

MCHB/DHSPS Webcast

Medical-Legal Partnerships: A Life Course Perspective

October 12, 2010

JOHANNIE ESCARNE: Good afternoon, my name is Johannie Escarne from HRSA's Division of Healthy Start in the Maternal and Child Health. I would like to welcome you to this webcast titled "Medical-Legal Partnerships: A Life Course Perspective".

Before I introduce our presenter 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 do not need to do anything to advance the slides. 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 typically provides optimal performance for the audience. We encourage you to ask questions of the speaker at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question 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 on 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 will you have the 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 are very pleased today to have Dr. David Keller, Dr. Keller is a clinical associate professor of pediatrics and senior analyst of the Center for health policy and research at the University of Massachusetts medical school. A little bit of a mouthful. From 2009 to 2010 he served as the Robert wood Johnson health policy fellow in the office of the assistant secretary for planning and evaluation at the Department of Health and Human Services from January 2010 through September of 2010. Prior to that, Dr. Keller served for many years as the medical director south county pediatrics a community-based teaching practice located in Webster, Massachusetts. He was also the pediatric director of the community faculty development center, a collaborative faculty development program for community preceptors, a physicians advocacy fellow for the Center for medicine as a profession and founding medical director of Family Advocates of Central Massachusetts. He served the leadership positions of the American Academy of pediatric and the academic pediatric association. His work on medical-legal partnerships, faculty development and advocacy training has been presented at national and international magazines and published in peer review journals. In order to allow ample time for the presentations we'll defer questions and answers to follow the presentation. However, again, we encourage you to submit questions via email at any time during the presentation. If we do not have the opportunity to respond to your question during the broadcast, we'll email you afterwards. Without further delay, we would again like to welcome our presenter, Dr. Keller, and the audience, to begin our presentation. Dr. Keller.

DAVID KELLER: Thank you very much for that kind introduction and I apologize for having such a complicated resume. I'm here to talk to you about medical-legal partnerships from a Life Course perspective -- perspective. When I was invited to do this I wanted to do it because I've been thinking about medical-legal partnership for a long time but I hadn't thought of it from this point of view, this Life Course perspective so what you'll see over the course of a next hour is a description of an intervention program really designed to directly address the social determinants of health in a patient-centered and individual way in the context of a way of thinking that encompasses the entire life span of a person in the context of the community in which they live. Next slide, please.

I, of course, have nothing to disclose other than to gratefully acknowledge that support we received for this program through the Healthy Tomorrows partnership program from 2004 to 2009. Next slide, please.

Let's start by talking a little bit about a Life Course perspective. This is from some of the literature I found on this and much of which has been supported by the Maternal and Child Health Bureau over the last several years. A Life Course perspective suggests the complex interplay of biological behavioral, psychological and social protective and risk factors contributes to health outcomes across the span of a person's life. When I read through that I said boy, that sounds really similar to several other things that I've

read over the last decade. So with your permission I would like to compare that to the next slide.

This is from the Institute of Medicine report children's health, the nation's wealth published in 2005. In that report they review the data that found that again, biology, behavior, social and physical environments are interacting and impacting on children's health and that that creates a developmental trajectory which can change very quickly. And they came up with this great graphic which is the one I'm going to use throughout the talk that I would like you all to look at just for a little bit here. I call it the kaleidoscope graphic because that's what it is. There are four circles and for those of you whose resolution is good enough, you can see that it says social, environment, behavior, biology and physical environment in four circles and the middle there is a not quite circle that says children's health in the middle of that. It starts off as a small big circle. The bigger social is the policies and services in the environment around them and you can see the circle difficult urgess and has wider possibilities the older the person gets. It causes you to pick a line to intersect the kaleidoscope at different places and this is how I think about this going forward. That wha* that means for us in program design, we need to think about interventions that work on different parts of the circle at different stages and in different domains all the way across the life span and that's a little bit more complicated than we usually have done. But I find it very interesting. The other thing that this model explains is something that we all know and that's been shown in a number of economic analyses, that the greatest bang for the buck. The greatest ability to intervene and to change the trajectory is at the beginning before you've gone

very far down the path and that is very, very clear in this kind of model, so that's one of the reasons I like it. However, it's complex and multi-factored. Let's move to the next slide.

This is perhaps a little bit easier to follow because it really goes back to that original definition we talked about. Risk reduction and health promotion. And if you look at a Life Course and sort of your measure of health and development along the Y axis and your age along the X axis you notice your healthy development goes up in the early years up to about age 20. For those of us who are past 40 it's sad to think we've already peaked but according to this model we more or less have. I would like to think we'll continue to develop. Perhaps this is more pessimistic than I would be. What they're really showing here is that if you add risk reduction and health protection factors at different points along the Life Course you can change that trajectory from the lower dotted line to perhaps the higher upper line and for those of us who are real optimists you can keep going up even when you're up over your 50s as my gray hairs may suggest that I am. Next slide, please.

The other thing this made me think about is a line of work that we've been doing at the American Academy of Pediatrics over the last decade or decade and a half and that is really in defining and enriching the field of what we now call community pediatrics and we have again a more complicated definition of community pediatrics but I want to point out two pieces of our definition of community pediatrics. It's a recognition that family, educational, social, cultural and other forces act favorably or unfavorably but always

significantly on the health and functioning of children. That's from our statement on the pediatrician's role in community pediatrics. As I looked at that I said boy, that sounds like a Life Course approach and it sounds an awful lot like the institution of medicine kaleidoscope going forward as to how we should ask. Pediatricians are not just scholars who study this. We act. And community pediatrics includes a synthesis of clinical practice and public health principles directed towards providing healthcare to the given child and promoting the health of all children within the context of family and school and the community. And the challenge for every community pediatrician is to think, how do you operationalize that? The concept is sound but it is hard to operationalize. How do you make this real? That's really the background for what we're going to talk about that. I think every pediatrician who has ever tried to make this real has run into the same problem that a pediatrician -- he's not just a pediatrician, he's the chair of pediatrics at Boston Medical Center ran into back in 1993. Next slide, please.

The origins of the medical-legal partnerships. In 1993, a doctor was working at Boston city hospital seeing children who were being adversely affected by the social and physical environment around them and by the -- by their behaviors and by a lot of social factors and he was frustrated with this. He knew that health and social conditions were linked. He was adept at working the system as a pediatrician but he couldn't write a prescription for food. He couldn't write a prescription for housing. He could refer people to programs but the programs just didn't do what he wanted them to do a lot of the time. And I'll give the example that Barry uses all the time. This is his story, not mine. But the story is he was seeing a child in the clinic for asthma and was writing ever stronger

prescriptions for more and more steroids every time the child came in because he kept coming in wheezing and they would do things and of course the initial assumption was well maybe the parents aren't giving the medication because we worry about that. Or maybe the medications are just the wrong ones. Let's try different brands and different mixes of these things and it just wasn't working. He was talking to the family and they said to him, you know, the issue here is I think that there is mold in our house. We're living in public housing. It's got mold on it. And we need to get out of there and so Barry crafted his best letter. He wrote this amazing letter about how medically it was the mold and that there was a moral duty of the landlord to move them into housing that didn't have a mold and in fact there were laws and regulations that said that they had to do this. He wrote this letter off and nothing happened. Nothing happened. He sat there and said what? I need a lawyer. And then Barry did something that the rest of us couldn't do. He is the chair of pediatrics at Boston Medical Center so he went out and hired one because chairs can do that sort of thing. And he hired an attorney who came in and said I need to take what we're doing already and give it more UMPH. Build me a program that lets me get done what you can do. And he said do you know what I can do? Take this case. He took it and within, I don't know, a day, two days, the family was being moved into new housing because attorneys are better at working the system than doctors are. They just are. It's their training. It's what they do. So that moved into thinking about how to structure a program to do that. Next slide, please.

And as they conceptualized this program, look at all the things you need to have health. You need food, employment, income, access to healthcare. You need to have sorted

through your immigrant status. You need childcare and education for you and for your kids. You need a home that is safe and stable without threats of violence. You need housing and utilities to be taken care of. These things are all possible for those of us who are employed and those of us who are fortunate enough to have good jobs.

But for those who live at the margins, next slide, please, we have a whole bunch of complex bureaucracies that they deal with. In general, all states have these systems in place that are going to be dealing with all those issues we had up there before and each one of them a lawyer can do something about. And it turns out that legal assistance lawyers have been working in all these areas for years but those of us in the medical profession didn't know that. And so Barry's genius was to say let's put these two things together and we'll create a program initially called the family advocacy program. When they went to try to disseminate it we found out somebody already had that program and we changed the name to medical-legal partnership so we would have a unique name going forward. The medical-legal partnership at Boston Medical Center was started with really three big goals. They wanted to provide direct proactive legal assistance in housing and other issues that were going to work for children and by in-house they meant they wanted it housed at the hospital. They didn't want to have to tell families that you had willing to off to another agency to get this to happen. And the second piece was that they wanted to educate health professionals to identify non-medical barriers to the patient's health and the third piece they wanted to address systemic problems and gaps in services. Over the last six or seven years they built a really impressive program. Physicians and lawyers got to know each other and physicians

referred patients to the attorneys in realtime in the clinic to deal with legal issues that had come up. Many of them were fairly simple legal issues. They developed a program called the health desk that relied on student volunteers. Of course, in Boston there is about 100 different colleges and all the students want to volunteer in the hospital and they said great, give us your students and they taught them how to do some simple advocacy work and set up the help desk and they did the easy stuff and the lawyers were reserved for the stuff that was more complicated. They came up with training mechanisms to teach the residents what was going on. The advocacy code card was come up with after the code card. If you are in a hospital and ask a resident to see their code card they have one. It tells them what to do? A cardiac arrest. The dose is there and you do it. They had a code card that said I need to call public housing. Here is the phone number now. I need to argue about food stamps. Oh, here is the grid that tells me what is eligible for food stamps and what's not. They would carry it with them in the hospital so they had it with them ready and it fit in how residents work. They came up with clinical practice guidelines around legal issues that could be used much in the same way as we were using clinical practice guidelines to guide the therapy of stroke or other illnesses. And then finally the lawyers worked with the physicians to actually advocate for changes in laws and regulations within Massachusetts that would benefit children and so it got us involved into advocacy at a state level and certainly at a city level as well to try to insure the rules were actually fair and would benefit children going forward. It was a great program. Barry would come to the meetings and say to us all, why don't you have one of these? Why don't you all go out and hire a lawyer and we'd look at them. Those of us who were interested. There were actually many, and we all

said we're not the chair and I can't just go out and hire a lawyer. We had to come up with an alternate way and there were a number of meetings and discussions about how to create these partnerships when you are not just able to go out and hire the lawyer with money that you have.

So you go to the next slide we'll talk about the gradual dissemination of this model.

Boston Medical Center started their program in 1993. It wasn't until 2,000 that Hartford got in the game at the Children's Hospital there they had a specific program that was set up around a group of patients with specific needs and they got a grant to set that up and then a few years later Providence, Cleveland and Chicago all came up with programs. Each taking a different way into the system. Providence began by setting up the help desk and built their program off that. Cleveland was fortunate to be able to hire a lawyer in-house and build on a very similar model. Chicago partnered with the local legal assistance corporation. And 2003 was when we got into the game and that was when an intern, Valerie within dom and her colleague Rebecca both graduated out of law school in Boston. Both had spent time at the medical-legal partnership in Boston city and taken jobs at the legal assistance corporation in Worcester, Massachusetts and saying why aren't we doing this in Wooster, we had lunch and the rest is history. This has continued to disseminate around the country in a big way. The real challenges to dissemination are three. I want to talk about those. I think they're important for people thinking of doing this to consider. There is a challenge to developing trust. Doctors and lawyers do not have the strongest history of working together. And we need to be able to develop the trust that we need to be able to work together on this. I need to be able

to tell my colleagues that these attorneys aren't going to sue them, for example. That's an important part of the program. And we also need to be able to speak to each other about legal concerns and about medical concerns in a language that we both understand. A lot of the same problems of establishing partnerships in any area are there but again the trust issues with doctors and lawyers make them even more difficult. And then there is the issue of refining the model to local conditions. And we were the first one -- and I'll get into that detail in a bit -- that didn't really base its program out of a central city hospital. All of those other programs I mentioned were based at big hospitals and we looking at Worcester county faced a different challenge that others have faced since but we were the first to come up with an answer to it. That was not going to be based on the same kind of model where there is one place where everybody goes and they all get the same services, which is really how the model started. Move to the next slide.

Let's talk a little bit about adapting this model to central Massachusetts, which is where I've had the privilege of working for the last 19 years. Now I'm not the chair. So I couldn't go out and hire a lawyer. I needed partners to do this. Worcester. The center is Worcester and as you can see, there is a number of areas outside of Worcester where there are high concentrations of poverty. In Worcester they're called rural areas. In the rest of the country they would be called suburban and, you know, but in any event, they are not in the inner city and so we had that challenge as we were setting up that we had to deal with different kind of poverty and we had dispersed, low income communities.

As we were developing our partnership, next slide, please. We developed it in collaboration with a number of pediatric and family medicine practices located all over Worcester county. When I do this talk in the world, and not on the Internet as we're doing now, each of these dots pops up in sequence as I list all the places but apparently the animation stuff doesn't work on the webinar so you can't see that cool special effect right now. But you see we worked in five different clinical practices within Worcester including a specialty practice. Our genetics clinic was interested because of the unique problems faced by families with genetic diseases. We worked with two community health centers, one is now the Edward Kennedy health center. They changed their name last movement I haven't modified the slide. South county pediatrics in Webster is where I worked. The dot by the Connecticut border in the south and two other southern sort of places off to the southeast, Milford pediatrics and triver family health center and in Fitchburg we worked with a community health center to establish a presence up there to help children as well. So we had sites -- we were doing a multi-site model. That meant we had traveling lawyers who went to all these places instead of having a single attorney the way they did in Boston Medical Center.

Let's talk a little bit about barriers to partnership development on the next slide. Now, doctors and lawyers each have powerful social roles. We know who we are in the community. We're well respected going forward. We have well developed social norms within our profession. We have confidential relationships with our patients or clients. We're both used to being in charge of things. That's one of the major challenges to

partnership between doctors and lawyers is figuring out who is in charge. We both have a fairly dense jargon. All of these things can impede the development of a program. They can make it hard to work together to make this program happen.

Now again, the next slide is one that I've used, if you can switch to that, to talk about these things in more realistic terms. I use these a little bit tongue in cheek. When you think about our social roles we also have our stereotypes about each other. Attorneys make jokes about quack doctors at their functions. I've been to some of them and heard them. And the -- and I was at the academy of pediatrics meeting last week out in San Francisco and if I heard a good word about lawyers out there, there weren't very many. There was a lot of talk about malpractice and the problems of that. We perceive lawyers as sharks circling around. We need to cut through the stereotypes if we're going to make it work. We have social norms. This was an interesting one for me to realize. In the law, the highest praise for a lawyer is to say that was a really effective argument. That's what -- lawyering is about making the effective argument. Taking the facts and crafting them together to be able to make your point going forward. Whereas in medicine, our highest form of praise is that was good science. That it stood the rigor of peer review. That it came out of a randomized controlled trial in which we actually didn't know the answer going in. And that we didn't do anything really to gussy up the facts to make them look better than they are. That's different. Those are two different ways of thinking about both science and about argument and we both do both of those things. But in the back of our heads we have cultures that come from those places and you have to keep that in mind as you're talking. Particularly when you're discussing

evaluation because we have different perceptions of what evaluation means because of that, I think. Mandatory reporting versus privilege. Confidentiality both professions claim confidentiality in their relationships but in pediatrics we have that special case of the mandatory reporting of children to child protective agencies that we have to deal with. Lawyers have no such mandatory requirement. They are not required to do that reporting and you need to think through those rules as you are going into this relationship because if the attorney learns something in the course of their discussion with the families that indicates child abuse, they actually are required not to tell us about it. And if we are seeing a family -- if we're seeing families that are in distress and living in poverty, quite often we'll see things that involve abuse and neglect and we need to consider when we're reporting and how we do that in such a way that we're able to maintain our relationship with the child through that. Those are complex issues. We had a lot of conversations about them. We sort of came to a hum, that's really interesting and we were really fortunate through all of our cases where it never came up. There are a number of other areas in confidentiality that you need to address. Adolescents, who is the client. You want to work those things as you're building your relationship. The habit of command. It's kind of a military phrase but really we function in that kind of hierarchy both in medicine and the law. In the law -- in medicine we have the power to prescribe and write orders. We expect the orders to be obeyed. They can be questioned a little bit but not a lot. It's a funny place that we hold in the hierarchy. Attorneys are allowed to exert their power through questioning, by the power of subpoena and asking questions. A different way of asserting their power and they're used to working in that kind of context whereas we're not. That's another difference

between the professions and finally, the jargon. My favorite example is the difference in jargon is the word intern. In medicine you know what an intern. Oh, yeah, that was that year from heck that I spent where I never slept and people barked orders at me all the time and I had to obey them. I was responsible but didn't have any authority. That's what it was. Whereas for a legal intern is someone who comes into the office for the summer and does a project and then leaves and expects a letter of recommendation from it. It is a different process. And we had some interesting conversations until I realized we didn't mean the same thing by intern. And as we were thinking about roles within this process. Next slide, please.

There are a whole bunch of perspective conflicts but in the end it's all about helping people. I think for physicians that comes down to our understanding of the social history. The social history is a somewhat disjointed thing that we take and one of my least favorite phrases is the social history was non-contributory. It's always contributory but you need to collect it in a way to make it useful. A colleague of mine, Megan, proposed this mnemonic for thinking about social history. Think I help. What kind of housing, in, what kind of education, what is the legal status, what is their level of literacy and personal safety within that? And that actually matches pretty well to the lawyers' sense of what they can do through what they call focused advocacy and the attorneys. This was one of the major aha moments in our early conception of this project. I realized that lawyers didn't just think of these things as enforcing the law. They had sort of domains that they thought of them in. They thought about housing stability. They thought about financial security. They thought about dignity and safety as being free of

domestic violence and safe in your home from the threat of deportation. And they thought of access to services in a really Broadway. Access to health services certainly but also to the ancillary services that go with that. The educational services. As you can see from the lines, those match well with how we think about a social history. There is a line of communication. But the nice thing about the focused advocacy perspective is that the attorneys have a very specific set of things they can do about each of these in each of these areas and the attorneys had also developed a fairly robust set of outcome measures that they could use for looking at what came out of each of these areas and that really led us to be able to put our project together when we started thinking about it that way. Next slide, please.

I would like to talk for a little bit about the nuts and bolts. How does this work in real life? These are four cases we've taken from our files. We have over 500 as part of the project. They illustrate each of these four areas of focused advocacy. I use these slides in training residents when we're talking about residents we say listen for these things in your history. We don't want you to ask the question. Are you in subsidized housing? That's not a good way to ascertain if someone has housing stability. But if in the course of taking the history you're hearing uncontrolled asthma, problems in the past with lead or living in an older house, multiple -- a child who has moved from multiple schools in a single year, family talking about the stress of having to move or not being sure they will be able to stay in their apartment and family stress and the history of frequent moves. This is a really for me the most common one, the history that they're staying with family or friends. In particular, if they stayed with a different family or

different set of friends last week. Those are things as a physician that should make me think hum, I might be dealing with housing instability here. Maybe I should be talking to my attorneys. Next slide, please.

Let's talk about a specific case. This is Sarah, not her real name and it's a notice of eviction, a picture of it will. I had to dig around some legal files to find one. I had never seen one before and didn't know what they looked like. Sarah was a 16-year-old girl. Patient of a colleague of mine. Severe mobility. Had cerebral palsy and was wheelchair bound and had extensive services that she received at her home. And the family received an eviction notice that looked like this. A notice of payment or quit. They were evicted from their current apartment because the owner was going to remodel it and sell it as a condo. It wasn't because they hadn't paid the rent, he just wanted them out by a certain date. He had them evicted. Because the lease allowed him to do that. They had gone through public housing. The child was disabled so they qualified and the public housing had found them a new place but it wasn't going to be ready for a month. There would be a month where a child with complex equipment and needs would have to move to a shelter and try to manage that in a shelter. The agencies had policies about not doing work in shelters and it would be a mess. This child would be adversely affected by this. We thought so and the physician recognized this was a problem and because there was an eviction notice on it. We thought getting a lawyer involved would be a good thing.

This was early in our program & I put up the kaleidoscope with an arrow showing where we were intervening in the kaleidoscope. They referred the family to family advocates. The attorney worked with the family, with the pediatrician and with a social worker who was involved in the case to develop a strategy on how they were going to deal with this. They you will I had Sarah's mother go to housing court and ask for a stay of execution. Don't you love legal language? A stay of execution. I always thought that meant the gas was about to be turned on in the chamber. It turns out it means not going to execute something that had already come down as an order from the court. They weren't going to execute the order. And they actually had the physician write the letter but they had the mother, the child and the social worker be the ones who appeared in court without the attorney. They thought it would be a more effective advocacy to the judge because legally the judge didn't have to let them stay in the house. They were really trying to get the judge to see the moral case and it was the attorney's suggestion for strategy in this case and that's what they went into. They went to the court and it worked. Her family was able to stay in the apartment until ready to move to the new apartment. Her services were able to stay in place and only transferred once. It was a much better outcome for the child and the family. Next slide, please.

Let's talk a little bit about financial security. That's a really hot topic in these days and as was mentioned earlier, I just spent a year working in Washington so I haven't been working directly with the medical-legal partnership although I've stayed in touch with them over the year. They tell me financial security problems have been the major problem this year, as you would expect given the economy. What do you hear? The

history that you're taking? You hear somebody working multiple jobs trying to make ends meet. Somebody who has changed jobs recently. Somebody told you they applied for benefits and dropped from a program. I used to have food stamps but they stopped giving them to me. I used to have something else. SSI and that's gone now. WIC. I didn't make it to my WIC appointment and I got cancelled from WIC and too embarrassed to go back and get back on it. The family can't afford medications. I have a lot of families in my practice that are working but don't have a lot of money. And -- but have insurance through their work and so they have commercial insurance that, unlike Medicaid, actually has a substantial co-pay for each prescription. If you have a child who is on asthma inhalers, especially as all of us know because Albuterol lost its generic status. The cost can go out of sight. The family can't afford the medications. You hear people talking about choices where you get the sense they're choosing between paying the rent for paying for food or you hear somebody say they can't go to work because they can't afford childcare. These are all issues of financial security that need to be addressed. Next slide, please.

Now, we'll talk about a patient. This is a patient of mine and -- who came in. He had had a brain tumor a few years earlier and because in Massachusetts if you have cancer, you're automatically eligible for disability. Had gotten on Medicaid as part of that for that and his parents also worked. His parents were divorced and father carried insurance. Now, because of his treatment for his cancer, he not only cured his brain tumor but damaged his pituitary gland in the process and required growth hormones. It's very expensive. And even with the 80% coverage by the private insurance the fact that

Medicaid was picking up the other 20% was really, really necessary for the family. But because he was pronounced in remission he suddenly wasn't eligible for disability anymore. He no longer had cancer and it lost him his MassHealth and back to private insurance in the 80/20 rule and they couldn't afford the co-pay because of the expense of the growth hormone. I looked at him and said you haven't been in for your growth hormone shots for the last three months. We were giving them. We were practicing far enough away from the Medical Center and we were giving the growth hormone there. So I noticed he hadn't gotten those things and I said -- mom told me he lost MassHealth? I said I need to refer you to a lawyer. I D. I called Valerie and she came down and talked to them. And they gave the mother -- after talking to the mother they found out that mother had lost her job so now was eligible for MassHealth directly and was able to get back on to Medicaid so the child could get the Medicaid -- the benefit of that going forward but what was interesting about this case is in the course of this evaluation, next slide, please, the mother mentioned to the attorney that he was having some difficulties in school also as a consequence of the radiation and he was having some behavioral problems and having just difficulty learning and the attorney learned that no one had done a detailed neuropsych evaluation after his brain had radiation. Radiation can cause damage to the brain. The attorney called me up and said why don't you do this. I said great idea, let's do this. We did it and discovered that he had sustained significant amounts of brain damage that was interfering with his schooling. It qualified him for SSI and -- SSA actually, but also qualified him for special education in school which he had never had before and certainly was not qualified for just on the basis of his medical condition. We needed someone to dig down further past where the

endocrinologist and the oncologist had gone and that came out as a result of the attorney's intervention. So I think the lesson here is that we thought we were intervening at one of those circles at the social environment and looking at financial support. It turned out we were also intervening in behavioral support as well for this family. Really multiple interventions that wouldn't have been discovered if we didn't have this collaborative approach to care. Next slide, please. I'm going to skip this slide and there is a small problem. Go to the slide after this. You'll see what I mean in a second.

Let's talk about access to services now. In access to services, you will hear things like your medications and services have been denied by MassHealth or families are having difficulty paying for medication because it's a non-covered medication or you'll hear the child is supposed to be getting some services at school and hasn't gotten them since they moved from the early intervention center to the school. The school isn't being responsive to the needs of the child. You hear these things and after you've taken a more detailed history it can be good to talk to an attorney. The next case is a 13-year-old boy named John diagnosed at 8 with ADHD and a learning disability. Put on an IEP and treated with stimulus medication at age 8. Followed by a developmental pediatrician and a general pediatrician. He had had repeated IEP meetings at school and he came in for his eighth grade physical and the pediatrician gave him a chapter book to read. Something simple. Something from reach out and read, another great program we won't talk about today. And he couldn't read it. He couldn't read the paragraph and he's going into eighth grade and in special ed. and I said what is going

on here? You get barely passing grades or D. He said to me, I don't understand what they're talking about. I don't even know what I don't know. Next slide, please.

So I said boy, he needs to get re-evaluated and I did my -- the pediatrician in this case did his usual thing, the same thing I would have done, which was ask the school to do more testing. The school did more testing and said he was functioning at a third grade level and had an adequate plan in place. The physician and specialist wrote letters saying no he doesn't. The school said yes, he does. The school said we won't do any more testing and the specialist and pediatrician said he's made no progress in five years. How can you say that's okay? The physicians all were feeling very frustrated and the young man was feeling like a complete failure. He didn't know what he was supposed to do but he knew everyone was unhappy with what he was doing. And at this point the child was referred to family advocates. Next. Now, family advocates met with the family and pediatrician and came up with a strategy. They said to the mother, how could you -- what would be the best thing for your child? A new school. So they explored an option called school choice which allowed them to move to a new district. When they got to the new district they asked for a new team meeting. At this team meeting both the lawyer and pediatrician showed up with the mother. The lawyer said nothing. He sat there and the school said oh, we have to do things and they ordered neuropsych testing. It turned out he was borderline mental retardation. Had a completely inappropriate education plan and the new school put new services in place and able to make progress without just complaining to the pediatricians that he needed new and different medications because that wouldn't help him. The intervention

happened. The lawyer was the thing that allowed us to get over the hump of getting services for this child but if you look at the Life Course model, wouldn't it have been nicer if we had done that five years ago? The lower arrow there. We would have had a much greater affect on his trajectory than we will by beginning this intervention at age 13. It made it possible and it is a Life Course but it is not the optimal Life Course we would have wanted to come out of that.

Now, in the next slide let's go back a little bit to issues of dignity and safety. As I mentioned earlier with dignity and safety issues you want to listen for evidence of violence in the house. Accessing benefits for citizen children and that sort of thing and DSS involvement. And, you know, again, these are all things that I think we all hear and then we aren't sure what we're going to have to do about them as pediatricians we mostly worry we're going to be called on to address these issues in front of DSS and there will be fall-out to that. When you have legal assistants working with you there are other things you can do. Let's go forward to the next slide and talk about this family.

This is another of my families, actually. Margie was a 10-year-old. One of five kids. All came back from Florida looking for physicals a few Septembers ago because the mother had just moved back up from Florida and I said oh, why did you move back up from Florida? I knew she had moved with a new husband several years earlier. It turns out she was moving back because the new husband had been making their home unsafe. There had been domestic violence and she needed to get the kids out of there and she came back and said great, let's get them into school. You have custody of the

children, no, he says he's going to come back up and get them from me. I said have you talked to an attorney? She said no, I can't afford one. I said aha, I have an attorney for you. And so we called our attorneys to come in and talk to them. Next slide, please.

So the attorney met with the family. Talked to them about how to do a restraining order. Helped the mother finalize the custody and divorce. The legal aid assistance agency doesn't do the work directly but they can direct people to resources to allow them to do that. So the children stopped moving around so much. Now, what's nice about this is that this was a case where the indexed child, Margie, the 10-year-old, I guess if we were talking about what we were doing with her we were intervening at the middle kaleidoscope thing. This is a family of five and we actually intervened for all of them by doing this and stabilized things for all five of the children. So we're doing multiple interventions on multiple Life Courses in the kaleidoscope that is a Life Course approach. Next slide, please.

Now, I mentioned early on that Boston Medical Center had set up their program with a heavy emphasis on looking for ways of doing systemic advocacy around these issues. Take the single issues and combine them up into larger issues going forward. We've had that happen for us a few times as well. It is serendipitous when it occurs. The first story was a parent who had a passion. We had a 12-year-old girl who had really poorly controlled bipolar disorder. A lot of conflict between the folks treating the bipolar disorder and the school and the special ed. services. When she would spin out of

control which happened fairly regularly, she -- the school would automatically call for someone to transport her out of the school building to emergency mental health in downtown Worcester and they would sometimes call an ambulance or a police. There was no protocol by the and the mother felt very strongly that it was inappropriate for the school to call the police to have a child transported to the emergency room in a police car because that really stigmatized her mental illness and made her mental illness seem like it was a legal issue, she was doing something wrong. This isn't about wrong, it was about safety but still she was worried about that. And rightfully so. We worked with them and the school in trying to construct a policy that would work and an IEP that would work. This all happened at the time we were also involved in children's mental health reform throughout Massachusetts. I was involved in that statewide movement and I suggested she get involved and she became a sports person for the children's behavioral health issues. It could be the subject of another webinar if anyone is interested. Early results are pretty promising, actually. The other one is -- was a more mundane but equally important one. We had children with cerebral palsy losing services. Their physical therapy was being denied. Each of us as practitioners probably only have one or two patients who needs those kinds of services so we wouldn't notice but what we were -- those of us, because there were many practices involved in the medical-legal partnership, we were all referring them in and the medical-legal partnership noticed that they had four referrals from different practices around Worcester county for the same problem and recognized the four problems went through the same Medicaid office and so they walked down to the Medicaid office and discovered there was a new person there reading the regulations differently than they

had been red before and suddenly denying services for kids who had never had services denied before. After a discussion and going through some of the historical record and looking at the requirements and talking to some people at the state level that person said I got it wrong, sorry, I'm new and it all got fixed. It wouldn't have gotten fixed so easily if we couldn't identify it was a system problem and not just an individual child having services denied. So that's the nuts and bolts of a medical-legal partnership and that's important. Some of the concepts I was talking about earlier sound vague until you have the actual patient/client in front of you to figure out what you're doing with this. Next slide, please.

Now, of course, we're here at the Maternal and Child Health Bureau and we're not only interested in giving -- providing services that seem like a good idea. We also want to measure that they are a good idea. That that's a really important problem. And I have been wrestling with the problem about how to evaluate a medical-legal partnership in various ways for the five years of my Healthy Tomorrows funding. I haven't solved. I want to share some of the thoughts I had and some of the things we were able to do in the context of our Healthy Tomorrows funding. The challenges are, as you can hear from the different kinds of cases that we have, really one of qualitative or quantitative outcomes. If you look at this issue we can all tell great stories of kids who were helped. But can we take them and combine them in such a way and aggregate those things in such a way that we can show a statistically significant difference for children or groups of children? What do we compare those children to? That's a real problem. You heard me talk before about the fact when we intervene for one child we're intervening for all.

Do we use the child or family as the unit of analysis? Real cases can be made in both directions and actually there are certain issues where I think using the child makes sense and certain issues where using the family makes sense. It is hard to come up with a single unifying analytic framework. We're trying to improve health and health has been hard to measure in children. The best measure is still asking someone how healthy do you feel? And that's a measure that is not as rigorous as we would like in a lot of cases. And finally, measurement in all this is happening in the context of legal services. This is where any colleague.

I should -- I meant to mention early on if I seem at all uncomfortable with this talk it's because I've never given the whole thing by myself. We're a medical-legal partnership and generally I do this with Valerie, who is the attorney I work with. She does half is slides and I do half the slides and we finish each other as sentences. It is fun to watch. This is her slide and wanted to make point as I'm talking about evaluation, from an academic standpoint may seem so important but from the legal services standpoint they're cutting staff, they're operating close to the edge. They're having huge cuts in their legal services funding. A lot of legal services was funded by the interest on the turnover of real estate. That how legal services gets funded in a lot of states. With the collapse of the real estate market it was hit very hard. So for many of the attorneys that we've worked with, the idea we'll spend some of that money on evaluation and not service delivery is hard for them to fathom because funding is so tight. Those are some of the challenges. As we put this together. Several of us have tried to put this together.

Move to the next slide and when you're trying to put it together you do logic models.

This is a logic model from the Boston hospital medical-legal partnership from several years ago. It was still called the family advocacy program. It builds off those three core goals we talked about before. Direct services, education, systemic advocacy and it sets up a set of short-term, intermediate and long-term outcomes that can be measured and the print up there is kind of fine but it basically walks through things like self-efficacy and knowledge. What have you learned? What do you feel you could do? To what you actually do. At the practice level is does the physician make the referral? Does the attorney get the referral? Is the case solved in a legal sense and then the ultimate pink box at the very end, does that translate into better health? Then it also shows how systemic advocacy feeds into the process as well. It may help you with a whole bunch of cases. It will be one of those protective factors that moves you a little better up the curve. It's a nice logic model for folks thinking deeply about this. Our program, Healthy Tomorrows is funded at a level where we didn't do the most sophisticated evaluations in the world but we have an evaluation component and our own logic model that was simpler. It looked at the resources we brought the bear. The activities we did, mostly training and implementation of direct services. That our outputs. We looked at training and screening instruments delivered and we looked at outcomes as change in the practice that medical providers refer family appropriately for legal counsel. Are the children receiving more legal services than they used to, the things that are need? Are parents better to advocate for themselves and can we show at least their health is improved by improving the housing stability, financial security, dignity, savings and

access to healthcare of the different groups. So I think that was what we used as a rubric for the evaluation we did.

Let's talk about that evaluation now in the next slide. The first thing that we said we were going to do is develop a screening instrument and we were actually successful. This is one of our great successes. We took ten items that we thought were important issues. We developed a brief screening instrument that could be filled in less than five minutes in an office setting my colleague is fluent in Spanish and a licensed translator and we had a Spanish translation of that document. We field tested it in five of the practices we worked with and showed it was as effective as the clinical interview in identifying patients who would benefit from referral for legal assistance. The curve you see there is the operating characteristic curve which is a nice arc and shows if two questions or more are answered in a positive leaning direction on this questionnaire you probably would want to refer this. This family is probably ready to be referred to legal services. Worked great. Worked great. Then we ran into a small glitch. Practices were eager to take it and start doing it but remember that behavioral health initiative I talked about? One of the pieces of that was that Medicaid then mandated that everybody, all children at their well child visits be screened for behavioral and mental health problems using the normal screening instrument. A list on the committee of nine norm screening instruments. We were not yesterday a norm screening instrument and we weren't on the list and it wouldn't have been appropriate. We're screening for social determinants of health not behavioral problems which is what the new program was looking for. Every practice in Massachusetts now is handing out screening instruments

at every EPSDT visits and other well child visits for kids not on Medicaid looking for behavioral health problems and they couldn't bring themselves to add -- to give out two screening instruments at the same time so we had the misfortune of developing our instrument when -- at the time that all the screening instruments were washing over the Commonwealth of Massachusetts. I couldn't even convince the nurses I worked with to do it because it was just felt to be too much on the patient. So we developed and normed the instrument but not able to disseminate it and that work still needs to be done. I will say that others have used this instrument. Others have craft evidence it and developed one that's part of an EMR. A lot of people have done the same thing but this was the first and it was developed with Healthy Tomorrows funding. So again thank you very much. Next slide, please.

If you look at the growth of our program you can see it's really taken off over the five years of the program that we were funded with Healthy Tomorrows. We grew from 66 clients in the first year to over 180 in the third year and the mix of cases varied a little bit from year to year, as you can see in the last year there were a lot more issues around dignity, safety, domestic violence and immigration issues primarily than there had been in previous years and an uptick in financial issues. Which makes sense. It was the first year of the great recession when things were starting to unravel. It was showing up in who was coming into our program. If you look at who we served and looking at the case outcomes. The reason this is only from 2006 to 2008 is that it took us the first two years to get the legal side and the medical side of these partnerships to agree on what common information we should gather. We thought we had it all set up on the intake

form and discovered there were a lot of bits of information that we thought were being collected that weren't being collected. For example, when we said race, we meant race of the child. The legal folks were filing the race and ethnicity of the client, usually the mother. We had different datasets between the pediatric practices and legal assistants and we didn't realize what was happening until well into the second year and then we had to fix it. So we have case outcome data. The same thing with the case outcomes. We didn't agree on how to collect case outcome data. I thought they were collecting more than they were. They were collecting less than we thought there were. We came to consensus by the third year of the project and why we have the last three years with the common dataset. You'll see the families we cared for were the poorest of the poor. More than 75% of them were families living at less than 125% of the poverty line. In Massachusetts you're eligible for Medicaid and SCHIP at higher levels than that we were dealing with folks at that end of the spectrum. The vast majority were women, mostly mothers, many single mothers. The race and ethnicity reflects what is going on. We have a large Hispanic community, large white community, very small African-American community and a somewhat bigger Asian community. The Asian community is southeast Asian and accesses some of our social services less frequently than some of the other communities in the area. The language was English and Spanish. We were fortunate one of our attorneys is a native Spanish speaker and that made that easy. We were collecting referrals from all the sites that we worked with but the majority of our referrals came from two sites, family health center, a large community health center and the UMASS pediatrics that deals with children in Worcester county. If you look at the level of services being delivered to these families, a number of them

were receiving what we call brief service. That was an evaluation. A brief service means it was a phone call with the lawyer. The lawyer gave the family advice and the family said that's great. I don't need to talk to you anymore and we never heard from them again. It was -- they were instructed to call back if they had a problem or if it wasn't good enough but we never -- we had trouble tracking them down to try to get long term data on that class of service and so we elected not to pursue them. It was too difficult and challenging. We had a group of clients sent to other places for services and again when we send them out of the legal services network, we had no way of collecting outcome data because of confidentiality rules and sharing things between attorneys. The group we worked with were the ones who had extended services and multiple assistance in meetings and document presentation and the, which was 10% of the group. I assumed when we were starting this everyone would end up with a lawyer. In court I had this Perry mason thing going on in my head. It's not how it works. Most gets negotiated outside of court. Very little ends up burdening the court system. When you talk about success of the program this is the measurement of legal outcomes. Over 80% of all of our clients had positive legal outcomes of one sort or another. Now, some outcomes are bigger than others and a lot of times the outcome was the family successfully for the next time it will happen. Blue bars are outcomes of family plans to cope with the problem when it comes up again and that's what a lot of the work that the attorneys do with the client. The green bars are the people that I call the saves. The ones where they went to court or had an eviction reversed or had services granted that had been previously denied or something that would make a good plot on law and order are the green bars there. And so again, we had those kind of outcomes but families got

something out of most of the encounters they had with the attorneys. That was the extent we were able to evaluate outcomes. The other thing we looked at is how does this affect the practice of medicine in our area. We did that with focus groups. Had a great medical student. I should give a shout-out to the medical students who did a lot of leg work. The second author on the paper on the screening instrument is a medical student. Was a medical student at the time that we put that study together. Anyway, next slide, please.

When we were evaluating our medical-legal partnerships and provider focus groups. We asked them what did the partnerships do well. Foster comfort, enhanced ability to overcome social medical barriers and address needs of patients in an informed manner. We felt confident doing this. It was a big change for a lot of physicians we worked with. There was a transcript of the interviews. I felt like there was a place for me to turn when I identify something with a patient that seems unfair whether it's the school not offering services to a child that I think merits it or a family being unfairly treated by their landlord. I think whereas in the past I would just commiserate now I feel there is way to at least help them fight. That's a good feeling for a physician, I di.

Next slide, barriers to our success. Inadequate screening. Everyone said they wanted to use the instrument, they couldn't do it with the other screening they were doing. We did have -- hear from several physicians about the overwhelming biomedical concerns. Sometimes the medical concerns are so complicated with some families that they have to take precedence and we have time constraints and hard to fit this into a 17-minute

visit and everybody talked a little bit about how it can be initially difficult to communicate interprofessionally and that's a concern shared both by the attorneys and by the physicians who are on this group. If you go to the transcript, I don't think we're in the habit of asking the breadth of questions that might identify a lot of patients. We don't necessarily ask a lot of questions about housing, food, security, safety. Should we? Sure we should be asking those questions. Do we have time? Does it come up as a priority?

So what did we learn from all this coming up on the final slide and then I get to address some of the questions that I think people have been asking as we go along. I think the first thing is that we can address the multiple inputs of a Life Course perspective in a medical practice if we take a multidisciplinary approach and use a broad definition of health. I would urge us to be thinking about multidisciplinary teams, a phrase that appears all over the Affordable Care Act and many of the things that we're trying to do as part of health reform right now to high outside the box. What disciplines do we want there? And I think it's just fabulous that we can partner with lawyers to do things that are good for patients and not always think of that profession as a source of pain and suffering, if you will. And this is really a mechanism that allows you to do that. I think that we also learned establishing a medical-legal partnership requires physicians and lawyers to establish a different kind of relationship than one that they've had before. Like all relationships, that relationship takes time and effort and so you have to plan to put time and effort into relationship building. I've actually been to legal society dinners and things like that where they tell jokes about doctors. Oh well. But then they always

say present company accepted and we have a good laugh and that's part of the game and the same thing happens when they come to our dinners so there you go.

Screening for legal problems is possible and should be integrated into other screenings as part of preventive care. With the big push for screening toward so many things the big challenge for all of us is how to do it in a concise way so it doesn't overwhelm the physicians and healthcare system trying to deal with all the things we find as a result of the screenings. For children living in poverty, access to legal advice can improve their lives without overburdening the judicial system. It was a big deal to understand that I wasn't giving 300 new cases to the court that had to be dealt with. But really probably if I send 300 cases to the court, only 30 of them will end up in the court. The courts are overburdened and that is a problem but it shouldn't be -- shouldn't make me hesitate to involve the course in the problems of my patients especially that's the way we have in society for resolving the kinds of differences that are going on. Finally a thought about evaluation and establishing the effectiveness of this model will require a different kind of research. I don't think you'll be able to do a randomized control of this model for a number of reasons and maybe we can and I know somebody who is trying. I'm pessimistic that we'll achieve true randomization. You'll need an ecological approach and looks at them in the housing. Healthy intervention and really looks at the children, families and practices as things that are going to be effected by this. We're changing the way you practice pediatrics by participating in this program and you have to want to do that. But that also should be a piece of the evaluation.

Last slide. It's to give you all a sense of how this has grown. I mentioned we were the fifth program to join. There are 255 hospitals and Health Care Centers around the country that have begun or beginning to establish medical-legal partnerships. I'm looking carefully. I think Alaska is still zero. And I'm not sure who else. I think there is one almost everywhere. But if you do see a spot on here. I guess the color in the Midwest there is an area that doesn't have them. The spots of darkness that don't have medical-legal partnership, come on in, the water is fine. This is a nice idea for moving forward. For those of you who have lots of medical-legal partnerships, the states in blue like California and Virginia know there are regional networks where everybody is helping everybody out. We do that within Massachusetts. I would hope New York, Ohio and Illinois are doing the same. Those working their way toward the dark blue of multiple legal partnerships, good luck. At the top of the screen there is the website for The National Center for medical-legal partnership if you want to find out more about this and there is a national meeting every year. I think next years will be held in Baltimore sometime in March which you can go to if you want to learn more about the model. That's it and we move to the next slide and it will say question and answer period. Thank you for participating today.

JOHANNIE ESCARNE: Thank you so much, Dr. Keller, great presentation. Actually I think it was so good that we don't have many questions.

>> Oh no.

JOHANNIE ESCARNE: At least not right now. Sometimes the audience is just typing away right now so I wanted to give the audience here an opportunity to ask questions if you have any. Or Dr. Keller, if you have anything else you wanted to talk about.

DAVID KELLER: What did I leave out?

JOHANNIE ESCARNE: Sometimes we'll get those last-minute questions as people are typing away.

DAVID KELLER: Okay.

JOHANNIE ESCARNE: One of the issues with Healthy Tomorrows project is sustainability. Clearly your program has sustained itself. How has it been sustained?

DAVID KELLER: Well, this is the question I was actually just asked this -- I've been the last couple of days at the Institute of Medicine at their annual meeting and there was another physician there whose wife is starting one of these programs. I've exactly which state it's in is struggling with finding the funding for it. We've been fortunate. Fundraising is part of the job since we first met in 2005 and I'll have to say that our legal partner has been essential to whatever fundraising we've done going forward. Healthy Tomorrows was wonderful for us because of the five year sustained funding and the need for a match. I think that was critical for us to be able to go to local funders and say look, we can keep this program going if you match it. And so we were able to get

funding from local foundations. We tapped into a couple of unusual foundations. I don't usually send in applications to the bar foundation, which was a source of funding. Through legal assistance. We were fortunate to get -- be part of a regional consortium grant through the Cox foundation. With the Boston folks we were part of a grant through Kellogg to develop evaluation techniques. They helped fund some of the evaluation work that we did so we've been nimble, agile and we had a private donor who gave us a substantial contribution at one point to keep it going? It's a patchwork with a big enough network now that we'll be able to support ourselves. Some of the novel things that have been tried in different parts of the country. I know in the -- somewhere in the Midwest and I'm betting it was Kansas, this is my memory, was funding theirs in collaboration with a hospital as part of a program to increase access to Medicaid and SCHIP for families by using the attorneys as -- to help get kids through the system and then funding some of their time with the revenue generated by having insured patients in the hospital instead of uninsured patients so there are some arrangements like that. I know would be problem that has a substantial endowment by a major donor. That's lovely if you can do it. I think programs all over the country, you have to be very creative and maximize the number of sources you're going for trying to keep it going. It is a constant challenge. One other thing that I know has been mentioned is -- it's the 10% idea. Whenever one Medical Center that does a lot of research has tried writing in 10% of an attorney into every grant they do so if they're doing a case management program for asthma or something for kids with special healthcare needs or something with somebody else. Part of their team is the attorney and the attorney gets funded to participate in these different research demonstrations

projects and that's another way you can think about doing it. Of course, last year HRSA, Maternal and Child Health Bureau did a call for proposals for medical-legal partnerships. I believe you awarded three last month.

>> We did for the Healthy Start grants.

DAVID KELLER: Supplement to Healthy Start. Of course, we're all hopeful that would continue but look at my colleague and smile.

JOHANNIE ESCARNE: Okay. Are there any other questions from the audience?

[[inaudible question] ooh

>> When you talk with your colleagues or other projects around the country do they realize that this Life Course framework until now -- or how it may have an effect?

DAVID KELLER: I think we all think of this -- I don't know that we use the word Life Course and I think that for me was, you know, your request that I put this into a Life Course context put me into a literature of which I was unfamiliar and as I was reading it I realized I actually was familiar with it just not from that perspective. I don't think there is anything in any of the Life Course literature that I read that would be foreign to the people who are doing medical-legal partnership. I don't think it was central to the evolution of it going forward. I think they really will fit. I can tell you that I intend to speak of this with people as going forward. We have our regional meeting coming up in

November and I believe I'll be on a panel on research and evaluation for that meeting and I was actually thinking it would be good to introduce this and ask people are you using this as you conceptualize this. It's another example of a model developed in the context of one sort of subset of public health specialty that hasn't really been widely taken up by others even though we're actually doing the same thing. That's a communication issue that I'll want to address going forward.

>> You talked a little bit about the medical side and then the legal side. Are there other professionals that you found that have -- that get pulled into the partnership? It sounds like some of what is going on is like case management or services that don't necessarily need to be provided from a medical side or a legal side but they could be someone sort of--

DAVID KELLER: In the context of a medical home in particular.

>> Yeah.

DAVID KELLER: Right. One of the things we've discovered and I think is true at many different centers is that when you have a practice that is organized around the lines of a medical home with someone explicitly designated as the care coordinator within the practice, whether that person is a parent who has been recruited and hired into the practice, which is one of the models, some models use professionals for this. Either professional care coordinators or professional case managers and community health

centers, of course, often have whole departments of social work that work as part of the community health center and at least one place it was a mental health worker. It was a physician -- there was a licensed social worker who mostly did mental health work but who ended up taking on the care coordination responsibility. Those practices seem to be better able to adapt to the team concept of having a lawyer on the team and I don't have evidence to back this up but anecdotally I think it's because they're already used to thinking in teams and you are just augmenting the team. I think bringing in the attorney and doctor and saying you can do it is kind of like saying a physician can be the medical home. Yes, we need a physician and we need a practitioner -- I'm sorry my nurse practitioner colleagues would be mad at me for saying that. We need a practitioner in there. Somebody with clinical skills in the mix but you really need a team that is going to look at the child and the family holistically going forward. That is not going to be just a single person. I think all the people who tried to do it as a single person burn out because it's too much to do. So I think if you look at the different -- roughly, when you look at the different practices that were part of our project, the ones that had more effective teams to start with were the ones that generated more referrals into our program. It's kind of the opposite of what you would expect. The people that had the more developed system that we could latch onto and able to access this system better. You almost would think the people with no system would have more things to dump into this. The reality is they're spinning their wheels so much they can't dump it into anything. I think that's true. We certainly have social workers involved in this. We have long discussions about what the social worker and the lawyer would do. Those

are discussions that you have at a granular level as you figure out how the program works.

JOHANNIE ESCARNE: Great. Thank you, Dr. Keller.

DAVID KELLER: Thank you very much.

JOHANNIE ESCARNE: I don't see any other questions that came up. Okay. Well, then on behalf of the Division of Healthy Start and perinatal services I would like to present our presenter, Dr. Keller and the audience for participating in this webcast and 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 at 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.