Journal of Legal Medicine
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ulgm20

Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy

Daniel Atkins JD [a], Shannon Mace Heller JD MPH [b], Elena DeBartolo [c] & Megan Sandel MD MPH [d]

[a] Community Legal Aid Society, Inc.

[b] Temple University College of Health Professions & Social Work

[c] Boston Medical Center and National Center for Medical- Legal Partnership

[d] National Center for Medical-Legal Partnership

Published online: 26 Mar 2014.

To cite this article: Daniel Atkins JD , Shannon Mace Heller JD MPH , Elena DeBartolo & Megan Sandel MD MPH (2014) Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy, Journal of Legal Medicine, 35:1, 195-209, DOI: 10.1080/01947648.2014.885333

To link to this article: http://dx.doi.org/10.1080/01947648.2014.885333

The Journal of Legal Medicine, 35:195–209

0194-7648 print / 1521-057X online
DOI: 10.1080/01947648.2014.885333

Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy

Daniel Atkins, JD, Shannon Mace Heller, JD, MPH, Elena DeBartolo, and Megan Sandel, MD, MPH*

INTRODUCTION

By resolving a wide range of civil legal needs, civil legal aid attorneys have a tremendous impact on the lives of people who are living in poverty.[1] Through improving housing conditions, preserving public benefits, and restoring utilities, civil legal aid attorneys provide assistance critical to the health and

* Daniel Atkins is an Adjunct Professor for Widener University School of Law and the Legal Advocacy Director for the Disabilities Law Program at Community Legal Aid Society, Inc. Sharon Mace Heller is a Public Health Law Specialist at the Health, Education, and Legal Assistance Project: A Medical-Legal Partnership (HELP: MLP) at Widener University School of Law. She is also a Public Health Policy & Planning Manager at Philadelphia Department of Behavioral Health and Intellectual DisAbility Services and an Adjunct Professor at Temple University College of Health Professions & Social Work. Elena DeBartolo is a Research Assistant at the Boston Medical Center and National Center for Medical-Legal Partnership. Megan Sandel is an Associate Professor of Pediatrics at Boston Medical Center and an Associate Professor of Public Health at Boston University School of Public Health. Dr. Sandel is also the Medical Director at National Center for Medical-Legal Partnership. The authors thank: Joanne Craig, Administrative Director of Crozer-Keystone Women and Children's Health Services, for her leadership being the first Healthy Start program in the country to integrate MLP into a Healthy Start program and her steadfast support of the partnership ever since; and Benita Baker, Branch Chief, Healthy Start, Division of Healthy Start and Perinatal Services, U.S. Department of Health and Human Services, Health Resources Services Administration, for her support of MLP at the federal level. Please direct correspondence to Daniel Atkins at da.helpmlp@gmail.com.

[1] In September of 2005, the Legal Services Corporation (LSC) published *Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans*. LSC updated the report in 2009 and concluded that

> only a small fraction of the legal problems experienced by low-income people (less than one in five) are addressed with the assistance of either a private attorney (pro bono or paid) or a legal aid lawyer. . . . [O]n the average, only one legal aid attorney is available for every 6,415 low-income people. By comparison, there is one private attorney providing personal legal services (those meeting the legal needs of private individuals and families) for every 429 people in the general population who are above the LSC poverty threshold.

well-being of vulnerable and at-risk populations. Nevertheless, because of an inadequate level of funding, needs overwhelm resources. While civil legal aid attorneys represented more than 2 million poor people in 2011, 80% of the civil legal needs of people who are living poverty were unmet.[2] The value of civil legal aid services historically has been confined to theories of social justice; however, public health evidence strongly suggests that civil legal aid services positively can impact individual and population health. The medical-legal partnership (MLP) model provides civil legal aid attorneys a new framework to measure and communicate the true value of their work.

This article: (1) presents the public health evidence demonstrating how resolving unmet legal needs improves health; (2) describes the MLP model; and (3) reframes the value of civil legal aid services by focusing on the work of one MLP partnering with a social services agency serving very low-income, pregnant women, and parents with young children.

I. SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDHs) are broadly understood to be the set of conditions in which people are born, live, learn, work, play, and age that affect their physical and mental well-being.[3] Tarlov summarized this concept as "the social characteristics within which living takes place."[4] In 2005, the World Health Organization (WHO) assembled a Commission on Social Determinants of Health. The Commission's final report[5] points to the deeper structural conditions of society as the driving forces that result in the poor daily living conditions that negatively impact health.[6] While traditionally health and disease have been viewed as exclusively "healthcare" issues, the roots of health equity and SDHs are deeper, and the implications are broader. SDHs are largely responsible for the health disparities that exist in the world today.

Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans, LEGAL SERVS. CORP. 1, 13 (2009), http://www.lsc.gov/sites/default/files/LSC/pdfs/documenting_the_justice_gap_in_america_2009.pdf.

[2] Evelyn Nieves, *80% of Poor Lack Civil Legal Aid, Study Says*, WASH. POST (Oct. 15, 2005), http://www.washingtonpost.com/wp-dyn/content/article/2005/10/14/AR2005101401861.html.

[3] *See About Healthy People*, HEALTHYPEOPLE.GOV, http://www.healthypeople.gov/2020/about/default.aspx (last visited Oct. 23, 2013).

[4] Alvin R. Tarlov, *Social Determinants of Health: The Sociobiological Translation*, *in* HEALTH AND SOCIAL ORGANIZATION: TOWARDS A HEALTH POLICY FOR THE TWENTY-FIRST CENTURY 71, 86 (David Blane et al. eds., 1996).

[5] *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, WORLD HEALTH ORG. 1 (2008), http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

[6] *See id*.

A. SDH Framework

The public health community widely accepts that poor health is a result of more than biological agents alone.[7] Nancy Adler and Judith Stewart proposed a ladder framework for understanding SDHs. In this framework, "the rungs of the ladder represent the resources that determine whether people can live a good life—prosperous, healthy, and secure—or a life plagued by difficulties—insufficient income, poor health, and vulnerability."[8] The top rungs include those people who are well-educated, and have job security, savings, and good housing, while the bottom rungs correspond to people who are poorly educated, unemployed or in a low-paying job, have little to no savings, and are housing insecure. "The nature of the U.S. ladder is such that the risk of dying before the age of 65 . . . is more than twice as likely for middle[-]income Americans as for those at top of the income ladder," and "more than three times greater for those at the bottom than for those at the top."[9] Premature death is not the only outcome that is affected by one's position on the ladder; disparities in newborn health,[10] chronic diseases,[11] infectious diseases,[12] disabilities, and mental illness are all directly impacted.[13] Children on the bottom rungs develop health problems at younger ages than their peers on the top rungs, and the longer people remain on a lower rung of the ladder, the worse their physical and mental health will be later in life.[14]

The ladder framework does not discount the effect genes have on health, but rather highlights the importance of environment. Adler and Stewart state:

> [T]he ease or difficulty of practicing healthy behaviors is powerfully affected by our place on the ladder. Environments mold health habits. At each stage of life, from birth onward, the conditions we live in—the physical and social environments we encounter—constrain or expand the options available to us for improving our health and avoiding disease. Each step down the ladder provides fewer tools to help the individual engage in health-protecting behaviors. . . . The rung we're on affects our health, and in turn our health affects our ability to reach higher rungs.[15]

---

[7] *See* U.S. DEP'T HEALTH AND HUMAN SERVS., HEALTHY PEOPLE 2010 (2d ed. 2002); Alan H. Goodman, *Why Genes Don't Count (for Racial Differences in Health)*, 90 AM. J. PUB. HEALTH 1699 (2000).

[8] Nancy Adler et al., *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the US*, JOHN D. AND CATHERINE T. MCARTHUR FOUND. RES. NETWORK ON SOCIOECONOMIC STATUS AND HEALTH 1, 4 (2007), http://www.macses.ucsf.edu/downloads/Reaching_for_a_Healthier_Life.pdf.

[9] *Id*. at 6.

[10] *See* Michael S. Kramer et al., *Socio-economic Disparities in Pregnancy Outcomes: Why Do the Poor Fare So Poorly?*, 14 PED. PERINATAL EPIDEMIOLOGY 194 (2000).

[11] *See* Michael G. Marmont et al., *Contribution of Job Control and Other Risk Factors to Social Variations in Coronary Heart Disease Incidence,* 350 LANCET 235 (1997).

[12] *See* Stephen S. Lim & Ali H. Mokdad, *Socioeconomic Inequalities and Infectious Disease Burden*, 379 LANCET 1080 (2012).

[13] *See* Adler et al., *supra* note 8; B. Claussen et al., *Impact of Childhood and Adulthood Socio-economic Position on Cause Specific Mortality: The Oslo Mortality Study*, 57 J. EPIDEMIOLOGY & COMM. HEALTH 40 (2003).

[14] Adler et al., *supra* note 8, at 4.

[15] *Id*. at 8.

In low-income communities, the causes of health, legal, and social problems are complex, and the resultant cost has been enormous: decreased quality of life and morale of the community; physical, emotional, and developmental problems for the most vulnerable individuals; and increased public service and healthcare costs.

The WHO Commission on Social Determinants of Health and other experts agree that, to improve population health and reduce disparities in health outcomes, the root causes must be addressed. Adler and Stewart have found that

> [t]he most critical long-term strategy for reducing health expenditures is to address the underlying determinants of disease . . . policies that support the healthy growth of children and adolescents are particularly important. These investments pay off more handsomely because correcting for the damage later on in life is far more costly and less likely to succeed.[16]

B. SDHs and the Life Course Perspective

The Life Course Perspective (LCP), much like Adler's ladder, "encourages viewing the individual as integrated within their environment and recognizes that multiple protective and risk factors exist along a continuum."[17] The LCP, developed by Lu and Halfon, is the synthesis of two longitudinal models of health disparities: an early programming model and a cumulative pathway model, to form the perspective that "disparities in birth outcomes are the consequences of differential developmental trajectories set forth by early life experiences and cumulative allostatic load over the life course."[18] In other words, birth outcomes are affected by the mother's entire life course leading up to and including the pregnancy, rather than just the nine months that a child spends in the womb.

---

[16] *Id*. at 12.

[17] Cheri Pies et al., *Making a Paradigm Shift in Maternal and Child Health: A Report on the National MCH Life Course Meeting* 1, 7 (2009), http://cchealth.org/lifecourse/pdf/2009_10_ meeting_ report_final.pdf.

[18] Michael C. Lu & Neal Halfon, *Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective*, 7 MATERNAL CHILD HEALTH J. 13, 13 (2003). Stress is commonly defined as a person's response to any real or perceived threat (i.e., the stressor). Allostasis (*allo,* meaning other, and *stasis,* meaning stability and taken from the Greek "to stand") refers to the body's ability to adapt to stress, through the output of hormones, to maintain or return to homeostasis. Bruce S. McEwen & Eliot Stellar, *Stress and the Individual: Mechanisms Leading to Disease*, 153 ARCH. INTERNAL MED. 2093, 2094-95 (1993). Daily life requires the constant adjustment of physiologic systems in response to stressors. *Id*. McEwen and Stellar initially put forth the theory of allostatic load in which a person is exposed to chronic stress and is unable to return to a state of homeostasis. *Id*. Over long periods of time, this can accelerate disease processes and impair the body's ability to adapt to future stressors. *Id*. Multiple studies have shown that people in lower socioeconomic groups experience greater exposure to chronic stress than their more advantaged peers, and allostatic load may help to explain some of the health disparities that exist. *See id*. at 2095.

Lu and Halfon recognized that eliminating birth disparities would require "interventions and policy development that are more longitudinally and contextually integrated,"[19] and Lu, with colleagues, later at a National Maternal and Child Health Life Course Meeting, called for an approach that "needs to be *both* clinical and population-based, addressing individual factors as well as social determinants of MCH (maternal and child health)."[20]

II. THE MLP MODEL

The Robert Wood Johnson Foundation recently released a study that surveyed 1,000 physicians nationwide, finding: (1) 85% of physicians believe that "unmet social needs are directly leading to worse health"; (2) 85% of physicians (95% serving low-income communities) believe "patients' social needs are as important to address as their medical conditions"; and (3) 80% of physicians "are not confident in their capacity to address their patients' social needs."[21] Because the remedy for alleviating the root causes of poor health, especially within impoverished communities, is often beyond the scope of the traditional healthcare setting, a new model of care must be implemented.

The MLP model provides a construct for legal and healthcare professionals to work together to improve the health and wellbeing of vulnerable populations.[22] The MLP model integrates lawyers into the network of healthcare providers in primary care and other healthcare settings offering an intervention that coalesces diverse disciplines—medicine, nursing, social work,[23] psychology, public health, and the law—to benefit low-income and other vulnerable populations. By combining the skill sets of medical professionals and lawyers to treat and teach SDHs, professionals are able to ensure that laws impacting health are implemented and enforced, particularly with regard to vulnerable populations.[24]

This intervention is premised on the idea that a high proportion of low-income individuals face serious legal and social challenges that adversely affect their social, emotional, and financial well-being. "Common barriers to good health include food and income insecurity, lack of health insurance,

[19] Lu & Halfon, *supra* note 18, at 13.
[20] Pies et al., *supra* note 17, at 10.
[21] *Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health: Summary of Findings from a Survey of America's Physicians*, ROBERT WOOD JOHNSON FOUND. 1, 3-6 (Dec. 2011), http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795.
[22] Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations*, 29 HEALTH AFF. 1697, 1698 (Sept. 2010), http://www.medical-legalpartnership.org/sites/default/files/page/MLP%20Transforming%20Primary%20Care.pdf.
[23] Jeffrey Colvin et al., *Integrating Social Workers into Medical-Legal Partnerships: Comprehensive Problem Solving for Patients*, 57 SOCIAL WORK 333, 336 (2012).
[24] Ellen Cohen et al., *Medical Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities*, 25 J. GEN. INTERNAL MED. 136, 136 (2010).

inappropriate education or utilities access, poor housing conditions, and lack of personal stability and safety."[25] These barriers undercut the effectiveness of treatment regimens prescribed by physicians to treat medical issues. MLPs use various methods of assessment to identify families' legal problems, which, if remedied, could improve their health and well-being.

Currently, more than 275 hospitals and healthcare institutions are participating as MLPs across the nation, serving more than 54,000 individuals each year.[26] While MLPs share a common set of goals, each MLP is unique. MLPs are located in a variety of healthcare settings, including hospitals, federally qualified health centers (FQHCs), medical schools, residency programs, and health-related social service agencies. Additionally, while all MLPs serve low-income and other vulnerable populations, each MLP has its own set of priorities, special populations, and expertise.

A. Three Goals of MLP

The MLP model works to achieve three core goals: (1) provide direct legal assistance to individuals, (2) transform healthcare and legal institution practice, and (3) impact policy and effectuate systemic change to improve population health. The first goal focuses on providing free legal services to low-income populations to improve their overall health and well-being. MLPs serve a wide-range of legal needs, including healthcare access, housing, food insecurity, income maintenance, disability, immigration, and special education. The second goal involves improving the ability of healthcare professionals to recognize when SDHs are negatively impacting their patients' health and wellbeing. The third goal aims to accomplish systemic change that benefits large numbers of people. By affecting change at the policy level, MLPs can positively impact population health outcomes.

Incorporating poverty lawyers into healthcare teams enables MLPs to address SDHs more effectively. The paradigm example is a child suffering from asthma who lives in a roach-and mold-infested apartment. The best medical care and medicine will not make the child healthy as long as the child is enduring those conditions. A poverty lawyer who can help the family terminate the lease early or force the landlord to remediate the infestation will improve the patient's living environment and enable the medical care to take hold. As a result of legal intervention, the potency of the healthcare is maximized.

B. Return on Investment

The MLP model also can benefit healthcare institutions. Across the country, in cost-benefit analysis, the return on investment (ROI) for healthcare institutions partnering with MLPs has been positive. For example, the

[25] *Id*.

[26] *The Movement*, NAT'L CTR. FOR MEDICAL-LEGAL PARTNERSHIP, http://www.medical-legalpartnership.org/movement (last visited Oct. 29, 2013).

City of New York's MLP, LegalHealth, demonstrated improved patient satisfaction and an ROI to the healthcare institution of three dollars for every dollar invested into the MLP.[27] "Similarly, a rural MLP in Illinois was able to demonstrate a 319 percent return on the original investment of $116,250 between 2007 [and] 2009."[28]

The timing is right for a new approach to healthcare for the poor. As healthcare providers, and especially FQHCs, confront healthcare reform, increasing numbers of uninsured patients will be seeking care. MLPs can be a crucial component of a patient-centered medical home that improves health outcomes for patients and families, while reducing cost for providers.

III. MOVING UPSTREAM

By focusing service on especially vulnerable populations (e.g., children,[29] people with disabilities,[30] and cancer patients[31]), many MLPs disrupt the status quo resource deficit plaguing the legal system and reinforcing inequality.[32] From a public health perspective, there are special populations that might provide an even greater ROI.[33]

---

[27] Robert Locke et al., *Medical-Legal Partnerships: Lawyers and Physicians Working Together to Improve Health Outcomes*, 83 DEL. MED. J. 237, 243 (2011), http://www.pachc.com/pdfs/Schultz%20Legal%20Article.pdf.

[28] Tishra Beeson et al., *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, THE NAT'L CTR. FOR MEDICAL-LEGAL PARTNERSHIP 1, 5 (Feb. 2013), http://legalaidresearch.files.wordpress.com/2013/04/medical-legal-partnership-literature-review-february-2013.pdf.

[29] Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224 (July 2004); Barry Zuckerman et al., *From Principle to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCH. DISEASE IN CHILDHOOD 100 (2007), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2083336/pdf/100.pdf.

[30] *See generally* Jeanette Zelhof & Sara J. Fulton, *MFY Legal Services' Mental Health-Legal Partnership*, 44 J. POVERTY L. & POL'Y 535 (Mar. 2011), http://www.mfy.org/wp-content/uploads/MFY-Legal-Services-Mental-Health-Legal-Partnership.pdf;Ellen Lawton et al., *Medical-Legal Partnership Philadephia: Meeting Basic Needs and Reducing Health Disparities by Integrating Legal Services into the Heathcare Setting*, PA. SOC. INNOVATIONS J. (May 2010), http://www.philasocialinnovations.org/site/index.php?option=com_content&id=170:medical-legal-partnershipphiladelphia-meeting-basic-needs-and-reducing-health-disparities-by-integrating-legal-services-into-the-healthcare-setting&catid=19:disruptive-innovations&Itemid=30.

[31] Stewart B. Fleishman et al., *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLIN. ONCOLOGY 2123, 2123-26 (2006), http://jco.ascopubs.org/content/24/13/2123.full.pdf.

[32] David R. Williams et al., *Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Heath and Reduce Disparities*, 14 J. PUB. HEALTH MGMT. PRAC. S8, S11 (2008), http://www.medical-legalpartnership.org/sites/default/files/news_story_file/Moving%20Upstream.pdf.

[33] *See generally Preventive Medicine: A Ready Solution for a Health Care System in Crisis*, 13 POPULATION HEALTH MGMT. S3, S3-S11 (2010), http://www.uspreventivemedicine.com/Files/PDFs/In-Line/Supplemental-Article-Population-Health-Management-.aspx.

A. Chester, Pennsylvania

Chester, Pennsylvania, is one of the poorest cities in the nation with more than 32% of its residents living below the federal poverty level.[34] An effective response to the needs of Chester's poverty population requires coordinated and efficient access to a wide range of comprehensive supportive services. In 2009 and 2010, Widener University School of Law (WUSL) students administered a "Needs Assessment Survey" to hundreds of patients at healthcare centers in Chester, Pennsylvania. The purpose of the surveys was to understand what legal and social problems patients were facing and whether they ever received any legal assistance to try to resolve the problems. The Executive Summary of the 2010 Survey reported:

> [P]atients manifest high levels of financial stress, food uncertainty, anxiety about their housing, and grave concerns about the environments in which their children live and learn. Prospects for relief are tempered by their financial limitations, child-care difficulties, and for many, the lack of a car. Public benefits programs, including Medical Assistance, are under-utilized. ... The health implications are obvious when poverty, psychological stress, nutritional deficiency, environmental hazards, violence, and an absence of support, are a persistent feature of patients' lives.[35]

The report noted, however, that "'very few of the respondents had consulted an attorney about their problems or concerns.' The Chester findings are consistent with the national experience."[36]

Widener helped to fill this void through the creation of the Health Education and Legal Assistance Project: A Medical-Legal Partnership (HELP: MLP) in 2009.[37] HELP: MLP, a collaboration between poverty lawyers and Chester healthcare and social service providers, aims to improve client health and wellbeing by providing legal and social service assistance to address SDHs, specifically for pregnant women, first-time parents, and parents of children under two years of age and their family members. Serving clients in Chester, Pennsylvania, since 2010, HELP: MLP trains healthcare and social work staff to identify legal issues for referral, and it handles public benefits, housing, consumer law, family law, and disability cases, among other legal matters.

[34] *Chester (City), Pennsylvania*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/42/4213208.html (last updated June 27, 2103).
[35] *Our MLP*, HELP: MLP, http://www.helpmlp.org/our-mlp.html (last visited Oct. 29, 2013).
[36] *Id.* (quoting the results of a 2010 Needs Assessment Survey of participants in Chester, Pennsylvania).
[37] *See id.*

B. Healthy Start

The United States Department of Health and Human Services (HHS) funded the development of the Healthy Start[38] initiative in 1991 to address the alarmingly high infant mortality rate in 15 rural and urban areas.[39] Healthy Start used community-driven strategies to address the medical, social, behavioral, and cultural needs of high-risk populations with a special focus on maternal and infant care. Currently, there are 105 funded Healthy Start programs throughout the nation, working with the communities that they serve to ensure that every child is given a healthy start in life.[40]

Crozer-Keystone Healthy Start (CKHS) is a community-based maternal and child health case management program that is an extension of the Crozer-Keystone Health System.[41] The program has more than 13 years of experience establishing and maintaining memoranda of understanding (MOUs) and partnerships with: service area healthcare practitioners (i.e., obstetrics/gynecology, pediatric, and family medicine); the local FQHC; the mental health base service unit; Head Start; the family center; school districts; the Nurse-Family Partnership Program; Communities That Care; Widener University schools and departments; other colleges and universities; homeless services; daycare providers; the local Women, Infant and Children (WIC) program; the Pennsylvania Department of Public Welfare; Pennsylvania children and youth services; and more. These formal and informal partnerships have facilitated access to services, assisted CKHS in troubleshooting and resolving problems, and aided broader lines of communication. CKHS is also the founding member of the Pennsylvania Perinatal Partnership (PPP), a statewide partnership of Healthy Start and Title V programs within Pennsylvania.

CKHS provides case management, health education, social work services, perinatal depression screening, transportation, and translation and interpretation services to new and expectant mothers and families with young children in Chester and surrounding communities. Noticeably absent from CKHS's impressive array of services, however, was any form of legal assistance, until recently. In September of 2010, CKHS was one of three Healthy Start projects awarded funding to demonstrate the value of collaboration to promote family advocacy within Healthy Start through MLP.[42] By training

---

[38] *See Saving Our Nation's Babies: The Impact of the Federal Healthy Start Initiative*, NAT'L HEALTHY START ASS'N (2013), http://www.nationalhealthystart.org/site/assets/docs/NHSA_SavingBabiesPub_2ndED.pdf.

[39] *See Healthy Start Initiative*, NAT'L HEALTHY START ASS'N, http://www.nationalhealthystart.org/healthy_start_initiative (last visited Oct. 23, 2013).

[40] *Id*.

[41] *See CK Healthy Start*, CROZER KEYSTONE HEALTH SYS., http://www.crozerkeystone.org/services/maternity/service/healthy-start/ (last visited Oct. 23, 2013).

[42] *See Health, Education, & Legal-Assistance Project: A Medical Legal Partnership*, HELP: MLP, http://www.helpmlp.org/ (last visited Oct. 23, 2013).

CKHS staff to identify legal needs and appropriately refer CKHS clients to HELP: MLP attorneys, HELP: MLP and CKHS case managers now work together to provide comprehensive legal and social assistance to improve program participants' health and well-being.

C. HELP: MLP Addressing the Three Goals of MLP

In congruence with the MLP model, HELP: MLP at CKHS operates to achieve three main goals: (1) to provide direct legal services to Healthy Start program participants in order to improve overall health and well-being; (2) to provide training to Healthy Start staff to transform the service delivery system; and (3) to engage in systemic advocacy efforts to positively impact population health. To achieve these three goals, HELP: MLP and CKHS act as a true collaboration. Staff attorneys are fully integrated on site with case managers and other Healthy Start staff. CKHS provides three offices within its case managers' suite, rent free, to HELP: MLP attorneys, so that collaboration is seamless. In this model, staff attorneys have become part of the Healthy Start team and provide comprehensive services to program participants alongside case managers.

1. Legal Assistance

HELP: MLP attorneys provide legal assistance to Healthy Start participants on a wide range of matters and in various ways. Among the ways attorneys provide assistance include a formal screening and referral method by case managers, regular on-going case consultations, and informal referrals in urgent matters. HELP: MLP attorneys address participants' legal needs by handling cases directly with participants and providing consultations directly to case managers. Cases signify that HELP: MLP entered into an attorney-client relationship with a program participant and provided representation to the individual. Occasionally, representation entails brief advice or a referral, but the vast majority of HELP: MLP's cases involved full representation, including appearance at hearings.

Upon inception of the partnership, Healthy Start staff and HELP: MLP attorneys worked together to develop a referral method for cases. A modified version of the National Center for Medical-Legal Partnership's I-HELP[43]

[43] I-HELP is a screening tool developed by the National Center for Medical Legal Partnership as a practical method for clinicians to elicit a history of social circumstances from their patients. It helps focus the history on specific domains vital to health and well-being that are amenable to direct intervention. I-HELP is a mnemonic for: income supports and health coverage (I); housing and utilities (H); education and employment (E); legal (immigration) status (L); and personal and family stability and safety (P). It is easily remembered by clinicians, and empowers them to screen for unmet needs and address issues, each of which directly impacts health. Screening can be done during a series of healthcare visits or in a more focused manner if one of these issues is identified as a significant contributor to or risk factor for poor health. *See* Chén Kenyon et al., *Revisiting the Social History for Child Health*, 120 PEDIATRICS e734-38 (2007).

screening tool is used to identify unmet legal needs of program participants. All Healthy Start case managers and staff receive training on how to administer the I-HELP screening tool, and, when an unmet legal need is identified, the program participant is referred to a staff attorney.

HELP: MLP opened more than 200 legal cases and provided in excess of 150 legal consultations to CKHS staff in the last three years, benefiting more than 400 participants and their family members. Participants received assistance with a wide range of legal needs, including housing, public benefits, disability benefits, employment, custody and dependency, utility shut-off prevention, and debt collection. HELP: MLP attorneys were able to assist several participants proactively by preventing potential crises, and clients reported a significant reduction in stress and improvement in health and wellbeing after receiving services.

During the most recent grant cycle of June 2012 to May 2013, HELP: MLP attorneys resolved 70 legal cases. The average number of legal issues addressed per client was 2.4; however, the number of issues per client ranged from 1 to 9. Additionally, HELP: MLP attorneys conducted 59 consultations with Healthy Start case managers and staff and led eight trainings on substantive legal issues for staff. These numbers are consistent with numbers reported from the first two grant years at HELP: MLP.

2. Health and Legal Institutions and Practice Transformation

a. Training

Between June 2012 and May 2013, HELP: MLP presented more than 48 hours of legal and advocacy training to CKHS staff and community partners. These trainings are an integral part of transforming the healthcare, social service, and legal delivery system. Some of the training topics include identifying unmet legal needs and referring participants to services, public benefits, consumer law issues, disability issues, and the Patient Protection and Affordable Care Act (PPACA). A particular training emphasis in the last year has been on changes in state welfare programs, which has provided case managers with the most up-to-date information and advice possible. Formally, trainings are provided by the HELP: MLP attorneys to Healthy Start staff; however, bidirectional learning takes place naturally through the integrated nature of the partnership and the interactive nature of the trainings.

b. Consultations

HELP: MLP lawyers provide case managers and nurses with dozens of informal consultations, quietly enhancing the effectiveness and capacity of staff. Case consultations might be focused on a specific program participant or might come in the form of a question about a specific area of law. Through these consultations, Healthy Start staff increase their knowledge about issues

and, in some instances, can provide direct support to clients without the attorney having to retain formal representation.

The cases directed to HELP: MLP are typically the most intractable, challenging, and time-consuming ones on the CKHS's caseload. Before the MLP was in place, case managers, social workers, and nurses either spent inordinate amounts of time trying to resolve the legal problems—with mixed results—or referred participants elsewhere with little assurance that the problems were resolved successfully. HELP: MLP provides consultations to CKHS staff after the staff has identified program participant legal concerns, with more than half of them related to Medicaid/public benefits matters. Case consultations are on-the-spot interactions between lawyers and CKHS staff, ranging from advice to more extensive one-on-one training. Legal staff provide situational and case-specific help so that case manager staff can assist their clients directly, obviating the need for a referral to a lawyer. The communication is bi-directional, which has enabled the attorneys to provide feedback to case managers and for the case managers to notify the MLP before client problem reaches a crisis. Consultations increase case managers' capacity and effectiveness to advocate for program participants, and they enhance communication between MLP and Healthy Start staff, which has enabled the case managers to learn about legal issues on a daily basis.

c. Capacity

Integrating legal services into Healthy Start increases case managers' capacity by alleviating their time and by increasing their capacity to advocate on behalf of clients. Healthy Start case managers and staff provide assistance to program participants in a variety of ways to ensure that their healthcare and social needs are being met, specifically with regard to having a healthy pregnancy and good birth outcomes. Prior to MLP integration, Healthy Start case managers would spend an excessive amount time attempting to resolve participants' complex social needs that often require a legal remedy. Having an attorney on staff allows case managers to refer the most complex issues to the attorney, thereby freeing up time for other participants and issues. Additionally, through case consultations and trainings, case managers and staff have reported an increase in both knowledge and ability to advocate on behalf of their clients. Being armed with basic information and tools allows them to provide efficient and effective support for their clients.

3. Policy Change

An important goal of the MLP model is to impact systemic policies to improve population health. Collaboration among medical, legal, and social work professionals strengthens the advocacy capacity to challenge policies that negatively impact vulnerable communities. HELP: MLP engages in systemic advocacy efforts to impact the Chester community. Often, advocacy

efforts are centered on forcing local agencies to abide by existing regulations. HELP: MLP attorneys successfully have advocated for positive changes in the public benefits, housing, and children and youth services in the Chester community. For example, a HELP: MLP staff attorney was successful in correcting a systematic failure by the local welfare office that was providing notices to non-English-speaking benefit recipients in English.

Additionally, HELP: MLP advocacy efforts resulted in the local welfare office using an expanded definition of "emergency" that includes prenatal care for high-risk pregnancies for purposes of receiving emergency medical assistance. After Hurricane Sandy, numerous clients suffered losses of power and food. As a result of HELP: MLP's advocacy, the local welfare office complied with existing regulations and issued replacement food stamps to recipients affected by the storm. HELP: MLP attorneys also advocate for the development of new policies and to stop harmful policies from being implemented. For example, one HELP: MLP attorney is actively involved in an effort to prohibit organizations that offer so-called payday loans or payday advances from operating in Pennsylvania. Currently, there are legislative efforts to allow such businesses to operate in the state, which would harm low-income residents financially because the lending practices of such organizations disproportionately affect low-income individuals by subjecting them to extremely high loan repayment agreements. While these efforts benefit HELP: MLP clients directly, they also benefit the entire community.

IV. IMPLICATIONS FOR FUNDING

The MLP model not only transforms the way in which poverty law services are conceptualized but also can expand the types of funding sources. The MLP model also demonstrates that integrating legal services into the healthcare setting improves health and drives down healthcare costs.[44] Because of these emergent findings, a greater variety of stakeholders have an interest in supporting poverty law services. As insurers, hospitals, and healthcare systems face increasing responsibility for the health of the communities they serve, they will have a greater interest in investing in services that address the root causes of poor health. Currently, MLPs receive funding through a wide range of sources, including: private philanthropic organizations; traditional legal services supporters; federal, state, and local governments; universities; hospitals; community health centers; and large healthcare systems. Through partnership with a healthcare entity or health-related social service organization, poverty law providers can expand their service capacity, redefine the value of their work, and increase the likelihood of sustainability.

[44] *See generally* Robert Pettignano et al., *The Health Law Partnership: Adding a Lawyer to the Health Care Team Reduces System Costs and Improves Provider Satisfaction*, 18 J. Pub. Health Mgmt. & Prac. 1 (2012); Locke et al., *supra* note 27.

V. IMPORTANCE OF MEASUREMENT OF EFFICACY

One key shift in the traditional legal services framework to that of the MLP model is the importance of measuring outcomes. Legal aid programs are generally unaccustomed to tracking outcomes other than the resolution of legal cases. Because the ultimate goal of MLP is to improve the health of individuals, MLP staff are encouraged to track health outcomes and other measures. A plan for public health evaluation needs to be resourced and developed at the outset, and it should be a collaborative process with both legal and healthcare partners engaged. The question that needs to be asked at the start is: What results do we need to show in order for the partnership to be institutionally sustained? The answer to that question must then drive an evaluation with metrics designed to measure whether those results have been achieved. MLPs across the nation are conducting different types of evaluation, including: tracking the financial impact on specific health systems; measuring the impact on client stress and sleep; and monitoring the healthcare delivery system. A current need exists for longitudinal data showing the impact of MLP services over time on factors such as health, birth outcomes, mortality, emergency room utilization, treatment compliance, and absenteeism to provide even more compelling evidence on MLP efficacy. As the MLP model continues to grow and mature, we can expect to see an increase in the evidence showing the connection between MLP and improved health outcomes.

CONCLUSION

The MLP model has tremendous potential to improve health for vulnerable individuals and communities significantly, and to provide an avenue for poverty law attorneys to reframe the value of their work. Through participation in an MLP, civil legal service providers have an opportunity to prove what many already know anecdotally: that resolving unmet legal needs is critical to improving health and well-being. Partnership with healthcare and social services entities provides a venue to engage in shared learning, streamline processes, collect and analyze data, and jointly fundraise. The growing network of MLPs has shown that the MLP model is an effective model to improve individual health and address systemic inequities.

MLPs focused on improving the lives of the most vulnerable can mitigate the impact of poverty throughout the life course. MLPs specifically working with pregnant women and young children have an opportunity to intervene at a critical time of development and growth, which, in turn, can have a long-lasting impact. MLPs can help lift individuals up the ladder described by Adler and Stewart, providing for better health and opportunities in life.

In addition to improving individual and population health and well-being, the MLP model may be a more sustainable method to fund poverty law services due to its value to healthcare partners. Growing evidence shows that MLPs are producing strong ROI for healthcare systems.

The field of legal aid and poverty law would be remiss if it did not consider healthcare and other social services practitioners as natural collaborators. Driving forces, such as the PPACA, movement toward outcomes-based payment, and community responsibility, are forcing healthcare systems to begin attending to individuals' holistic needs, including those outside of the traditional healthcare system. Simultaneously, massive reductions in funding are being experienced by legal services providers while needs simultaneously continue to overwhelm resources. This current environment provides many opportunities for healthcare and legal professionals to work together to best address the needs of their communities.