ORIGINAL RESEARCH

Better Together: A Descriptive Analysis of a Medical-Legal Partnership in Western North Carolina

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BACKGROUND The medical-legal partnership (MLP) is an innovative and proven-effective approach to addressing health-harming social needs that have legal remedies (e.g., housing concerns, intimate partner violence). Yet, few MLPs exist within outpatient primary care practices and in rural settings.

METHODS We describe the impact of an MLP between Pisgah Legal Services and the Mountain Area Health Education Center, which serves rural North Carolina counties, over a 24-month period.

RESULTS Overall, 629 cases were referred to the MLP. Three hundred seventy cases were opened and investigated by a lawyer. Three hundred sixty-four cases were closed (i.e., a resolution was reached), yielding 808 outcomes, with an average of 2.2 outcomes per case. Domestic violence/family law and housing were the main socio-legal concerns addressed by the MLP. Eighty-six (24%) of cases included at least 1 representation outcome; the success rate in representation cases was 90%.

LIMITATIONS We did not examine the impact of the MLP on patient health outcomes, nor did we have comparative outcomes data for similar individuals with unmet social needs but who did not receive MLP services.

CONCLUSIONS The MLP was successful in helping to address multiple social needs faced by patients that contribute to worse health status and outcomes. Monetary benefits to patients were $309,902 plus an additional $174,733 from tax returns and the Earned Income Tax Credit. The MLP lawyer provided education and training to support clinicians, learners, and community organizations. These data highlight the benefits of collaboration between health professionals and lawyers in advancing equity by addressing unmet social needs.

Social and economic conditions, such as substandard housing, lack of affordable housing, or lack of access to education and employment, are barriers to optimal health. In the United States, federal and state laws have established a variety of programs, services, and protections to meet these needs. However, clinicians are traditionally not trained and/or lack resources to identify or address health-harming legal needs, defined as social, financial, environmental, or other problems that have deleterious impact on health and are amenable to civil legal solutions [1]. Having a legal professional on the health team can provide needed expertise to address social and economic needs that have a legal remedy. Yet, medical-legal partnerships are relatively new.

Medical-legal partnerships (MLP) are an innovative approach to addressing socio-legal concerns (social problems related to meeting life's basic needs that are potentially remedied through legal advocacy/action) [2]. In MLPs, attorneys are integrated within the health care team to address legal problems that affect the health of vulnerable individuals and families. MLP efforts target up to 5 key domains of health-harming legal needs, which correspond to social determinants of health. These domains are referred to with the mnemonic I-HELP [3]: income and insurance; housing and utilities; education and employment; legal status (immigration); and personal and family stability and safety (e.g., domestic violence, guardianship, custody, advance directives). I-HELP is used by many MLPs to screen patients for health-harming civil legal needs [4].

Although they represent a promising strategy for addressing socioeconomic needs of vulnerable patients, utilization of MLPs is variable across settings and less common in rural areas. This gap is important given that individuals in rural areas experience higher poverty and greater social needs than those in suburban or urban areas, with fewer resources, higher morbidity and mortality rates from preventable illnesses, and more limited access to health services [5]. Moreover, over half of all MLPs are embedded within hospitals, especially children's hospitals, as opposed to in federally qualified health centers or area health education centers [2]. The types of needs addressed and the value proposition of MLP services are likely different in hospitals versus outpatient health care centers that provide largely primary care services. The objective of this paper is to describe the processes and impacts of an MLP affiliated with an outpatient area health education center serving adults and children in a rural area in Western North Carolina.

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Methods

Description of the Health Center and Legal Partner

Mountain Area Health Education Center (MAHEC) opened in 1974 as part of the area health education center statewide system to increase health education throughout the state. MAHEC has both a clinical/care-delivery mission and a mission to train future health care providers. MAHEC is a safety-net provider, offering primary health care services to patients regardless of their ability to pay [6]. MAHEC is especially concerned with the supply, retention, and quality of clinicians in rural parts of the state, where population density is low. MAHEC has over 17,000 annual patient visits and serves 16 western counties in North Carolina that are part of the Appalachian Mountain region [6]. Some people in Western North Carolina face challenges due to a lack of affordable housing options, limited or nonexistent public transportation, and insufficient access to living wage jobs [7]. Many patients live in rural areas that are far from medical care, social services, employment opportunities, higher education, and other key resources.

Pisgah Legal Services is a community-based nonprofit law firm with a 41-year track record of effective service delivery that helps low-income people meet their most basic and urgent needs. Attorneys work collaboratively with dozens of nonprofit and government partners across the region to improve services and tackle tough community problems [8]. The mission of PLS is to pursue justice by providing legal assistance and advocacy to low-income people in Western North Carolina to meet their basic needs and improve their lives. PLS offers free civil legal aid consultations and representation, ACA Marketplace assistance, and free tax preparation to qualifying families. PLS's primary service area includes all 16 counties covered by MAHEC, plus 2 additional counties (Avery and Burke) [9].

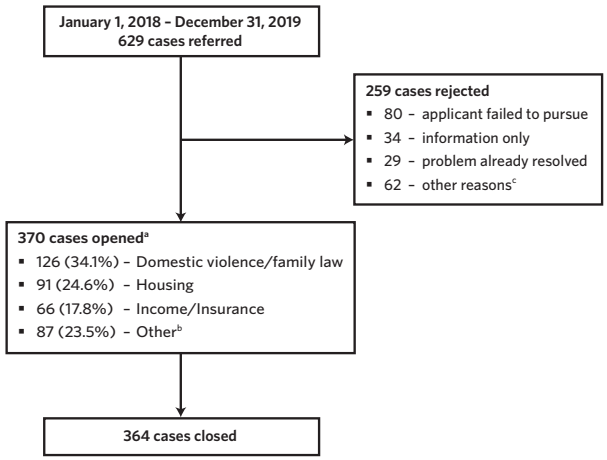
Description of Medical Legal Partnership

In 2006, Mission Health and PLS formed Health, Education, and Legal Support (HEALS), the first medical-legal partnership in Western North Carolina to use lawyers as a part of the health care team in the hospital to address social determinants of health. In 2017, PLS and MAHEC joined together to form an MLP for the outpatient setting. This outpatient MLP provided patients with access to PLS during routine appointments rather than only in acute health care situations. The MAHEC MLP was originally designed to implement services for underserved individuals who utilized the health center in rural Western North Carolina and educate learners on legal solutions that impact health. Additionally, specific grant funding from Wells Fargo was used to support the MLP's Earned Income Tax Credit program work. The Earned Income Tax Credit program, the largest needs-tested anti-poverty cash assistance program, helps low-income workers receive a subsidy in the form of a tax credit. Volunteer tax preparers, who are certified by the Internal Revenue Service and trained by PLS, help coordinate this program and prepare taxes for qualifying MAHEC patients and employees on-site. MAHEC employees were included because many of them are also MAHEC patients, and the partnership wanted to offer MAHEC employees all the potential benefits that are available to other MAHEC patients.

Formal process, impact, and outcome evaluation were not original goals of the MLP. However, based on perceptions of program success, the partners chose to conduct an evaluation of the program using existing program documentation. The staffing model utilized an embedded poverty law attorney who is generally present on site at the health center from 8:30AM to 5:00PM daily.

Figure 1 outlines the disposition of referrals and subsequent outcomes. Referrals to the MLP attorney come from MAHEC outpatient clinicians from Family Medicine, Obstetrics and Gynecology (Ob-Gyn), Behavioral Health (services provided within Family Medicine and Ob-Gyn), the Dental clinic, and from Buncombe County Medicaid Care Managers and patient financial advocates. Clinician referrals to the MLP are part of routine care. The decision to refer a patient to the MLP attorney is based on patient need, in the same way that a clinician might make a referral to a therapist, nutritionist, or another member of the health care team. There is no financial incentive for clinicians to make referrals to the MLP. The MLP attorney provides training on MLP services and referral processes to MAHEC learners at faculty and staff meetings and resident didactics at least once per year. Referrals are made via a "warm handoff" (i.e., walking the patient to the attorney's office), telephone, email, or fax and require completion of a referral form compliant with privacy laws. This form is scanned and sent via a protected system to comply with patient privacy laws and regulations.

FIGURE 1.
Disposition of Referrals



[a]5 cases were referred prior to January 1, 2018 but were opened in 2018.
[b]Guardianship, tax law, employment, wills and advanced directives, criminal record expungement, name change, licenses, and estates and probate cases
[c]Conflict of interest, already represented, non-priority/out of scope case, over-income, over asset, outside PLS jurisdiction, insufficient merit

Notably, completion of this form is a requirement of the health center; however, if a patient is uncomfortable signing the form, s/he could call the legal partner to receive services outside of the health center referral. Notably, referral source tracking did not start until July 2018.

Patients could meet with the attorney either before or after their appointment, or they could contact the attorney by telephone. The referral process was meant to reduce barriers to accessing legal services and help the health care team address upstream health issues that are exacerbated by a social need. The attorney then worked the patient's case until a resolution was reached (i.e., case was closed). Certain concerns, such as criminal issues and personal injury, were outside the scope of the MLP.

Data Collection/Measurement

To evaluate the impact of the MLP, we examined descriptive data over a 24–month period from January 1, 2018, to December 31, 2019. In 2020, after the onset of the COVID-19 pandemic, the MLP entered a time of transition, operating remotely and increasing services in the areas of unemployment law and stimulus check assistance. Likewise, MAHEC increased its telehealth appointment capacity and created a Resource Center to be readily available to providers and staff members to connect patients with community resources, including the MLP.

Standardized quarterly reports provide information on all referrals received, including: referral source; type of social-economic need; a detailed breakdown of specific types of case outcomes; quantifiable benefits, which are monetary or otherwise directly calculable benefits (i.e., monthly Supplemental Security Income or monthly housing vouchers received by patients and MAHEC because of the legal assistance); and total number of client contacts and "closed" cases (i.e., a resolution was reached). Reports also included a complete description of all educational and outreach activities conducted by the attorney. Since there is no standard way to categorize or report on educational and outreach activities conducted by the attorney, the evaluation team, with input from the MLP attorney, chose to categorize these activities into those which supported: 1) community partnerships and education; 2) education of health center staff and clinicians regarding health-harming socio-legal needs and legal services; and 3) outreach to increase referrals to the MLP, including referrals for the Earned Income Tax Credit program and the Affordable Care Act services. Two members of the research team independently reviewed and categorized all the activity descriptions on each quarterly report. A third member of the research team resolved any conflicts in the categorization between the 2 research team members.

This evaluation was exempt from Institutional Review Board approval.

Data Analysis

To evaluate the needs addressed by the MLP, the evaluation team conducted a secondary analysis of 8 quarters of aggregated, deidentified data, using descriptive statistics (means, proportions as appropriate). Similarly, we used descriptive statistics to analyze the educational and outreach activities. Given the descriptive nature of the evaluation, we did not conduct hypothesis testing or use multivariate statistical analyses.

Results

Overall, 629 cases were referred to the MLP and reviewed during the 24–month evaluation period from January 1, 2018, to December 31, 2019. Two hundred fifty-nine referrals were rejected for various reasons (Figure 1). Three hundred seventy cases were opened and investigated by the attorney

FIGURE 2.
Referral Sources over Evaluation Period

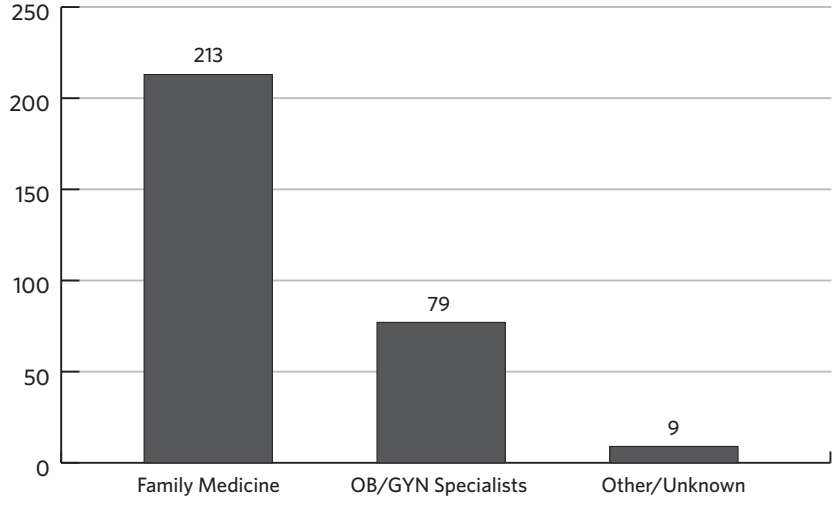
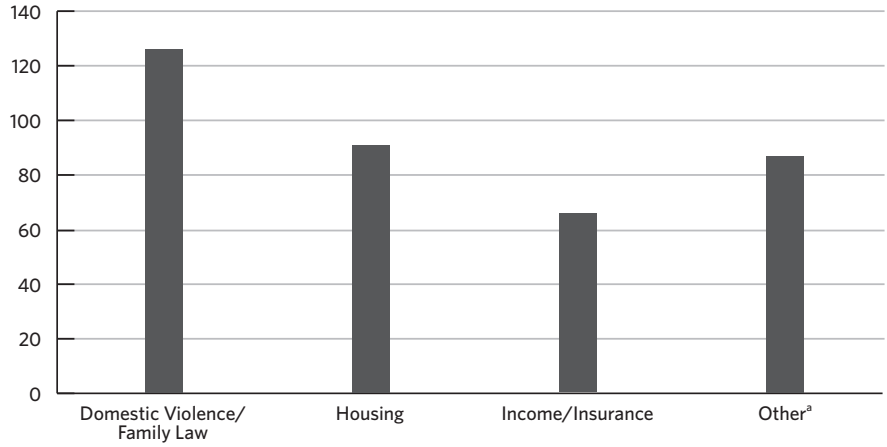


FIGURE 3.
Breakdown of Opened Cases by Need Type



[a]Other cases included: guardianship, tax law, employment, wills and advanced directives, criminal record expungement, name change, licenses, and estates and probate cases.

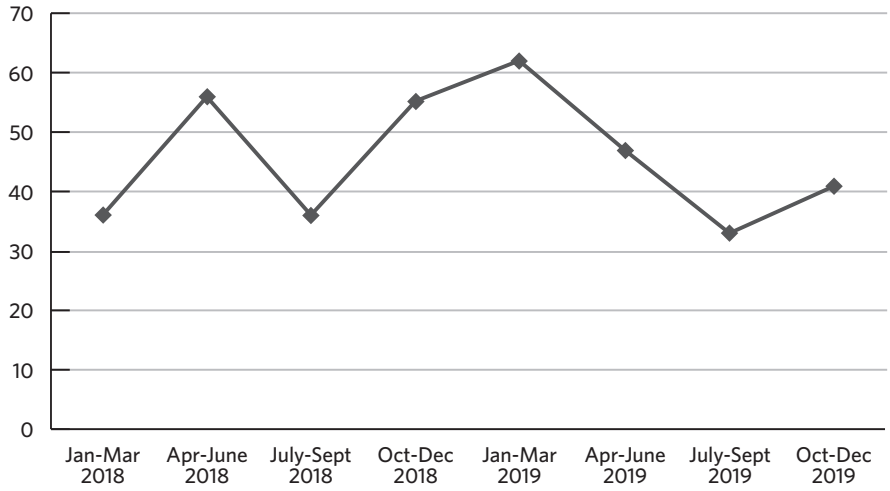
during this period. Notably, 5 cases were referred prior to January 1, 2018, but were not opened and investigated until 2018. Of the 629 referrals, the referral source is described for 301, as shown in Figure 2. Of the 370 opened cases, approximately 34% were for domestic violence/family law, followed by 25% for housing issues. Figure 3 shows the breakdown of opened cases by need type. The mean age of clients with cases opened during this period was 41 years; 87% were female; 69% were non-Hispanic white, 18% were non-Hispanic Black, and 8% were Hispanic. The households represented by the 370 opened cases included 559 adults and 394 children under age 18.

Three hundred sixty-four cases were closed during this period (Figure 4). These closed cases yielded 808 outcomes, with an average of 2.2 outcomes per case. Eighty-six (24%) cases included at least 1 "representation" outcome. This is in contrast with closed cases that involved "advice only" and did not require representation by the attorney. Of note, the success rate in representation cases was 90%, and only 2% (n = 9) of cases had 1 or more loss outcomes (i.e., not in the client's favor). Over this time, monetary benefits were significant, at $309,902, largely due to securing Social Security benefits for patients. Figure 5 shows a graph of the total number of education and outreach activities conducted during the evaluation period.

Discussion

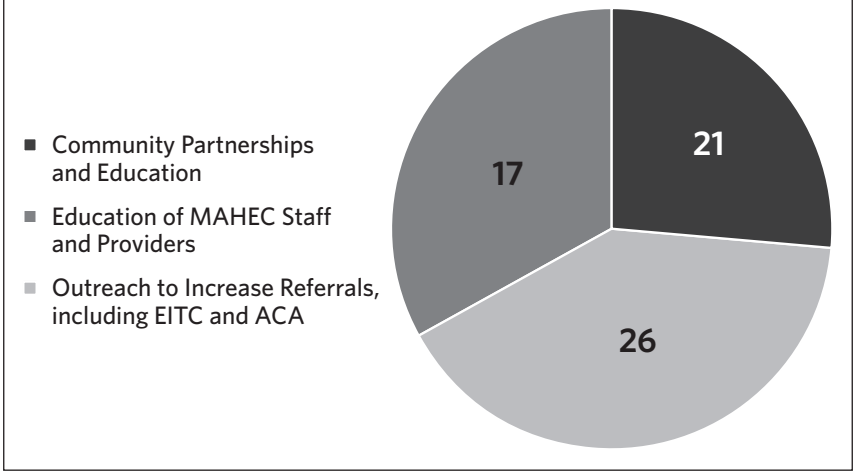
We describe the socio-legal needs evaluated by the MLP over a 24–month period and highlight the benefit of MLP services to patients, clinicians and staff, and the health center.

FIGURE 4.
Number of Cases Closed during Evaluation Period



Note. Funding for the MLP was cut in June 2019 and replacement funding began in September 2019.

FIGURE 5.
Educational and Outreach Activities During 18-month Period



Patients

As a *general population* model MLP (i.e., civil legal services are available to the health center's general patient population), the MLP has been effective at addressing unmet legal needs of rural patients, having a positive outcome in 90% of the representation cases and generating over $300,000 in monetary benefits (avoided and recovered), plus an additional $174,733 if we include money from tax returns and Earned Income Tax Credit. Previous studies have documented the beneficial short- and long-term health effects of Earned Income Tax Credit [10–13].

Domestic violence/family law and housing were the main socio-legal concerns addressed by the MLP. This is consistent with other MLP studies, including those conducted in ambulatory care clinics [14, 15]. Domestic or intimate partner violence (IPV) is common, affecting more than 1 in 3 women and 1 in 4 men [16]. Victims of this crime frequently visit health care settings, necessitating that health care teams be knowledgeable of laws and mandates around IPV. Having civil legal aid services available in health care settings is a promising but underutilized strategy, with proven effectiveness for the individual facing the violence, as well as a broader social return on investment [17, 18]. In other words, the benefits of an MLP outweigh the monetary investment required, and the benefits extend beyond the social need(s) addressed by the attorney. This is because there are other "downstream" negative consequences or costs that are averted by addressing the immediate need. One analysis found that investing in 100 new legal aid lawyers in Massachusetts would result in a savings of approximately $16 million in avoided medical costs resulting from incidents of IPV [19].

The prevalence of civil legal needs among individuals experiencing homelessness and unstable housing situations is very high (more than 90%) based on a survey of a national sample of 48 homeless service sites across 26 states [20]. Studies have shown that low-income individuals with housing issues who receive MLP services were more likely to get adequate, affordable, and stable housing than similar individuals in the same community who did not have access to MLP services [15]. Despite this, few sites that serve this vulnerable population have MLPs [20]. Moreover, targeted legal assistance directed at improving housing conditions leads to improved health outcomes [15, 21, 22]. One study found a 91% reduction in emergency department visits for adult asthma patients following MLP-related housing interventions [22]. These studies highlight the value of MLPs for improving health outcomes for individuals living in rural and socioeconomically disadvantaged counties. Notably, housing ranked number one among social determinants of health issues that are critical to address in Western North Carolina, according to the 2018 Buncombe County Community Health Assessment [23].

Clinicians

Our study demonstrates the benefit of an MLP to support clinician and staff education and training in legal solutions to health-harming social and economic needs. Our findings are consistent with other studies that document benefits of interprofessional medical-legal education for increasing attention to and screening for social determinants of health as well as referrals to legal resources for patients experiencing socioeconomic, environmental, or legal issues that affect their health [24, 25]. Clinicians want to know their patients' unmet social needs and such knowledge changes clinical decision-making, even if there are insufficient resources to mitigate the identified needs [26].

Interprofessional medical-legal education can improve clinicians' knowledge of resources and confidence in addressing patients' unmet social needs [24]. Moreover, findings from a 2016 survey of MLPs across the country found that the majority of clinicians had a positive view of MLP services due to their perceived benefits on improved patient outcomes, better patient adherence with medical

treatment, and improved ability to perform "at the top of their license" [2]. The long-term impact of educating learners in poverty law and legal remedies for health-harming social needs remains unknown but is a ripe area for additional study.

Health Care Centers

As health care centers strive to meet the Triple Aim of health care [27], they must move beyond providing only clinical services to addressing non-medical drivers of health. MLPs can be key players in this effort. Studies have documented economic benefits to the health center of having an MLP through resolving previously denied claims or non-reimbursed clinical services [5, 28].

However, the benefit and return on investment for an MLP may vary depending on the location of the MLP. Inpatient or hospital-based MLPs largely focus on helping obtain insurance benefits; in this situation, the monetary benefit is easier to calculate. Assessing return on investment for an outpatient MLP is more challenging since the benefits are often indirect and difficult to quantify, as they accrue to various stakeholders within and outside the health system and result from both *obtaining* care/services and *preventing* actions (e.g., avoiding an eviction). Evaluation of the return on investment and value proposition in ambulatory settings is an area that is ripe for future study.

This study has several notable limitations. First, we did not evaluate health outcomes of individuals who received MLP services, nor did we have comparative data on individuals with health-harming social needs with civil legal solutions who did not receive MLP services. Second, during the time of this evaluation MAHEC was not systematically screening all patients for social needs; therefore, the potential impact may be greater as more individuals are eligible for and receive MLP services. Third, since there is no standardized guidance for how to classify educational and outreach activities of the MLP, it is possible that we could have misclassified the activities. Fourth, the MAHEC MLP is an embedded MLP model, where the lawyer is present on-site in the clinic and performs the intake for the patients' social needs. While this model likely improves the likelihood that a patient will receive and follow through on a referral, it remains unclear whether this is a sustainable model, or one that can be replicated broadly. For other MLPs, the on-site lawyer functions more like a "traffic cop" who directs/refers patients to a broader network of lawyers who can address their particular social need. Other models do not have a lawyer on-site at all; instead, clinicians and attorneys use information-sharing agreements to facilitate communication regarding patients' needs and make referrals to community legal service providers.

Future research should seek to identify which model works best for whom, and under what circumstances, and how assistance from an MLP impacts health outcomes. Initiatives such as NCCARE360 might help answer some of the unanswered questions. NCCARE360 is the first statewide network that unites health care and human services organizations with a shared technology to enable a coordinated, community-oriented, person-centered approach to delivering care, including providing civil legal aid services, in North Carolina [29].

Conclusion and Implications

Addressing health-harming social needs is critical to achieving health equity—the *opportunity* for all individuals to attain their full health potential, regardless of demographic, social, economic, or geographic strata [30]. As health systems increase efforts to screen for and address health-related social needs, it is apparent that there is a clustering of social needs within the same individual. As such, there is a need for interventions like MLPs, which can simultaneously address multiple social needs. However, the difference between civil legal aid *needs* and civil legal aid service *provision*, referred to as the "justice gap," persists due to inadequate funding for civil legal aid, including MLPs [31, 32]. Several national organizations, including the American Bar Association, the American Academy of Pediatrics, the American Medical Association, and the Agency for Healthcare Research and Quality, support and promote the MLP model [33–36]. Policy makers, in collaboration with funders, must work closely with clinicians, attorneys, and researchers to fully realize the potential for MLPs to improve population health and advance health equity. NCMJ

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