Community health partnerships have increased in popularity, but their effectiveness is often not evaluated. Through secondary data analysis, this study evaluates a program that offered access to legal services to address health-related issues, such as Medicaid reimbursement, Social Security benefits, medication coverage, and divorce. Based on the analysis reimbursements to expenditures, the health and law program appears to be cost-effective and thereby economically sustainable. The cost-effectiveness of this program increases the likelihood that it will be institutionalized and/or expanded. This program evaluation is used to exemplify how community stakeholders could partner to leverage resources to establish a sustainable community health and law program to address the needs of people living in medically underserved areas.

**Keywords:** partnership; community health; law; sustainability; evaluation

The Jakarta Declaration on Leading Health Promotion Into the 21st Century recommended expanding partnerships to increase community health capacity and infrastructure (World Health Organization, 1997). In the past two decades, there have been many examples of health-focused partnerships in the United States that utilized various partnership structures (e.g., Campbell & Conway, 2005; Erwin, Hamilton, & Welch, 2005; Greenberg, Howard, & Desmond, 2003; Kassler & Goldsberry, 2005; Lyons, Lindsell, Ledyard, Frame, & Trott, 2005; Roussos & Fawcett, 2000; Suarez-Balcazar, Harper, & Lewis, 2005; Yancey et al., 2004; Zahner, 2005). Although many have not been evaluated, some of these partnerships, such as the Turning Point Project and other public health initiatives serving underserved communities, have shown effectiveness in improving community health (Hann, 2005; Margolin, Hasnain-Wynia, Torres, & Pittman, 2004).

**Barriers to Community Health**

Three of the important barriers to receiving health care—(a) access to health care, (b) community members’ navigation of the health care and related systems, and (c) sustainability—provide opportunities for partnerships to make a difference in medically underserved communities. Based on Healthy People 2010, many people are underserved with regard to access to health care (U.S. Department of Health and Human Services, 2000). Furthermore, programs that assist economically disadvantaged individuals in navigating complex health care and legal systems can help those in need better utilize health care services. People in need of navigation services could be identified by community partners on an ongoing basis and referred to navigation programs in ways that could be sustainable. Health navigators in the health care system have successfully integrated the efforts of health care partners to improve the effectiveness of the health care systems by acting as “interorganizational integrators” (Lemak, Johnson, & Goodrick, 2004). This study extends the integrative role of health
navigation beyond the health care system by better integrating the legal system.

**Defining Types of “Partnerships”**

Though often used interchangeably, the terms collaborative, coalition, and cooperative have been distinguished in the literature (Padgett, Beckemeier, & Berkowitz, 2004). On a continuum, cooperatives involve the least commitment from community partners, whereas collaboratives involve the most. Cooperatives are loose associations of parties working together based on a common interest or goal; coalitions also include sharing resources and joint planning toward a single issue; collaborations involve longer term commitments and often are directed at more than one issue (Tobacco Technical Assistance Consortium, 2004). Partnerships can also be intersectoral, for example, governmental and nongovernmental organizations working together. The health and law partnership, which is the focus of this study, is best categorized as an issue-oriented (Cheadle, Senter, Solomon, Beery, & Lovick, 2001) coalition.

**Challenges and Opportunities for Effective Health-Focused Partnerships**

Health promotion programs should be enacted that address ongoing and new issues of current and future clients. Furthermore, addressing the current and future needs, assets, and interests of each of the partners involved in planning, implementing, and/or evaluating a health promotion program is also necessary to increase the likelihood of partnership sustainability.

To overcome issues in interdisciplinary partnerships, partners should carefully delineate professional roles, address unique structural characteristics, recognize personal characteristics, and build on their history with interdisciplinary collaborations (Bronstein, 2002; Thompson, Socolar, Brown, & Haggerty, 2002). While planning a collaborative partnership, stakeholders should meet regularly to build trust and ownership of the partnership and its programs, develop a strategic plan for the partnership, identify a shared vision and mission, provide administrative support, identify social networks and leadership styles, and ensure mutually beneficial outcomes (Boswell & Cannon, 2005; Johnson, Wistow, Schulz, & Hardy, 2003; Olson, 2003; Porter & Baker, 2005).

When evaluating partnerships, logic models have been recommended as an effective tool in communicating processes and impacts. In addition to a logic model, this study’s evaluation will describe the partnership’s infrastructure, function, processes, program, and community change (Butterfoss & Francisco, 2004; Green, Daniel, & Lovick, 2001).

**Health and Law Collaborative Partnership**

**Background of the program.** According to the 2000 census, all of the counties’ poverty percentages exceeded the average percentage of families and individuals living below the poverty levels for the state of Illinois. The proportion of individuals living below the poverty level across counties in the program service area was 16.1%, and all except one county had an extreme poverty rate of greater than 5.0% (McNamara & Schenkelberg, 2007). Furthermore, all of the seven counties in the program’s service area were on either the Illinois Poverty Watch or Warning Lists in 2005 or 2006 (Illinois Poverty Summit, 2005, 2006), and all of the counties were designated as Health Profession Shortage Areas and Medically Underserved Areas by the United States Health Resources and Services Administration’s Bureau of Health Professions.

The health and law program was designed to enable underserved and socioeconomically disadvantaged individuals to receive legal assistance services and better navigate the complex health care system (Shi & Singh, 2004). Specifically, some of the pervasive problems of the disadvantaged (Marmot & Bell, 2006), such as medically based economic burdens (Geiger, 2006) or other financial and social hardships, were intended to be reduced through public health services (Plough, 2006). Legal assistance was provided mainly in the areas of public benefits, personal disability, family issues, and employment issues.

**Development of the program.** In the late fall of 2001, the program’s legal aid attorney and the community...
benefits director of a local hospital system met. During this meeting, they discussed a health and law project in an urban Boston area that was based out of a pediatric clinic and the possibility of implementing a similar program in rural southern Illinois. Based on follow-up planning meetings between representatives of a local hospital system, a legal aid foundation, and a local university law school, it was decided that a health and law pilot project would be conducted for 12 weeks in 2002.

To gauge the need and interest in the program, a law student with experience in interviewing and Medicaid law was placed at a local health clinic. During the 12-week pilot, 13 files were opened, and the program was considered cost-effective. Following the pilot, across 2002 through 2006, the program was expanded in both scope and staff. Although the health and law program has continued implementation beyond 2006, this study’s secondary data analysis focuses on and describes the health and law demonstration project conducted from 2002 to 2006.

Originally, the key partners for the health and law program included the community benefits director of a nonprofit health care system, a representative of a university law school, and a senior legal aid attorney specializing in public benefits law. The legal aid attorney provided the day-to-day oversight for the program. Funding provided by the nonprofit health care system to the legal assistance organization also enabled the legal assistance organization to secure the services of a paralegal to assist in the implementation of the program. The program was originally located within a community health resource clinic, a free medical clinic for the economically disadvantaged. Later the program was operated primarily out of an independent facility, though a strong link was maintained with the clinic.

Expansion of the program. When the health and law program began, referrals only came from the program liaison placed at a local health clinic. Then, 9 months into program implementation, an intake referral sheet was developed and distributed to all of the social workers and case managers in the local hospital system. Once a referral sheet was received in the legal assistance office, a legal assistant would contact the social worker or case manager and then meet with the patient. The legal assistant determined if the case warranted review by a foundation lawyer.

Several months later the program began soliciting referrals from other clinics and social service agencies. Program staff made presentations to applicable staff within these referral agencies to describe the services of the program. Referrals involving only administrative proceedings could be handled by either legal or nonlegal (e.g., social worker) program staff, whereas legal proceedings could only be handled by a foundation attorney or an outside pro bono attorney.

Purpose of the study. Although community collaborative partnerships are becoming more common, they often do not evaluate program processes or impacts. Without evaluation, the effectiveness of the partnership model cannot be established and partnership sustainability can be threatened (Hausman, Becker, & Brawer, 2005). Peer-reviewed documentation of collaborative partnerships between primary health care organizations and other community organizations is especially lacking (Schlaff, 2005).

This study focused primarily on evaluating the process and impact of a collaborative partnership among a nonprofit health care system, a nonprofit legal assistance service, a university law school, and a university health education program. Following the partnership model, the key stakeholders met with an evaluator from a local university’s health education program and collectively decided on a feasible evaluation plan that was useful and ethical.

METHOD

The health and law program was originally designed to (a) implement services for underserved people living in rural southern Illinois, (b) maintain client records, and (c) create reports for program partners. Formal process, impact, and outcome evaluation of the program were not initially planned. However, following perceptions of program success, the original partners wanted to determine whether the effectiveness of the program could be assessed using existing program documentation. In collaboration with two new partners from a health education program of a local university, a secondary data analysis of 5 years of existing documentation (2002-2006) was planned. Although formal evaluation was not planned a priori, existing data were of sufficient detail to allow for evaluation of cost-effectiveness to the funder.

Following approval from two institutional review boards and in accordance with the organizations’ policies, deidentified data were transferred to the university partners for transformation and analysis. The key elements of the data set included the amount of funding provided to the project, the organizations making referrals to the legal assistance program, the total number of client contacts, the number of closed cases, the type of cases, the resolution of cases, and benefits to the clients and to health care providers that resulted from program actions. The total amount billed to clients for medical services was also included in the
existing documentation. The actual amount paid to health care providers by Medicaid was estimated based on hospital-specific Medicaid reimbursement rates.

Two techniques were used to evaluate effectiveness: logic modeling and simple return on investment (ROI). Logic models, sometimes referred to as input-output models, organize the causative and outcome variables into chains of influence. The resulting model then represents the theory of how the outcome variables were affected. Logic models are often used to evaluate the effectiveness of programs (Schmitz, 2007). Because only descriptive statistics are used, logic models can be applied to programs with small sample sizes. Logic models are often depicted graphically (see Figure 1). Return on investment was calculated only for the funding health care partner. Only Medicaid returns were included in the numerator because they could be easily tracked and verified. In this study, return on investment is not an annual percentage but a percentage return for the entire project, which took place across 4 years.

RESULTS

From 2002 to 2006, 428 cases were reviewed by the legal assistance partner, and 372 referred clients had their cases closed by the legal assistance service. Note that some clients had more than one case. The mean age of clients at the time of referral was 47.6 (SD = 12.8). Females comprised 52.1% of the cases and about half of the clients, and Caucasians made up 76.1% of the cases (2000 census data showed that the percentage of Caucasian/White people in the served counties ranged from 80.8% to 98.6%; the average percentage of Caucasian/White across the service area was 91.0).

More than half (59.1%) of the referred cases originated from the health care provider affiliated with the
funding partner (the nonprofit health care system); 21.0% of cases were referred by a local nonprofit health resource clinic; 14.5% of cases were referred by a federally qualified community health care center; 2.3% of cases were referred by family practice physicians at a local university; 1.6% of cases were referred by a family member or other social network; the remaining 1.4% of cases were referred by a social service organization. The expended programmatic cost averaged $321 per client and $270 per case.

As of the end of 2006, 372 of the 428 total cases (87%) were documented as closed. The 13% of cases that remain pending were all opened in either 2005 or 2006. Of the closed cases, 95 (25.5%) resulted in positive outcomes for clients, meaning that a case was decided in the client’s favor (“winning cases”). Of the winning closed cases, 32 clients received Social Security benefits, 28 clients received Medicaid benefits and reimbursement, 15 clients received power of attorney rights; 6 clients had a property or housing dispute resolved, 4 clients received assistance with wills, 4 clients received a divorce, 1 client received child support, 3 clients received medication benefits or reimbursement, and 2 clients received employment benefits (payment for services and a dispute over wage garnishment). Of the closed cases, 159 (42.7%) resulted in clients receiving legal advice and/or referrals to an appropriate legal assistance entity. For example, 31 cases were referred to a local university law clinic, 17 cases were referred to pro bono attorneys of law, and 4 cases were referred to either social services or charity health care services. The remaining 118 closed cases were either not won (50), lost to follow-up (52), or closed due to a change in client’s interest or need (16).

The health care organization partner dedicated $115,438 to the health and law program across the 4-year period (2002-2006). Based on the 20 clients with documented Medicaid services and benefits resulting from the health and law program, local health care providers collected $296,704 in Medicaid adjusted reimbursement for health care services, and clients had $1,177,844 of billed health care services covered by Medicaid. The actual amount of medical benefit to clients and health care providers may be higher because the Medicaid reimbursement received by 8 clients was not adequately documented. If one assumed that the 8 clients with missing Medicaid reimbursement data received the mean amount of the known patients’ adjusted Medicaid reimbursement, then (a) the Medicaid coverage to clients would have been $471,138 higher (additional billing amount covered) and (b) the additional payment to health care providers would have been $118,681 more (the additional amount collected).

Simple return on investment for the funding partner was calculated by taking the difference between the documented Medicaid adjusted reimbursement collected by the funding partner, which resulted from the health and law program, and the funding partner’s original funding for the program. Based on this calculation, the known ROI for the funding health care organization was $172,135 ($287,573 - $115,438) or 149% ($287,573/$115,438) more than the amount invested. The known monetary benefits per case exceeded the costs ($270) by $402 per case. This case-level ROI calculation does not include estimated Medicaid reimbursement amounts for clients with missing data or potential indirect economic impact through receiving Social Security benefits, disability benefits, medication benefits, or the potential improvement in mental or physical well-being of clients who participated in the health and law program. The process and impacts of the health and law program are summarized in Figure 1.

DISCUSSION

The health and law program assisted clients in addressing personal issues such as Medicaid coverage, medication payments, Social Security benefits, and family law issues including divorce and child support. Family law issues, such as divorce, can be stressful for both parents and children (Canady & Broman, 2003; Martin, Friedman, Clark, & Tucker, 2005; Tschann, Johnston, & Wallerstein, 1989; Wallerstein, 1986), but some of the effects of divorce could be mediated by altering certain social or psychological circumstances (Canady & Broman, 2003; Martin et al., 2005). Although not measured directly, the health and law program may also have alleviated some of the stressors related to divorce or child support. Furthermore, certain income-related problems were either directly or indirectly addressed. For example, gaining access to Social Security benefits directly increased total income, whereas medication reimbursement influenced disposable income. In addition, due to high poverty, low Medicaid reimbursement rates, and shortage of medical providers, the process of receiving Medicaid reimbursements in many rural areas can be stressful for both the patient and health care provider (e.g., Waitzkin et al., 2002; Willging, Waitzkin, & Wagner, 2005). In this regard, the health and law program assisted individuals living in rural southern Illinois to navigate the complex medical and legal systems by establishing a health care legal navigator system that referred patients to pro bono legal aid, thereby facilitating legal solutions to health-related problems and improving access to legal counsel from credentialed.
trained, and experienced legal aid staff (Lemak et al., 2004).

The benefits of this program would likely not have been achieved without the formation of this partnership. The program could not have been implemented without an initial investment of more than $100,000. The health care organization had the ability and willingness to provide this funding because it believed it would directly benefit from the results. However, it did not have the legal credentials or the expertise to assist clients in gaining access to the social services financing systems.

In addition to evidencing a positive ROI, the structure of the health and law partnership offers an example of a health-focused program that may be sustained and potentially expanded in an underserved rural community. By showing a funder that the monetary returns outweigh expenditures, partners could recommend the continuation of the health and law program based on substantiated economic benefits above and beyond the implicit social benefits. For example, many grants fund programs for a finite period of time and when the end date for the funding arrives the program is removed from the community (planned obsolescence). Developing a strategic plan for community health-focused programs’ sustainability is crucial to building community capacity not only for the present but also the future.

**Recommendations**

The type of partnership discussed in this study has potential for replication in other communities. Although community benefits departments within nonprofit hospitals vary in their institutional policies and staff abilities, most share a similar mission to improve the health of the communities they serve (Seto & Weiskopf, 2000). For those nonprofit hospitals with access to nonprofit legal assistance programs and other local health-focused organizations, creating and funding a health-focused legal assistance program could help at-risk community members to navigate the health care and legal systems and potentially increase their number of billable patients. In other instances, partners may secure grants to initiate the program but make agreements to reinvest a portion of the returns to ensure sustainability. For example, preliminary data from this health and law program inspired another division of the local legal aid foundation to team with another hospital system to expand the health and law program in rural Illinois. Evaluation of health and law partnerships could assist in maintaining current programs or expanding these type of programs, thereby providing services for greater numbers of individuals who are underserved and in need.

Although this program had data sufficient for evaluation of cost-effectiveness to the funder, evaluation procedures should ideally be planned during the program development stage. Such programs may want to consider evaluating other outcomes in addition to funder ROI. For example, a limitation of this study is that existing data from this program did not allow the impact on other financial, social, or emotional benefits to the clients to be evaluated.

**Conclusion**

Program partners are currently attempting to expand the health and law initiative to include additional sites within the health care safety network (e.g., federally qualified health centers, community mental health providers, health departments). With added funding from the not-for-profit health care system, the legal assistance organization has hired a full-time paralegal that serves to assist patients in the free clinic setting (in which the program was initiated), the not-for-profit health care system, and other community health settings. In addition to direct service to patients, the legal assistance staff will provide education to the referral organizations so that they can better understand the legal process and more accurately identify potential cases for legal assistance referral. Educational seminars are being planned for nurses, case managers, and other health care providers to identify legal issues that the program may want to address to further improve the way it assists individuals and families. Specified training for physicians is also being planned so that they can better understand how to help their patients navigate the health care, public aid, and legal assistance systems, thereby increasing the health literacy of physicians as well as the patients they serve. This will further help expedite the approval of reimbursements from public aid programs and allow them to better provide health care for their patients.

The low-income, underserved people in many rural southern Illinois communities experience higher mortality and morbidity rates compared to state averages. Some of this disparity may be reduced by increasing access to care. In this respect, the program’s goals and activities in part address Healthy People 2010’s initiatives to improve access to health care. Some do not access medical care because the medical provider, payment, and financing systems are cumbersome. Through this unique collaboration of providers of health and
legal services, underserved individuals are gaining greater access to health care, legal, and social services.

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