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COMMENTARY

Addressing Social Determinants Of Health Through Medical-Legal Partnerships

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ABSTRACT The US health care system needs effective tools to address complex social and environmental issues that perpetuate health inequities, such as food insecurity, education and employment barriers, and substandard housing conditions. The medical-legal partnership is a collaborative intervention that embeds civil legal aid professionals in health care settings to address seemingly intractable social problems that contribute to poor health outcomes and health disparities. More than three hundred health care organizations are home to medical-legal partnerships. This article draws upon national survey data and field research to identify three models of the medical-legal partnership that health care organizations have adopted and the core elements of infrastructure that they share. Financing and commitment from health care organizations are key considerations for sustaining and scaling up the medical-legal partnership as a health equity intervention.

Clinicians have long recognized the role that social determinants play in the health and well-being of individuals and communities. Poverty, low educational attainment, unsafe or unstable housing, poor nutrition, lack of insurance, and limited employment are social conditions that are directly linked with shorter lives, poorer health, and disparities in health care access and outcomes.[1,2]

Despite these connections, the US health care system struggles to deliver comprehensive care that accounts for the social and environmental conditions of patients' lives. Separating health care from its social context creates situations such as when a woman with diabetes under a doctor's care sees her blood sugar plummet when she runs out of food;[3] a man with asthma takes his medicine but ends up hospitalized because his apartment is filled with mold;[4] and a child is repeatedly suspended from school as learning needs go unaddressed, despite being up to date on well-child care.[5] Meanwhile, the health care system plays catch-up in a costly race to manage health conditions that are worsened by circumstances outside the traditional health care enterprise.

Incentives in patient-centered medical homes, accountable care organizations, and other quality-driven payment reforms address clinical preventive efforts and medical management rather than social determinants of health.[6] Health care organizations need to adapt to align their business and social missions with the complexities of patients' lives to address health inequities and improve health outcomes in a meaningful way.

One such adaptation is the medical-legal partnership, a practical intervention to help patients resolve social and environmental circumstances that contribute to health disparities and have a remedy in civil law. As health care systems search for solutions to these injustices, medical-legal partnerships are a functional example of an effective community resource within a health care setting that targets health inequities faced by individual patients and entire communities—such as food insecurity, barriers to education and employment, and substandard housing.

This article draws upon field research from the National Center for Medical-Legal Partnership at the George Washington University Milken Institute School of Public Health. We synthesized findings from two 2016 national surveys of 275 health care and 150 legal organizations that participated in a medical-legal partnership.[7] (For the survey methodology, see the online appendix.)[8] We also included findings from site visits and interviews with dozens of health and legal professionals involved in medical-legal partnerships nationwide in 2017. Survey responses were analyzed to identify partnerships with sufficient levels of activity for us to study their operational patterns, financial investments from health care and legal partners, and mechanisms for sharing information across organizations. The specific partnerships highlighted in our research reflect the wide variety of health care settings, patient populations, and regions of the country where medical-legal partnerships have taken hold. We identified three partnership models that health care organizations adopted and the core elements of infrastructure they shared. Here we profile ten examples to showcase advances in screening processes, legal integration with health care teams, and innovative staffing arrangements. We conclude with some considerations for sustaining partnership infrastructure and bringing the approach to scale.

The Medical-Legal Partnership Intervention

Medical-legal partnerships add to the health care team lawyers who specialize in addressing social determinants. Patients who receive legal services have improved access to retroactive benefits[9] and debt relief[10] and are more likely to avoid utility shutoffs.[11] Evidence also indicates reductions in patient stress;[12] improvements in asthma control;[4] better use of preventive care for newborns and infants;[13] and decreases in readmission rates, inpatient stays, and emergency department visits.[14] Clinicians benefit as well, through greater confidence in their ability to initiate discussions about legal issues and greater understanding of the impact of poverty and social conditions on health.[15] Physicians may also be more comfortable discussing unmet social needs with patients when they have access to an in-house legal services provider to whom they can refer a patient.[16]

The medical-legal partnership is a flexible innovation that has been adopted in more than three hundred hospitals; health systems; federally qualified health centers; and other delivery sites such as Department of Veterans Affairs (VA) medical centers, primary care and behavioral health clinics, home health nursing programs, public health departments, and state primary care associations. The Health Resources and Services Administration (HRSA) and the VA support medical-legal partnerships as a mechanism for advancing health equity. In 2014 HRSA formally recognized civil legal services as "enabling services" that health centers can include under their federal grants. About 15 percent of health centers have a medical-legal partnership, and many more partnerships are in the planning stage. HRSA offers free training and technical assistance to health centers interested in forming or expanding a partnership through a national cooperative agreement with the National Center for Medical-Legal Partnership.[17]

Two dozen partnerships in VA health care sites provide legal services to veterans for common problems such as homelessness and chronic unemployment. The VA funds community organizations that provide legal services to veterans who are homeless or at risk of homelessness through its Supportive Services for Veteran Families program.[18]

Increasingly, health care organizations are being called upon to identify and address social determinants of health. In 2015 the National Association of Community Health Centers piloted the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) screening tool.[19] Now used in forty-four states, the tool includes core screening measures about housing, employment, stress, and insurance status as well as optional measures about, for example, incarceration history and domestic violence. Health Leads, a program that links health care providers and community resources, launched a screening tool in 2016 to identify resource needs including food and income supports, housing, and transportation.[20] In 2017 the Centers for Medicare and Medicaid Services released a ten-question screening tool for use by providers in Accountable Health Communities, addressing five principal domains: housing, food, transportation, utilities, and interpersonal safety.[21] All of these tools are suitable for legal screening in a health care setting.

Health care organizations are also beginning to track the results of screening in patients' electronic health records. Since 2015 providers have been able to code social determinants through Z-codes in the *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision, Clinical Modification (ICD-10-CM).[22] Specific Z-codes (Z55–Z65) create opportunities to systematically document problems—such as those related to education and literacy, employment, housing, and economic circumstances—across entire patient populations.

Medical-Legal Partnership Core Elements

Medical-legal partnerships have eight core elements. First, they are created through a formal agreement between a health care organization and a legal services provider, which in most cases is a nonprofit legal services organization or law school. The agreement outlines joint goals, establishes responsibilities for partnership staffing, and puts protections in place for patient privacy and confidentiality.

Second, partnerships designate a defined population for their work. Although some focus on specific patient conditions, the consistent thread across partnerships is that they target a low-income group of patients who have barriers to health stemming from social and environmental factors. Many legal partners receive funding from the Legal Services Corporation, a congressionally funded organization that awards grants to legal aid organizations that serve low-income people.[23]

Third, partnerships develop a strategy to screen patients for legal need. Many create home-grown legal screening tools based on I-HELP™, an organizing framework[24] with five domains developed in 2007 to help health care organizations identify patients' unmet civil legal needs (exhibit 1). These tools can be customized for a defined population or merged with a broader set of questions that identify additional social needs that can be addressed by various members of the health care team, such as social workers. Legal screening captures patient needs that cannot be addressed by social workers or case managers. Fewer than 10 percent of patients screened for legal services require an attorney.[16]

Fourth, medical-legal partnerships include legal staffing supplied by the legal services partner. Health care organizations dedicate staff to the partnership, generally to a lesser degree. Staffing arrangements vary substantially, with most partnerships using between one and two full-time attorneys plus some pro bono service from private attorneys. While health care organizations may employ lawyers for compliance and regulatory purposes, by and large, lawyers providing civil legal services are not employed by the health care organization.

Fifth, the "lawyer in residence" is the signature characteristic of a medical-legal partnership. In the majority of partnerships, lawyers are available on site a few days per week, enabling them to respond quickly to patients' needs and clinicians' questions. Close proximity to clinical staff members deepens lawyers' understanding of the health challenges patients face. When lawyers are off site, partnerships use established protocols for telephone consultations or follow-up appointments to address patients' needs. Over time, lawyers see patterns of benefit denials or discriminatory practices and work to change rules and policies to mitigate barriers to health and improve health equity.

Recognizing when legal help is best deployed is not intuitive to health professionals. Training provided by lawyers is the sixth core element that helps health care teams understand the opportunities for effective legal intervention. In 2016 more than 16,500 clinicians and staff received such training.[7]

Seventh, partnerships rely on information sharing between health care and legal staff. Referral forms from providers relay to legal services information from the social determinants screening. Some partnerships negotiate data-sharing agreements that allow comprehensive health and legal services information to flow across organizations, either through parallel data systems or directly within protected areas of the electronic health record. Regardless of the type of agreement, sharing a patient's protected health information can raise concerns about compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA's privacy rule generally prohibits covered entities such as health care providers from sharing a patient's protected health information.

EXHIBIT 1

The I-HELP™ framework for identifying health-harming social and legal needs of patients

	Legal domain	Examples of legal needs
I	Income and insurance	Eligibility for food stamps, disability benefits, cash assistance, health insurance
H	Housing and utilities	Eviction, housing conditions, housing vouchers, utility shutoff
E	Education and employment	Accommodation for disease and disability in education and employment settings
L	Legal status	Criminal background issues, military discharge status, immigration status
P	Personal and family stability	Domestic violence, guardianship, child support, advance directives, estate planning

SOURCE National Center for Medical-Legal Partnership. New MLP legal needs screening tool available for download [Internet]. Washington (DC): The Center; 2015 Oct 14 [cited 2018 Jan 16]. Available from: http://medical-legalpartnership.org/screening-tool/

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Medical-legal partnerships have learned to operate within the requirements of HIPAA to facilitate information sharing.[25] HIPAA permits the disclosure of a patient's information if the patient provides written consent. Patient consent is the most straightforward means of sharing information and can be obtained at the time of screening when a legal need is identified. Partnerships must also act in accordance with state privacy laws (which may be more stringent than HIPAA) and other specific consent requirements when highly sensitive health information, such as HIV/AIDS status, is disclosed.

Finally, partnerships need designated resources to operate effectively. Thirty-eight percent of partnerships are funded in part by health care organizations.[7] External grants, foundation funding, community benefit funds, and other charitable donations are also common. Despite these investments, nearly half of the health care organizations in medical-legal partnerships contribute in-kind resources only. The legal organization typically contributes the majority of the financing for the partnership's operational activities, especially in the initial years of the intervention. These resources come from the Legal Services Corporation, state funds,[26] legal aid fellowships, charitable donations, law school contributions, and law firm support.

Models Of Legal Services In Health Care Settings

Medical-legal partnerships can be categorized into the following three models (exhibit 2): The general population model establishes a civil legal services presence available to the health care organization's general patient population. The special population model entails a more focused intervention addressing the civil legal needs of subsets of the general patient population and thus requires legal expertise customized to the challenges faced by specific patient populations. The alternative legal services model reflects an evolving concept of legal services that uses novel organizational arrangements to respond to local or community needs.

GENERAL POPULATION MODEL Medical-legal partnerships have developed screening and training practices to identify and address legal needs among a general low-income population. Medical residents are a natural fit for partnership training. For example, at Cincinnati (OH) Children's Hospital Medical Center, all pediatric residents complete rotations in an on-campus primary care clinic with a high-Medicaid population. The residents also participate in multiday trainings on the impacts of social determinants and health-harming legal needs. These include visits to community-based organizations in a low-income Cincinnati neighborhood to learn about community barriers and assets. Physician faculty members sit on the partnership steering committee, which meets monthly to discuss topics ranging from patient referral data to housing conditions in the community. St. Christopher's Hospital for Children and the Legal Clinic for the Disabled in Philadelphia (PA) operate PhilaKids Medical-Legal Partnership, which stations a lawyer in a high-Medicaid ambulatory care clinic run by residents. The lawyer attends clinic huddles to reinforce screening and referral protocols. St. Christopher's intranet houses a website to help residents and attending physicians access legal resources, such as customizable letters to school administrators requesting Individualized Education Programs (IEPs) for children with special needs. At Kokua Kalihi Valley (KKV) Comprehensive Family Services in Honolulu (HI), medical and legal partners work together to educate health center clinicians and staff members to identify and address social determinants of health. The Medical-Legal Partnership for Children at KKV provides direct legal services as well as local advocacy, including regular workshops and self-advocacy academies for KKV patients on housing, family law, family safety, income/benefits, language rights, civil rights, and other topics. Services are designed to meet cultural and linguistic needs.

Improving screening processes can uncover previously undetected legal needs. Arkansas Children's Hospital piloted a new screening protocol at a high-volume clinic where most children are covered by Medicaid. Partnership staff members, social workers, and nurses collaborated to develop an easily identifiable bright-green screening instrument. Nurses lead the screening activities; in 2016 they referred more than a thousand patients to the partnership. At Santa Clara Valley (CA) Medical Center, physicians drive the legal screening process and use the electronic health record to document results. Screening questions are embedded within ques-

EXHIBIT 2

Key attributes of selected medical-legal partnerships, by model type

Health care organization	Legal partner organization	Referred for legal services in 2016		Primary site of legal services	Patient population served by partnership	Most common legal needs in order of prevalence
		Number of patients	Percent of patient population			
GENERAL POPULATION MODEL						
Arkansas Children's Hospital	Legal Aid of Arkansas	1,271	8	Ambulatory care clinic at nonprofit pediatric hospital	Children and families	1. Education 2. Housing
Cincinnati Children's Hospital Medical Center (OH)	Legal Aid Society of Greater Cincinnati	825	3	3 primary care clinics at a nonprofit pediatric hospital	Children and families	1. Housing 2. Public benefits 3. Education
Kokua Kalihi Valley Comprehensive Family Services (Honolulu, HI)	William S. Richardson School of Law, University of Hawaii at Manoa	116	2	2 federally qualified health centers	Children and families	1. Housing 2. Family law
Santa Clara Valley (CA) Medical Center	Law Foundation of Silicon Valley	371	1[a]	3 ambulatory care clinics at a county-operated public hospital	Children and families, unstably housed adults	1. Housing 2. Education 3. Guardianship
St. Christopher's Hospital for Children (Philadelphia, PA)	Legal Clinic for the Disabled	438	7	Ambulatory care clinic at a for-profit pediatric hospital	Children and families	1. Public benefits 2. Housing 3. Child custody or support
SPECIAL POPULATION MODEL						
Delaware Division of Public Health	Community Legal Aid Society, Inc.	181	0.5[a]	Maternal and child health program with a state health department	Pregnant and postpartum women	1. Family law 2. Immigration 3. Housing 4. Public benefits
Project HOME (Philadelphia, PA)	Legal Clinic for the Disabled	120	5	Federally qualified health center	Unstably housed adults	1. Housing 2. Social security benefits
ALTERNATIVE LEGAL SERVICES MODEL						
Multiple health care partners	MLPB	—[b]	—[b]	20 health care and human services organizations in MA and RI	Varies by site (includes pregnant women, elderly people, and cancer patients)	1. Housing 2. Immigration
Montana Primary Care Association	Montana Legal Services Association	350	2	4 federally qualified health centers	Rural and frontier populations	1. Housing 2. Family law
Whitman-Walker Health (Washington, DC)	No legal partner organization[c]	1,546	10	Ambulatory care and behavioral health sites of federally qualified health center	HIV-positive, LGBTQ, and health center patients	1. Public benefits 2. Transgender identity legal documentation changes

SOURCE Authors' analysis of information from site visits and interviews with providers and lawyers of select medical-legal partnerships identified from the 2016 National Center for Medical-Legal Partnership Surveys. [a]Legal services were not offered to the total patient population. Therefore, the share of patients served at this organization underrepresents patient need for these services. [b]Not available. [c]Lawyers are employed by Whitman-Walker Health.

tionnaires administered by medical assistants during well-child visits. Clinicians are also encouraged to ask patients a "question of the month." For example, in August 2017 as patients began the new school year, clinicians asked families, "Is your child getting the help that he/she needs in school?" Annual physician surveys indicate high provider engagement and satisfaction with the partnership (Lee Anna Botkin, pediatrician, Santa Clara Valley Medical Center, personal communication, August 7, 2017). The medical-legal team includes lawyers and a social worker employed by the civil legal aid office, who connects families to community resources and addresses poor housing conditions and difficulties obtaining an IEP.

SPECIAL POPULATION MODEL Special population partnerships focus services on an inten-

To be scaled up more broadly, partnerships need sustainable sources of financing from both the health care and legal sectors.

tionally defined high-need population. For example, the Delaware Division of Public Health's partnership provides legal services for its Healthy Women, Healthy Babies and Nurse Family Partnership pre- and postnatal care program participants. Health care staff members screen low-income pregnant and postpartum mothers for legal needs, and legal staff members follow up with patients at their health care site or the legal provider's office, or during a home visit. A successful six-month pilot with four Healthy Women, Healthy Babies health care partners showed decreases in anxiety and depression following the legal intervention.[27] The Delaware Division of Public Health has since expanded legal services to its Healthy Women, Healthy Babies programs statewide.

At the Stephen Klein Wellness Center, the focus is on populations with unstable housing. The center is part of Project HOME, a federally qualified health center in Philadelphia that provides health care and secures housing for these populations. The initiative requires special expertise from an on-site attorney from the Legal Clinic for the Disabled, who provides highly customized legal services and works hand in hand with the clinicians and staff at the health center who lead the screening efforts.

ALTERNATIVE LEGAL SERVICES MODEL A handful of organizations have adopted innovative staffing and resource arrangements. The examples presented here demonstrate opportunities for modifying staffing and using scarce resources to meet the legal needs of patients.

In 2015 the Montana Primary Care Association (PCA) assumed a coordinator role for medical-legal partnership services in four federally qualified health centers located in rural and frontier communities. Prior attempts at sustaining partnerships in these rural areas had failed because of limited interest in operating individual initiatives. The Montana PCA stepped in as a coordinating entity across the health centers to help secure funding for the sites to share one full-time lawyer from the Montana Legal Services Association. The lawyer is paid through a combination of grant funding to that association and an investment from each of the six partners, including the four participating health centers. The lawyer spends a day or two per month at each site but handles the majority of legal interactions with patients over the phone. The Montana PCA takes a proactive role to help manage the partnerships, including designing screening processes adapted to each health center's clinical workflow.

Whitman-Walker Health originally opened its doors in Washington, D.C., in 1973 as a gay men's sexually transmitted disease clinic. It later became an AIDS service organization and transitioned to a federally qualified health center in 2005, serving the LGBTQ and HIV-positive communities. Unlike many other partnerships, Whitman-Walker Health employs more than eleven of its own full-time lawyers and paralegals. It also employs fourteen public benefits and insurance navigators who screen patients and other residents of the District of Columbia for insurance eligibility and benefit denials as part of the integrated health care team. A senior leadership role was created to promote health and legal integration. The organization is known nationwide as an expert on health-harming legal issues related to HIV, sexual orientation and gender identity, access to health care, and disability benefits.

Founded in 1993 with funding from the City of Boston (MA) and private philanthropy, the MLPB (formerly Medical-Legal Partnership | Boston) began as an innovation by the Boston Medical Center (then the Boston City Hospital), Boston University School of Medicine, and Greater Boston Legal Services.[28] The MLPB grew into a regional entity and was spun off from the Boston Medical Center in 2012. Operating under the 501(c)(3) umbrella of TSNE MissionWorks, the MLPB supports twenty health care and human services organizations in Massachusetts and Rhode Island through service contracts. It focuses on systems design, workforce training, technical assistance, and research. The organization also facilitates the provision of direct legal assistance through formal partnerships and subcontracts with members of the public-interest and pro bono legal communities. This arrangement takes much of the infrastructure building off the shoulders of health care organizations and affords flexibility when organizations' needs shift.

Discussion

As health care organizations increasingly look to identify and address social determinants of health in systematic ways, they will need strong, integrated community partnerships. Medical-legal partnership is a small but growing cross-sector intervention that has garnered enthusiasm from stakeholders. The commitment of hundreds of health care organizations to medical-legal partnerships derives from the satisfaction in knowing that lawyers help patients in ways that were previously beyond their reach. Clinicians and health care executives who might have once balked at inviting lawyers into patient exam rooms are now among their most ardent supporters.

The ten medical-legal partnerships profiled in this article illustrate the breadth of activities across disparate health care organizations to bring civil legal help to patients. Yet forming and sustaining a successful partnership is not without its challenges. Staff time is needed to integrate legal assistance into clinical workflows. Screening and documenting legal needs involve the cooperation of registration staff members, information technology services, and many others beyond those who provide direct patient care. Partnerships can falter if they do not become part of routine service delivery.

To overcome these challenges, medical-legal partnerships use training to raise clinicians' and staff members' awareness of patients' legal needs and ways to access legal services. Some partnerships also benefit from linkages with other organizational efforts related to community benefit initiatives or resident education about social determinants. Going forward, legal care provided through these partnerships should be aligned with other clinical initiatives designed to identify social determinants of health and improve health equity for vulnerable patients and their communities.

Financing is also a key consideration. Because civil legal aid organizations view the partnerships as an innovative approach to advancing justice,[29] health care organizations have been able to draw from a reservoir of free or low-cost legal services. But this marriage of convenience can only go so far.

To be scaled up more broadly, partnerships need sustainable sources of financing from both the health care and legal sectors. HRSA and the VA are leading the way, but the civil legal services industry continues to shoulder most of the cost, despite competing priorities and insufficient funding.[29] One partnership in Colorado may serve as a model for incorporating payment for legal services into Medicaid payment rates. Salud Family Health Center participates in four of Colorado's seven Regional Care Collaborative Organizations. Two Salud sites provide legal services that are reimbursed by the organizations through a small per member per month add-on for enhanced care management. While this is the only case we identified in which funding for legal services is incorporated into Medicaid's per member per month payment rate, partnerships in Indiana, Oregon, and California are testing innovative models for legal services through Medicaid managed care contracts to improve health outcomes.[30] An evaluation of the Colorado initiative is currently under way.

In addition to funding, partnerships need practical guidance about how to direct scarce resources most effectively to patients who would benefit from legal assistance. Incorporating social determinants interventions into health care settings is a new endeavor and will require pilot testing and evaluation to develop an evidence base for health system and payer investment.

Building the case for medical-legal partnerships will require data; practice standards; and benchmarks consistent with health care priorities, tools, and financial resources. Nevertheless, existing partnerships have shown that doctors and lawyers can work together with shared goals to advance health equity for vulnerable community residents. ■

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