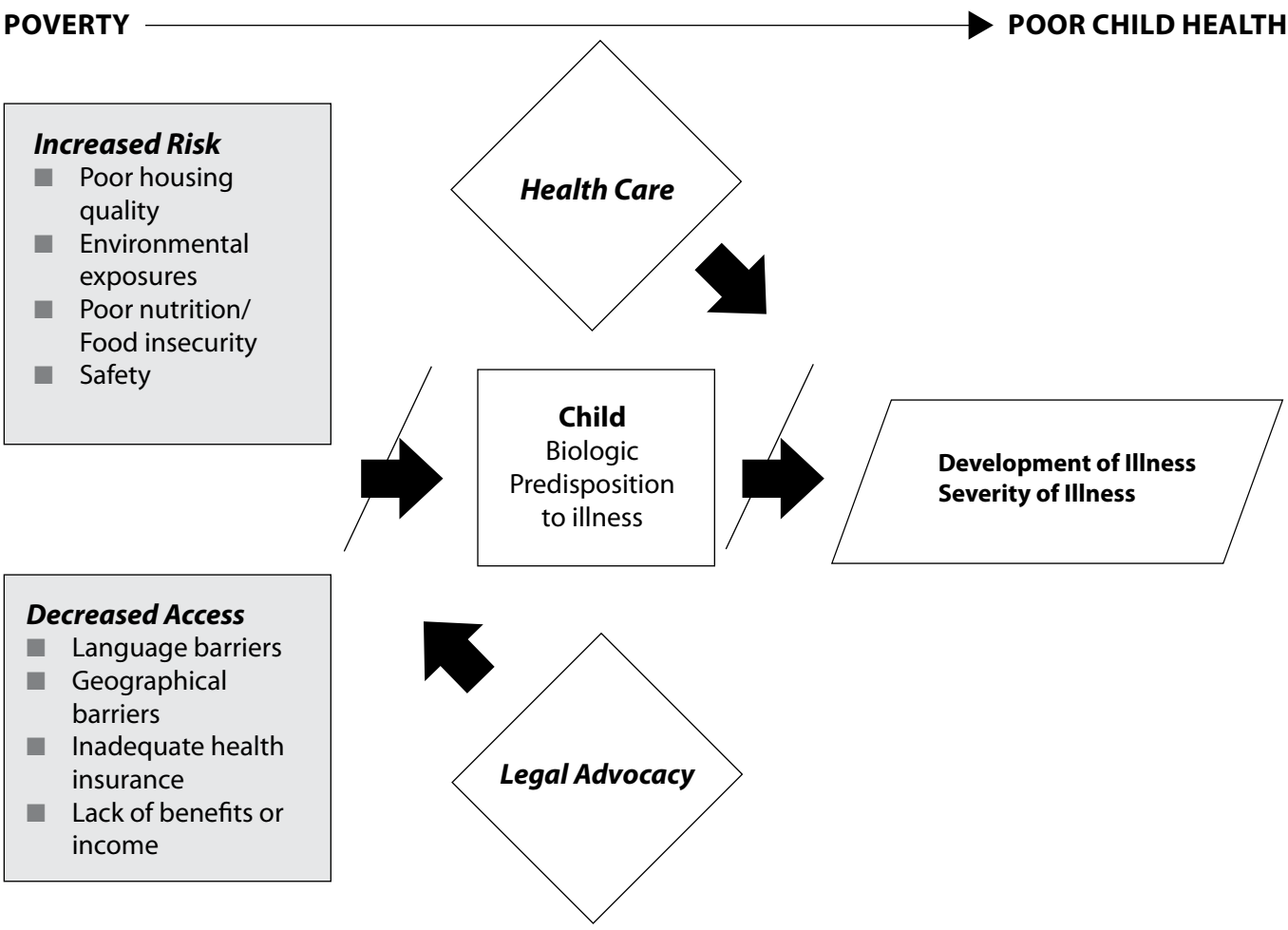
Legal Services Takes the Lead in Medical-Legal Partnership

A number of medical-legal partnerships have emerged as important contributors to the medical-legal partnership movement, and, along with their medical counterparts, are setting the stage for the development of standards and best practices over the next several years in areas such as training and education, systemic advocacy, evaluation and data collection, and innovative funding mechanisms.

Some of the earliest adapters — Jay Sicklick, Esq. (Children's Advocacy Center at University of Connecticut School of Law), Randye Retkin, Esq.(LegalHealth, of New York Legal Assistance Group), and Mallory Curran, Esq. (Cleveland Legal Aid) — have made significant contributions to the field in the areas of systemic advocacy, innovative funding and research, training and education, and breadth of vision outside of the pediatric realm. Other early adapters with important contributions to the field include Children's Law Center & Children's National Medical Center (Washington, D.C.), Jacksonville Legal Aid, Duval County Health Department, and Maryland Volunteer Lawyers Project & Johns Hopkins Harriet Lane Clinic.

Several partnerships have made enormous inroads

Figure 1: Interrupting the Biologic and Social Determinants of Health through Medical and Legal Intervention



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in the most difficult domain of medical-legal partnership: research and evaluation. In 2000, Health & Disability Advocates of Chicago partnered with two major Chicago hospitals on a leading edge medical, legal and case management study in the neonatal intensive care units, tracking outcomes of NICU families and generating critical data which advanced the field significantly. Other sites engaged in research projects include Atlanta Legal Aid (with Children's Healthcare of Atlanta and Georgia State University School of Law); Legal Aid Society of San Mateo County (with Lucile Packard Children's Hospital at Stanford University); and Southern Arizona Legal Aid (with University of Arizona College of Medicine, Department of Family and Community Medicine).

New England Regional Medical-Legal Network (NERMLN)

Funded by the Jessie B. Cox Charitable Trust since 2004, NERMLN is a regional working group comprised of five New England sites (including legal partners Legal Assistance Corporation of Central Massachusetts; Rhode Island Legal Services; New Hampshire Legal Assistance; University of Connecticut Center for Children's Advocacy, and Kids Legal Aid of Maine at Pine Tree Legal Assistance) at varying stages of development. The New England sites play an important "laboratory" role for the national sites; in 2005, NERMLN produced a series of White Papers describing evaluation, capacity-building and sustainability strategies. In 2007, NERMLN will undertake a pilot data collection effort for medical-legal partnerships: it will collect, across six sites, common process and outcome data, in an effort to identify data points and test collection strategies in preparation for rolling out evaluation initiatives and best practices nationally.

Pro Bono Opportunities — Subverting the Dominant Paradigm

At the same time that MLPC was initiating its program in Boston in 1993, the law firm of Leonard Street & Deinard in Minneapolis, M.N., was reaching out to a local health care setting intent on building a *pro bono* relationship. Fourteen years later, LS&D is still offering weekly legal clinics at Community-University Health Care Clinic, and, honoring the vision of founders Dr. Amos Deinard and attorney David Haynes, is linking to the local legal services community to explore expanding its vision and model.

MLPC began to leverage other resources in the legal community and seek active pro bono partnerships with private law firms in 2001. Since then, the enthusiasm in the legal community for our unique model has led three law firms — Day Pitney, Holland & Knight and Foley Hoag — to "adopt" local health centers where they run weekly legal clinics. MLPC acts as the facilitator to support training and education, and mentor cases. A number of sites across the country already incorporate *pro bono* as part of their traditional service delivery, but many are taking a fresh look at potential roles for *pro bono* attorneys in medical-legal partnerships.

Training and Education

Training and education for front-line healthcare providers — doctors, nurses, social workers and other members of the health care team — is a core activity, and one that requires the most strenuous "cross-cultural" awareness. Learning activities in the clinical setting are distinct from those in the legal setting, and part of creating a culture of advocacy entails adapting trainings to the medical model. In addition, residency programs and professional accrediting organizations are increasingly attaching value to advocacy training for clinicians, so the incentives on both the medical and legal sides are aligned.

At MLPC, we revisit our training curriculum regularly to ensure it is meeting the needs of the clinical team, and creating the desired linkages with our direct service delivery. Several sites, including LegalHealth, Baltimore, M.D., Rhode Island, San Mateo, C.A., Syracuse, N.Y., and Ann Arbor, M.I., have introduced creative cross-disciplinary trainings, joint medical/law student courses and other innovations that are quickly becoming standard practice in major academic medical centers across the country.

Who Pays for This? Funding Strategies for Medical-Legal Partnerships

A key start-up and/or expansion strategy for many sites has been through fellows in both the Equal Justice Works and Skadden programs. Mallory Curran started the program in Cleveland as a Skadden Fellow in 2002; that site was recently awarded a major multi-year grant from the Robert Wood Johnson Foundation for community innovation in medical-legal partnership. The support of both fellowship programs has been important and strategic; by our count, at least ten fellows have worked directly on medical-legal partnerships.

Other resources include IOLTA programs, hospital foundations and community benefits offices, and local and regional philanthropy.

The health care recovery dollars trend — where some legal aid programs have partnered with local clinics or hospitals to recoup money by securing health care benefits for eligible children and families, thereby accruing a benefit to the clinical setting—has led some of those programs to look at medical-legal partnership as a way to expand the narrow work of health insurance advocacy to offer families other supports.

Finally, LegalHealth in New York has led the field in securing direct funding from clinics and hospitals to offer their services on-site, and have generated impressive cost/benefit data that they are using to convince hospital administrators to increase their support from hospital budgets.

Evaluation & Data Collection — The $64 Million Dollar Question

The central question that drives any discussion about medical-legal partnership is this: Does legal intervention improve health outcomes?

On one level, we sense that it must be true: too many legal aid attorneys have seen families thrive and succeed after legal intervention, especially when closely pegged to physical health, such as housing condition cases. But is there any data to support this suspicion? The thinking is, of course, that if we could *prove* that legal interventions improve health, then perhaps legal services might be resourced and regarded in the same way as the health care system— and viewed as an important basic service that, if done preventively, can save communities and systems money.

Medical-legal partnerships have struggled with the contours of this research question for a long time. MLPC's analysis and approach has been to focus on the short-term and intermediate impacts of our activities in order to measure our impact. We think that by demonstrating increased access to basic needs like food, housing, education, etc., we can link the access to improved health outcomes that are already well-established. For example, the health impacts of homelessness are well-studied and documented, but there is a research gap is in the effectiveness of legal intervention on homelessness. (**See Figure 2**.)

Acceptance of the medical-legal partnership model into the healthcare mainstream will be a real possibility when we can explain with the support of data how legal services delivered in the clinical setting complements traditional medical care and enhances the lives of families. We are quite a distance from that goal, but we believe that we can begin to move toward it.

This is a moment of opportunity. The rapid expansion of the model over the past few years now allows us to learn much about how this collaboration can work in different settings and in different iterations. The testing grounds are in place, but we are challenged to ask the strategic questions and gather the information required to answer those questions.

Some Research Highlights

MLPC received funding from The Atlantic Philanthropies to conduct a series of evaluation research studies, working with a team from Cornell University's Department of Policy Analysis and Management. The research includes:

- A series of focus groups of clients;
- A concept mapping (see below);
- A comparison of sixty qualitative interviews examining how families with access to MLPC services deal with their housing issues, compared with families who do not have access to MLPC; and
- A comparison site study between BMC and two other clinical sites, to examine whether the presence of an on-site legal program (at BMC) increases the likelihood that a family's legal needs will be identified and addressed. Some health and well-being indicators will also be examined over the study's follow-up period.

Concept Mapping

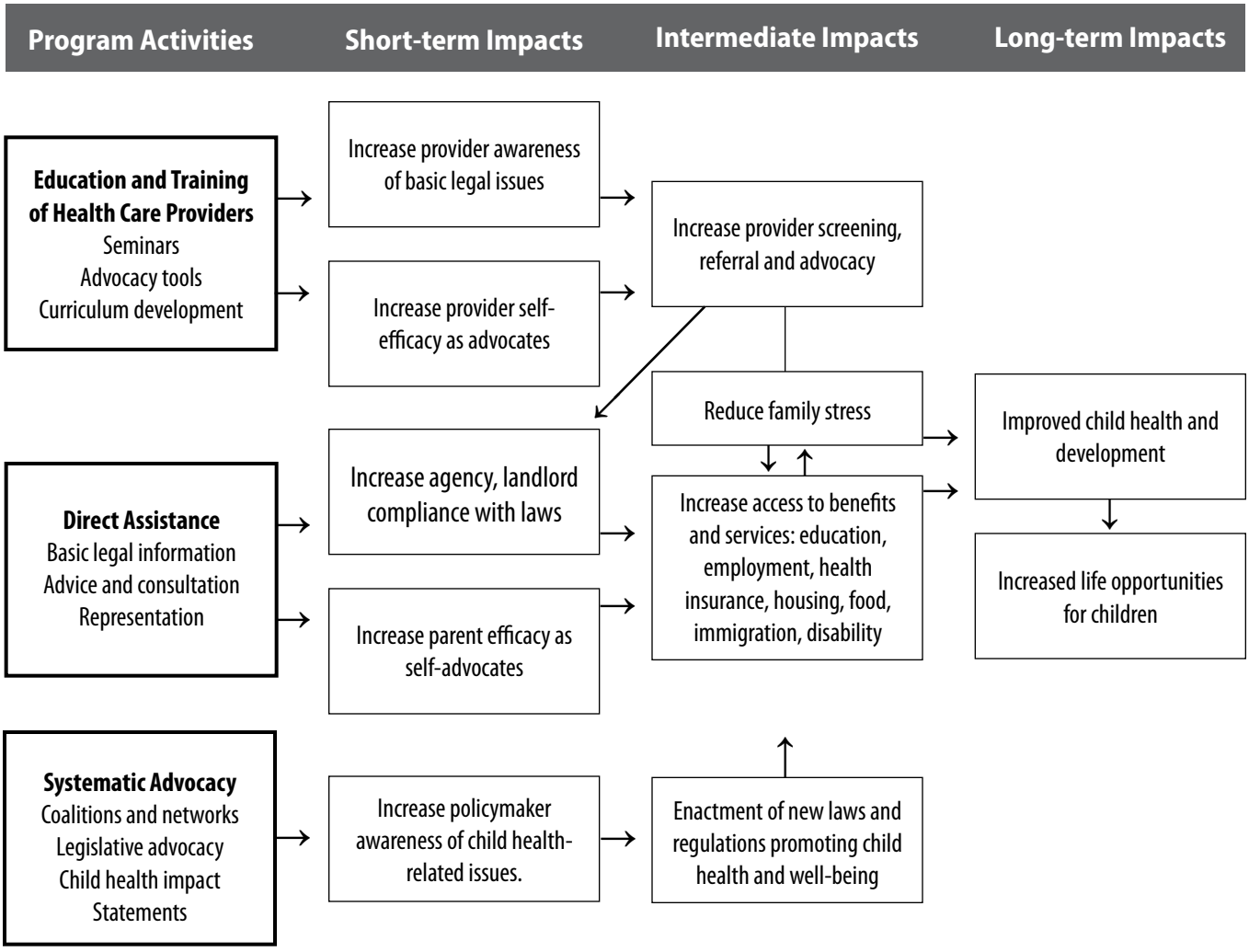
Developed as a process of engaging program stakeholders to identify the range of outcomes or benefits resulting from medical-legal collaboration, the mapping process resulted in identifying six domains of outcomes that medical and legal partners cite as important outcomes for medical-legal partnerships. They are: Family Empowerment Through Legal Assistance; Enhanced Family Health and Well-being; Enhanced Child Health and Well-being; Improved Access to Legal Assistance; Medical-Legal Collaboration; and Improved Provider Capacity to Address Social Determinants of Health.

We believe that these domains will form the framework for devising outcome and process measures nationally for medical-legal partnerships.

New Partnerships, New Opportunities

Things are moving quickly in the medical-legal partnership world. Last year, Iowa Legal Aid received a federal appropriation for a small pilot project with

Figure 2: Logic Model — Medical-Legal Partnership for Children



four rural health centers; just last month, the dynamic Virginia Family Advocacy Program in Charlottesville — a partnership of University of Virginia Law School, University Medical Center and Legal Aid Justice Center — secured a $1 million endowment of its program. In the ensuing press coverage, Alex Gulotta, Executive Director of the Legal Aid Justice Center, reflecting on the program's strengths, commented that "(t)his is the most efficient referral I have seen in twenty years in legal services." New programs with new stakeholders, funding sources and approaches are cropping up almost weekly.

So, back to the surgery/prevention analogy: MLPC's goal has always been to grow support — politically, philosophically, and financially — for the legal services community. We think that pediatricians and other health care providers are poised to be important new stakeholders in ensuring that growth. But it will take both clinical and legal resources to make this partnership work. We in the legal services community will be challenged to determine priorities in service delivery and scope of assistance in a way that ensures success — for our agencies, our clients and the partnerships we create. It is in the realm of "surgery" — where legal services agencies have traditionally practiced litigation — that the legal services community has the power to shift resources toward prevention.

1 Ellen Lawton has worked at MLPC since 1997, first as a staff attorney directing a welfare-to-work advocacy initiative, and becoming executive director in 2001. She has written numerous articles for both clinical and legal journals about medical-legal partnership, and has presented in a variety of national, regional and local forums as well. See www.mlpforchildren.org. Ellen may be reached at Ellen.Lawton@bmc.org.

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about program officers working in their substantive areas, keeping a calendar of due dates for reports and proposals, and reminding the attorneys to send messages by mail or telephone when progress has been made on a certain issue. Our attorneys keep in communication with a foundation even if the foundation is not currently funding our work.

Walz does an excellent job of keeping in touch with the foundations interested in housing preservation and has raised enough grant funding (over a period of years) to hire a second attorney to partner with her in housing preservation.

One last but not the least important task especially for an organization with limited resources is that management must celebrate good and successful work. This can be done in any number of ways: acknowledgement at staff and board meetings, on the website, and at public events such as our annual awards dinner, for example. Celebrating victories boosts staff morale and renews and maintains organizational energy. When all is said and done, a happy and fulfilled staff is the best way to manage limited resources to deal with poverty law issues.

1 Rita A. McLennon, is the Vice President of External Affairs of the Sargent Shriver National Center on Poverty Law. From 1993 until the end of 2006, she served as Executive Director of the Shriver Center. Under her leadership, SSNCPL grew as a strong national communication, research, and advocacy resource for public policy leaders, the poverty law community, and the voiceless in society. Previously McLennon served on SSNCPL's board of directors from 1982 to 1993. Before coming to SSNCPL, she was director of development and training at the National Center for Youth Law, development director at the Legal Assistance Foundation of Chicago, executive director of the Illinois Council/American Institute of Architects, and an administrative assistant to Illinois State Senator Dawn Clark Netsch. She currently serves as vice chair of the board of directors of the Alliance for Justice and as a board member of the National Equal Justice Library and Management Information Exchange.

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