

MCHB/DHSPS June, 2010 Webcast

Promoting Family Advocacy through Medical-Legal Partnership

June 29, 2010

JOHANNIE ESCARNE: Good afternoon I'm Johannie Escarne from HRSA's Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau. On behalf of the division I would like to welcome you to this webcast titled "Promoting Family Advocacy through Medical-Legal Partnership".

Before I introduce our presenters today, I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentation. You don't need to do anything to advance the slide. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. A 12 second delay provides optimal performance for the audience.

We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select questions for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you are participating from.

On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast the interface will close automatically and you'll have an opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

We're very pleased to have Ellen Lawton, the executive director for the medical-legal partnership at Boston Medical Center. Dr. Megan Sandel the medical director and assistant professor at the Boston School of Medicine and Leanne Ta from the Boston Medical Center.

In order to allow ample time for the presentation we'll defer questions to the question/answer session following the presentation. However, we encourage you to submit questions via email at any time during the presentations. If we don't have the opportunity to respond to your question during the broadcast, we will email you afterwards. We would again welcome our presenters and the audience and begin the presentation without delay.

ELLEN LAWTON: Thank you very much. Good afternoon. We're thrilled to be here coming to you live from Boston Medical Center. My name is Ellen Lawton and I'll kick us off this afternoon and then Megan Sandel will join in and Leanne Ta will join us near

the end. We're here to talk to you about how to improve your advocacy capacity and the history of medical-legal partnerships and we look forward to both sharing our experience with you but also hearing your questions and being able to respond to any inquiries that you have and helping you to think about medical-legal partnership in your community. The program was started in 1993 by a pediatrician here at BMC and it was out of his frustration as a pediatrician trying to address many of the problems that vulnerable kids in the pediatric clinic were presenting with. And the idea that medicine alone can't cure some of these challenges that present with kids. And so he had the idea to invite lawyers in as part of the healthcare team. And so that was in 1993 and we spent some time thinking about how do you have lawyers practicing as part of the healthcare team? What does that look like and what are the strategies that need to be in place in order to make that successful?

Next slide, please. And next slide. Just getting in the -- great. So that gives you a little bit of background on medical-legal partnership. The goal of the program is to help people get their basic needs met and to stay healthy. What we found over the years is that medical-legal partnerships help to address the negative impacts on health and eliminate barriers to healthcare. Many of these issues I'm sure are present for many of you in your program and so what we hope to offer you is new solutions to problems that have challenged you in doing the work that you do every day in your community.

Next slide. So one of the most important things to understanding how medical-legal partnership works is to understand how it's important to break the cycle of vulnerability.

Next slide, please. The next -- in thinking about adverse social conditions, oftentimes those can make people vulnerable to poor health. An example would be a mother who is homeless may be more susceptible to, say, getting infectious diseases like diarrhea or colds because they're in an overcrowded, homeless situation and it can lead to more poor health. The flip side can be poor health can make you more vulnerable to social conditions say someone with asthma living in a condition of a home that has cockroaches they were allege I can to. It can become a vicious cycle. The family with asthma may not work as much and became homeless and the cycle can lead to many health disparities and what the medical-legal partnership is designed to do is escape this cycle of vulnerability by bringing legal and healthcare providers together.

Next slide. I think that what's important to keep in mind is that many of these health disparities actually have legal solutions and so in breaking that cycle it is important to understand how a medical-legal partnership can work.

Next slide. So there are a wide range of laws governing basic needs that influence health. So this is a scheme that can look at different things. Food issues, employment or other income support, healthcare access, whether you have an immigration status that may make you eligible or not eligible for certain programs. Childcare, education, safety and stability. Whether or not from a domestic violence situation and others and housing and utilities. There are a wide range of laws that govern all these areas.

Next slide. So what you know maybe from your practice and what we know from working in a medical-legal partnership and as lawyers who work in legal aid offices and in government offices and as pro bono attorneys, what we know is there are complex burr -- it's overlaid on top of the prior slide where it says food, housing and immigration issues are now the names of the organizations, these are Massachusetts based but government organizations designed to meet the needs of vulnerable families and you can see it's really an alphabet soup of agencies that families need to navigate in order to get access to many of these benefits that are designed to support them but, in fact, have the effect of challenging families and leaving them without their basic needs being met. They also each agency has different requirements in terms of eligibility, different income requirements, different immigration status requirements, different applications many times and so you can imagine that a family trying to access all the different safety net programs that exist is going to be uniquely challenged in understanding what they're eligible for, when they can apply for it and if you've been denied whether they're eligible to appeal a denial.

Next slide. So why would you bring legal advocacy into the clinical setting? I think in many ways because these families have such difficulty navigating these areas, it's important to come to the healthcare setting because healthcare providers are trusted, credible resources for many families. I think that screening for legal issues in the clinical setting then facilitates detecting these legal problems before they reach a crisis. So say before someone gets the eviction notice you can detect there are issues with falling behind on rent or other thing. If there are protections in the law like around

condition problems, for instance, that can make a huge difference for a family to avoid that eviction in the first place. I think it's very important to note that social workers and case managers play a huge role in already screening for many of these issues and that lawyers are really an important supplement to those people to make them more effective advocates on their own and to be the resource for the very technical, difficult cases that can be -- arise for many families.

>> Going back to the multiple bureaucracy that challenge families there are a lot of things that a healthcare provider like a nurse or pediatrician can help a family achieve. But as Megan referenced, a lot of the challenges that families have, particularly in the immigration realm, are really more suited to an attorney's advice, counsel and guidance and what we're trying to achieve through medical-legal partnership is bringing that legal expertise closer to front line providers wherever they come from, whether it's physicians, nurses, case managers, home visitors, etc., bringing that legal expertise closer to you so that you can use them as a resource, not just the referral, but also to build your own knowledge and expertise about how these different programs work and how they can support your case

>> Partnership is the key aspect. We define it as being comprised of one legal partner institution with one healthcare partner institution. Examples of healthcare partner associates can be hospitals, medical schools, state health departments and s*sh or healthcare associations or societies such as the American Academy of Pediatrics statewide chapter or other chapters.

>> On the legal side legal partners in MLPs across the country in general they emanate from legal aid offices. Legal aid is a form of legal assistance designed for vulnerable populations below a certain income level. There is Federal and state funded legal aid offices throughout the country. I'm sure that there is one in your community. You may already be in touch or have a relationship with your legal aid office.

Traditionally legal aid offices have practiced a sort of emergency room practice with legal issues because they don't have the capacity to be some of the prevention that Megan referenced. So the core partners in many of the partnerships across the country are legal aid offices but there are also partnerships that work closely with law schools. Law schools typically have clinical programs that help law students practice law and so they accept cases and work with clients and have been a wonderful adjuncts to medical-legal partnerships. Private attorneys doing pro bono meaning they don't charge a fee for pro bono services is a big part of the network as well. They work in tandem with legal aid offices. Law firms as well do pro bono work and state bar associations then partner with medical-legal partnership in a range of ways to help coordinate services so front line healthcare and community providers get access to important legal resources. What's really critical to understand about the legal community is that the legal aid world has suffered from chronic underfunding for many, many years. And so what we see is that it is very hard to prioritize their allocation of their resources. Medical partnerships has provided an opportunity for legal aid offices to look freshly at how they prioritize the service delivery. How they can be more effective at reaching patients and creating systemic solutions that will hopefully mean that less families are facing eviction or facing a utility shut-off, etc. Those are things to

keep in mind about the legal aid community and I think we're happy to field questions in particular about the legal aid community and how you can work with them effectively. Next slide.

>> One of the key things to understanding medical-legal partnerships are what the core functions of that partnership are. One of the hallmarks is legal advice and assistance for patients and families. That is really the corner stone because through understanding patient issues you can then get a good grip on what are the policies or other things that may need to be changed or incorporated into the healthcare system to make differences. I think that one of the things that we've looked at here in Boston at our own medical-legal partnership is how are ways that you can make internal system improvements into the healthcare and legal side in order to take care of issues without ever having to see a lawyer in the first place? One example can be utility shut-off letters. This can present a real burden to a practice where many families will need this protection in order to keep electricity on in the summer hot months or the cold winter months and that they'll come to the office sometimes once or twice or three or four times every year needing to get that done and it can be a real burden. In order to change that, if you see that over and over again you can create new systems into the healthcare setting say a shut-off protection letter in the electronic medical record or a kit that has all of the information to fax the protection letters by the fax machine that can make huge improvements into the clinical staff time and therefore help the families get their legal needs met without involving the lawyers. I think the third piece can be external system change. If you're having to recertify every three months that you still

have sickle cell disease, a genetic disorder and doesn't change, it can be a huge burden on families. One of the things we did in Boston was moved upstream and went to the Department of public utilities and said we want to change the law because of the burden on families. It's silly to have to recertify. That was cited in Massachusetts as an example of why they changed the law to make certification less frequent and help families and providers take care of legal needs earlier.

>> I want to step back a moment to give you perspective again about the value of the legal profession in this type of work because it's a new kind of work for legal aid attorneys to be working closely with front line healthcare providers or home visitors in a structured way that we've identified in the medical-legal partnership model but what we see is that the value of the legal training can help a team that is frustrated and it may be a team in your community that's frustrated with a particular issue connected to access to basic needs whether it's food stamp applications, whether it's utility service. Some basic needs that you have an opportunity to have a system impact broader than one client at a time when you work alongside a lawyer as part of your team.

Next slide. So in terms of what is the level of service that medical-legal partnerships typically provide for patients and for the broader institutions the goal is realtime consultation for providers on legal needs and legal assistance provided directly to patients for complex medical problems and what we spend a lot of time talking about in the medical-legal partnership community is sufficient training to help our collaterals, whether they're physicians, nurses, case managers, understand how to screen and

triage and make referrals that are going to be helpful referrals for both the patient, the provider as well as for the lawyer. So part of successful implementation is to put together a referral process between the programs that is going to be meaningful for both partners. And I think what we know from experience in terms of working with the medical-legal partnership network across the country or over 200 hospitals and health centers around the country so we know that there are many referral processes between healthcare providers and legal providers where the goal is to shuttle a patient from the healthcare side to the legal side. This is the partnership that requires sharing of information and it requires feedback about referrals. There is an intentionality to the partnership that we think improves the services and also builds capacity on the healthcare team's understanding of the legal issues and what their role is. It is essential that the lawyer spend some time on site whether it's the healthcare institution or a community agency where the partnership is at least part-time every week to understand the relationship and what the pitfalls are. The legal aid community has been taking referrals from multiple community agencies for years. Some have very strong relationships with community agencies, but what the medical-legal partnership model asks is that some of those relationships get formalized and they get formalized in referral systems and in feedback and it's formalized in terms of how patient outcomes are tracked.

Next slide. So another example of internal system improvement can be seeing the same cases over and over again that you see through legal assistance. Through one-on-one interaction with families and I think that what's important is that by observing

the legal needs of a diverse patient population, that MLT staff are able to identify patterns of need and that it's then necessary to take approaches to address these needs at a more institution level. I think that what can be really important is that this is where the front line experience of either the case manager, the nurse, the physician or midwife can make a huge difference in understanding what are the legal barriers that are commonly faced by families and then thinking about are there ways we can address them more systematically. If someone is unable to work, they may be eligible for S.S.I. and Social Security income that may be helpful in supporting someone with additional dollars during a pregnancy or after a pregnancy. I think we talked about utility service as a common problem among particularly vulnerable populations that can be hugely influential and important that there are processes that can be looked at for getting additional legal services help from pro bono services. Ellen alluded to healthcare training is important. Having lawyers to be able to do not only consultations about certain types of issues they commonly see but talking about what are the common ways to detect legal needs. Many families will not identify they have a legal issue and being able to work with them around that can be really important. As in anything you want to be able to track your cases and your outcomes. Being able to build the systems where you can figure out what is going on can be very important. Many of the Healthy Start sites are used to tracking and building legal tracking into that will be an important potential for this study and -- for this program and it will make a huge difference in being able to show benefit.

Next slide. External system change can be really important because particularly if you saw over and over that there were food stamp applications that were denied you would want to move into walking with the food stamp office about why they were routinely denying families what they were eligible before. Teen moms living with their parents about how to get applications into the program or other things and so this is an example of ways that medical-legal partnership can also help not only directly with families but also change policies that help a larger population as well.

Next slide. There is an example here that the patient story. A patient family is struggling to pay for a 7-year-old's medical care. The child has a heart condition, uses a wheelchair, depends on medical and school-related transportation. Medicaid refuses to cover the full cost of the surgery and the transportation saying the family hasn't provided the correct documentation. The medical-legal partnership with counsel the family about the receipt of public benefits and it automatically qualifies them for full medical benefits. The providers can draft a letter in order to say there is an alternative provision for providing documentation and within a week the agency reverses the decision. The child is qualified for the full Medicaid benefits and able to get the surgery done and the transportation. This is an example without the medical-legal partnership the there wouldn't have been the overturning and getting the benefits so crucial to health. Next slide.

>> I want to give you an overview of the MLP network of which we hope that you will become part of. It is growing. We're in over 200 hospitals and health centers across

the country. You can see the partnership sites on the map and more are coming online every day and what that means is that we've grown increasingly adept at providing technical assistance for sites to help them start well and grow in a sustainable fashion and so to do that we engage in conversations both in the healthcare community as well as in the legal community at multiple levels from the local to the national. Next slide.

>> The MLP network started in pediatrics but it's grown beyond pediatrics to serve multiple vulnerable populations because it is a model that has universal -- cancer patients and in the families that you see and serve there is overlap amongst all those populations, from children to adults with disabilities and elderly and many, many people with chronic illness who confront the issues that we talked about today. Our impact, we've been doing annual site survey the past couple of years in 2009 MLPs across the ___ provided legal assistance to 13,000 individuals and families and trained over 10,000 providers including many, many case managers and social workers on the link between unmet basic needs of health and how to integrate legal strategies.

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>> There are many different types of clinical settings. This is an example of a different array, whether it's from behavioral health in emergency departments to family medicine, geriatrics, internal medicine. Many can be based out of a NICU. OB/GYN is represented. Pediatrics is a strong presence. Other sites can be specialty sites such as diabetes or others. As you see there is a real array including a prevalence in community health centers and also hospitals.

Next slide. I think that what's important is that the legal needs that are commonly seen can be referenced in a mnemonic called I help. I stands for income, it can include things like food stamps or disability income. It also can be around housing issues. Whether people have having difficulty with housing conditions or affording their housing. It also can be around education and job training. There are some medical-legal partnerships that deal with immigration status or legal status as we refer to it and personal and family stability. As you can see there is a wide range of medical-legal partnerships and those are common legal needs that medical-legal partnerships can help. Next slide.

>> So this is just to reference that legal aid didn't always practice this way and medicine didn't always practice this way. What we're seeing in a very real way in the hundreds of healthcare providers and legal providers across the network that they are indeed shifting the paradigm of how things work and we're hoping that you can be a part of that.

Next slide. I want to invite Leanne Ta. Thanks. She is program assistant here at the national center and one of the faces of the national center in terms of providing front line technical assistance. So Leanne, maybe you can talk a little bit about what it is that you do so that folks have a sense of that.

LEANNE TA: Sure. I would like to tell you a little bit about The National Center for MLP. We're an organization based in Boston. And we're here to support the range of

health and legal providers who are both engaged in MLP and who are interested in developing medical-legal partnerships. One of the major activities that Ellen mentioned earlier is facilitating the MLP network which is a voluntary association of all the attorneys, physicians, case managers, social workers, professionals who are engaged in MLP. We spend a lot of time providing technical assistance both in the form of email and phone and webinars similar to this presentation. And helping people to understand, you know, what are some of the best practices that MLPs have developed? What are some of the things that MLPs have successfully done to engage their healthcare partners and to positively impact their patient's lives? One of the things we do is host the annual MLP summit which typically occurs in the springtime. It is a way for the MLP network, which is spread across 37 states to come together and talk about what they're doing in their local communities. We also engage a lot of local leadership including the medical advisory board and we liaison with professional organizations including the American Bar Association, the American Medical Association, the American Academy of Pediatrics in order to kind of help MLP become a standard of care across the country and to help people who are interested in MLP understand what the model is all about. And one of the things we do is coordinate a lot of national research and policy activities related to health disparities in vulnerable populations. A lot of the doctors have published articles and their findings about the medical-legal partnerships.

>> Next slide. One of the things that really important I think in helping to disseminate this model, because what we think is at times a very simple idea of let's bring lawyers

in to be part of the care team is actually quite complicated in its implementation and so what we find is that housing all of our references like many do on our website.

Providing webinars, providing telephone conversations and helping you get your program off the ground and help you have the conversations in order to have a successful program is part of what we're really dedicated to. So I encourage you to go on our website. If you don't see what you need, please contact us and let us know how we can help you put together your proposal. How we can help you think about procedures when you're putting together an MLP in your community. So we look forward to doing that.

Next slide, please. As you can see this is the getting started section in our website. We hope it will be helpful to you as you consider getting a program going. Again, check that out and let us know if you don't see what you need. Next slide. And additional resources on our website that hopefully will be helpful for new this process.

Next slide. Just some suggested further reading. You may have already checked it out but we think in particular the most recent publication from the RCHN community health foundation talks a lot about legal need and the prevalence of legal need, how to address legal needs that we think will be helpful both data and information and strategy for you to think about as you are putting together your proposal. And then last slide, please. Stay connected with us. Sign up for our MLP newsletter that comes out every other week where we try to share resources and ideas and let you know what's happening in the network. And alert you to webinars, etc. So we're going to stop there,

I think. And see if we have hopefully some questions that have come in. Because what we know again is that people always have lots of questions about how to put this model into play and we're eager to share our experience and passion and we think the model works. We're thrilled to field your questions.

>> Thank you, Boston. We are now entering the question/answer portion. Before I go into the question and answers there are a few things that I would like to remind the audience. This is a Healthy Start supplemental award which means that only Healthy Start grantees are eligible for this in 2010-2011. It's up to three grantees will be awarded these funds at approximately \$150,000. In order to apply for these funds, Healthy Start grantees must go into the electronic handbook and go through the prior approval module in order to get access to these funds. To submit their application, I'm sorry. Okay. So our first question is have protocols been developed so there is no overlap or mix-up between the work of the MLP and the social worker?

>> Great, I'm so glad that was the first question. Thank you. And I have -- I think we all have responses to that question. It is a great question and I think points out the reality that there is -- I don't want to say overlap. I think it is bringing in a new member of the team, the lawyer, requires that everyone think about what their job responsibilities are on the team. And so medical-legal partnership has required healthcare providers whether they're social worker, case managers, physicians, nurses, all to think about what part of this is my job and what part of this is actually the attorney's job. Because what lawyers and social workers do are so closely knit and then it requires special

attention. So I just say that as a general comment. Our best program, our most effective programs are the ones where the lawyers and the social workers are working very closely together and there is an acknowledgement between the two professionals about who does what. And the fact that there are many domains that lawyers are not effective in that social workers more effective at and there are things that social work would love to be able to do if they had access to legal expertise. That's my global statement. I would say that specifically it really depends locally. Those are conversations that need to happen locally because in some healthcare settings and some community agencies social work responsibilities look very different. In some places social work responsibilities are focused on discharge or they're focused on emergencies like domestic violence. They're focused not on the long-term economic well-being of the family. They're much more focused on the short-term. Maybe child protection intervention and so the work of the lawyer and the social worker may look different depending on what the social worker's domain of activity is. I think that when they're working together and working together well that is when the client benefits best -- benefits most because the client can benefit from the interchange of information between social worker and lawyer and physician rather than having to play the role that's traditionally legal aid clients have had to play, which is that they need to carry the information about their particular case from provider to provider. By establishing those communication links between social worker and lawyer and physician, then you have taken the burden away from the patient in terms of problem solving and supporting them.

>> I would definitely echo that absolutely there are protocols that exist and so the answer to that question is yes. I think that many of our medical-legal partnerships are actually very social work driven so the front line producer may see a case, send it to the social worker and the social worker will triage whether or not there is a legal issue or not. Sometimes if there isn't a great social work environment where there are so many needs out there and the social worker has to focus their case and sometimes the lawyer will end up sending it directly but that's where again I think our technical assistance can be really helpful in terms of alluding to what Ellen said around the issues of making sure that the local kind of understanding plays into how to do that triage. I think we definitely have examples of that and as Leanne alluded to we have a medical advisory board. Many are social workers and can provide social work specific expertise.

>> We've started to do more publishing in the social work literature about medical-legal partnership. Just stepping back social workers and lawyers and legal aid attorneys have worked together for a longer time than the traditional healthcare providers such as physicians and nurses. So we actually have a longer history working with social work and supporting each other's strengths in trying to achieve the best outcome for the patient clients that we serve. I think the challenge for many partnerships is making sure that everyone on the team is in the loop about the impact of legal intervention on patient and also on the institutions that takes care of the patient. And I think in that realm the social work team can really help the legal team to do a better job navigating the institutions that are caring for their clients.

>> Thank you for your response. The next question gets us away a little bit from the social work. Has any MLP been implemented within a community-based nurse home visiting program? Our Healthy Start program is not based in a clinic or hospital and we're interested in this concept for our site. How do you recommend we proceed?

>> Great. Thank you again for your question. It is so great to be able to respond to your questions and so I would say that the answer to the first question is has there been one implemented not a formal one, but I would say there are many partnerships in the medical-legal partnership and one of them that has developed relationships with the local home visiting programs that we've done training, that we've had small grants to do technical assistance for those teams. That much of the information that is disseminated in a local MLP to front line healthcare providers is absolutely applicable to community-based home visiting programs. And that's the reason that we've had some of those relationships with, for example, Boston public health commission programs doing home visiting. So we also see many of those members, those teams can often become part of our clients' lives when we see the clients in the healthcare setting, we also as legal advocates then encounter them -- encounter our home visiting programs in other contexts so it's a resource that we're familiar with, I think, but I think it benefits from explicit partnerships between the legal aid community and the home visiting program. I think that they have some different needs. I think they have some different capacities and I think that they have different strengths that will really serve the medical-legal partnership network well to become involved more intentionally

instead of sort of as an off-shoot of a local MLP that is anchored in a hospital or health center and so I hope I'm answering the question to say that, you know, it sort of happened organically that MLPs have worked with home visiting programs but we're really excited about the opportunity for it to happen more formally and we're really encouraging those applications as well. I think that the learning that we have from applying legal assistance into different settings are eminently relative to home visits and the program.

>> I think the key to a medical-legal partnership is the longitudinal relationship. Many Healthy Start programs have that. You see the women and families over a period of time and therefore are able to impact their lives and therefore provide a lot of the information that's necessary on the legal side to be able to solve their legal issues. I think that we have sampled in Philadelphia or others where there are nurse-run health centers with home visiting components that have integrated legal services into it and in many ways we think it may be the model of the future where case managers are the people who interact with families, whether it be a community health worker, patient navigator or home visiting nurse that are going to be armed with the legal need screening information and be able to triage issues and have the lawyer as the backup for them when they hit a wall and need that additional resources help.

>> I'm glad Megan mentioned patient navigators. There are a lot of analogies and movement in the MLP network to work with patient navigators as well and actually studies that are being pursued in terms of patient navigators in the oncology setting.

There is a lot of opportunity there in terms of thinking about how to make those physicians, whether they're patient navigators, social workers, home visitors, more effective in their work by having access to a lawyer and then this goes back to, as Megan referenced and walked through the core components where, you know, I'm just imagining I'm in this big amphitheater and if there were Healthy Start folks filling this amphitheater and had 40, 60, families they were taken care of. The slide that didn't make it into our slide show is about the prevalence of legal need and you'll see that in a report which is that for families that are low income in all of our Healthy Start families are they have an average of two or three unmet legal needs. If you have one attorney who is working with you in your Healthy Start program, they're not going to be able to take every single referral that all of your case managers have so we'll need to find a different way to address those legal needs more systemically and empower and give better tools to the case managers so that we can really leverage the resource of having access to an attorney and I think we figured out a lot of those strategies and we're eager to share them with you.

>> Thank you for your response. The next question that came up was how many of the current Healthy Start programs have an existing MLP collaboration? I'm not sure if you can answer that question. Over on the programmatic side. We've discussed it here and we don't know of any in particular but -- I don't know if you guys know of any Start Healthy sites.

>> We actually don't know. Again, what we know anecdotally and keeping in mind that this is a fast-moving network that is growing. We're struggling to keep ahead of the network growth collecting the right metrics to be able to tell the story like, you know, related to the question you've just asked me. And so we know anecdotally that again many of the programs that have medical-legal partnerships are also working in communities where there is a Healthy Start presence whether it's in a community health center, whether it's in a community-based agency that is partnering with the legal aid office. They may be coming in a different door at the legal aid office that isn't being seen as a medical-legal partnership. And I think again it goes to what is the framework of the model. This is not a referral network. Direct client assistance is certainly part of it. But if we tried to open up another portal for cases to come in the door, the legal aid community would not be able to manage the flow of cases. So part of the strategy with medical-legal partnership is to work smarter and focus more preventively and one reason we're so thrilled to be in this audience with this audience is because we know that this is all about prevention in the workplace. The feeling is heavily focused on prevention. That's a shift in the legal aid community. We haven't had the sort of thinking and resources and impetus to be able to focus on prevention as opposed to responding to legal emergencies like eviction. It's a long winded way to say I don't know the answer to the question but we think that there are seeds out there in the community -- in the MLP program and the communities that will contribute and can really create those programs with Healthy Start.

>> Keep in mind there are over 100 legal service agencies across the country. Almost half of them are doing medical-legal partnership. As the grant announcement

discussed you want to find someone with experience with medical-legal partnership. It's not a new concept in the legal aid world and it's part of the technical assistance the national center wants to do for people applying is to play matchmaker and introduce you to the different legal partners and help you find the one that has the best fit for you. There are different legal partners. It is legal aid, pro bono, state bar association. Our Boston medical-legal partnership has worked a lot with the Healthy Start site even though it's not a formal partnership. In Indiana they have a state-wide medical legislature partnership network and many states are doing -- that may be almost a silent partnership where they haven't formalized it. It won't be a big stretch.

>> Thank you. Going into an implementation question, if the Healthy Start organization is affiliated with multiple medical sites, does the medical-legal partnership need to accept legal referrals from all of the medical sites?

>> No way. I will say that because again going back to legal needs. The prevalence of legal need for your patient population and, you know, hopefully we'll get to a time where when a home visitor has a legal issue there will be an attorney available to help that family. But we're not there yet. We're just starting that trajectory so you need to really scope the project in a very manageable way and part of that is having conversations with your legal partner and that's part of the facilitation we offer you. It's one of the reasons that we value and we hope -- we want to see some new programs come out of this but we'd also like to see Healthy Start programs benefit from the existing medical-legal partnership infrastructure that might be in place in your

community because then you have the opportunity in terms of thinking about how to pilot in a community, how to select the population and pilot and collect data on that population and build that relationship. If you had a Healthy Start program, the impact of the legal intervention would be so diluted it would be hard to deliver on the value of that program so we'd really encourage you to focus on one or maybe two healthcare institutions that are engaged and invested and want to do it with you in terms of having to convince them. That would be one way to figure that out. Do they return your call right away and help you draft the proposal? If they aren't going to do that they aren't going to make a good partner for you but I would like on our website to see what are the healthcare institutions that are in medical-legal partnerships because you may be ahead of the game if you are able to start with them. And if that's not an option for whatever reason, then we're happy to talk with you about that as well because as Megan said, we've certainly played matchmaker but in contrast to the healthcare community where there are multiple hospitals and health centers concerning a major urban area or even some rural areas, you'll probably only have one legal aid office and so we may be able to provide you with guidance about that legal aid office and what they do well and what they are, you know, what is going to be the best way to work with them.

>> Thank you, you spoke about the populations. The next question is are there best practices we can model from specific ethnic populations? For example, Latinos.

>> I think the answer to that is yes. I think particularly there is a lot of experience in different populations. Latinos can be one example where there may be a specific question either about immigration and/or fear of using public benefits for certain issues. Many of our sites are exclusively serving Latinos so we can share best practices. One of the best parts of the network is being able to share best practices around many of those issues. I think that it's also important to keep in mind that many of the issues can be difficult for families to identify and being able to work with them especially you as trusted healthcare providers can help families identify these issues and discuss them. I think that we're very excited about collaborating particularly with such a high-risk group of pregnant women and being able to reduce a lot of those disparities that can be really detrimental to long term child health.

>> I think I would add to that that one of the benefits of medical-legal partnership is that we get to join together what we know in the public health and medical community about a particular population, whether it's Latinos, refugees, whether it's people with HIV/AIDS, whatever the population may be, we get to join together the knowledge that we accrue in the public health and medical community with what we know in the legal community. And that just right there can be a very powerful opportunity to frame the needs of particular population in a way that hadn't occurred to advocates in that community. And that's what we're starting to see with the medical-legal partnership. So I think that there is ways in which we can improve visibility for some of these challenges and also include that for some of the solutions.

>> Can I just add? The national center. One of the things we do a lot is bring together, we pair partnerships that are working with similar patient populations. So a lot of the tools that we have in our website are actually very much tailored to the patient populations that the medical-legal partnerships are working with so we have certain screening forms that are available on our website both in English and in Spanish. We have a variety of tools that are geared towards screening for legal needs and geriatric population and I think that we have done a very good job of representing a broad range of patient populations. You'll find a lot of those on our website.

>> Thank you. The next question I believe is a programmatic one. Can the medical-legal partnership address legal issues for the entire family? That is, client/patient of the healthy start organization. For example, can a special education case for an 11-year-old son in the house count under this grant when the Healthy Start organization is working with a pregnant mother?

>> So that's a really good question. And I think it goes to, you know, my original comment which is that this is such a simple concept which is really challenging in its implementation and why you have to have an hour and a half webcast to talk about it and a website and, you know, to provide technical assistance because that question goes to both the grant, which I don't have it burned in my memory as to whether or not it's permissible but I can tell you from an MLP perspective that's a decision that's made locally. So that's a priority setting response that -- priority-setting issue for the local medical-legal partnership. At some point you have to decide are we going to focus on

housing? Are we going to focus on everything? Are we going to focus on everything for this small patient population in the clinic or do just one thing for a lot of people? And so those are questions that all partnerships have confronted and they've confronted them in a variety of ways. And that's what the -- that's what you would do as getting your partnership off the ground. What I would say from a legal perspective is that we see the legal intervention as benefiting the whole family, right? Because this mom is not going to be successful in the things you need her to be successful in if her child educational needs are not being met. It may not be squarely in the mantra of Healthy Start but it is certainly in the rubric of medical-legal partnership and that's how we look at the legal intervention. The mom may be the client for the housing eviction because she's the adult but obviously the entire family is impacted. And so I think those are decisions that can be made either on a case by case bases. They can be made at the local level. And I think those are, again, subject to conversations with your legal partner because the legal partner may say to you, if I have that issue and I can handle it I may need to treat it like a doctor has to provide a certain kind of service if he's identified an illness.

>> I think the other thing to keep in mind is that legal assistance is a limited quantity and so you may want to prioritize the issues that are going to directly affect the pregnancy of the patient and/or the first two years of life since those are the metrics you'll be measured most. I will admit I think a mom can be preoccupied with an 11-year-old special education and not prioritize her own health and therefore you could envision a site prioritizing that need for that reason. But realize that you are going to

have to think through which case gets through the system first and which is the prioritized need because it is a limited resource and so thinking that through will be an important part of both the application and the implementation.

>> Thank you. We've had a conversation here about that same question and we agree it is a decision based on the local Healthy Start program and really you need to look at caseload and your priorities for your Healthy Start clients. So that would be the response we would give also.

>> Glad we're consistent there.

>> I don't think we have any other questions right now. I'll give them about a minute more to see if anything else comes in. While they're doing that, is there anything else that you guys wanted to kind of mention or wrap up as one or two other questions may come in?

>> I think what we really want to encourage folks is to email us if they're considering applications. We really want to support applications and we want to provide as much information as possible to support those applications and hopefully people will take advantage of those resources.

>> I think the other thing to keep in mind is that we will be able to provide technical assistance after the grants are awarded as well. Part of the -- part of our job working

with HRSA on this grant is to do site visits and to be able to do a lot of strategic planning with sites for successful implementation. We're thankful for that and have a lot of experience. We have been instrumental in starting the programs across the country that serve over 200 health centers. We don't want you to reinvent the wheel. We want to help you make the best decisions to be the most successful program and we're really excited about this innovation in medical-legal partnership. That's what it is. Promoting family advocacy through Healthy Start sites and we really think that will be a huge benefit to both your patients and families and also to the network itself.

>> Thank you, Megan. I think you just answered the next question but I'll repeat it just to make sure. What support exists for designing and implementing evaluations of these programs?

>> Evaluation is a really good question because I think that it's something that we have struggled with and also learned a lot especially over the last five years. I think in many ways we can talk about the simple idea of tracking, whether or not legal needs are detected and met is a whole part of an evaluation process. I think it's also exciting for us to think of health benefits both in terms of actual direct health and then also indirect health. Things like reduced stress and having more attention for parenting or other things that can be part of improved well-being of patients and family. I think one of the things that we're very interested in around evaluation is thinking about does having medical-legal partnerships tie you more closely to your clients? And so in a medical setting is it improving the medical home or in a Healthy Start setting is it improving the

satisfaction of your client around the home visiting services? And then I think for us we always are very interested in improving the clinical workforce. Are we making you more effective as case managers, nurses, doctors or other healthcare providers because you're able to detect these issues that are important to families that they may not think you can help them with but very important to their long term health. If you want to look at our website we have a whole list of those kind of four areas, improved health and well-being, improved tying to medical homes or associations, improved clinical workforce and improved provision of legal services and examples of different type of studies that have all been tied to that. As Leanne alluded to we have a lot of surveys and other things that have already been developed. Please don't start from scratch. We can give you those types of tools that you can adapt locally that can be hugely important for your improved evaluation.

>> Thank you for your response. I believe the final question is how applicable is MLP to rural health?

>> Thank you so much for that question because we think it has tremendous application. Where you can combine the two you'll have much more profound impact on patients. When patients see the local health center or the local community agency as a place where they can get questions that they have about their challenges like housing stability, when they see that as a place to get those responses as Megan alluded to it ties them more closely to those associations and that's a good thing but I think almost more important what it helps to do is build that knowledge capacity for the

front line folks that are seeing people in rural settings every day to understand some of these systems going back to the web of your bureaucracy that individuals rely on when they're low income, individuals and families, it helps to build their knowledge about how do I help this family access this benefit that is going to be so important to their health? And not feel as helpless at supporting families in the case of what can be a very intimidating bureaucracy. That's what lawyers are trained to do. Our special skill set is navigating administration and bureaucracy. Not only can we do that on behalf of patients, and clients, but we help others to learn how to do that and to support them because sometimes they're more effective for the patients than we are as attorneys and so our job is to help them to be better advocates on behalf of their patients and I think the last piece is really demystifying the system that patients have to rely on, clients have to rely on in their low income. Demystifying it so that we can help many more patients and not feel as frustrated in the day-to-day work of serving vulnerable patients. That gets away from the rural question but I think because of the -- in terms of the number of agencies, individuals and families in the rural setting because of the frustration level that we hear about from the front line providers not being able to support families when there aren't as many resources as there are in a place like Boston. Helping to arm them with the tools to be more effective with their patients I think is certainly something we hear from our rural sites as being very, very positive.

>> Many of our sites are in rural places. Montana, Iowa, even rural parts of Massachusetts and other sites so we have a lot of experience with how do you have to necessarily implement a medical-legal partnership a little differently in a rural setting.

Legal services coming on site if it's a five-hour drive away from the clinical site. It may be something you have to negotiate around. When do they come on site and when do they not. How do you do the referral systems and trainings? That is not an insurmountable barrier is having a legal and healthcare partner or Healthy Start partner not necessarily be geographically very close and understanding the legal issues in the rural setting is a different -- different web of bureaucracy and issues that may be coming up and those may be where we can share expertise among our sites peer-to-peer mentorships that can be very important.

>> Just add on top of that in some rural sites. I'm thinking of Arizona, for example, there are some wonderful technology resources that the medical community has been able to introduce in terms of things like webcasts that the legal aid community has not had the resources to do and so in some cases the medical community is bringing resources to the legal community to be able to reach client populations that the legal community has not been able to effectively serve before and so I think that's another opportunity that MLP presents for rural populations.

>> Thank you for your response. I believe we have no more questions. Do you have anything else that you would like to -- would you guys like to make any other closing remarks?

>> No, I think early dismissal is always a good thing. Thank you for your time.

>> Thank you very much.

>> Okay. Well, on behalf of the Division of Healthy Start and Perinatal Services I would like to thank our presenters and the audience for participating in this webcast. I would also like to thank our contractor, the Center for the advancement of distance education at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website mchcom.com. We encourage you to let your colleagues know about this website. Thank you and we look forward to your participation in future webcasts.