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**Geiger Gibson/
RCHN Community Health Foundation Research Collaborative**

Policy Research Brief No. 18

**Medical-Legal Partnerships:
Addressing the Unmet Legal Needs of Health Center Patients**

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

Medical-legal partnerships (MLPs), now available at over 180 hospitals and health centers across 38 states, are an important option for addressing the legal needs affecting low-income and vulnerable patients, and thereby improving their overall health. We estimate that each year, anywhere between 50 and 85 percent of health center users - or between ten and 17 million people - experience unmet legal needs, many of which negatively impact their health. In a medical-legal partnership, health care staff at hospitals, clinics, and other sites are trained to screen for health-related legal issues, refer the patient to an affiliated lawyer or legal services team as necessary, and work with the attorney to resolve problems that impact patient health. Medical-legal partnerships assist patients with securing health care and other public benefits, addressing housing issues and family problems, and other concerns that can affect one's health and are often more successfully remedied through legal, rather than medical, channels. This brief examines the role medical-legal partnerships can play in addressing the unmet legal needs negatively affecting the health of health center patients.

Introduction

Law as a Social Determinant of Health

The relationship between poverty and poor health, though well-documented, is highly complex and involves a broad range of factors, including legal issues. Poor environmental and housing conditions, unsafe neighborhoods, lack of access to health care resources, poor educational opportunities and low levels of education, occupational hazards, food and energy insecurity, discrimination, family pressures, and employment status may combine with legal problems and other stressors to affect a person's physical and mental health.¹

Law, as embodied in federal or state statutes, regulations, executive orders, administrative agency decisions, and court decisions, plays a profound role in shaping life circumstances, particularly as it relates to access, financing, and quality of individual health care.

Law can lower barriers to health care access in multiple ways. One way is through the enactment of health care financing programs that subsidize health care services for vulnerable populations (e.g. Medicaid). The Public Health Service Act (PHSA) also includes several mechanisms for developing and providing health care to medically underserved and vulnerable populations, including funding for community health centers, persons with HIV/AIDS, persons with mental illness or substance abuse disorders, and project grants to provide preventive and immunization services, breast and cervical cancer screening and detection, and other programs.

Law can also lower barriers to accessing health care through the regulation of provider conduct. For example, the Emergency Medical Treatment and Active Labor Act

(EMTALA) requires Medicare-participating hospitals to screen and provide necessary stabilization or appropriate transfer care to individuals who present at an emergency department and request treatment. The emergency care requirements under EMTALA are universal, and are required irrespective of the presenting patient's socioeconomic or insurance status.

Other laws connected to federal financing, such as Title VI of the 1964 Civil Rights Act, also play a role in reducing barriers to accessing health care. Title VI prohibits discrimination on the basis of race, color, or national origin by any recipient of federal financing. Its "limited English proficiency" guidelines, applicable to all health care providers receiving federal assistance or other federal funds (e.g., Medicaid and the Children's Health Insurance Program) are specifically designed to ensure that at various points along the health care continuum, individuals whose primary language is not English are able to receive adequate care. Finally, public health departments funded under state and local legal authority monitor the health of communities and provide specific primary and preventive health care services, such as childhood immunizations.

Law is an important determinant of health in other ways as well. Through their inherent police powers (i.e., their authority to regulate individual and corporate behavior in order to protect and promote the general health and welfare), states accredit health care facilities, regulate the food supply and food establishments, enforce occupational health and safety rules, curb pollution, control the sale of firearms, restrict the marketing of tobacco products, and incentivize us all (through the risk of a fine) to wear our seatbelts. Police powers are often classified as the most expansive power exercised by a state and local governments, and their overarching aim is to promote health.

The law's authority over the administration of services and attendant health care quality is similarly remarkable. Physician practice is governed by legal principles aimed at promoting a professional standard of care. Patients have a legal right to certain medical information prior to granting consent for a recommended treatment, and to a legally-defined level of health information privacy. Hospitals, managed care organizations, and health insurers have institutional legal responsibilities related to the quality of care provided to patients, as well as a duty to oversee the quality of care furnished by their medical staff and physician networks.

These examples focus on the law as it relates to: 1) the individual's interaction with the health care system and its stakeholders (e.g., creating access to services where none previously existed, subsidizing the cost of necessary care, making sure that the treatment received is of high quality, regulating provider conduct); and 2) community health, by imposing limits on individual and corporate liberties (e.g., by making sure restaurants do not cause illness among their customers, regulating businesses so that employees have safe work environments, reducing the number of guns on the street).

Less obvious, perhaps, are the opportunities to identify and mitigate the causes of poor health among individuals by leveraging laws aimed at reducing discrimination, abating public nuisances, and providing funding for needed social services. For example,

housing and residential conditions may directly and negatively influence individual health. Their consequences can be treated medically, but their causes are social, rather than medical, and better addressed through legal advocacy. Substandard housing conditions, including the presence of rodents, mold, peeling lead paint, exposed wires, and insufficient heat - all of which are common among low-income housing units - can cause or exacerbate asthma, skin rashes, lead poisoning, fires, and common illnesses,² yet none of the housing problems will be “cured” by a clinical encounter. Indeed, many of the social indicators that most severely influence the development and severity of illness are potentially remediable by the enforcement of existing laws and regulations.³

The law could effectively play a significant role in addressing the underlying causes of poor health and health disparities. This is particularly true in the case of patients who live in communities in which the social determinants of health - jobs, housing, public safety, education, transportation, open space, good nutrition - may be the most compromised. By creating access to needed legal resources in medical-clinical settings, it may be possible to secure legal interventions that can help reduce the burden of social conditions that affect health.

The Role of Health Centers

The concept of integrating social and health care services is central to the ideal of the health center as a community-centered medical home.⁴ Given their comprehensive approach to health care and high proportion of low-income patients, health centers could serve as an excellent entry point for low-income populations to legal services, with better patient health a likely outcome.

National data show health centers serve one in six low-income individuals, of whom two-thirds are racial and ethnic minorities. Approximately nine in ten patients have incomes less than 200 percent of the federal poverty level and seven in ten live in poverty. As a result of their low family incomes, nearly half of health center patients are covered under Medicaid, Medicare, or the Children’s Health Insurance Program (CHIP). While these public insurance programs may finance the clinical mitigation of the health consequences of poverty, they cannot address the underlying causes.

As part of their effort to improve health outcomes, health centers provide a wide array of services to address the complex social needs affecting the health of their low-income populations. Health centers not only furnish direct medical, dental, and behavioral health services to meet complex health needs, but also coordinate enabling and ancillary services to address emotional, social, cultural and environmental factors affecting patient health. For example, Table 1 shows that over 90 percent of select health centers provide case management, eligibility assistance, and outreach on-site, and nearly all health centers provide the services either on-site or by referral.

Table 1. Select Ancillary Services Intended to Address Barriers to Better Health		
	On-site	On-site or by referral
Coordinate health and psychosocial support services (case management)	92%	98%
Secure access to health, social and other public programs (eligibility assistance)	92%	98%
Identify and educate potential patients about available services (outreach)	93%	97%
Help patients to qualify for Medicaid (out-stationed eligibility workers)	37%	79%
Assist with nursing home and assisted-living placement	37%	80%
Assess and address unhealthful living conditions (environmental health risk reduction)	31%	93%
Assist in obtaining housing	29%	90%
Provide employment/educational counseling	16%	89%

Source: 2007 Uniform Data System, HRSA

Health centers are less likely to offer on-site assistance with employment, housing, and environmental risk reduction - all issues frequently handled through legal channels. Health centers are also less likely to offer on-site out-stationed benefits eligibility determination and enrollment, with only 37 percent offering this service; this is important as low-income populations continue to face significant enrollment and retention barriers to public insurance programs because of the complexity of applying for and maintaining coverage.⁵ Access to public benefits involves stringent and complex eligibility rules and documentation requirements, and requires beneficiaries to be fully informed about their rights and obligations.⁶ When their benefits are terminated, reduced, or denied, beneficiaries are generally not equipped to identify unlawful actions or assess fairness in procedures and policies that led to the decision. In particular, the 1.2 million elderly health center patients tend to be the most vulnerable to poor health as a result of the loss of income and benefits.⁷

Methods

In addition to reviewing the general literature, we met with ten health centers and their legal partners from California, Iowa, Illinois, Kansas, Massachusetts, Missouri, Texas, and West Virginia to discuss the health-related legal barriers their patient population face and the benefits of a medical-legal partnership. These centers were located in urban, suburban, and rural settings with varying demographics and populations. In addition to these setting differences, the participating partnerships varied by length of time since establishment - some were relatively new, while others have been in place for a number of years. The meeting was convened on March 26th, 2010, and a

short questionnaire was provided to assess levels of unmet legal need and to identify type of legal assistance needed.

On average, health centers estimate 90 percent of their patients have an unmet legal need. The perceived level of unmet need ranged from 40 to 100 percent. Health-related legal issues most commonly related to family law, housing, and health insurance eligibility assistance. The uninsured, Medicaid patients, the disabled, and patients with chronic health conditions were most likely to require legal assistance.

Based on the information provided by this panel of MLP participants, survey findings, and a site evaluation conducted by a Boston-based MLP (to be discussed later in the paper), we estimate the percent of patients requiring some type of health-related legal assistance ranged from 50 to 85 percent. Due to internal and external validity problems in each of the studies used to estimate unmet legal needs, we can only provide a broad range of estimates. To date, no state or national assessment of unmet legal needs among health centers has been conducted.

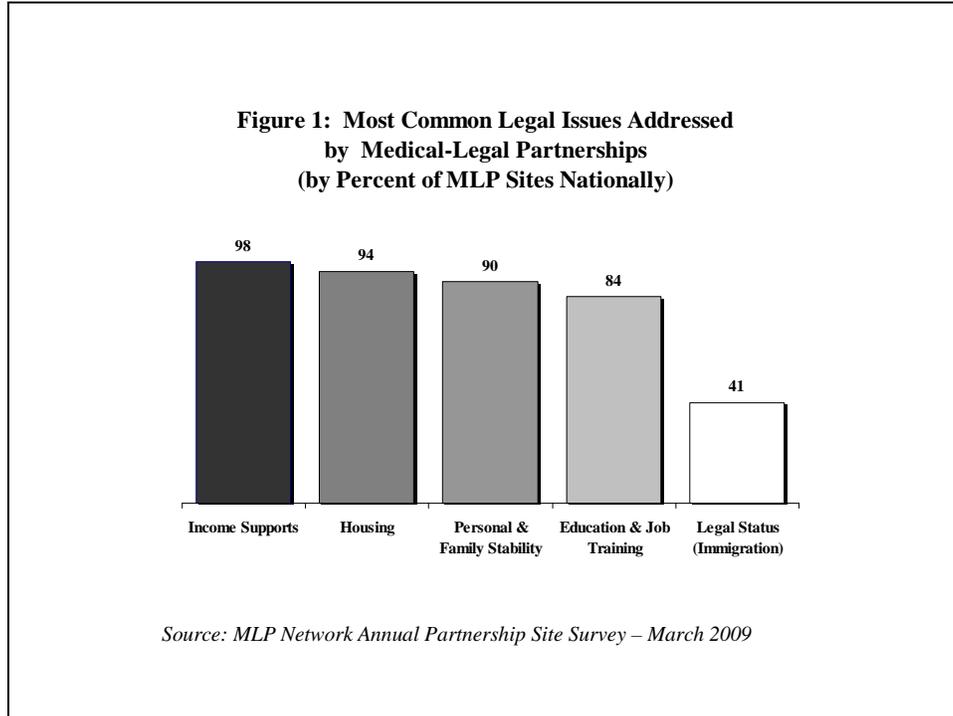
Findings

Medical-Legal Partnerships

An increasing number of health centers have forged an effort to better link patients with neighboring law schools, legal aid offices, and law firms to address their legal problems. Although the MLP model began as an on-site legal intervention specifically for pediatric patients, it has grown to encompass internal medicine practice and training, especially with indigent populations and the management of chronic disease.⁸

Under the MLP model, attorneys work with front-line health center staff to screen for health-related legal problems, such as family matters (divorce, custody/visitation, domestic violence), housing problems (eviction, habitability, utility advocacy), special education advocacy, immigration issues, disability issues, end-of-life care, employment instability, receipt of public benefits (health insurance, disability/supplemental security income, Social Security Income), food security concerns, and additional problems and situations that lead to stress and cause or exacerbate health problems. Working with social workers and case managers, MLP staff help to secure housing assistance, Social Security Income, public insurance, early intervention programs for children with special needs, and other public benefits.

Figure 1 illustrates the array of issues addressed by MLPs.



To date, over 180 hospitals and health centers across 38 states operate MLPs.⁹ With over \$8 million in public and private funding, the MLP networks served nearly 10,500 individuals and families and provided more than 7,800 legal consultations to front-line health care staff at one of 66 medical-legal partnership sites in 2008.¹⁰

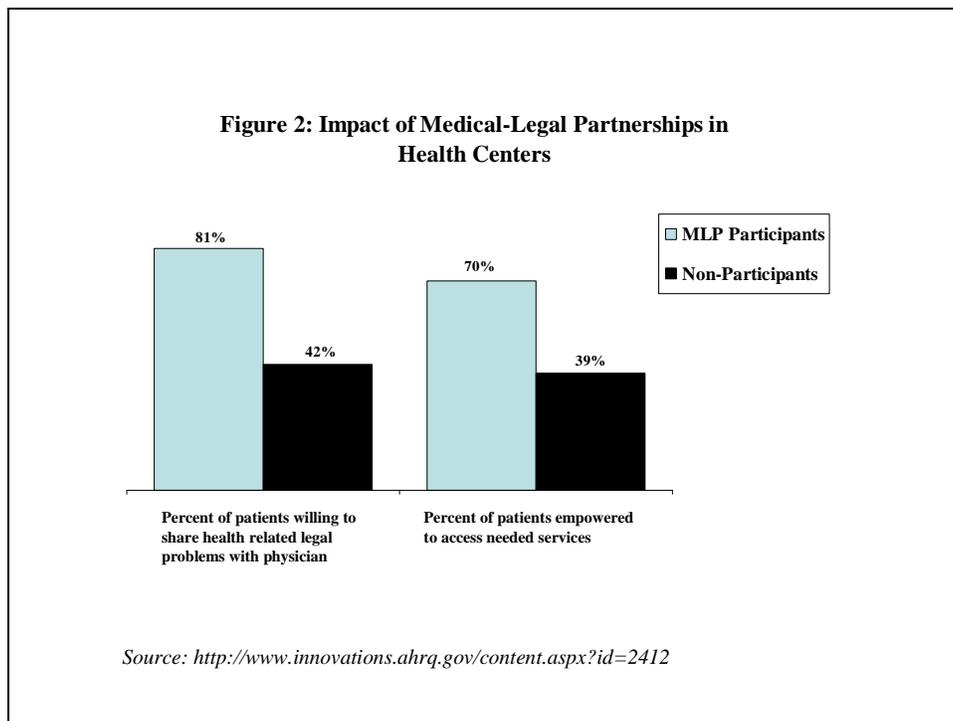
Unmet Legal Needs among Health Center Patients

Numerous studies have found a significant level of unmet legal need among low-income individuals most often cared for in health center settings. For example, one study conducted by the American Bar Association indicates nearly one in two low-income households has an unmet legal need.¹¹

Low-income households experience one to three legal problems every year, but only between nine and 37 percent receive legal help.¹² In a survey of low-income households in Utah, researchers found that nearly 47 percent of low-income residents are estimated to have two or more legal problems, and an additional 14 percent have five or more legal problems, stemming from family issues, employment, housing, consumer issues, health care, and public benefits.¹³ However, only one in ten low-income Utah households received legal assistance due to cost, language barriers, inability to recognize a problem as a legal issue, and lack of awareness of available help with legal matters.

Although no national data exist on the unmet legal needs of health center patients, preliminary findings from a site evaluation of a Boston-based MLP serving six health centers suggests health center patients are likely to benefit from on-site legal assistance.¹⁴

In interviews conducted with 72 patients, half of whom received MLP services and half of whom did not, the majority (81 percent) of MLP participants reported being more willing to discuss health-related legal problems with their physician. In contrast, only 42 percent of the 36 non-participants felt able to do so. (See Figure 2) Seventy percent of MLP participants reported feeling empowered to access needed advocacy for the health and well-being of their families, while only 39 percent of non-participants reported feeling this empowerment. Most importantly, half of those who received legal services reported improvements in their family’s well-being (indicated by fewer hospitalizations or asthma attacks, and decreased stress, anxiety, or depressive symptoms).



Based on the available research and a focus group of 10 health center MLP partners in eight states, we estimate that between 50 and 85 percent of health center patients - anywhere between 10 and 17 million users - require some level of legal assistance. In addition, given high unemployment levels, an increasing number of bankruptcies, and growing medical debt, demand for legal assistance may be higher than even this significant level of need. Research shows, for example, that the number of bankruptcies related to medical costs rose by nearly 50 percent between 2001 and 2007; in 2007 alone, nearly two-thirds of bankruptcies were linked to medical debt.¹⁵

MLP Costs and Benefits

The costs of operating a medical-legal partnership vary based on the size of the program, the level and number of services provided, the ability to leverage *pro bono* assistance, and the number of patients served. As a general marker, 42 percent of MLP

sites surveyed in 2009 had an annual budget between \$101,000 and \$250,000.¹⁶ Financial support generally comes from three types of sources:

- Legal funding from federal and state funded legal aid programs, legal fellowship programs, law schools, law firms, and state and local bar associations;
- Medical funding from hospitals, health centers, and health conversion foundations, including federal and state contracts; and
- Community and family foundations.

About half of the legal partners in the MLP network are federally-funded legal aid agencies that secure small private grants and rely on pro bono legal assistance to extend capacity. However, each partnership in the network varies with respect to scope of services, compensation levels, and contributions from providers, depending on local conditions and opportunities. According to the National Center for Medical-Legal Partnership (NCMLP) operated by the Boston University School of Medicine and Boston Medical Center, and reflected in their 2008 site survey, MLPs across the network match resources fairly evenly between the legal and health care partners, whether through in-kind contributions of staff time by both partners and/or provision of space and other in-kind services such as interpreter access, or through explicit cost-sharing of attorney time with multiple health care providers.¹⁷

Medical-legal partnerships can benefit health centers in multiple ways, including generating increased revenues for health centers. MLPs may increase health center revenue by assisting eligible patients with obtaining public insurance coverage or helping to reinstate coverage for those patients who lost Medicaid for varying reasons.¹⁸ MLPs may also generate increased revenues by mitigating claim denials on behalf of health centers; with nearly 46 percent of health center patients covered under Medicaid, Medicare, and CHIP, and an additional 16 percent with high-deductible private insurance, health centers already face significant challenges navigating varying payment rules and are financially vulnerable to claim denials.¹⁹ A November 2007 financial impact study of LegalHealth Services in New York City hospitals found that patient legal assistance positively impacted the revenue of the hospitals. This revenue is in addition to assumed, but non-quantified, benefits of savings in hospital staff time, improved healthcare decision-making, and community benefits.²⁰

Additionally, by redressing the complex social issues faced by their patients - including, for example, those associated with housing access, substandard housing conditions, employment problems, limited income and domestic violence - legal advocacy can benefit the patients directly. Such benefits translate into reduced medical debt, less stress, increased access to preventative medicine, and improved general well-being - all factors associated with better health outcomes.²¹

Although it is difficult to estimate cost-savings, the success of other patient advocacy programs suggests significant benefit. For example, social workers and patient navigators help decrease disparities in health outcomes by helping patients and their families navigate the complex healthcare system, from clinics to hospitals, payment

systems, and support organizations. The literature indicates that integrating social workers into healthcare settings can reduce emergency visits, hospitalizations, nursing home placement, and overall costs.²² An evaluation of programs for patients in community and migrant health centers in New York City found that those patients using the services of patient navigators were more likely to be up to date on their colorectal screenings (63 percent, versus only 50 percent of patients without the assistance of patient navigators).²³ In some instances, the cost-savings of these programs can be substantial, especially when partnered with legal services. For example:

- A community health worker pilot program located at a health center in Hawaii was able to reduce costs for pediatric asthma patients from \$735 to \$181 through reduced emergency room visits, while improving patient quality of life as measured by drastically decreased frequency and duration of asthma attacks after the intervention program.²⁴
- A study of African-American Medicaid patients with diabetes in Baltimore found an intervention by a community health worker resulted in fewer emergency room visits and admissions, resulting in average savings of \$2,245 per patient.²⁵
- A health-law partnership in rural, Southern Illinois resulted in a positive return on investment as an overall program and in terms of costs per case, with an average monetary benefit of \$402 per case above costs.²⁶

However, the mere promise of increased revenues may not be a sufficient incentive for many health centers to adopt an MLP. Relatively little information exists on the economic and health benefits of MLPs, and since health centers already operate at or near the margin, adopting such innovative programs can be cost-prohibitive, particularly without significant levels of guaranteed funding to sustain them over time. Unlike other patient advocates that are funded either through grants or insurers, such as social workers and patient navigators,^{*} medical-legal partnerships are true partnerships that leverage commitments from both the health and legal communities, and this can present a challenge for both initial program implementation and sustainability. However, health centers are increasingly investing in MLPs as they come to recognize the potential revenues accrued through legal intervention are available through meaningful partnerships with existing community based organizations, coupled with added capacity through volunteers, foundations, law firms, law schools and legal clinics, or the health care facilities themselves.

^{*} The Centers for Medicare and Medicaid Services reimburses Federally Qualified Health Centers and Rural Health Centers for behavioral health services, including the costs for clinical social workers. Additionally, Health Resources and Services Administration in the US Department of Health and Human Services awarded demonstration grants to health centers to recruit, train, and employ patient navigators

Conclusion

The medical-legal partnership can be a highly valuable service for health centers and their patients. Working with frontline CHC staff, attorneys can help to identify legal problems and mitigate or prevent legal crises that negatively affect patient health. The benefits of a medical-legal partnership are not limited to patient well-being; they may also serve to increase health center revenues while lowering the direct costs borne by patients. The MLP can also be an effective means for addressing patterns of unmet legal needs and the systemic problems communities face when existing laws are unenforced or inadequate, or when new laws are implemented. The legal aid community, including federal- and state-funded legal aid agencies, law school clinics and pro bono initiatives, are natural partners for health centers seeking to understand and address these issues.

While health reform greatly expands coverage for most health center patients who are uninsured, health center patients will need significant information and assistance in navigating the new rules and regulations. Working with social workers and other enabling service staff, attorneys can help address some of the complex social-cultural and legal needs of their patients and their families. Further, the need for legal assistance is likely to increase, particularly with significant changes in the terms of eligibility, plan enrollment, provider selection, and service delivery embodied in the newly enacted health reform law. Studies show the advent of managed care in the 1990s and the citizenship documentation requirements in 2006 adversely affected low-income patients, and in some instances, many U.S. citizens (and newborns) were disenrolled from Medicaid due to lack of appropriate documentation, while others were simply left unable to navigate the health care system.²⁷ These past experiences suggest the importance of medical-legal partnerships to identify and address community need.

As with any innovative program, successful implementation and sustainability of a medical-legal partnership relies heavily on shared funding streams. While both legal aid and health centers can shift their federal and state funds to address unmet health-related legal needs, this arrangement can be complex and challenging, particularly for health centers operating at the margin. However, MLPs can be strategic investments for health centers as legal services have been proven to assist in recouping health care costs for providers by enrolling eligible patients in assistance programs and services, in addition to providing direct legal services to prevent or control chronic environment-triggered diseases like asthma or provide other legal protections like restraining orders to prevent domestic violence.

Appendix

Patient Advocates

Social workers and patient navigators have objectives similar to those of MLPs but differ in their roles and areas of expertise. In health care settings, patient navigators and social workers serve to integrate available resources to improve effectiveness of medical care provided, but they are generally not trained to screen for and address legal issues that affect patients' living and environmental conditions. Furthermore, few front-line staff and physicians are equipped to screen for and address the social determinants of health that require legal remedies.²⁸

MLPs are not necessarily substitutes for other patient advocate programs, but often provide health centers with an added service, collaborating with social workers and patient navigators to better secure needed services.

Table 2 profiles key attributes of patient navigators, social workers, and medical-legal partnerships to illustrate their diverse responsibilities, costs, and skills.

	Social Workers	Patient Navigators/Community Health Workers	Medical-Legal Partnership
Services Provided	Psychosocial, emotional support, including grief counseling.	General patient support and health system coordination of services.	Medical and legal assistance with chronic conditions, abuse, and other issues preventing health and wellness.
Required Education & Training	A Masters of Social Work (MSW) or bachelor's degree is often required.	No degree or training requirements for lay navigators who are often former patients/survivors of cancer or other diseases and go through onsite training. Can also be Registered Nurses (RN).	Attorneys, paralegals, health care providers, including doctors, nurses, and hospital staff can be involved and trained. Some MLP activities are accredited. ²⁹
Budgets/Salary	Generally paid by hospital/care center as grief counselor or patient services and not a separate program. Median annual wages were \$46,650 in May 2008. ³⁰	Can be paid entirely by hospital/care center or costs can be shared with grants from the American Cancer Society or other groups. 64% of the positions paid new hires less than \$13 per hour. ³¹	42% of MLP sites surveyed had an annual budget between \$101,000 and \$250,000. ³²

	Social Workers	Patient Navigators/Community Health Workers	Medical-Legal Partnership
Specific Prevention Groups	Cancer, chronic disease, trauma, and specifically trained for terminal diseases and family support. ³³	General services but most notable for oncology, particularly colorectal and breast cancer.	Began in pediatric setting, but expanded to other low-income patients and their families.
Benefits and Intervention Focus	Organize support for emotional and family needs, especially with chronic and terminally ill patients and their families.	Guide patients through entire process, e.g. cancer screenings, treatment and recovery; navigate patients through combination of insurance and care providers; arrange transportation to medical care; point person for patient through process.	Legal assistance with income supports and benefits like Medicaid; housing assistance to alleviate chronic disease (e.g. mold in home); and family law including domestic abuse and custody .

Like attorneys employed by legal aid programs, most health care safety net patient navigators (also referred to as community health workers) have strong ties with the communities they serve, facilitating the communication process.³⁴ Patient navigator programs are most noted for their effectiveness in assisting cancer patients and their families, as well as cancer prevention in low-income communities. Often the navigators are cancer survivors themselves and can relate directly to the patient experience and provide comfort and guidance.

While cost information is included above, the costs of the three programs are difficult to compare due to varying data, salary requirements, and responsibilities, as well as within job categories. For example, the majority (70%) of lay community health workers without a degree in nursing earn an average hourly wage of less than \$13; only 3.4 percent of them are paid at or near the minimum wage (less than \$7 per hour); and 21 percent are paid \$15 per hour or more.³⁵

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