From Practice to Theory: Medical-Legal Partnership Enters its Third Decade

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By Samantha Morton

Over the last two decades, there has been an increasing recognition that the healthcare system and the legal community share a large swath of low-income, medically vulnerable clients (patients), and that the two professions can better serve those constituents if they collaborate with more intention and structure.[ii]

The medical-legal partnership (MLP) model was founded in 1993 at Boston Medical Center,[iii] and the depth and breadth of MLP integration into healthcare delivery and related medical education and training systems has accelerated rapidly over the last 20 years. Today, the model has taken root in over 250 health care sites across the United States; indeed, 38 medical schools[iv] and 46 residency programs[v] participate in these programs. A first-ever MLP textbook was published in August 2011.[vi] MLP programs have expanded internationally as well: in November 2012, an *Inaugural Symposium on Advocacy-Health Alliances* was hosted in Melbourne, Australia.[vii]
MLP had important origins in earlier innovations in legal services delivery to vulnerable, low-income people, particularly in the domains of advocacy for (a) persons with disabilities[viii] and (b) domestic violence survivors. These service delivery paradigms were consonant with evolving theories of ethical and optimal allocation of scarce legal services resources for the poor, particularly theories and models cultivated at Harvard Law School as early as the 1970s.[ix]

The MLP model was "born" at a hospital, and founded at a time when the healthcare system was growing – by necessity if not inclination – more attune to patients' non-biological determinants of health. However, as the model has matured, it increasingly harmonizes with a range of important legal frameworks. These frameworks connect to a diversity of theoretical underpinnings, many of which are relevant to health law practice, especially where that practice involves the interests of low-income, medically vulnerable patients and the providers, staff, and institutions that serve them. Against the backdrop of the monumental 2012 milestones in federal and Massachusetts health reform, and at a time of profound reflection within the access to justice community regarding prioritization of even scarcer resources, this article seeks to update MLP's theoretical landscape, and to identify specific paradigms through which MLP (and similar) interventions can be understood, leveraged, and critiqued.

The Original Framework: Advancing an Individual Patient's Health and Well-Being Through Referrals to Legal Adjuncts

Simply put, some social determinants of health have legal solutions. The originating MLP model focuses on integrating legal advocates into healthcare teams so that those teams can leverage their legal colleagues' advocacy skills and expertise on behalf of patients with health-harming legal needs.[x] These needs range from those with obvious connections to health and healthcare access (correction of housing conditions that exacerbate asthma, legal advocacy for domestic violence survivors needing protection from their abusers, appeals of unlawful health insurance denials on behalf of persons in need of treatment, and so forth) to those with more attenuated but no less important connections to health and well-being (special education advocacy, disability benefits access, estate planning and guardianship preparations for persons with terminal illness and their families, vindicating non-discrimination rights, and many more). The MLP legal partners often have been characterized as an adjunct to social work infrastructure (itself, of course, historically considered an adjunct to the clinical team) in helping patient-families to meet their basic needs.

Historically, the professional adjunct framework has positioned MLP projects primarily to "catch" individual patients' emergency legal needs that are filtered through existing healthcare "triage" systems – which tend to focus on acute needs. This default MLP operating model aligned with the long-standing orientation of legal services agencies to allocate the majority of their scarce resources to those people at the greatest legal (and immediate human) risk.[xi]

This professional adjunct MLP framework may be revised in the coming years, substantially, by the Patient-Centered Medical Home (PCMH) model, which embodies five key attributes and functions: (1) comprehensive care; (2) patient-centered care; (3) coordinated care; (4) accessible services; and (5) quality and safety.[xii] At least in theory, this model urges healthcare delivery systems (and the teams that comprise them) to be built around the patient's reality, whatever that may be, and to that extent the model may productively disrupt long-standing organizational charts and service flow models. If fully realized, a patient treated in a PCMH will benefit from a "hub" (such as a primary care physician) with many integrated, coordinated "spokes" (a nurse; and, as needed, a mental health provider, a social worker, a substance use counselor, a housing advocate, and so forth).

As described below, sharing a "room" in the patient-centered medical home with legal advocates – a level of systematic integration thus far without precedent – might also allow for more proactive, population-level benefits for vulnerable patients and the healthcare teams that treat them. Massachusetts already has been a leader in this regard. The Massachusetts payment reform legislation signed in August 2012 invites the State's Office of Medicaid, when developing new cost containment methodologies that will impact healthcare delivery to a range of patient populations in the Commonwealth, to account for the costs of

care coordination and community based services provided by allied health professionals, including but not limited to community health workers, *legal advocates*, medical interpreters, clinical prevention specialists, human services workers, social workers, and licensed alcohol and drug counselors *(emphasis added)*.[xiii]

This provision — developed and advanced by the Disparities Action Network (http://cchers.org/health-disparities-and-health-equity/disparities-action-network/) –

is a milestone acknowledgment of the broad diversity of professionals required to keep people healthy.

A Corollary Framework: Advancing Population Health and Well-Being Through Structured Integration of Legal Advocates

In medicine, prevention is the province of public health[xiv] and, to some degree, primary care. Primary care is understood generally to be comprehensive first contact and continuing care for patients, with a focus on primary prevention but also diagnosis, referral, and occasional management of conditions. Public health systems are charged with preventing disease and promoting good health within groups of people, and those systems deploy unique strategies (such as policy development, research, door-to-door outreach campaigns, and population health surveillance) to achieve these goals.

In the last five years, MLP services increasingly have been described as a new kind of public health tool,[xv] with accompanying integration into a range of public health systems. In September 2011, the New York State Legislature amended its public health law to define and endorse "Health-Related Legal Services Programs."[xvi] The U.S. Health Resources and Services Administration (HRSA, part of Health and Human Services) is supporting the model in a variety of ways, including hosting a current MLP demonstration project involving Healthy Start programs in three communities.[xvii] Healthy Start programs are committed to reducing infant mortality and other health disparities affecting communities of color.

When thinking about the role of legal collaborations in the context of combating health disparities, it is necessary to parse the concept of health equity, which often is imprecisely conflated with the phrase "health disparities." This Boston Public Health Commission Center for Health Equity and Social Justice explanation is useful:

Health disparities, or health inequalities, are differences in the presence of disease, health outcomes, or access to health care between population groups. Health inequities, on the other hand, are differences in health that are not only unnecessary and avoidable, but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups.

Consider the following example. Male babies are generally born at a heavier birth weight than female babies. This is a health disparity. While there may be a difference in the birth weight between male babies and female babies, the difference is unavoidable and rooted in genetics. On the other hand, babies born to Black women are more likely to die in their first year of life than babies born to White women. Some of this difference is due to poverty – a higher percentage of Black mothers are poor and face hardships associated with poverty that can affect their health. But we find differences in the health and Black and White mothers and babies even if we compare Blacks and White[s] with the same income.

Many scientists believe that it is racism experienced by Black women that explains this extra difference. Racism creates stress, and too much stress creates a risk for mothers and babies. This is a health inequity because the difference between the groups is unfair, avoidable and rooted in social injustice.[xviii]

This definition of health inequity – emphasizing "unnecessary," "avoidable", "unfair," and "unjust" conditions – reveals that in many respects (and as further discussed below), health equity work is the public health iteration of the civil rights work historically led by, and almost exclusively associated with, the legal community.

MLP as a Civil Rights Strategy

In many respects, health equity work is civil rights work. Its focus on changing conditions (such as structural racism) that have the effect of harming large groups of people – regardless of whether responsible decision-makers intended these harms – is fundamentally analogous to disparate impact theory, a legal concept that has driven decades of important national civil rights litigation on behalf of a range of populations. The work of public health departments in both (a) educating people about health risks and (b) monitoring the prevalence of health problems is directly analogous to the civil rights outreach and enforcement efforts of bodies like the Fair Housing Center of Greater Boston and the Massachusetts Attorney General's office.

To the extent that MLP projects serve to identify patterns and practices that put vulnerable patient populations at health risk (or greater health risk), they can play an important role in supplying both (a) documentation of the harms to a group of patients' health and well-being, and (b) linkages to medical experts who can attest to the current and potential future health risks to that population.[xix]

This has important implications for a range of civil rights-informed legal strategies that are gaining more currency nationally, and increasing relevance and impact regionally. Spearheaded by the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University, opportunity mapping is deployed to "illustrate where opportunity rich communities exist (and assess who has access to those communities) and to understand what needs to be remedied in opportunity poor communities" based on systematic analysis of key metrics across zip codes and neighborhoods.[xx] With funding from the Massachusetts Legal Assistance Corporation, in 2009, the Massachusetts Law Reform Institute's Race Equity Unit supported publication of a groundbreaking report on opportunity disparities in Massachusetts.[xxi]

MLP as a Community Lawyering Strategy

The community lawyering model, with deep roots in criminal justice[xxii] and environmental justice practice, has evolved significantly over the last two decades. Key elements of this model include: (1) structured collaboration with community members (around priority-setting and strategy, etc.), (2) a focus on "empowering communities, promoting economic and social justice, and fostering systemic change," and (3) interdisciplinary thinking and collaboration.[xxiii] One example of a thoughtful community lawyering practice in Massachusetts is the Environmental Justice Legal Services project at Alternatives for Community & Environment.[xxiv]

Increasingly, MLP projects are understood to be effective mechanisms for meaningfully infusing legal advocacy work with community perspectives and client priorities.[xxv] A range of MLP sites are integrated into formal community lawyering practices, including but not limited to the Community Lawyering Project of the Volunteer Legal Services Program of the Bar Association of San Francisco, and the Community Lawyering Clinic at the University of New Mexico School of Law.

MLP as Preventive Law

Notions of preventive law are embedded in a familiar paradigm: the customary practice of corporations and organizations to engage legal counsel on how to both conduct business successfully and, simultaneously, avoid legal problems. Typically this is accomplished through integration of in-house general counsels, or external lawyer advisors on a range of subject matters. However, a deeper theoretical basis for preventive law is developing, with significant support over the last two decades from the National Center for Preventive Law at California Western School of Law.

Preventive law theory underscores law as, fundamentally, a problem-solving tool.[xxvi] It also argues that legal problem-solving is most effective when approached as problem prevention.[xxvii] Honoring the early theoretical contributions of Louis M. Brown, preventive law theory advocates, among other things, that clients' engage in periodic legal check-ups.[xxviii] This concept historically has been viewed as a luxury in the access to justice domain, primarily because of perpetual and deepening resource constraints that necessarily drive a more reactive referral and assistance

paradigm. Preventive law theory invites consideration of whether MLP presents an opportunity for patients to have access to a "primary care legal advocate" dedicated to primary prevention of health-harming legal problems.[xxix]

Challenges to Fully Realized MLP Integration in the Next Decade

Not all interests align.

Historically, the MLP model has leveraged the substantial intersection of institutional interests and individual client (patient) interests. This predictably has eased joint, interdisciplinary priority-setting processes for MLP projects. After all, eliminating an asthmatic patient's housing conditions problem through legal strategies dovetails with a healthcare team's interest in reducing preventable emergency department or inpatient readmissions for that patient. This concrete alignment also has meant that MLP projects do not tackle legal issues on behalf of patients that might be adverse to the interests of their partner institutions (classic medical debt advocacy, medical malpractice, and so forth).

It remains to be seen whether MLP projects focused on health-harming legal issues that do not hew closely to the incentives embedded in healthcare finance systems will flourish, at least in the short- and mid-term.

Interdisciplinary, public health-informed work challenges deeply-held professional culture and identity attributes.

Particularly in the legal services domain, engaging in interdisciplinary work focused on prevention demands a substantial reorientation, implicating both expansion of professional values and priorities and adaption of front-line resource allocation/workloads.

First, effective partnering between the healthcare sector and the access to justice community requires that the access to justice community in particular (1) understand its (healthcare) allies and the systems that drive them, and (2) embrace its professional responsibility to conduct zealous advocacy for clients as well as develop strong professional cultural competence when communicating with allies from other professions – professions that increasingly are inviting, and funding, legal services agencies.

Second, public health and healthcare ventures are extraordinarily and data-driven, and the access to justice community must accelerate its current efforts to support data collection, aggregation, and analysis relating to the varied impacts of its work on patients and on society. Many such efforts are underway nationally, regionally, and locally.

Third, the access to justice community and the healthcare community share a common history of seeking to divide team-based labor through reliance on the notion of "practicing to the top of one's license." In the access to justice domain, this has reinforced a culture of lawyer as litigator and combatant (perhaps analogous to a "legal surgeon"), and a corresponding de-valuing of legal screening, referral, and delivery of legal information and advice short of full litigation (typically performed by legal hotline and related infrastructures, perhaps analogous to "legal primary care"). It bears noting that social work has experienced similar dynamics in the healthcare environment, *e.g.* those engaging in clinical therapy are positioned differently than those focused on addressing patients' material hardships and other basic needs barriers to health and well-being.

While there may be reasonable differences of opinion regarding the efficacy of various strategies in a significantly resource-constrained environment, there is no doubt that a true public health-infused model of legal services delivery would allocate more resources upstream than downstream. Perhaps the common ground within the access to justice community will be found in upstream systemic, policy, or impact, work. Achieving this kind of common ground certainly would require funders of legal services delivery for low-income people to adapt their priorities accordingly, and to substantially move away from the case-counting model.

There are other sectors, aside from healthcare, with which the legal community could systematically partner in ways that could be productive for vulnerable members of society.

The "footprint" of healthcare in American society is so expansive, and the intersection of that sector with low-income, medically vulnerable consumers so deep, that medical-legal partnership was a natural nexus for a sustained experiment in interdisciplinary access to justice. But healthcare certainly is one among several, if not many, sectors that present such opportunities, albeit if at a smaller scale.

Will the MLP movement lead new experiments in these other domains, such as education-legal partnerships? Or will the next decade be focused on replication and deepening of MLP infrastructures in many more communities and healthcare

delivery systems across the country? Or are these false distinctions, since all roads (schools, prisons, etc.) lead back to the bedrock concept of social determinants of health and well-being?

It would appear that given the expanding theoretical landscape on top of which the MLP model "sits," there is ample opportunity for these and many other consequential questions to be answered thoughtfully in the next decade.

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[i] The author thanks JoHanna Flacks, Medical-Legal Partnership | Boston's Legal Director, for her critical conceptual input on this article.

[ii] Setting the Stage: Need for MLP, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/model/need (last visited Jan. 16, 2013); Transforming Delivery Models for Healthcare and Law, Nat'l Center for Med. Legal Partnership http://www.medical-legalpartnership.org/model/transforming (last visited Jan. 16, 2013); The Movement, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/movement (last visited Jan. 16, 2013); Awards and Recognition, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/network/awards (last visited Jan. 16, 2013); Academic Articles, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/resources/additional-resources/academic-articles (last visited Jan. 16, 2013).

[iii] History: One Doctor's Vision, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/movement/history (last visited Jan. 15, 2013).

[iv] Medical Schools, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/movement/healthcare-partners/medical-schools (last visited Jan. 15, 2013). See generally Amy T. Campbell, Teaching Law in Medical Schools: First, Reflect, 40 J.L. Med. & Ethics 301 (2012); Jeremy Long et al., Developing Leadership and Advocacy Skills in Medicine Through Service Learning, 17 J. Pub. Health Mgmt. and Prac. 369 (2011).

[v] Residency Programs, Nat'l Center for Med. Legal Partnership, http://www.medical-legalpartnership.org/movement/healthcare-partners/residency-programs (last visited Jan. 15, 2013).

[vi] See generally Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership (Elizabeth Tobin Tyler et al. eds., 2011) (positioning health in the broader social context of people's lives and advancing legal advocacy and related interdisciplinary strategies as key responses to complex social problems).

[vii] Advocacy Health Alliances: 2012 Advocacy Health Alliance Symposium, Pub. Interest L. Clearinghouse, http://www.pilch.org.au/ (last visited Jan. 15, 2013).

[viii] See Jeanette Zelhof & Sarah Fulton, MFY Legal Services' Mental Health-Legal Partnership, 44 Clearinghouse Rev. 535, 535 (2011). Of course, the Americans with Disabilities Act was passed by Congress in 1990, and this informed legal services priority-setting greatly.

[ix] See generally Biographies, Bellow-Sacks Access to Civ. Legal Services Project, http://www.law.harvard.edu/academics/clinical/bellow-sacks/Templates/biographies.htm; Gary Bellow's Papers, Bellow-Sacks Access to Civ. Legal Services Project, http://www.law.harvard.edu/academics/clinical/bellow-sacks/Templates/bellowpapers.htm; http://www.garybellow.org/people/gsingsen.htm.

[x] Stewart B. Fleishman et al., The Attorney As the Newest Member of the Cancer Treatment Team, 24 J. Clinical Oncology 2123, 2123–26 (2006); Barry Zuckerman et al., Why Pediatricians Need Lawyers to Keep Children Healthy, 114 Pediatrics 224, 224–28 (2004); Paul R. Tremblay et al., Commentary: The Lawyer is In: Why Some Doctors are Prescribing Legal Remedies for Their Patients, and How the Legal Profession Can Support this Effort, 12.2-3 B.U. Pub. Int. L.J. 505-527 (2003).

[xi] The access to justice infrastructure has been compelled to ration its services since its inception, due to profound (and often politicized) resource constraints. This challenge has only deepened over the last few years. See I. Glenn Cohen,

Rationing Legal Services, J. Legal Analysis (November 25, 2012) (forthcoming; available at SSRN: http://ssrn.com/abstract=2180453).

[xii] Patient Centered Medical Home Resource Center: Quality and Safety, U.S. Dep't of Health and Hum. Servs. http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/PCMH_Defining%20the%20PCMH_v2 (last visited Jan. 15, 2013).

[xiii] Chapter 224 of the Acts of 2012.

[xiv] Public health has critical corollaries in social medicine, population medicine, and preventive medicine. References to public health herein incorporate those practices.

[xv] See, e.g., Emily Rosenbaum, Racial/Ethnic Differences in Asthma Prevalence: The Role of Housing and Neighborhood Environments, 49 J. Health & Soc. Behav. 131, 141-42 (2008); Megan Sandel et al., Medical-Legal Partnerships: Transforming Primary Care By Addressing the Legal Needs of Vulnerable Populations. 29 Health Aff. 1697, 1697–1705 (2010); David I. Schulman et al., Public Health Legal Services: A New Vision, 15 Geo. J. on Poverty L. & Pol'y 729, 729–79 (2008); David R. Williams et al., Moving Upstream: How Interventions That Address the Social Determinant of Health Can Improve Health and Reduce Disparities, 14 J. Pub. Health Mgmt. S6, 811 (2008).

[xvi] See http://m.nysenate.gov/legislation/bill/S5556-2011 (last visited Jan. 16, 2013).

[xvii] Hearing on Numerous Public Health Bills Before Comm. on Energy and Commerce, Subcomm. on Health, U.S.H.R., 111th Congress (2010) (statement of Marcia K. Brand, Ph.D., Deputy Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services), available at http://www.hhs.gov/asl/testify/2010/09/t20100914d.html (last visited Jan. 16, 2013).

[xviii] What is Health Equity?, Boston Pub. Health Comm'n., http://www.bphc.org/chesj/about/Pages/WhatisHealthEquityDisparities.aspx (last visited Jan.15, 2013).

[xix] One can predict that a human rights-based theoretical basis for MLP interventions is close at hand. In November 2012, the Program on Human Rights and the Global Economy and the Program on Health Policy and Law at Northeastern University School of Law hosted an institute on Human Rights and the Social Determinants of Health, at which an MLP scholar presented.

[xx] GIS Mapping, Kirwan Inst., http://kirwaninstitute.osu.edu/research/opportunity-communities/mapping (last visited Jan. 15, 2013).

[xxi] Report Finds That 90% of African-Americans and Latinos are in the Lowest "Opportunity" Neighborhoods in Massachusetts, Mass. L. Ref. Inst., http://www.mlri.org/mlri-announcements/report-finds-that-90-of-african-americans-and-latinos-are-in-the-lowest-opportunity-neighborhoods-in-massachusetts (last visited Jan. 15, 2013).

[xxii] Roger L. Conner, Community Oriented Lawyering: An Emerging Approach to Legal Practice, 242 Nat'l Inst. Justice J. 27, 27-33 (2000).

[xxiii] Karen Tozark et al., Conversations on Community Lawyering: The Newest (Oldest) Wave in Clinical Legal Education, 28 J. L. & Pol. 359, 364 (2008).

[xxiv] See generally EJLS: Environmental Justice Legal Services, Alternatives for Community and Env., http://www.ace-ej.org/services (last visited Jan. 15, 2013).

[xxv] See Liz Tobin Tyler, Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health, 8 J. Health & Biomed. L. 211 (2012).

[xxvi] See Thomas D. Barton, Preventive Law for Three-Dimensional Lawyers, 19 Preventive L. Rptr. 29 (2001).

[xxvii] See id.

[xxviii] David B. Wexler, Beyond Analogy: Preventive Law as Preventive Medicine, National Center for Preventive Law

Symposium (2000), available at http://www.preventivelawyer.org/main/default.asp?pid=essays/wexler.htm (last visited Jan. 16, 2013).

[xxix] See Samantha Morton et al. (2009). Advancing the Integrated Practice of Preventive Law and Preventive Medicine. In Thomas D. Barton, Ed., Preventive Law and Problem Solving: Lawyering for the Future. Lake Mary, Florida: Vandeplas Publishing.