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MEDICAL-LEGAL PARTNERSHIP

EVOLUTION or REVOLUTION?

By Pamela C. Tames, Colleen M. Cotter, Suzette M. Melendez, Steve Scudder, and Jeffrey Colvin

Pamela C. Tames
Director of Training

National Center for
Medical-Legal Partnership
Medical-Legal Partnership I Boston
Boston Medical Center
88 E. Newton St. Vose 5
Boston, MA 02118
617.414.7315
pamela.tames@bmc.org

Colleen M. Cotter
Executive Director

Legal Aid Society of Cleveland
1223 W. Sixth St.
Cleveland, OH 44113
216.861.5273
cmcotter@lasclev.org

Suzette M. Melendez
Director, Children's Rights and Family Law Clinic
Codirector, Syracuse Medical-Legal Partnership

Office of Clinical Legal Education
Syracuse University College of Law
P.O. Box 6543
Syracuse, NY 13217-6543
315.443.4582
smmelend@law.syr.edu

Steve Scudder
Counsel

ABA Standing Committee on
Pro Bono and Public Service
American Bar Association
321 N. Clark St.
Chicago, IL 60654
312.988.5768
steve.scudder@americanbar.org

Jeffrey Colvin
Pediatrician, Children's Mercy Hospitals and Clinics
Physician Liaison, Legal Aid Referral Program

Children's Mercy Hospitals and Clinics
2401 Gillham Rd.
Kansas City, MO 64108
816.802.1493
jdcolvin@cmh.edu

In 1993 Dr. Barry Zuckerman, chairman of the Pediatrics Department at Boston University School of Medicine and Boston Medical Center, hired a lawyer to work directly with pediatric patient-families. Building on a pilot initiative developed by Prof. Gary Bellow at Harvard Law School and Brigham and Women's Hospital, and citing numerous instances of pediatric patients who had asthma and suffered repeated attacks and hospitalizations due to abysmal housing conditions, Dr. Zuckerman realized that patient health would not improve without remediation of those housing conditions through the intervention of a lawyer. Thus the first medical-legal partnership was born.

Fast forward to the year 2010; more than 235 hospitals and health centers in the United States and Canada partner with more than 90 legal aid organizations to provide legal help to patients in multiple medical disciplines such as pediatrics, family medicine, oncology, geriatrics, and internal medicine.

Multiple law and medical schools are affiliated with medical-legal partnerships (MLPs) and many residency programs incorporate MLP curriculum into their graduate medical education.[1] Dozens of recent law school graduates have been funded through Equal Justice Works and Skadden fellowships to create or enhance MLPs. The MLP model has been recognized by the American Bar Association (ABA) and the American Medical Association (AMA).[2] In 2010 the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HHS) funded three MLP pilot projects and, on July 29, the bipartisan Medical-Legal Partnership for Health Act, calling for a nationwide demonstration project for MLP, was introduced in the U.S. House of Representatives and the Senate.[3] The MLP model is rapidly creating a new standard of practice for vulnerable populations.[4]

Here we examine why so many lawyers—especially those associated with legal aid, law schools, the private bar, and hospital general counsel—are collaborating with health care providers to deliver health-promoting legal services to low-income persons. We describe (in I and II) the history of the legal and medical professions and present context for their respective commitments to serving vulnerable people.[5] We discuss what

[1]National Center for Medical-Legal Partnership, 2011 MLP Network Site Survey (2011), http://bit.ly/lyVmR1.

[2]National Center for Medical-Legal Partnership, www.medical-legalpartnership.org.

[3]Medical-Legal Partnership for Health Act, H.R. 5961, 111th Cong. (2010); S. 3668, 111th Cong. (2010).

[4]Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations,* 29 Health Affairs 9 (2010).

[5]Medical-Legal Partnership (MLP) involves more than just two professions. Nurses, social workers, case managers, and public health professionals, among others, participate in MLPs. For instance, social workers have long been considered an integral part of the medical team and often are the most prepared to engage in advocacy with vulnerable patients. For simplicity, we discuss the health care professional's perspective and role through the doctor.

these professions have in common, how they differ, and the barriers they must overcome to collaborate. We paint (in III) a comprehensive picture of the MLP model and how it works, describe the impact of MLP on legal services, health care delivery, and public policy, and explain how transformation of professional practice can result in substantial investments in legal services by health care institutions. With long-term experience in legal services, national and state bar associations, law school clinical teaching, the private bar and health care practice, we present diverse perspectives.

I. Lawyers: Professional Roots Serving Those in Need

The legal profession's history—as that of doctors and the clergy—is rooted in service to the public. In its earliest days, as far back as ancient Greece, making a living was secondary to providing service to persons in need. Yet, by the third century, tension was already developing between the law as a trade and the law as a public service profession. As advocates began collecting money for service, codes evolved to prohibit or regulate fees.[6]

In England, during the reign of Edward I (1272–1303), the legal profession began to be more strictly regulated with statutes prohibiting such actions as deceit, collusion, conflicts, and the like. Notably attorneys could not charge unreasonable fees for services. Over the course of the next few centuries this regulatory approach became fully incorporated into modern rules of lawyer professional conduct.

The earliest forms of the legal profession in America were guided by common law encompassing local traditions, ethos, and community norms. As the profession became more organized, and the need for rules of practice was recognized, the ethos of pro bono was an important part of the dialogue. For example, in 1884, University of Pennsylvania law professor George Sharswood wrote: "It is to be hoped that time will never come, at this or any other Bar in this country, when a poor man with an honest cause, though without fee, cannot obtain the services of honorable counsel, in the prosecution or defense of his rights."[7] This core principle of the legal profession was ultimately incorporated into formal rules of professional ethics, the first of which was adopted by the Alabama State Bar in 1887.

Eleven states adopted codes of professional conduct by 1906, most of which contained language governing the professional responsibility of lawyers to serve the poor. In 1908 the ABA adopted its first Canons of Professional Ethics with the declaration that "it should never be forgotten that the profession is a branch of the administration of justice and not merely a money-getting trade."

In 1969 the *ABA Canons of Professional Ethics* were converted to a *Model Code of Professional Responsibility*. The *Model Code* contained aspirational standards, disciplinary rules, and ethical considerations. The public service responsibility of lawyers was included as ethical considerations with language such as:

> The basic responsibility for providing legal services for those unable to pay ultimately rests upon the individual lawyer, and personal involvement in the problems of the disadvantaged can be one of the most rewarding experiences in the life of a lawyer.... Every lawyer, regardless of professional prominence or professional workload, should find time to participate in serving the disadvantaged.... The rendition of free legal services to those unable to pay reasonable fees continues to be an obligation of each lawyer....[8]

[6] This section on the early history of the legal profession and rules of professional conduct is a very short summary of the outstanding research found in the following articles: James L. Baillie & Judith Bernstein-Baker, *In the Spirit of Public Service: Model Rule 6.1, the Profession and Legal Education*, 13 Law and Inequality 51, 58–62 (1994); Robert E. Hirshon, *ABA Standing Committee Proposes Revisions to Model Rule 6.1*, 10 ABA PBI Exchange 7 (1992); Dennis A. Kaufman, *Pro Bono: The Evolution of a Professional Ethos*, 10 ABA PBI Exchange 3, (1992); Judith L. Maute, *Changing Conceptions of Lawyers' Pro Bono Responsibilities: From Chance Noblesse Oblige to Stated Expectations*, 77 Tulane Law Review 91, 136–37 (2002).

[7] George Sharswood, Professional Ethics 53 (5th ed. 1884).

[8] Model Code of Professional Responsibility EC 2-25 (1969).

For reasons having to do with both construct and content, the ABA revisited the professional conduct rules again in 1983 and promulgated the *Model Code of Professional Conduct*. For the first time a specific pro bono rule—Model Rule 6.1—was created. In 1993 the ABA Standing Committee on Lawyers Public Services Responsibility proposed amendments to Model Rule 6.1 that maintained the core value of the 1983 rule but added clarity, emphasis, and quantifiable measurement.[9] The pro bono rule was amended again in 2002 with stronger introductory language replacing the more aspirational sentiment of the earlier iterations.[10]

As the professional ethos of public service was developing in America, lawyers in a number of communities across the country began to develop legal projects devoted entirely to serving the needs of the poor. Starting in 1876 with the German Immigrants' Society (later to become the Legal Aid Society of New York), the legal aid model became an increasingly common strategy in America's cities for dealing with the legal issues of individuals who could not afford to pay private law firms. While many of these programs were operated as staffed poverty law offices, others were served by pro bono lawyers.

The staff attorney legal aid model expanded considerably with the creation of the Office of Economic Opportunity legal aid program in the early 1960s and continued with the authorization of the federal Legal Services Corporation (LSC) in 1974.[11] LSC programs began to take a more serious look at how to involve the private bar. They engaged their local bar associations as partners in the delivery system and developed programs in legal aid or bar offices. As pro bono gained momentum, some communities chose to create free-standing programs. Whereas there were only just over 85 organized pro bono programs in 1980, today there are well over 1,500, when specialty (such as domestic violence, AIDS (acquired immune deficiency syndrome), and homelessness) and law firm and law school pro bono programs are considered along with the pro bono programs of legal services offices and bar associations.[12]

To help support the development of high-quality pro bono programs, the ABA House of Delegates adopted the *ABA Standards for Programs Providing Civil Pro Bono Legal Services to Persons of Limited Means* in 1996.[13] The Pro Bono Standards recognized that pro bono programs and their volunteer lawyers need to view their clients and cases in a holistic way. Standard 2.10, under the *Program Effectiveness* section, states: "A pro bono program should strive to develop and maintain active and cooperative relations with community organizations and social service agencies that serve clients."[14] The Commentary to Standard 2.10 discusses the value of these relationships in helping to serve the client beyond the immediate legal needs presented. This principle has led to many programs working with social workers and other nonlegal supporter providers and notably to the involvement of private attorney volunteers in medical-legal partnerships.

The legal profession positions lawyers to learn about pro bono in law school, presents them with an ethical framework

[9]Model Rules of Professional Conduct R. 6.1 (1994 ed.) (Voluntary Pro Bono Publico Service 87).

[10]See [American Bar Association], State-by-State Pro Bono Service Rules: Appendix B—Development of ABA Model Rule 6.1: Historical Timeline (June 23, 2011), http://bit.ly/iJbtS6.

[11]Alan W. Houseman & Linda E. Perle, Center for Law and Social Policy, Securing Equal Justice for All: A Brief History of Civil Legal Assistance in the United States (rev. 2007).

[12]Various entities of the American Bar Association compile listings of pro bono projects across the country (see ABA Standing Committee on Pro Bono and Public Service and the Center for Pro Bono, Publications (2011), http://bit.ly/f7DLmy; *id.*, Projects and Awards (2011), http://bit.ly/pkDVNv; ABA Commission on Domestic Violence, http://bit.ly/kno06h; ABA Commission on Immigration, http://bit.ly/mf3bd7; and others at www.americanbar.org.

[13]American Bar Association, Standards for Programs Providing Civil Pro Bono Legal Services to Persons of Limited Means (Feb. 1996), http://bit.ly/lju9rC.

[14]*Id.*

setting out their pro bono responsibility, and offers a wide range of volunteer opportunities. Encouraged by pro bono programs to think about their clients' needs in a broader context, the legal profession and doctors not surprisingly have come together in medical-legal partnerships.

II. Physicians: Altruism and Ethics Driving Health Care of Vulnerable Populations

As early as ancient Greece and Egypt, a distinct medical profession has existed.[15] In the fifth century BC the Hippocratic Oath was written and remains one of the most well-known codes of medical ethics in Western medicine.[16] Although it does not mention care of indigent populations, the Hippocratic Oath requires members of the medical profession to adhere to the values of beneficence, honesty, and compassion.[17] And, while the medical profession went through several transitions in Medieval Europe and the Renaissance, historians note that the "enduring factors in medicine have always been compassion, pity, care, and love."[18]

Not until the development of anesthesia and antibiotics in the mid-nineteenth century and early twentieth century did medicine have the ability to cure disease.[19] The first American Code of Medical Ethics was written during this period. This Code, drafted at the first meeting of the AMA in 1847, aligns the duties and obligations of the medical profession with the tradition of Hippocrates nearly 1,500 years earlier:

> From the age of Hippocrates, to the present time, the annals of every civilized people contain abundant evidences of the devotedness of medical men to the relief of their fellow-creatures from pain and disease, regardless of the privation and danger … a sense of ethical obligations, rising superior … to considerations of personal advancement.[20]

The Code explicitly places the duty of a physician above both personal well-being (e.g., "even at the jeopardy of their own lives") and compensation (e.g., "that moral duty, which is … far superior to all pecuniary consideration").[21] It also recognizes the role of free care in medical practice: "Poverty … should always be recognized as presenting valid claims for gratuitous services."[22]

Today the AMA continues to require that physicians support access to health care for all segments of the population.[23] The AMA's current code of ethics and related ethical opinions require physicians to "ensure that the needs of the poor in their community are met" through medical service and political action.[24] In 2001 the AMA adopted the "Declaration of Professional Responsibility," which states that "[h]umanity is our patient" and that physicians must seek "social, economic, educational, and political changes that

[15]Philip Rhodes, An Outline History of Medicine 182 (1985).

[16]History of Medicine Division, National Library of Medicine, National Institutes of Health, Hippocrates and the Rise of Rational Medicine (last updated Jan. 14, 2009), http://1.usa.gov/kC1s7B.

[17]History of Medicine Division, National Library of Medicine, National Institutes of Health, The Hippocratic Oath (last updated June 24, 2010), http://1.usa.gov/sx5h5.

[18]Rhodes, *supra* note 15, at 181.

[19]Jacalyn Duffin, History of Medicine: A Scandalously Short Introduction 122–23 (1999).

[20]American Medical Association, Code of Medical Ethics of the American Medical Association 83 (1847), http://bit.ly/mDZrzi (App. D: Introduction to the Code of Medical Ethics).

[21]*Id.* at 91 (App. E: Code of Medical Ethics ch. 3, art. I, § 1) ("when pestilence prevails, it is their duty to face the danger … even at the jeopardy of their own lives"), http://bit.ly/mDZrzi; *id.* ch. 1, art. I, § 5.

[22]*Id.* ch. 3, art. I, § 3.

[23]American Medical Association, AMA Code of Medical Ethics: Principles of Medical Ethics (rev. June 2001), http://bit.ly/AQhal.

[24]*Id.*, AMA Code of Medical Ethics: Opinion 9.065—Caring for the Poor, http://bit.ly/mQJvlz.

ameliorate suffering and contribute to human well being."[25]

A. The Duty and Practice of Free Medical Care

Whether based upon intrinsic altruism or adherence to the AMA's code of ethics, physicians in private practice remain the most common source of free care in the United States.[26] An estimated 68 percent of physicians (or 397,000 physicians) provide charity care.[27] Physicians provide this care in their private practices, through free clinics, and through volunteer referral networks, where specialists agree to treat patients in their own office for free or a nominal charge.[28] An estimated 1,007 free clinics serve 1.8 million patients (or approximately 10 percent of the uninsured working-age population) in over 3.1 million medical visits per year.[29] Free clinics and volunteer physician networks are often the result of "the efforts of one or more committed physicians or other health professionals who tapped their colleagues' idealism."[30] This commitment continues despite evidence that approximately 80 percent of medical school graduates have student loans with a mean indebtedness of $100,000 and $135,000 for graduates of public and private medical schools, respectively.[31] Even with this degree of personal debt, studies find no evidence that greater debt deters physicians from entering primary care or influences them to enter more lucrative specialties.[32]

Physicians also serve the poor and uninsured at public hospitals and federally qualified health centers.[33] An estimated 40 percent of the fourteen million patients seen at such centers are uninsured, and 16 percent of the care at the 1,300 public hospitals in the United States is uncompensated.[34] Despite this allocation of care to those in poverty, research shows that when reimbursement for Medicaid patients is reduced, fewer physicians are willing to see Medicaid patients.[35] Beyond differential health care access based on insurance source, multiple studies demonstrate pervasive disparities in access to quality health care based upon race, ethnicity, and socioeconomic status, leading to explicit prioritization of research funds at the

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[25]House of Delegates, American Medical Association, Declaration of Professional Responsibility: Medicine's Social Contract with Humanity (adopted Dec. 4, 2001), http://bit.ly/lVPSQW. But see David H. Thom et al. *Measuring Patients' Trust in Physicians When Assessing Quality of Care*, 23 Health Affairs 124, 125 (2004) (patient trust in physicians is, in part, determined by patients' perception of whether physician puts patients' interests over costs); Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 Journal of the American Medical Association 1708, 1710 (1996) (patient trust in physician is dependent on method of compensation physician receives).

[26]Stephen L. Isaacs & Paul Jellinek, *Is There a (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States*, 26 Health Affairs 871 (2007) ("[C]ontrary to common perceptions, doctors in private practice are the most important source of care for this rapidly growing part of the population [i.e., individuals who are uninsured or receiving Medicaid]. Roughly four out of five patients who are uninsured or Medicaid recipients receive their primary care in a physician's office. The reason for this is the sheer number (some 72,000) of practicing physicians. Although each may see only a few uninsured patients, because there are so many practitioners, the aggregate number of such patients is large.").

[27]Peter J. Cunningham & Jessica H. May, *A Growing Hole in the Safety Net: Physician Charity Care Declines Again*, Center for Studying Health System Change Tracking Report No. 13, at 1 (March 2006), http://bit.ly/jIopIG.

[28]Isaacs & Jellinek, *supra* note 26, at 872.

[29]Julie S. Darnell, *Free Clinics in the United States: a Nationwide Survey*, 170 Archives of Internal Medicine 946, 947–48, 952 (2010).

[30]Isaacs & Jellinek, *supra* note 26, at 873.

[31]Paul Jolly, *Medical School Tuition and Young Physicians' Indebtedness*, 24 Health Affairs 527, 528 (2005).

[32]*Id.* at 533.

[33]Isaacs & Jellinek, *supra* note 26, at 872.

[34]*Id.* at 872; *2008 Annual Survey Underscores the Key Role of the Nation's Safety Net Hospitals and Health Systems*, National Association of Public Hospitals and Health Systems Research Brief 1, 2 (Dec. 2009), http://bit.ly/klLbxX.

[35]Diane Rowland & James R. Talon Jr., *Medicaid: Lessons from a Decade*, 22 Health Affairs 138, 140 (2003) ("When Medicaid payment rates—whether for physicians or managed care plans—fail to keep pace with payments in the private sector, access to care for Medicaid beneficiaries suffers and the goal of 'mainstreaming' the poor becomes more difficult to achieve.").

philanthropic and government level to determine the etiologies of such disparities and strategies to eliminate them.[36]

B. Altruism in the Next Generation of Physicians

The medical profession attempts to preserve a tradition of altruism through its education of medical students and residents. In reinforcing medical students' desire to care for underserved populations, the Association of American Medical Colleges requires all medical students to demonstrate a "commitment to provide care to patients who are unable to pay and to advocate for access to health care for members of traditionally underserved populations."[37] Calls for reform within medical education state that "[p]rofessional identity formation—the development of professional values, actions, and aspirations—should be the backbone of medical education, … extending to aspirational goals in performance excellence, accountability, humanism and altruism."[38]

Medical schools support the altruistic aims of medical students through student-run free clinics managed by medical students but supervised by a practicing physician; such clinics provide medical care for uninsured and low-income patients.[39] The first medical student-run clinic was established in 1967 in New Jersey, and the movement quickly spread to medical schools across the country.[40] Over 110 medical student-run free clinics are operated at nearly half of American medical schools.[41] Some of these clinics have gained national recognition and have multiple sites with hundreds of staff members.[42]

Medical education has evolved to include accredited courses and electives that teach students about the social determinants of health and the importance of working with other professionals to screen, diagnose, and treat nonmedical problems that affect patient health. Brown Medical School was the first medical school to create a joint course with a law school, Roger Williams University School of Law in 2003.[43] *Poverty, Health and Law: The Medical-Legal Collaborative,* offered by Brown Medical School and Roger Williams University School of Law, uses the MLP model to teach interdisciplinary collaboration between legal and health professionals; it is an increasingly common tactic for identifying and studying the complex and multidimensional social problems faced by disadvantaged and vulnerable clients. Through topics such as access to justice and health care, poverty and public benefits, safe and affordable housing, family violence and child safety, the course explores how legal and health care professionals can engage together in creative problem solving to promote justice and health.

Twenty-three medical schools now offer such courses, electives, or rotations; many of which are offered jointly with law schools.[44] Educators have called for

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[36]See, e.g., Institute of Medicine of the National Academies, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Brian D. Smedley et al. eds., 2003); Commission on Social Determinants of Health, World Health Organization, Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Final Report (2008), http://bit.ly/xnx3.

[37]Association of American Medical Colleges, Learning Objectives for Medical Student Education: Guidelines for Medical Schools 9 (1998).

[38]Molly Cooke et al., Carnegie Foundation for the Advancement of Teaching, A Summary of Educating Physicians: a Call for Reform of Medical School and Residency (n.d.), http://bit.ly/c0PEQE.

[39]Scott A. Simpson & Judith A. Long, *Medical Student-Run Health Clinics: Important Contributors to Patient Care and Medical Education*, 22 Journal of General Internal Medicine 352 (2007).

[40]Mary K. Nordling, American Medical Student Association/Foundation, Starting a Student-Run Homeless Clinic 8 (n.d.), http://bit.ly/ikgq8V.

[41]Simpson & Long, *supra* note 39, at 353.

[42]*Id.* at 8.

[43]Elizabeth Tobin Tyler, *Allies not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 Journal of Health Care Law and Policy 249, 281–90 (2008).

[44]National Center for Medical-Legal Partnership, *supra* note 1.

the development of interdisciplinary courses to promote further the similar altruistic values and understanding between the professions.[45]

After medical school, students enter residency programs of three-to-five-years' duration to be trained in the specialty of their choice. All residency programs are required to educate their physician residents in the specific core competencies of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.[46] To meet the competencies of professionalism and systems-based practice, physician residents must demonstrate "accountability to patients, society and the profession" and "responsiveness to patient needs that supersedes self-interest."[47] All physician residents must show that they "advocate for quality patient care" and that they can effectively work in "interprofessional teams … and improve patient care quality."[48] To meet the core competencies, a growing number of residency programs in family medicine, internal medicine, and pediatrics are partnering with lawyers in educating resident physicians to identify legal issues of patients and to consult with and refer to legal partners.[49]

Despite the perceived antagonism between doctors and lawyers, the two professions seem to share much in common.[50]

III. Medical-Legal Partnership: The New Standard of Care

MLP joins the legal and health care professions to improve the health and well-being of vulnerable populations through preventive legal care.[51] In an MLP legal staff members are on-site at a medical facility at least part-time and are considered members of the health care team. The legal team educates health care providers about patient and family health problems that can be resolved or lessened by legal intervention; they also train health care providers about the remedies that each profession can apply, and they reorient clinical activities and workflow to identify and resolve more efficiently legal issues that affect health. MLP is a true partnership, not merely a system of referrals. By working closely together, the health care and legal teams learn to appreciate the value that each brings to the table—how their skills and experience can complement each other to resolve their patient-clients' problems and make their lives better, healthier.[52]

A. Medical-Legal Partnership: The Core Components

MLP's three core components and activities transform the delivery of health and legal services for vulnerable populations. Although MLP programs can vary, all engage in providing legal assistance in the health care setting, transforming health and legal institutions and practices, and influencing policy change (see fig. 1).

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[45]Tyler, *supra* note 43, at 251–52.

[46]American College of Graduate Medical Education, Common Program Requirements: General Competencies (Feb. 13, 2007), http://bit.ly/kij9S2.

[47]*Id.*

[48]*Id.* Pediatric residency programs, in particular, are required to educate their residents on the "healthcare needs of all children within a community, particularly underserved populations" American College of Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Pediatrics IV.A.5(b)(1)(e)(ii)(a) (July 1, 2007), http://bit.ly/iyplmO.

[49]See, e.g., Ellen Cohen et al., *Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities*, 25 Journal of General Internal Medicine S136 (Supp. 2, 2010); Tyler, *supra* note 43.

[50]Peter D. Jacobson & M. Gregg Bloche, *Improving Relations Between Physicians and Attorneys*, 294 Journal of the American Medical Association 2083 (2005).

[51]See Barry Zuckerman et al., *Medical-Legal Partnerships: Transforming Health Care*, 372 Lancet 1615–17 (2008).

[52]For a discussion about the social determinants of health to which MLP can attend, see Ellen Lawton et al., *Medical-Legal Partnership/Philadelphia: Meeting Basic Needs and Reducing Health Disparities by Integrating Legal Services into the Healthcare Setting*, 3 Philadelphia Social Innovations Journal (Spring 2011).

1. Giving Legal Assistance in Health Care Setting

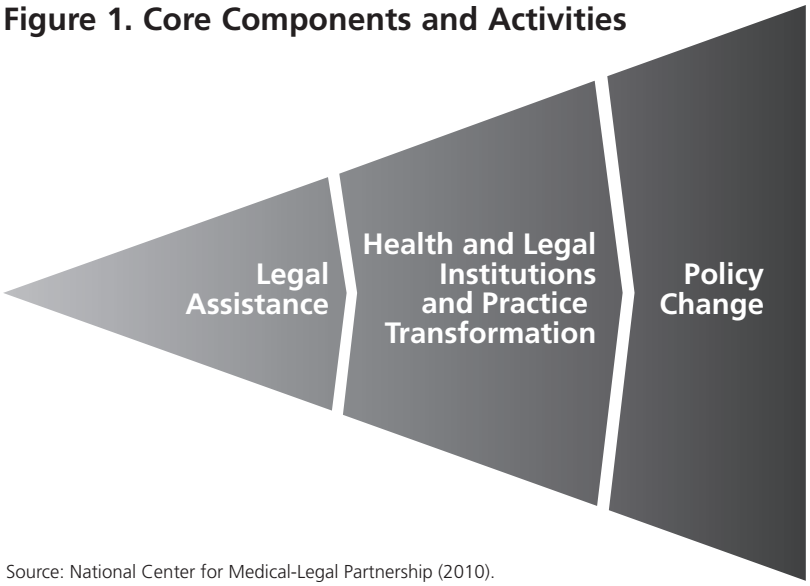
MLP brings legal professionals into the health care setting to meet the complex legal needs that confront low-income patients every day. With a focus on early detection of legal problems and prevention of legal and health crises, MLP legal practice is frequently understood as analogous to primary care.

MLP attorneys provide on-site assistance to patients needing legal help in the form of consultations, brief advice, and direct legal representation. Cases are referred to attorneys by frontline clinicians, who are trained to screen for and identify patients struggling with unmet legal needs. Attorneys communicate frequently with providers and give feedback on advocacy outcomes. MLP is more than a referral service—it is an integrated approach to health and legal services that facilitates critical, efficient, shared problem solving by health and legal teams who care for patients with complex health and legal needs.

The legal issues addressed by MLPs are broad, but all focus on ensuring, through enforcement of legal rights, that the basic needs of a low-income individual or family or both are met. Doctors and other members of the health care team often use the assessment tool I-HELP (*I*ncome Supports, *H*ousing and Utilities, *E*ducation and Employment, *L*egal Status/Immigration, and *P*ersonal and Family Stability and Safety) to identify unmet basic needs that have an impact on health and that may be responsive to legal remedies.[53]

Screening patients can be done over a series of health care visits or in a more focused manner if one of the issues is identified as a significant risk factor or contributor to poor health. For example, when a health care provider sees a patient who has widespread musculoskeletal pain and reports depression and anxiety related to chronic underemployment and unemployment, the provider is trained under the MLP model to inquire about the impact on the patient's income and housing security.

Figure 1. Core Components and Activities



Source: National Center for Medical-Legal Partnership (2010).

2. Transforming Health and Legal Institutions and Practices

The Patient Protection and Affordable Care Act has created a multiplicity of opportunities for MLP expansion. With the Act's focus on expansion of health care access to underserved populations, low-income patients with legal problems will converge in health centers and hospitals, requiring new strategies to meet their needs. Further, facets of the Act are designed to reconcile health disparities, build clinical workforce capacity, and improve coordinated care—all of which are domains where MLP has an impact.[54]

MLPs transform health and legal practices in multiple ways, such as training frontline providers to screen for, identify, and triage or refer, or both, patients with potential legal needs facilitating joint data tracking and the documenta-

[53]The I-HELP acronym was originally presented as part of MLP I Boston training curriculum, recently published in the second edition of a guide entitled Clinical Partners in Advocacy: How Can I-HELP? A Handbook for Clinicians Caring for Adult Populations (Pamela Tames & Adam King eds., 2d ed. 2010). For further examples of legal needs that affect health, see also Sandel et al., *supra* note 4, at 2.

[54]Elizabeth Tobin Tyler et al., Poverty, Health and Law: Readings in Medical-Legal Partnership (forthcoming Aug. 2011).

tion of legal information within patient medical records. At the institutional level, MLPs make evidence-based recommendations to improve quality of care and internal systems so that patients and families are better served.

MLP staff members dedicate a significant amount of resources to the development and delivery of advocacy training curricula to medical faculty, residents, nurses, social workers, attorneys, and students. The goals of these efforts are to (1) enhance provider understanding of the social determinants of health and unmet legal needs of patients in their community, (2) increase provider awareness of the resources and interventions available for these unmet needs, and (3) encourage screening for remediable unmet legal needs and appropriate triage or referral or triage, or both, of patients who screen positive for potential legal problems.

A critical component of MLP is enhancing a health care provider's ability to identify legal needs early and help attend to them through improved frontline advocacy since health care teams have frequent access to vulnerable populations. Along these lines, MLPs develop and disseminate tools and resources to help providers identify and "treat" legal needs that affect health. For instance, Medical-Legal Partnership Boston (MLP | Boston) staff members created a form letter for physicians to use when requesting utilities shutoff protection for chronically ill patients. An MLP in Cleveland developed a special education calculator to help physicians stay on top of school timelines when the physicians advise families of children with special needs on compliance with the Individuals with Disabilities Education Act.

As attorneys become part of the MLP team, sharing information with allied professionals in a structured manner is also a core activity. With patient consent, attorneys share information with frontline providers about patient needs and case outcomes. In fact, a number of MLPs have integrated legal information into patient medical records. Thus MLPs transform the way that legal needs and the use of available legal resources are tracked and documented.

Through frequent interaction with patients, clinicians, and the health care system, MLP staff members are in a unique position to identify patterns of unmet needs among patient populations and opportunities for institutional and systemic improvement to consider those needs better. A core MLP activity is providing evidence-based recommendations to improve the programs and policies within health and legal institutions. Drawing on the combined insight and expertise of health and legal professionals who care for vulnerable populations in their day-to-day roles, MLPs can help make institutional programs and policies more effective and efficient.

3. Influencing Policy Change

Although direct legal assistance and institutional change can improve the health and well-being of hundreds of individuals and families who are cared for in health settings by MLPs, the true power of the MLP model lies in its potential to influence populations via broad-scale policy change. MLPs strive to enact multilevel policy change by leveraging health care and legal expertise to improve local, state, and federal laws and regulations that affect the health and well-being of vulnerable populations.[55]

The persistent barriers that prevent many vulnerable patients from receiving legal services warrant increased focus on policy-level advocacy; this affects entire populations. To ensure the health of vulnerable patients at a population level,

[55]Boston, Atlanta, and Cleveland offer some success stories. In 2008 Medical-Legal Partnership | Boston worked with the Massachusetts Department of Public Utilities and local and national organizations to achieve state regulatory reform that protects the utility service of low-income, chronically ill persons. In 2009 the Health and Law Partnership in Atlanta, Georgia, secured corrective state legislation that helped Medicaid-eligible disabled children access home health agency services. The Cleveland Community Advocacy Program in Ohio collaborated with the local police department to advocate U visas, a form of relief for immigrants who are victims of criminal activity and are suffering from physical or mental abuse. A resolution in support of U visas was unanimously passed by the Cleveland City Council in 2010.

MLPs offer special expertise and experience in working with other community groups to promote external system change by (1) ensuring compliance with existing health-promoting laws, (2) supporting the enactment of new or amended health-promoting laws and regulations, and (3) opposing the enactment of health-harming laws and regulations.

A unique advantage of MLP in the policy realm is the foregrounding of the clinical stories and experiences and perspective in debates regarding laws, rules, regulations, and practices—often allowing for strategies outside the traditional litigation model and maintaining a critical focus on how policy will affect the health and well-being of real people. One example of the ways in which MLP can have a positive impact on individual and community health and well-being is the story of Rosario.

An undocumented immigrant, Rosario was a victim of domestic violence. Her husband controlled all of her activities but did allow her to take their son to the doctor. Eventually she confided in her health care providers, who helped her enter a domestic violence shelter. Rosario's situation being complicated by her immigrant status, they also referred her to the MLP attorney, who pursued a U visa for Rosario. A U visa is an immigrant status for crime victims who assist the authorities in the prosecution of the perpetrator. Rosario now has a U Visa, which allows her to stay in the country and to work and opens the door for permanent residency.[56]

B. MLP and the Legal Services Evolution

Health care providers articulate their goals in terms of health—they seek to prevent illness, to cure their patients, or at least to control disease so that it interferes less with their patients' lives. Lawyers communicate their goals in a different way—they seek to advocate on behalf of their clients, to give them voice, to win in court. Legal services lawyers also aspire to help clients access the basic needs of life, including—income, safety, and shelter. By considering these needs broadly, we can conclude that they are each connected to health. To be healthy, individuals must have access to food, a safe place to live, regular income, and education. The underlying aspiration of legal services work—to help clients meet their basic needs—is the fundamental motivating factor of MLP.

At its core, the MLP model is a natural extension of traditional legal services work. First, MLP brings legal services to clients in settings in which they are familiar and comfortable. Second, MLP focuses on a priority that is essential to any individual or client community—health and well being. Third, MLP leverages limited resources and builds bridges with some of the most critical community resources—health care institutions. And, fourth, MLP helps the legal services community learn from the medical and public health disciplines. Figure 2 illustrates some of the key differences between the prevailing legal and health care delivery models and how those professions prioritize and function under MLP.

The MLP model reaches back to the early days in the legal services community when neighborhood legal aid offices were a part of the fabric of the community. Neighborhood residents trusted the lawyers because they were among them every day; the legal aid team developed relationships with community leaders. Over the past few decades, legal services programs moved away from the local model for a number of reasons, among them cuts in funding and a desire to ensure that their organizations provided training, supervision, and a culture of consistently high-quality work. While the move away from neighborhood offices has been a positive one for many programs, it came at a price. Many programs lost those intangibles of trust and relationship. Legal resources became harder to access for many low-income people with language or cultural barriers or disabilities. The MLP model changes this by enabling lawyers to meet their cli-

[56]Rosario's story appeared in Julia Yacobucci & Megan L. Sprecher, *Beacon of Hope for Immigrants*, Social Work Today, July–August 2009. Rosario (whose name was changed for this story) was a client-patient of the Legal Aid Society of Cleveland and the MetroHealth System.

Figure 2. Legal and Health Care Delivery

	PREVAILING MODEL	MLP MODEL
LEGAL ASSISTANCE	■ Service is crisis-driven ■ Individuals are responsible for seeking legal assistance ■ Primary pursuit is justice	■ Service is preventive, focuses on early identification of and response to legal needs ■ Health care team works with patients to identify legal needs and makes referrals for assistance ■ Aims include improved health and well-being
HEALTH CARE	■ Adverse social conditions affect patient health but are difficult to change ■ Health care team refers patients to social worker or case manager for limited assistance ■ Advocacy skills are valued, taught, and deployed inconsistently	■ Adverse social conditions with legal remedies are identified and attended to as part of care ■ Health care, social work, and legal teams work together to meet legal needs, improve health, and change systems ■ Advocacy skills are prioritized as part of the standard care

Source: National Center for Medical-Legal Partnership (2010).

ents on familiar, safe ground—their doctor's office. Thus MLP can help rebuild that trust and relationship.

Legal services programs have long lived with the overwhelming truth that their resources are insufficient to meet the legal needs of all low-income individuals and communities. They must engage in triage and priority setting to ensure that they have the greatest possible impact on individual clients and communities.[57] MLPs continue the practice of setting priorities but do so by focusing on the overarching goal of improving health in partnership with health care allies. While legal services programs might establish a priority for housing work with the goal of preventing homelessness, MLPs might prioritize housing work with the goal of improving health (since being homeless is extremely unhealthy). The difference is that MLPs establish priorities in consultation with health care partners. Moreover, by identifying the needs of the patient community, MLPs may take housing and other issues further upstream—for example, before any notice of eviction is given. This has the concomitant effect of reaching many more vulnerable patients than through the current practice model.[58]

Under the MLP model, legal services providers also benefit from the combined power of the legal and health care professions to confront individual and systemic issues. Individual client cases can be more powerful and more easily developed with the cooperation and collaboration of a physician who provides relevant records and testimony. For example, in a

[57]These practices are described in detail in American Bar Association Standing Committee on Legal Aid and Indigent Defendants, Standards for the Provision of Civil Legal Aid (2006). The evolution to a legal services program that does not just respond to demand but prioritizes and recognizes impact as a goal is also described in Houseman & Perle, *supra* note 11.

[58]For a full discussion of the benefits of public health legal services and how MLP fits this new mold, see David I. Schulman et al., *Public Health Legal Services: A New Vision,* 15 Georgetown Journal on Poverty Law and Policy 729 (2008).

housing case, the professional guidance of a physician can help a lawyer understand better a client's disability and need for accommodation. Health care providers see problems and develop solutions from a different vantage point; they also bring a unique set of problem-solving skills. Frequently health care providers can bring additional partners to the table when seeking to educate lawmakers and can give very persuasive testimony to lawmakers about health care issues. A physician's testimony before a legislative committee about the impact of a change in the housing code on children's health can have far more impact than a lawyer's on the same issue.

MLPs are learning lessons from the medical and public health professions. Doctors have long embraced the value of preventive medicine. Avoiding medical problems has great value to the patient and to the public health system. MLPs carry this same lesson to the practice of law—most people would rather avoid a legal problem than resolve one. Focusing on preventing rather than just resolving legal problems may indeed be the next logical step in the evolution of legal services.[59] Also, MLPs and the broader legal community can benefit from the tools and metrics used by public health professionals to track, aggregate, and analyze outcomes. For example, where an asthmatic individual's mold-infested home leads to multiple emergency room admissions, an attorney might compel the landlord to abate the mold, and this in turn might improve the patient's health: "If several such actions within the same community result in similar improvements, such outcomes might be aggregated and evaluated using traditional public health metrics."[60] Such research can document the public health value of these activities just as studies of vaccine effectiveness or improved sanitation can.

C. The Growth of MLP

MLP | Boston started in 1993 at Boston Medical Center with $35,000 and one lawyer on loan from Greater Boston Legal Services; the lawyer was primarily focused on Medicaid and housing issues. MLP | Boston is now a full-fledged integrated MLP serving multiple clinical sites across Boston, with a multidisciplinary staff and substantial pro bono support from the Boston legal community. In its capacity as the founding site of the MLP Network, MLP | Boston provides a leadership laboratory for innovation in the MLP Network.[61]

Legal services providers have long offered their services to and sought referrals from health care and social service providers. Joint health care–legal collaborations emerged especially during the AIDS crisis in the 1980s; HIV (human immunodeficiency virus) legal services became a component of health care, and the prevention of legal crises, such as unemployment, homelessness, and denial of benefits, was deemed a valuable goal.[62] In the ensuing years both informal and formal medical-legal collaborations developed in disease-specific (cancer, mental health), pediatric, and geriatric clinical settings.

Key distinguishing facets in the emergence of the MLP model are the commitment and leadership of the health care partner together with the prioritization of legal resources toward prevention.[63]

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[59] *Id.*

[60] *Id.*

[61] The MLP Network is coordinated by the National Center for Medical-Legal Partnership; membership signals adherence to the MLP model's basic tenets, including joint fund-raising, priority setting and metrics, integration of legal staff into the health care setting, and commitment to transform the practices of law and medicine, so as to deal with and prevent legal problems better. MLP network members commit to supply data to the National Center, to share best practices, and to work to innovate and raise the visibility of the model locally (see National Center for Medical-Legal Partnership, MLP Network (2011), http://bit.ly/lWJvSd).

[62] Randye Retkin et al., *Attorneys and Social Workers Collaborating in HIV Care: Breaking New Ground,* 24 Fordham Urban Law Journal 533 (1997).

[63] Ellen Lawton, *Medical-Legal Partnerships: From Surgery to Prevention?* 37 Management Information Exchange Journal 1–7 (Spring 2007).

From the outset at Boston Medical Center, the integration of legal expertise and insight was balanced with an understanding of the role and capacity of health care providers in the lives of vulnerable children and families. If the MLP intervention were to succeed, it would have to be more than a referral system for direct services; it would need to be an integral part of the health care system.

As Boston developed the MLP model throughout the 1990s, expanded it to multiple community health center sites, and broadened its core work to include frontline health care provider training and policy advocacy, the model spread to other cities. Some "early adapters" were the Medical-Legal Partnership Project in Hartford, Connecticut; LegalHealth in New York City; Rhode Island Medical-Legal Partnership for Children in Providence, Rhode Island; the Cleveland Community Action Program; and the Washington Medical-Legal Partnership for Children in Washington, D.C.[64]

1. Power of the Press

On May 16, 2001, the *New York Times* featured an article entitled "Boston Medical Center Turns to Lawyers for a Cure."[65] The national visibility led to multiple inquiries for information about MLP from lawyers and health care providers across the country. Other media outlets, such as CBS and CNN, followed with requests for interviews and newscasts, and in September 2001 more than fifty lawyers, doctors, nurses, and social workers gathered in Boston to learn more about MLP and how to start one in their own communities. By 2005 there were thirty-two MLPs across sixteen states. By 2010 more than ninety partnerships were found in 235 hospitals and health centers across thirty-five states. Most were implemented by energetic and committed lawyers and physicians who wanted to create MLPs in their home institutions or communities. Technical assistance to new and developing sites on topics such as how to start an MLP, how to measure impact, and how to train health care providers became a sizable component of Boston's work.

2. National and Health-Related Funding

The National Center for Medical-Legal Partnership was developed in 2005 with support from the W.K. Kellogg and Robert Wood Johnson Foundations.[66] The National Center took a leadership role in actively shaping the planning and development of MLPs around the country, providing substantial technical assistance and small seed and challenge grants. As the national MLP Network expanded, and leaders in Connecticut, New York, San Francisco, and elsewhere grew their programs, the National Center helped stimulate national research and evaluation on MLP, publish academic articles about the model, develop metrics to measure MLP impact, disseminate training best practices, and guide program integration and sustainability.

As the MLP footprint grew across the country, the National Center began to partner with a range of government, professional, and industry organizations—the ABA, the AMA, and dozens of other medical and bar associations.[67] Indeed, the ABA was an early, enthusiastic and creative partner; after passing a resolution in support of MLP in 2007, the ABA established the Medical-Legal Partnerships Pro Bono Support Project to promote and assist in expanding the MLP model. MLPs' visibility was raised by features in major health care journals such as *Lancet*, *Health Affairs*, and profiles in the Agency for Healthcare Research and Quality.[68]

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[64]Everett M. Rogers, Diffusion of Innovations 298 (5th ed. 2003).

[65]Carey Goldberg, *Boston Medical Center Turns to Lawyers for a Cure*, New York Times, May 16, 2001, at A20.

[66]Sylvia Pagan Westphal, *Lawyers Help Patients Solve Problems*, Wall Street Journal, April 11, 2006, at D3.

[67]See *id.*

[68]Zuckerman et al., *supra* note 51; Sandel et al., *supra* note 4; for an innovation profile on the Iowa Legal Aid Health and Law Project, see, e.g., Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, AHRQ Innovations Exchange, Provider-Lawyer Partnerships Enhance Access to Health-Related Legal Services for Low-Income Rural Patients, Leading to Favorable Resolutions for the Client (June 23, 2010), http://bit.ly/lQrWHK.

This increased visibility of MLPs triggered in 2010, as aforementioned, the first explicit MLP funding from HHS' Health Resources and Services Administration.[69] A critical milestone was reached in mid-2010 when health and legal advocates joined with the MLP Network to support the bipartisan MLP for Health Act, which would authorize federal funds for a national demonstration project of MLP.[70] U.S. Senator Tom Harkin remarked on the MLP for Health Act of 2010:

> Assistance in navigating our legal system is sometimes all it takes to prevent individuals and their families from making repeated trips to the doctor or the hospital for a recurring condition. MLPs help people obtain legal aid necessary to ensure that they receive the care and benefits they deserve to lead healthier lives and to avoid future injuries and illnesses.[71]

The impact on the ground has been significant. In 2011 MLP teams at 235 hospitals and health centers provided direct legal assistance to more than 34,000 individuals and families.[72] MLP teams trained more than 10,000 frontline health care providers to recognize the connection between unmet legal needs and health.[73] MLPs also engaged in dozens of initiatives on behalf of patient-families to change institutional and regulatory systems.

For example, the Tucson Family Advocacy Program in Tucson, Arizona, partnered with law students from the University of Arizona, health care providers from a federally qualified health center, medical residents from the University of Arizona Department of Family and Community Medicine, and pro bono attorneys to attend to the dearth of advance directives, such as medical powers of attorney and living wills for elderly and disabled patients. MLP and pro bono lawyers supervised law students as they helped elderly and disabled residents of low-income housing complexes complete advance directive forms. The patient-clients obtained information and documentation necessary to make informed decisions and plan for end-of-life care, while students and practitioners learned about the interplay between law and medicine.[74]

An attorney from the Lancaster Medical-Legal Partnership for Families in Lancaster, Pennsylvania, was invited by a health care partner's medical director, who also chairs Lancaster's board of health, to contribute to and assist in revisions of the city's lead paint ordinance. The MLP attorney drafted detailed comments, suggested revisions, and collaborated with City officials on rewriting the law. Adopted by the city council in July 2010, the new ordinance contains greatly expanded protections for tenants.[75]

D. MLP—From Planning to Implementation

The simplicity and appeal of the MLP paradigm—an alliance of legal and health care professionals to promote the health of vulnerable people—is balanced by the complexity of MLP development and implementation. Aligning stakeholders, raising funds, and reaching agreement on goals, strategies, and priorities are just some of the challenging waters that MLPs navigate.

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[69]Crozer-Keystone Healthy Start, Chester, Pennsylvania; Shields Center Healthy Start, Los Angeles, California; and Mary's Center Healthy Start, in Washington, D.C., each received a one-year $166,000 grant.

[70]See *supra* note 3 and accompanying text.

[71]Press Release, Sen. Tom Harkin's Office, Harkin, Bayh, Bond Introduce Bipartisan Bill to Improve Health and Lower Health Care Costs Through Medical-Legal Partnerships (July 29, 2010), http://harkin.senate.gov/press/release.cfm?i=326804

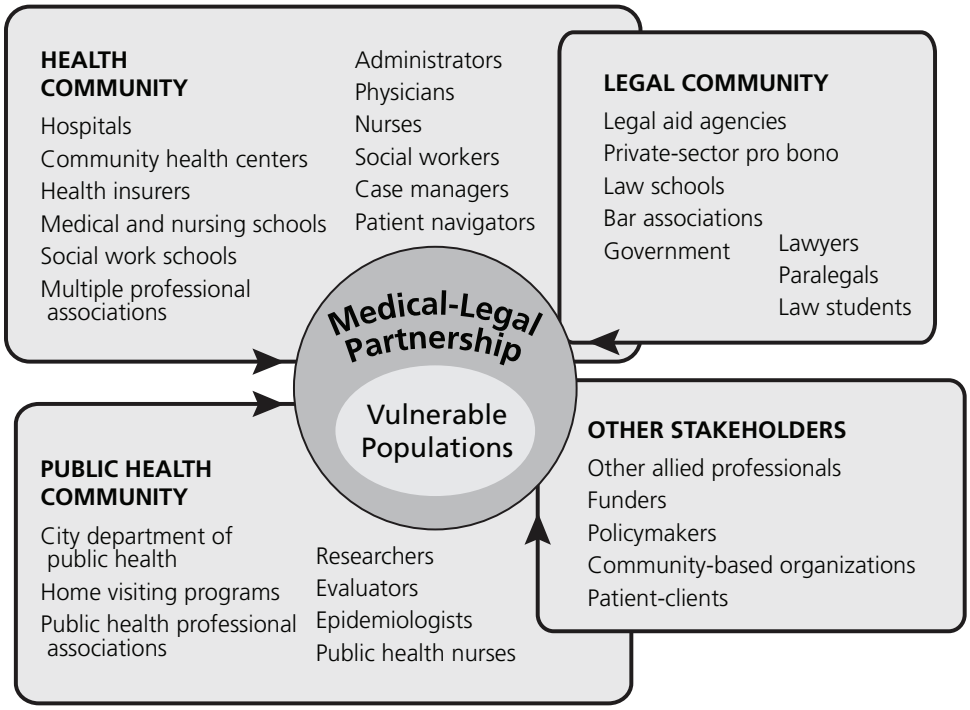
[72]National Center for Medical-Legal Partnership, Medical-Legal Partnership: A New Standard of Care (n.d.), http://bit.ly/lb8m95.

[73]*Id.*; National Center for Medical-Legal Partnership, *supra* note 1, Executive Summary.

[74]*Id.*

[75]*Id.*

Figure 3. MLP Stakeholders



Source: National Center for Medical-Legal Partnership (2010).

Creating a sustainable MLP requires joint planning. Identifying and bringing together prospective stakeholders from multiple professions and communities—legal, health, public health, community organizations, policymakers, funders, and others—and meeting regularly are critical throughout planning. Figure 3 represents a wide range of prospective stakeholders from multiple professions and communities—legal, health, public health, community organizations, policy makers, and, philanthropies.

A successful MLP planning process has these hallmarks: (1) joint discussion of vision, goals, and objectives for MLP; (2) cross-partner education on the demographics of patient-clients served, community legal needs, and health data, with particular attention to overlapping themes and opportunities; (3) candid discussions on project budget and institutional and individual roles and responsibilities related to fund-raising and project management; (4) joint priority setting for target populations, legal issues, and activities; and (5) joint discussion of process and outcome metrics across health and legal domains.

MLPs look somewhat different in each health care setting. Health care partners have unique needs related to their interests and expertise in patient care, research, and teaching. For example, oncologists at one MLP developed an institutional review board–approved research protocol for a clinical study before offering direct legal assistance to patients through a pilot program. At the same hospital, family medicine practitioners conducted an institutional review board–approved needs assessment with health care providers to be followed by a provider-oriented training series. Building on the priorities and opportunities in the health care setting is strategic and more likely to generate necessary financial support for the MLP.

MLPs are poised for greater success when legal and health care partners at the highest level of staff and board are committed to the MLP model as a mechanism to improve patient-client health as well

as a strategy for more efficient, effective service delivery.

A foundational element of MLP practice is that legal staff members are regularly present on-site in the health care setting, not just to triage with health care providers but to build relationships that allow legal staff to become a credible and trusted part of the health care team. Being present on-site also creates a forum for the providers, both health care and legal, to share their observations about the different problems and trends they experience through the population served. These informal conversations often implicate a better approach to complex problems and, in some instances, possible policy initiatives that can be pursued.

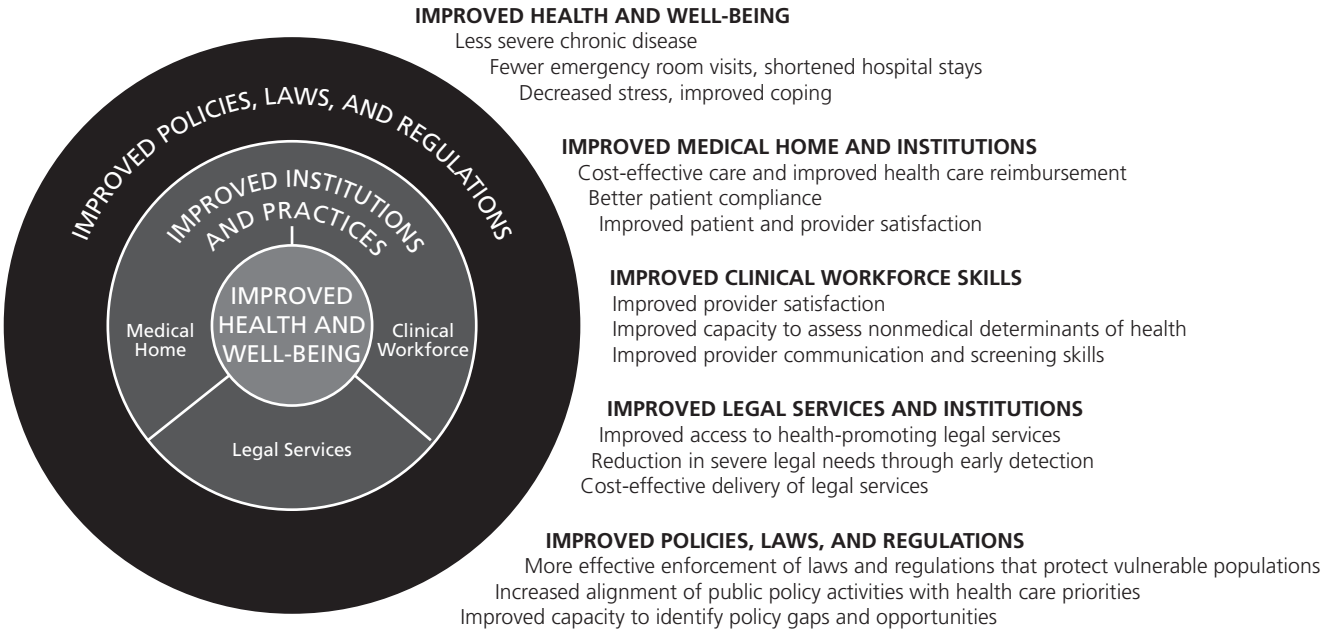
The feedback loop also is a prime example of practice transformation by health care and legal professionals. Screening, diagnosis, and treatment of patients for nonmedical conditions that affect health (also known as "social determinants of health") are more likely when health care providers have a legal team to help resolve such problems. Legal professionals can prioritize prevention over emergency care when they can reach individuals while in need but not in crisis, to counsel them about their legal rights and their options. And together the MLP legal and health teams can reduce barriers to health through the use of the legal system.

E. Measuring Impact on Legal Services and Health Care Delivery

MLP delivers a range of impact and benefits for multiple legal, health, and community stakeholders. Significantly MLP helps the legal aid community frame a legal intervention as a *health* intervention—which is the key to triggering substantial investment from health care institutions and government health care funding streams, among others.

Figure 4 represents the broad impact of the MLP model. It was created by and for the National Center for Medical-Legal Partnership.[76]

Figure 4. Impact of the MLP Model



Source: National Center for Medical-Legal Partnership (2010).

[76]Read from the inner circle out, the figure illustrates the broad impact of MLP on individuals, institutions and practices, and external laws, regulations, and policies; frames legal remedies as health interventions; and depicts the benefits to multiple legal, health, and community stakeholders.

1. Improved Health and Well-Being

Through preventive legal services, MLPs help patients meet their basic needs. This can foster patient health and well-being. For example, by improving housing conditions or securing adequate nutrition, MLPs can help patients reduce the risk of illness and conditions that are exacerbated by the lack of these basic necessities. MLP looks beyond the resolution of legal problems—the goal being to improve the health and well-being of vulnerable patients and families.

2. Improved Legal Services

A primary MLP goal is to identify legal needs early before they become crises that harm health. MLPs can create access to "preventive legal care," whereby patients with unidentified but health-harming legal needs receive legal information. With this early intervention, the patient and the patient's family can make an informed decision and may pursue a remedy before any negative consequences befall them. [77]

For example, an elderly woman tells her longtime primary care provider that she has been afraid of losing her apartment ever since her landlord complained about her granddaughter's extended stays. The patient says that her granddaughter helps with basic tasks, such as bathing, shopping, cooking, and cleaning. Triage with legal staff informs the health care provider of the patient's legal right to remain in her apartment, to have her granddaughter stay with her, and perhaps to secure compensation for the granddaughter as a "personal care assistant."

3. Improved Clinical Workforce

Institutionally integrating legal staff can be an important facet of primary care and the management of chronic diseases.[78] For instance, health care providers can be trained to probe the nonmedical aspects of asthma by asking a series of screening questions related to a patient's living conditions that would determine whether consulting with the legal partner would be appropriate to discuss tenants' rights. This also would be true for a patient being treated for cancer and possibly having to handle matters such as power of attorney, health care proxies, and custody or guardianship for any minor children in the patient's care. Moreover, qualitative interviews with health care providers who serve vulnerable populations reveal that access to legal services for their patients improves their own efficacy and reduces professional frustration and burnout.[79]

4. Improved Medical Home

MLPs bring about opportunities for legal and health care providers to resolve the health disparities that continue to persist among racial and ethnic groups and other socioeconomically deprived populations. Well documented is that, in the twenty-first century, racial minorities continue to suffer with regard to key treatments for certain illnesses and in the emergency room.[80] Although many of these problems are beyond the sole purview of the health care provider, the MLP model can assist health care and legal professionals in understanding better how poverty affects health outcomes.[81] Health care and legal professionals can teach and examine the social determinants of health, foster a greater sensitivity toward the vulnerable populations served, and work together to improve care.[82] They also collaborate in improving the medical home model.

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[77]Samantha Morton et al., *Advancing the Integrated Practice of Preventive Law and Preventive Medicine*, in Preventive Law and Problem Solving: Lawyering for the Future (Thomas Barton ed., 2009).

[78]Cohen et al., *supra* note 49.

[79]Legal Health, New York Legal Assistance Group, Impressions and Impact (Dec. 7, 2010) (brochure).

[80]Rebecca Voelker, *Decades of Work to Reduce Disparities in Health Care Produce Limited Success*, 299 Journal of the American Medical Association 1411–13 (2008).

[81]Cohen et al., *supra* note 49.

[82]On fostering a greater sensitivity toward vulnerable populations, see Edward Paul et al., *Medical-Legal Partnerships: Addressing Competency Needs Through Lawyers*, 1 Journal of Graduate Medical Education 304–9 (2009).

A medical home is a trusting partnership between patient and primary care team; it oversees the patient's health and well-being within a community-based system that provides uninterrupted care with appropriate payments to support and sustain optimal health outcomes. The American Academy of Pediatrics developed the medical home as a model of delivering to children and adolescents primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. It has since been adopted by multiple adult disciplines.

5. Improved Policies, Laws, and Regulations

MLP's strength is ensuring the enforcement of laws and government programs designed to promote health and in preventing or resolving legal problems that pose a direct threat to health. Likewise, health care providers have opportunities to join forces with the legal staff on behalf of families served to institute systemic change based on the patterns observed in the medical setting.

One example involves expanding regulatory protections for medically vulnerable utility consumers.[83] Health care providers, after training, were able to recognize those patients in need of utility shutoff protection. Identified patients received both necessary medical documentation and utility-related advocacy services to obtain this protection. For the health care providers, legal staff prepared a kit containing relevant forms, letters, and a model utility access policy explaining what health care providers can do to help maintain utility access for eligible patients. The MLP team gave testimony to a state regulator of public utilities regarding the excessive frequency that medical documentation had to be submitted by these families. The medical documentation was cited by the regulatory agency as a decisive factor in finding in favor of the regulatory change expanding utility service protections for chronically ill patients.[84]

6. Leveraging the Health Care Setting for Maximum Impact

The legal community cannot be successful in meeting the legal needs of vulnerable low-income individuals and families without additional resources, partners, and strategies.[85] MLP allows legal aid to create significant visibility for its skilled interventions and paves the way for transforming health care systems to help patients avoid health-threatening legal problems.

Of course, such transformation in health care institutions and systems must coincide with such changes in legal services institutions as prioritizing health-promoting legal services and activities that build health care provider capacity for the early detection and resolution of legal problems. Consider if health care providers were to screen all newly diagnosed breast cancer patients for employment- and income-related concerns. Their legal partners would want to prioritize legal aid in employment protection and disability-related public benefits matters, conduct relevant training for health care providers, and identify appropriate medical forms and create sample letters that providers could access through the electronic medical records.

F. Sustainable Strategies for Medical-Legal Partnerships

Since the inception of the legal aid movement fifty years ago, legal aid attorneys have helped low-income individuals and families who are homeless, disabled, or otherwise vulnerable secure appropriate government benefits, such as food stamps, Medicaid, and Supplemental Security Income (SSI). As health care access improves for vulnerable communities, the overlap in interests between community health centers and safety-net hospitals and the local legal aid of-

[83]Sandel et al., *supra* note 4.

[84]*Id.*

[85]Legal Services Corporation, Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans: An Updated Report of the Legal Services Corporation (June 2007), http://1.usa.gov/MA2GS.

fice is substantial. For instance, a homeless man with chronic hypertension and mental health problems can potentially qualify for disability through SSI, with the assistance of a legal aid attorney; that can trigger a return on investment for the health care institution caring for him since there is now an insurance resource for the patient where before there was none.

MLP creates an opportunity for the legal community to showcase the return on investment for its work—and helps legal aid agencies identify likely health care partners who can share resources and collaborate to increase efficient service delivery for the benefit of patient-clients. But the first order of business is for legal aid agencies to reconceptualize their community impact in reference to the health care settings that serve their patient-clients—perhaps by documenting, for *all* clients, the health care institution where the client receives health care. Such a database would point to potential health care partners and help the legal aid agency describe its impact on a population basis.

A cornerstone of the MLP funding strategy is to build in the expectation of a *funding partnership* between the legal and health care communities. That level of partnership envisions the active leadership and participation of health care and legal providers who, with their respective institutional development resources, work together to blend funding strategies, priorities, and opportunities that could not occur without full collaboration by the partners. Examples abound:

- A cancer care specialist partners with lawyers to demonstrate through research, training, and direct service the efficacy of patient navigation.[86]
- A pediatric violence treatment program invites legal providers to train and consult with social workers about the legal issues that act as barriers to recovery; in turn, the social workers partner with lawyer and paralegal to train pro bono attorneys about trauma-informed advocacy.
- A law firm "adopts" a community health center, staffs a weekly legal clinic with its lawyers and paralegals, delivers free legal assistance to patients, and works with its health care partner to pursue health-related policy issues of mutual interest. Jointly developed financial and pro bono resources are critical to meeting legal need and sustaining MLPs.

1. Legal Aid, Law Schools, Private Law Firms, and Bar Associations

That legal funding comprises a significant percentage of MLP investment in 2010 (29 percent) is no surprise; legal services (including LSC), state and local bar foundations, law firms, and law schools dedicated over $3 million in funds to MLPs. IOLTA (Interest on Lawyers' Trust Account) funds accounted for $400,000 of the legal funding for partnerships. For the most part, however, this funding reflects the legal community's redirection of time (an important but not sufficient resource to grow an MLP), not new cash funding coming into the legal aid community.

Pro bono support is a key strategy in expanding access to legal assistance for vulnerable populations. In 2010 the MLP Network received $2 million in in-kind services from *pro bono* partners. Fourteen MLP sites reported utilizing some form of pro bono assistance, and forty-five private law firms are affiliated with at least one partnership site. Of the twenty-seven partnership sites using pro bono, 89.9 percent utilized volunteers from pro bono partners outside case referral. A total of 6,600 hours of pro bono services were contributed to partnership sites in 2009.[87] Contributions by these firms range from accepting individual case referrals, "adopting" a health clinic and staffing a weekly legal clinic there,

[86]Patient navigation is a process whereby an individual—the patient navigator—guides patients with a suspicious finding (e.g., test shows a patient may have cancer) through and around barriers in the complex cancer care system to help ensure timely diagnosis and treatment. Established in cancer care, patient navigators now help patients overcome barriers to care in other clinical settings.

[87]National Center for Medical-Legal Partnership, *supra* note 1, Executive Summary.

establishing a "loaned associate" program, and conducting research on ethics and confidentiality issues arising in the MLP model, to engaging in systemic advocacy in partnership with health care providers.

2. Health, Community, and Family Foundations

With health as a goal, MLPs are well positioned to access funding from health, community, and family foundations. Indeed, in 2010 the largest single contributor to MLPs was philanthropic organizations, including community and family foundations, at over $2.89 million (27 percent).[88] Hospitals, health centers, health foundations, health care conversion foundations, pharmaceutical companies, and medical schools contributed over $2.42 million (23 percent) to MLPs.

3. Health Care and Public Health Resources

MLPs can draw together health and public health resources in innovative, efficient, transparent, and accountable systems of care that can help justify funding the MLP. Triggering health care resources requires that legal partners align their work clearly with health care priorities—such as reducing health disparities, improving quality and efficiency of care for those with chronic illness, and reducing costs for complex patients. Lawyers need to do their work differently and demand that traditional legal aid priority-setting activities incorporate the data-driven, efficiency-focused themes that are creating space for innovations such as MLP.

Especially for MLPs that are hospital-based and serving adults or those with chronic illness, MLP intervention has been shown to accrue financial value through basic civil legal aid advocacy. For example, if an uninsured patient's Medicaid application has been wrongfully denied, a legal services agency can help the patient appeal the denial, thereby allowing the health care institution to resubmit the Medicaid bill successfully.[89]

In one instance in Carbondale, Illinois, the Medical-Legal Partnership of Southern Illinois (a partnership of Land of Lincoln Legal Assistance Foundation, Southern Illinois University School of Law, and Southern Illinois Healthcare) was established in 2002; between 2002 and 2006 the hospital invested over $115,438 in the MLP. During this time the partnership saw 372 clients and successfully relieved those clients of $1,132,431 in financial obligations.[90] Of this amount, Medicaid and other insurance sources reimbursed Southern Illinois Healthcare $287,573, more than twice the hospital's investment.[91] The common legal issues were social security, Medicaid, power-of-attorney rights, property or housing, assistance on wills, divorce, child support, medication benefits or reimbursement, and employment benefits.

Return on investment was calculated just for the funding health care partner. Only Medicaid returns were included in the numerator because they could be easily tracked and verified. Simple return on investment was calculated by taking the difference between the documented Medicaid adjusted reimbursement collected by the funding partner and the funding partner's original funding for the program. Based on this calculation, the known return on investment for the funding health care organization was $172,135 or 149 percent more than the amount invested.

An alternate way of describing the effectiveness of this program is through a logic model. Summarizing the known

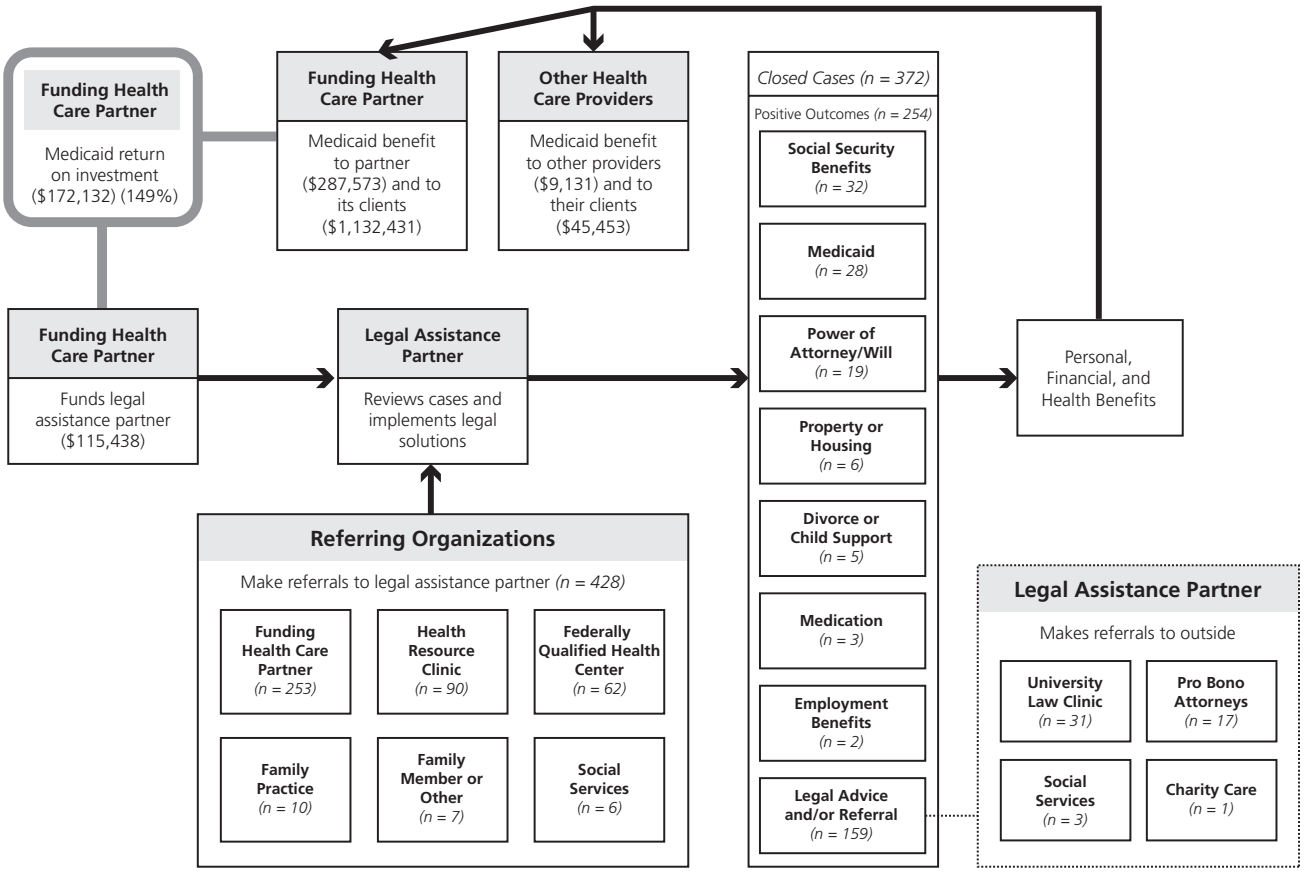
[88]In 2010 MLPs received over $10.6 million combined in cash funding (*id.*).

[89]Rachael Knight, National Center for Medical-Legal Partnership, Health Care Recovery Dollars: A Sustainable Strategy for Medical-Legal Partnerships? (April 3, 2008), http://bit.ly/molBI2.

[90]James A. Teufel et al., *Process and Impact Evaluation of a Legal Assistance and Health Care Community Partnership,* 10 Health Promotions Practice 378–85 (2009).

[91]*Id.* Furthermore, in 2007 alone, the program resolved more than a million dollars in clients' medical debt. From October 2007 through December 2007 the financial obligations relieved totaled $253,362.58. The estimated reimbursement for Southern Illinois Healthcare for that quarter totaled $83,609.

Figure 5. Medical-Legal Partnership of Southern Illinois Logic Model



Source: James A. Teufel et al., Health Promotions Practice 378–85 (2009). Reprinted with permission of SAGE Publications.

processes and impact of the Medical-Legal Partnership of Southern Illinois, figure 5 shows the input and output of the legal and health care partners and the theory of how the outcome variables were affected.

This and other examples demonstrate that hospitals and health care institutions are open to funding MLPs when the work provides a documented, quantifiable cash benefit to the institutions. In turn, MLPs can (and should) seek financial support from hospitals and health care institutions where a return on investment is possible. This type of investment requires that legal aid partners conceptualize and execute their activities differently and may necessitate the development of new communication strategies, data collection protocol, or other practice changes.

4. Government Grants and Contracts

Two strategies that depend upon leadership at the national MLP level are of particular interest. The first strategy integrates MLPs into Health Resources and Services Administration community health services grants or Healthy Start sites to address the legal issues at the root of many health disparities.

The other strategy uses innovation funds and medical home initiatives at the Centers for Medicare and Medicaid Services (CMS) to attend to legal issues that pose barriers to effective medical care. As CMS embarks on medical-home demonstration projects, MLPs can be an important tool for case managers or patient navigators who work with patients hav-

ing complex primary care needs.[92] CMS graduate medical education dollars could be used to support MLP training, especially since fifty-five residency programs already have such training.[93]

■ ■ ■

MLP is a compelling opportunity to leverage existing health and legal resources in communities across the country toward a new ideal of protecting and promoting health and justice for vulnerable populations, thereby reducing health and legal disparities. MLPs are founded on the understanding that many intractable problems in people's lives that impair health can be solved through legal intervention and the realization that skilled legal resources are found alongside health resources in every community. MLPs offer lawyers and paralegals the opportunity to reach vulnerable people earlier, before crises ensue, to build advocacy capacity among all health care professionals and to transform practice so that patients can be helped as part of their regular care and without the assistance of legal staff for each patient. With these alliances and their health-oriented goals, a broader array of funding dollars and substantial pro bono resources are available.

Getting the most from MLPs requires legal and health care professionals to approach their work from broader perspectives and to contemplate how in working together they can fulfill their combined potential for the patient-clients and communities they serve. Paradigm shifts in training, graduate education, legal and health care practice, and policy work are all possible.

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[92]Sandel et al., *supra* note 4, at 7.

[93]*Id.* (citing Paul E. Fullerton et al., *Medical-Legal Partnerships: Addressing Competency Needs Through Lawyers,* 1 Journal of Graduate Medical Education 304–9 (2009)).

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