THE STATE OF THE Medical-Legal Partnership Field

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Findings from the 2016 National Center for Medical-Legal Partnership Surveys

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THE NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP

The mission of the National Center for Medical-Legal Partnership (NCMLP) is to improve the health and wellbeing of people and communities by leading health, public health, and legal sectors in an integrated, upstream approach to combating health-harming social conditions. Over the past several years, NCMLP has helped increase the number of medical-legal partnerships in the U.S. to nearly 300. These partnerships serve children, chronically ill adults, the elderly, Native Americans, and Veterans. NCMLP spearheads this work in four areas: (1) transforming policy and practice across sectors; (2) convening the field; (3) building the evidence base; and (4) catalyzing investment.

ACKNOWLEDGMENT

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INTRODUCTION

Now more than ever, the U.S. health care system strives to address the social and environmental factors that affect health. Health care organizations deploy social workers, case managers, navigators, and lawyers alongside clinicians in order to tackle a myriad of determinants of their patients' health and wellbeing.

Meanwhile, more Americans now have health insurance under the Affordable Care Act (ACA) thanks to new insurance exchanges and Medicaid expansion. In addition to increasing the number of Americans insured, the ACA has propelled a shift from the traditional fee-for-service payment model toward value-based care, incentivizing health care organizations to invest in outcomes and to cultivate population health strategies. There has never been a more opportune time for health care organizations to begin to systematically address the social and environmental factors that can keep their patients from attaining the best possible health outcomes.

While many health care organizations have long recognized the role that social factors play in their patients' lives, the concept of having lawyers on-site assisting patients is a relatively new idea. Nevertheless, for a growing number of health care organizations, civil legal aid is a lifeline that is routinely called upon to assist patients with problems that cannot be addressed by traditional clinical resources. Legal aid attorneys have an in-depth understanding of how federal, state, and local policies affect a patient's ability to access health insurance and other critical public benefits, maintain safe and affordable housing, navigate immigration issues, and seek out solutions to so many other health-altering problems. They are uniquely suited to help patients, physicians, and administrators navigate shifting political landscapes, and are primed for playing a role in new innovations in population health.

Simple in design yet elegant in purpose, medical-legal partnerships (MLPs) integrate civil legal aid services alongside health care services to mitigate the most complex social conditions that may disadvantage individuals, families, and communities. Health care and legal professionals in MLPs work together to identify vulnerable patients who have unmet civil legal needs — such as those related to housing, public benefits, and educational needs — that negatively impact their ability to live healthy lives. MLPs train clinicians and other health workers to recognize these "health-harming legal needs" and do something to help. They establish protocols and interventions to address many of these needs at the health care site and also create a fast-track pathway to civil legal aid professionals who specialize in helping people get access to a broad range of benefits and services, and can prevent some of the most intractable problems, like illegal eviction. In communities across the country, MLPs have also leveraged their considerable knowledge and expertise related to health-harming legal needs to advance local and state policy to provide safer and healthier environments.

Today, over 300 MLPs comprise the landscape of partnerships nationwide, demonstrating enormous diversity in terms of the patient populations served, as well as the size, structure and scope of the particular MLP. MLPs are growing and spreading at a time that other federal and state initiatives are not only recognizing, but are also investing in a systematic approach for identifying and addressing social determinants of

health. Over the past couple of years the National Association of Community Health Centers, for example, has helped to implement its Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) in dozens of federally qualified health centers to better understand the social determinants of health faced by their patients. At the core of PRAPARE is an assessment tool that includes a core set of measures, aligned with other national efforts around social determinants of health, to capture social and environmental risk factors among patient populations. This year, the Centers for Medicare & Medicaid Services funded an Accountable Health Communities Model in several communities throughout the country to bridge the gap between health care and community services, and to assess whether identifying and addressing social needs impacts cost.

The National Center for Medical-Legal Partnership (NCMLP) at George Washington University serves as the leading resource on the MLP approach to care (see www.medical-legalpartnership.org). Founded in 2006, NCMLP has nurtured the growth of partnerships from Hawaii to Maine. In 2016, NCMLP surveyed individual MLPs across the country to develop a deeper understanding of the particular characteristics of organizations that actively participate in this rapidly growing field. Specifically, we sought information to answer five important questions:

1. What are some of the characteristics of medical-legal partnerships?
2. Whom do medical-legal partnerships serve?
3. What resources are associated with operating a medical-legal partnership?
4. How do health care and legal organizations integrate service delivery and information sharing to accomplish their goals?
5. In what ways do medical-legal partnerships advance health and wellbeing?

This report presents findings from the 2016 NCMLP Surveys of MLPs. It describes the methods used to conduct the survey and follows with five sections of findings that correspond to the questions posed above. Finally, the report offers three primary areas for MLP growth and improvement based on the survey results. The recommendations include to:

Establish standard practices for identifying and addressing health-harming civil legal needs, including a screening process in the health care setting and protocols to link patients with legal services when appropriate.

- Without consistent screening, it is impossible to understand the actual demand for civil legal aid among patients.

Capture the impact of MLP services on patients and MLP health care organizations.

- Collecting data on the financial benefits that result from MLP services, both for patients and health care organizations, is one feasible and quantitative way to demonstrate impact. This information can be used to leverage continued and increased investment in MLP programs, though the survey data shows that few MLPs are collecting this information.

Grow, improve, and sustain MLPs by building out critical infrastructure elements like diverse and stable funding streams, information technology supports, and dedicated staffing.

- This survey shows that funding and staff support, and data infrastructure for MLP activities is more likely to come from legal organizations. An investment of dollars, staff, and information technology from the health care organizations to help support the activities of the MLP could bring greater sustainability and strengthened partnership.

SURVEY METHODS

Health care and legal organizations actively operating an MLP in 2016 were invited to participate in the 2016 NCMLP Survey. The list of MLPs was drawn from NCMLP's contact lists accumulated through periodic solicitations to the field. The survey was conducted over an eight-week period during December 2016 and January 2017.

The NCMLP survey questionnaires were developed by researchers from the National Center for Medical-Legal Partnership, with input from experts at Westat Corporation. The survey was first fielded in 2015. Some questions were revised to collect additional detail in the 2016 survey.

The NCMLP Survey consists of two separate questionnaires to gather information about MLP characteristics and activities. One questionnaire solicits information from health care organization partners and another seeks information from legal organization partners. The two-questionnaire design reflects the fact that MLPs generally operate across different organizational domains and professional sectors. The questionnaires included a number of identical questions, which allowed comparison across organizational type. They also included questions that were relevant only for a health care or a legal partner organization.

NCMLP sent emails to contacts at individual MLP partner organizations, highlighting the importance of the survey and encouraging their participation. Contacts were asked to forward the survey to the person at their organization who was most knowledgeable about the MLP and its operations. The questionnaires were designed such that health care organizations could complete all questions without input from their legal partner organization, and legal partner organizations likewise could complete them independent of their health care partner organization.

A total of 425 organizations were considered eligible for the survey, meaning that they were a health care or legal organization actively engaged in an MLP. Of these, 275 were health care organizations and 150 were legal organizations. We received a total of 232 completed surveys, for an overall response rate of 55 percent. The response rate for legal organizations was slightly higher than for health care organizations; the legal organization response rate was 69 percent compared to 47 percent for health care organizations. Survey data was collected through Survey Monkey and analyzed by NCMLP staff.

FIGURE 1. NCMLP SURVEY RESPONSE RATES

TYPE OF RESPONDENT	TOTAL SURVEYED	RESPONSE RATE
All organizations	425	55%
Health care organizations	275	47%
Legal organizations	150	69%

Source: 2016 NCMLP Survey

The data have not been weighted. Because the survey sample is based on those who self-selected for participation rather than a probability sample, no estimates of sampling error can be calculated. All sample surveys may be subject to sampling error, coverage error, and measurement error.

Survey responses reflected MLP activities in 41 states and the District of Columbia. The top three states with the highest number of survey responses were California, Illinois, and Pennsylvania. The nine states that are not represented are Alabama, Alaska, Colorado, Idaho, Nevada, North Dakota, South Dakota, Utah, and Wisconsin.

Questionnaires were completed by different MLP participants depending on the type of organization or the engagement of different staff in the MLP enterprise. In the case of legal partner organizations, 85 percent of questionnaires were completed by a lawyer. A variety of individuals responded to the questionnaire on the health care organization side. Thirty-six percent of survey respondents were physicians, 20 percent were administrators/managers, 14 percent were social workers, 8 percent were nurses/nurse practitioners, 6 percent were CEOs/executive directors, 4 percent were attorneys and 9 percent were other staff. The health care and legal questionnaires are both available on NCMLP's website at www.medical-legalpartnership.org/2016-mlp-survey-report. Click here to view the health care partner questionnaire, and click here to view the legal partner questionnaire.

RESULTS

1. Key Characteristics of Medical-Legal Partnerships

HEALTH CARE ORGANIZATIONS WITH MLPS AT-A-GLANCE

The field of medical-legal partnership continues to be in a growth phase. Approximately 41 percent of health care organizations indicate that their MLP has been active for more than five years. These more mature MLPs are the pioneers of the field. Serving as early testing grounds for incorporating legal aid into the health care setting, they act as leaders for spreading the innovation more broadly across the health care landscape. Even with the experience of these MLPs, however, it is important to acknowledge that the MLP approach is still quite young, with much to learn as the field grows and matures. According to health care organization survey respondents, nearly one third of MLPs (31 percent) are two years old or less and 28 percent are three to five years old. As Figure 2 illustrates, children's hospital-based MLPs tend to be more established (in terms of age) compared to general hospitals and health center-based MLPs.

While the first MLPs to be formed were mostly based in hospitals (often in pediatrics services or a children's hospital), other types of health care organizations have since embraced the MLP approach to care. As Figure 3 indicates, today half of health care organizations engaged in MLPs are located in hospitals or health systems, including children's hospitals. Community health centers, the Veterans Health Administration facilities, behavioral health organizations, home health organizations, and other health care organizations are also home to MLPs.

Reflecting MLP's mission to address health-harming needs of low-income and vulnerable populations, health care organizations with MLPs tend to be situated in areas with high health care needs. Most health care organizations with MLPs are located in underserved areas and report that at least one quarter of their patients are on Medicaid. Many of these health care organizations serve high numbers of uninsured — this is particularly prevalent in FQHCs, with over half (57 percent) reporting high rates of uninsured (see Figure 4). In addition, many health care organizations are actively engaged in innovative practices related to the dynamic health care environment. Half of health care organizations with MLPs are certified as Patient-centered Medical Homes and more than one quarter (27 percent) are part of Accountable Care Organizations (ACOs).

Highlights

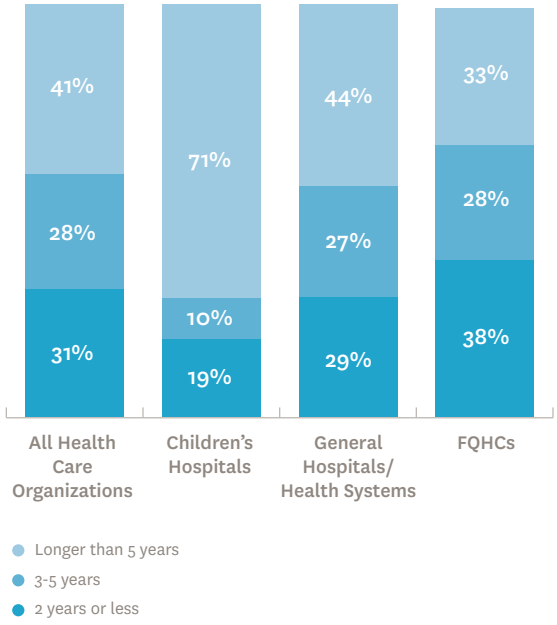
HEALTH CARE ORGANIZATIONS PARTICIPATING IN AN MLP TEND TO BE:

- Located at general hospitals, children's hospitals, or federally qualified health centers;
- Situated in underserved areas and serve high-Medicaid populations; and
- Less than five years old.

LEGAL ORGANIZATIONS PARTICIPATING IN AN MLP TEND TO BE:

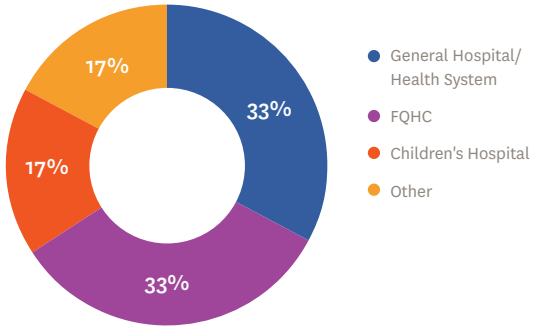
- Civil legal aid organizations, split between organizations who receive federal Legal Services Corporation funding and those who do not receive this funding; and
- Actively engaged in MLPs with more than one health care organization.

FIGURE 2. AGE OF MLP BY HEALTH CARE ORGANIZATION TYPE



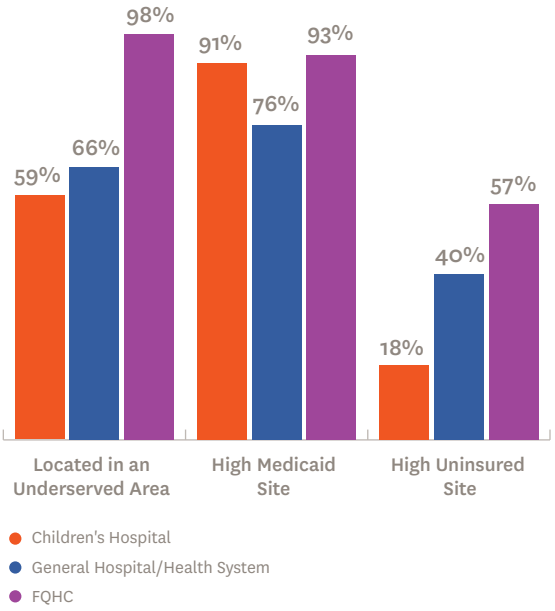
Notes: n=123 for all, 21 for children's hospitals, 41 for general hospitals/ health systems, and 39 for FQHCs.
Source: 2016 NCMLP Survey.

FIGURE 3. HEALTH CARE ORGANIZATIONS WITH MLPS BY ORGANIZATION TYPE



Notes: n=129.
Source: 2016 NCMLP Survey.

FIGURE 4. POPULATIONS SERVED BY HEALTH CARE ORGANIZATIONS WITH MLPS



Notes: n=22 children's hospitals, 43 general hospitals/health systems and 42 FQHCs. "High" refers to at least 25% of patients served by health care organization.
Source: 2016 NCMLP Survey.

Highlight: Federally Qualified Health Centers — An Area of Growth for MLPs

Notably, one-third of health care organizations that are home to MLPs are federally-qualified health centers (FQHCs). Although addressing social determinants of health has long been a part of the mission of FQHCs, these organizations represent an area of recent growth for the formation of MLPs. Two in three FQHCs with an MLP have established the partnership within the last five years (see Figure 2).

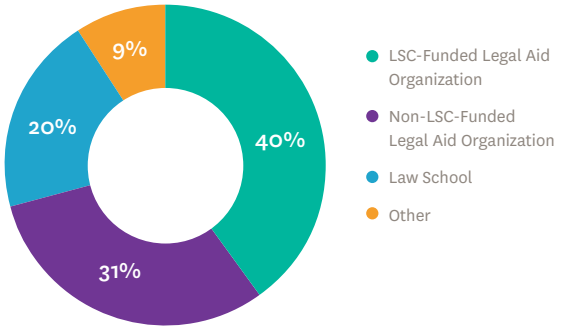
The Health Resources & Services Administration (HRSA) is now actively encouraging health centers to consider the benefits of MLP for their patient populations. HRSA works closely with NCMLP to provide technical assistance and support to interested health centers through a federal National Cooperative Agreement. The HRSA National Training and Technical Assistance Cooperative Agreements provide for free technical assistance and training to improve clinical quality and operations in health centers.

In July 2016, HRSA announced a supplemental funding opportunity under which health centers could apply for awards to expand the services they offer. Up to 20 percent of the award could be used to increase the availability of enabling services, including civil legal aid services. (See issue brief: "Building Resources to Support Civil Legal Aid Access in HRSA-Funded Health Centers.") Thirty-eight percent of health centers surveyed indicated that they use some enabling services funding to support MLP services for their patients.

LEGAL ORGANIZATIONS PARTICIPATING IN AN MLP AT-A-GLANCE

Like health care organizations with an MLP, their legal partner organizations also demonstrate diversity in terms of their organizational characteristics. Three-quarters of legal respondents are civil legal aid organizations, split between LSC-funded (40 percent) and non-LSC-funded (31 percent) entities. One in five legal organizations are law schools and 9 percent are other types of organizations such as private law firms (see Figure 5).

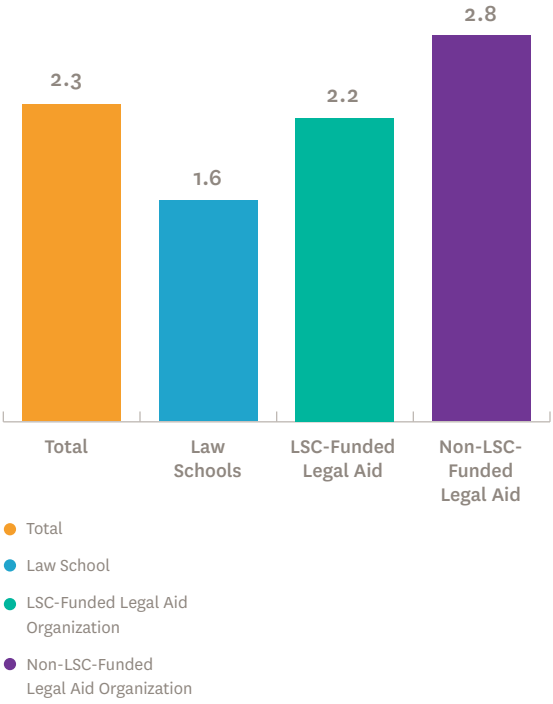
FIGURE 5. LEGAL ORGANIZATIONS WITH MLPS BY ORGANIZATION TYPE



Notes: n=103.
Source: 2016 NCMLP Survey.

Unlike health care organizations, which tend to be affiliated with only one legal partner, legal organizations often partner with more than one health care organization to provide civil legal aid services and support. Legal organization respondents indicated that they partner with an average of 2.3 health care organizations (see Figure 6).

FIGURE 6. AVERAGE NUMBER OF ACTIVE MLPS THAT LEGAL ORGANIZATIONS SUPPORT



Notes: n=103 for all legal organizations, 41 for LSC-funded legal aid organizations, 32 for non-LSC-funded legal aid organizations, and 21 for law schools. Means were not significantly different by legal organization type.

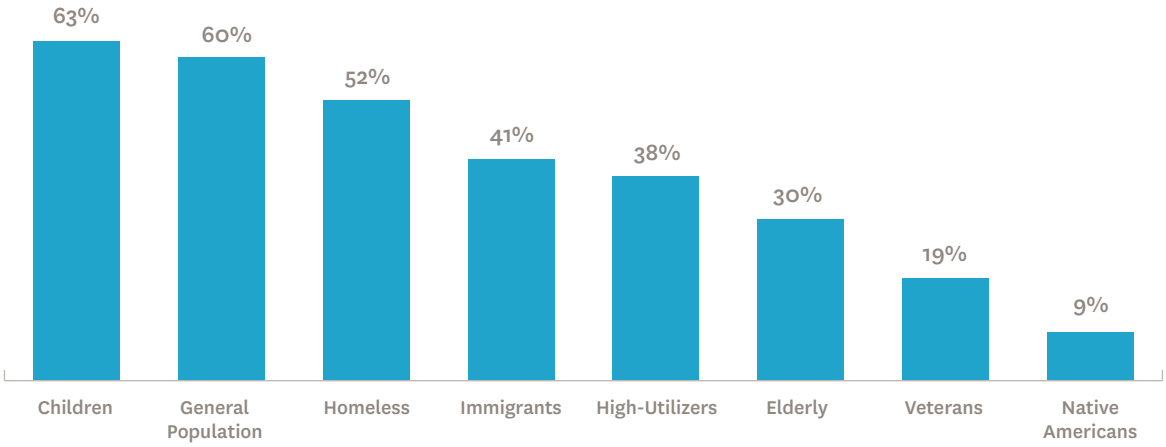
Source: 2016 NCMLP Survey.

2. People Served by Medical-Legal Partnerships

Health care and legal organizations who participate in MLPs do so for one overriding purpose — to improve the lives of the people in their community. Of paramount importance is an understanding of the conditions and challenges that impede people's health and the opportunities that legal interventions can provide. Some MLPs address a broad collection of health-harming civil legal needs, while others target a narrower patient population with a more focused set of civil legal interventions. MLPs adapt to their local surroundings, both in terms of the health care environment and organizational constraints, as well as the types of legal needs demonstrated by patients and the specific legal resources available to address those needs.

We asked the health care organizations surveyed to report the populations that their MLP serves, with the understanding that many MLPs serve multiple population groups. As can be seen in Figure 7, the most common response was children (63 percent) and the general population (60 percent). Half of the respondents reported that they provide civil legal services to the homeless (52 percent) and four in ten (41 percent) reported serving immigrants and high-utilizers. A substantial share of MLPs also serve elderly patients, veterans, and Native Americans.

FIGURE 7. POPULATIONS SERVED BY MLP INTERVENTIONS AT HEALTH CARE ORGANIZATIONS



Notes: n=129.
Source: 2016 NCMLP Survey.

HIGHLIGHTS

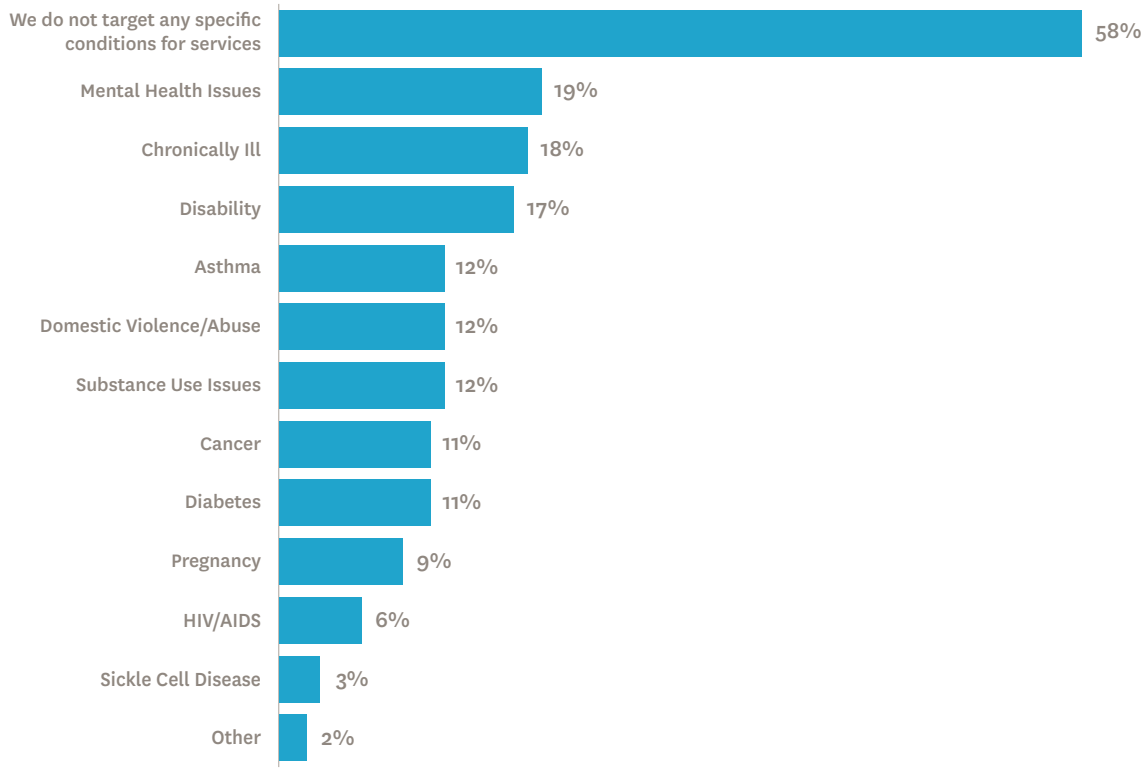
HEALTH CARE ORGANIZATIONS THAT PARTICIPATE IN AN MLP:

- Are likely to provide legal services to the general population and children;
- May target certain health conditions for MLP services; and
- Screen for health-harming legal needs, though inconsistently, and often rely on social workers to administer the screening.

LEGAL ORGANIZATIONS THAT PARTICIPATE IN AN MLP:

- Receive referrals from health care partner organizations for a variety of legal issues, and manage referrals through various levels of interactions with patient-clients and clinical staff; and
- Provide civil legal aid interventions related to all five I-HELP™ needs.

FIGURE 8. HEALTH CONDITIONS TARGETED FOR MLP SERVICES AT VARIOUS HEALTH CARE ORGANIZATIONS



Notes: n=129.
Source: 2016 NCMLP Survey.

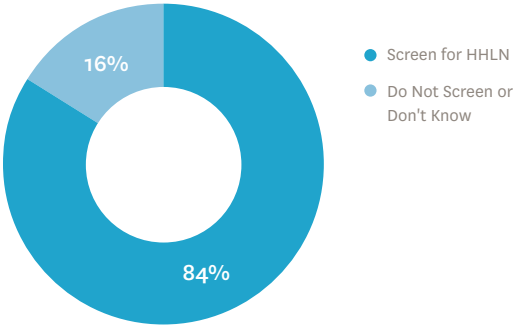
We also asked health care organizations whether they targeted specific health conditions for MLP interventions. More than half of health care organizations (58 percent) do not target any specific conditions for services; however, a notable segment of the MLP field targets patients with a specific condition or health need. In this context, "targeting" patients refers to focused screening or interventions, or eligibility for MLP services related to a particular health condition or circumstance. As can be seen in Figure 8, if an MLP targets a specific health condition, it is most likely related to mental health issues (19 percent), chronic illness (18 percent), or disability (17 percent). Some MLPs also report that they target specific chronic conditions, domestic violence/abuse, or substance use.

SCREENING FOR HEALTH-HARMING CIVIL LEGAL NEEDS

Through tools like PRAPARE (available at: http://www.nachc.org/research-and-data/prapare/) and the CMS Core Health-Related Social Needs Screening Tool (available at: https://nam.edu/standardized-screening-for-health-related-social-needs-in-clinical-settings-the-accountable-health-communities-screening-tool), health care organizations are increasingly investing in the systematic capture of information about the social and environmental needs of their patients. The majority of health care organizations that participate in MLPs have a process to screen their patients for health-harming legal needs, which can range from broad questions about the social needs of the patient to specific questions geared toward potential legal issues. Though the process is not always formal or consistently administered, eight in ten health

care organizations (84 percent) have some type of screening process for identifying patients who would benefit from an MLP intervention (Figure 9). Common screening practices observed in organizations with an MLP may be applicable to organizations that do not have an MLP, but screen for a range of social needs.

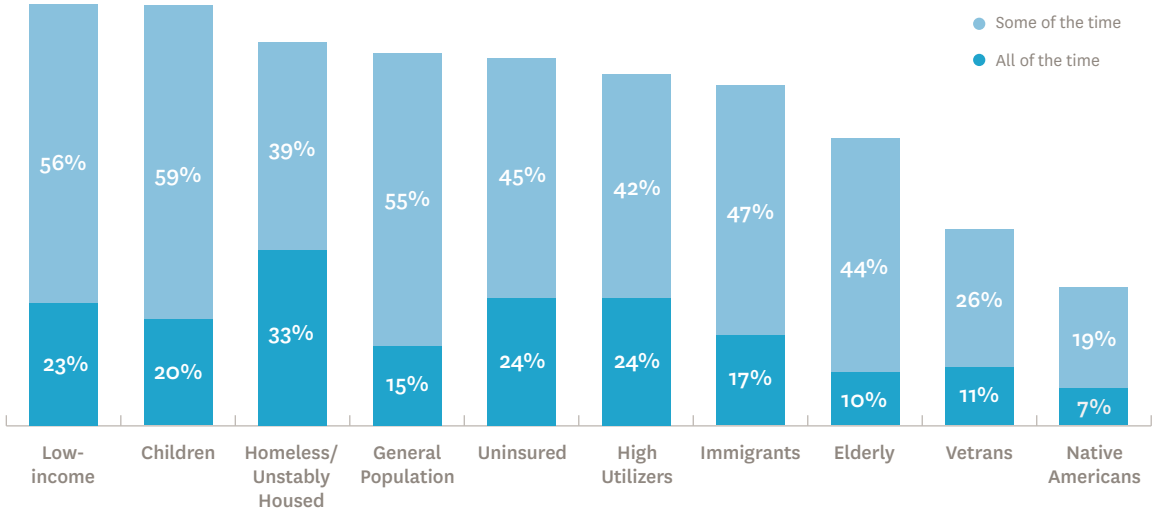
FIGURE 9. HEALTH CARE ORGANIZATIONS WITH MLPS THAT SCREEN FOR HEALTH-HARMING LEGAL NEEDS



Notes: n=129.
Source: 2016 NCMLP Survey.

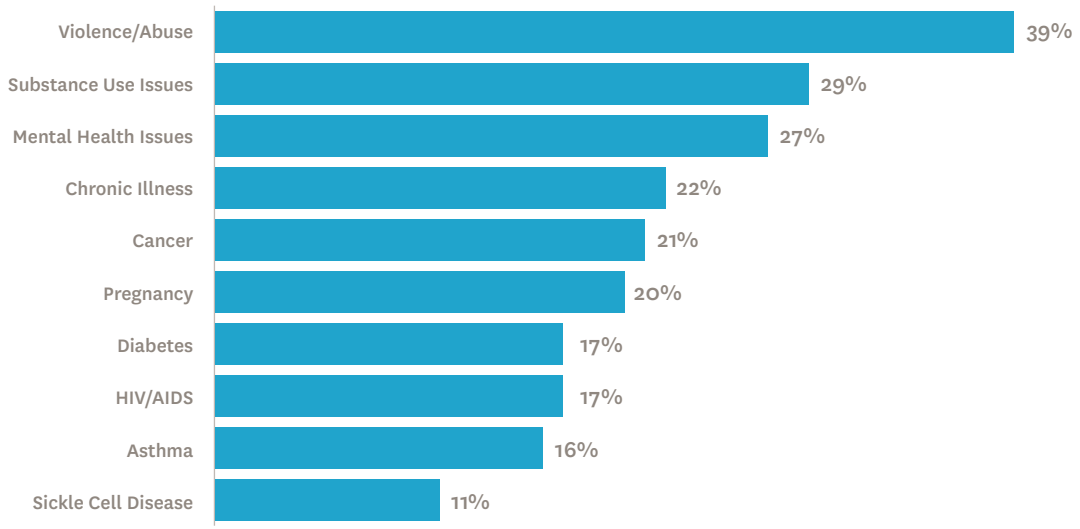
Despite the availability of a screening process, the majority of health care organizations with MLPs do not screen all patients — or all of the categories of patients who are among those targeted for services. Only 15 percent of health care organizations say that they screen the general population "all of the time" for health-harming legal needs (see Figure 10). The most common patient populations that trigger a screening "all of the time" are patients experiencing homelessness (33 percent), high-utilizers of health care services (24 percent), the uninsured (24 percent), and low-income patients (23 percent). Low-income patients and children are the most likely to be screened "some" or "all of the time" according to survey respondents.

FIGURE 10. PATIENT POPULATIONS THAT TRIGGER MLP SCREENING "SOME OF THE TIME" OR "ALL OF THE TIME"



Notes: n=110.
Source: 2016 NCMLP Survey.

FIGURE 11. PERCENT OF HEALTH CARE ORGANIZATIONS WITH MLPS THAT SCREEN FOR HHLNS "ALL OF THE TIME" (BY CONDITION)

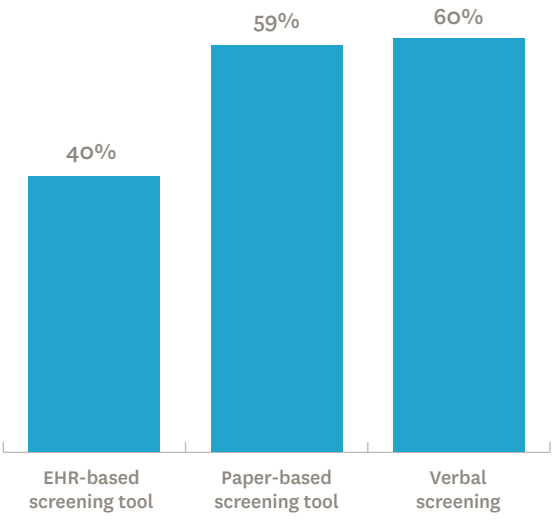


Notes: n=54-78. "HHLNs" are health harming legal needs.
Source: 2016 NCMLP Survey.

The percent of health care organizations indicating consistent screening by condition or patient circumstance is similarly low. As Figure 11 illustrates, just four in ten health care organizations with an MLP (39 percent) say that they screen "all of the time" among patients with a history or indication of violence or abuse; the percentages drop for other conditions such as substance use, mental health issues, and other chronic health conditions.

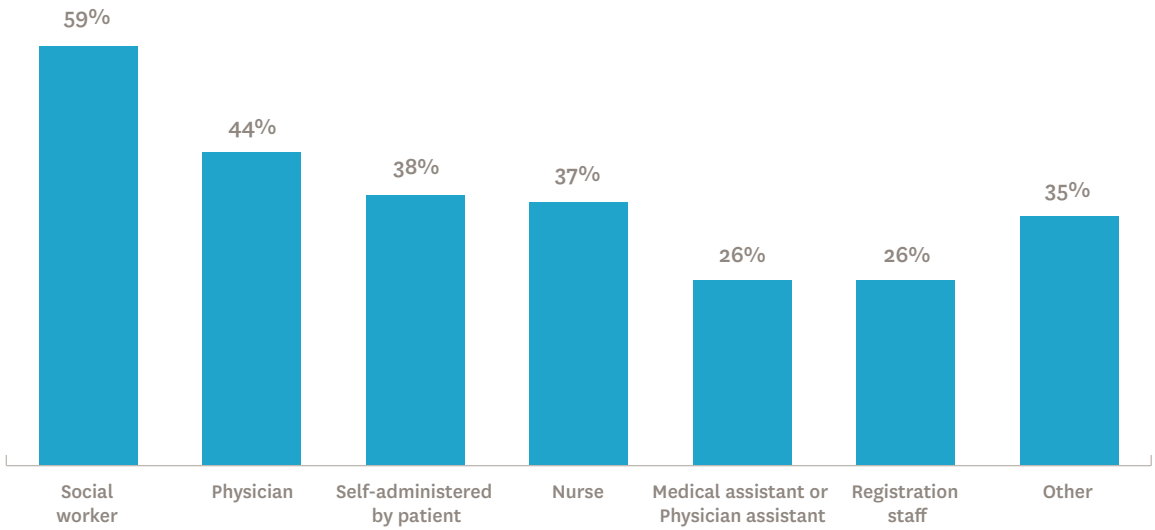
Organizations primarily rely on one or more of three screening methods: 1) an EHR-based screening tool, which embeds screening questions into the electronic health record; 2) a paper-based screening tool, administered to the patient at registration or point of care; and 3) a verbal method of screening, in which a member of the health care staff will ask the patient questions related to potential health-harming legal issues. An EHR-based screener may offer opportunities for data and health record integration, potential use in population health interventions, and other efficiencies. As noted in Figure 12, four in ten MLP health care organizations are using the EHR to screen for health-harming legal needs, while six in ten rely on a paper-based screening tool (59 percent) and/or verbal screening (60 percent).

FIGURE 12. DISTRIBUTION OF MLP SCREENING METHODS AMONG HEALTH CARE ORGANIZATIONS THAT SCREEN FOR HHLN



Notes: n=110.
Source: 2016 NCMLP Survey.

FIGURE 13. MLP SCREENING BY TYPE OF ADMINISTRATOR(S) AMONG HEALTH CARE ORGANIZATIONS THAT SCREEN FOR HHLN



Notes: n=107.
Source: 2016 NCMLP Survey.

It is not uncommon for health care organizations to use more than one method to screen for health-harming legal needs. In fact, about half of survey respondents (48 percent) said that they used two or three methods to screen their patients.

In addition to relying on several methods to screen patients, health care organizations also use a variety of staff to screen for health-harming legal needs (see Figure 13). Health care organizations with MLPs are most likely to report using social workers for screening (59 percent), followed by physicians (44 percent), and nurses (37 percent). Thirty-eight percent of survey respondents said that the screening process is self-administered by the patient. The majority of MLP health care organizations report using two or more types of staff to administer their screening tool. Only 29 percent rely on just one type of staff person (e.g. social workers) to screen.

Screening practices are clearly variable across organizations in terms of the methods used, staff involved, and patient populations and conditions targeted for screening. With the advancement of new, standardized social screening tools like PRAPARE and the CMS Core Health-Related Social Needs Screening Tool, screening for health-harming legal needs in organizations with an MLP may become more consistent and systematic.

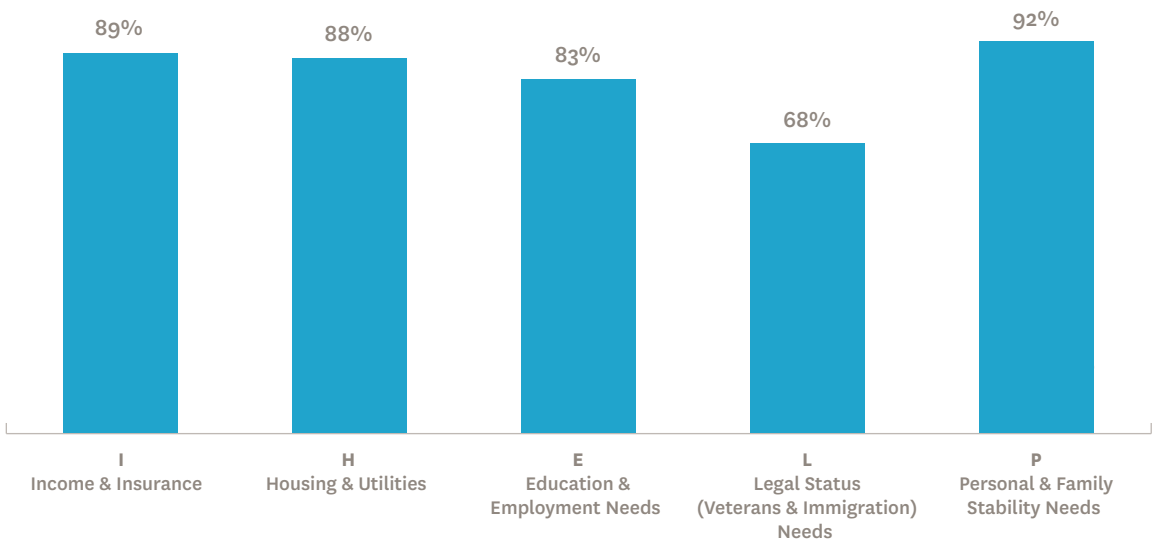
PATIENT REFERRALS FROM HEALTH CARE ORGANIZATIONS FOR CIVIL LEGAL AID SERVICES

Even without standardized or consistent screening protocols, legal organizations receive numerous patient referrals for various civil legal issues from their health care organizations on a monthly basis. Figure 14 illustrates the percent of MLPs that received referrals related to I-HELP™ needs over the past year. I-HELP™ is a system of categories designed by the National Center for Medical-Legal Partnership to capture the types of health-harming civil legal needs most often encountered and addressed by civil legal aid. The I-HELP™ categories are defined as Income and insurance, Housing and utilities, Education and employment, Legal status, and Personal and family stability. Eighty-nine (89) percent of MLP civil legal organizations received referrals from health care partners for income and insurance needs, 88 percent had referrals

for housing and utilities needs, and 92 percent had referrals related to personal and family stability. Slightly fewer reported referrals for education and employment needs (83 percent) or needs related to legal status (68 percent).

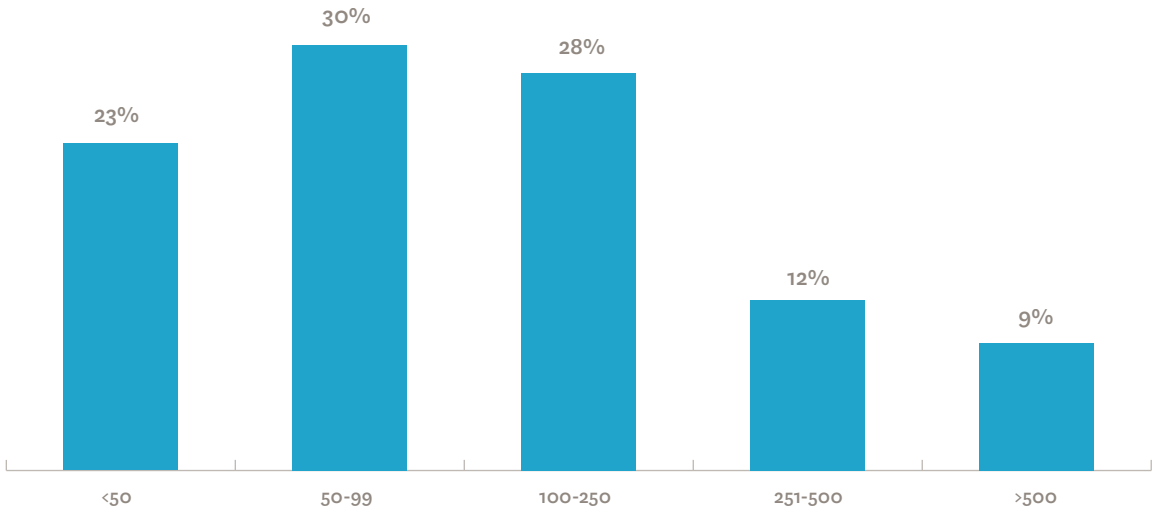
Legal organizations document the number of patients/clients referred by their health care partners and the type of legal interventions provided. Half of health care organizations (49 percent) referred 100 or more patients last year to their MLP legal partner for services (Figure 15). Each patient referral can translate to varying levels of work for the legal organization, ranging from multiple cases opened for a single patient-client to brief advice for a patient-client. Figure 16 provides information on annual MLP caseloads on the legal organization side, including the average number of cases for brief service and limited representation, extended service, cases opened and closed, and case consultations with health care providers at health care partner organizations in the past year. Clearly, legal organizations with an MLP provide an enormous benefit to thousands of patients and health professionals at health care organizations.

FIGURE 14. TYPES OF MLP REFERRALS RECEIVED BY LEGAL PARTNERS BY I-HELP CATEGORY IN THE PAST YEAR



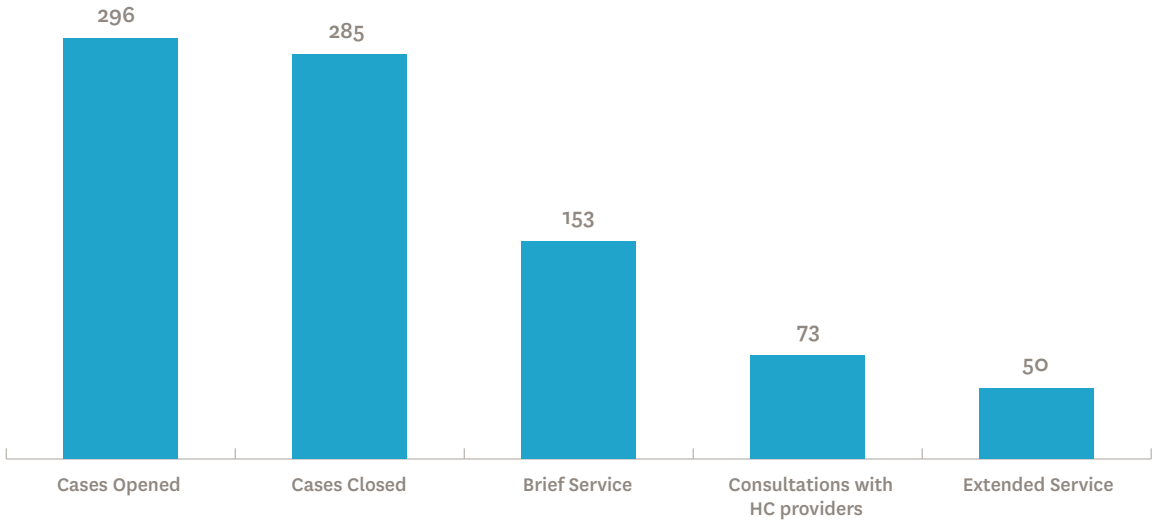
Notes: n=103.
Source: 2016 NCMLP Survey.

FIGURE 15. TOTAL NUMBER OF REFERRALS BY HEALTH CARE ORGANIZATIONS TO MLP LEGAL PARTNERS IN THE PAST YEAR



Notes: n=111.
Source: 2016 NCMLP Survey.

FIGURE 16. AVERAGE NUMBER OF MLP LEGAL INTERACTIONS IN THE PAST YEAR



Notes: n=90-96.
Source: 2016 NCMLP Survey.

3. Resources Associated with Operating an MLP

STAFFING

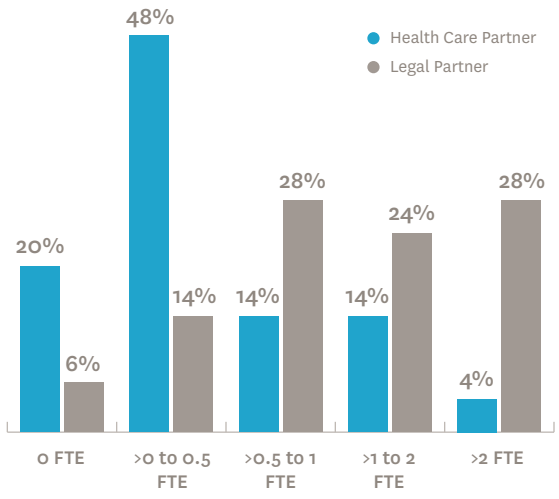
Health care organizations participating in MLPs are unlikely to commit considerable amounts of full-time equivalent (FTE) staff to MLP activities. One in five health care organizations with an MLP actually report zero FTE dedicated to MLP activities at their organizations — this number may be slightly exaggerated if staff do not have dedicated time from an MLP funding source. Among those respondents who reported that they do commit FTEs to their MLP, about half (48 percent) devote 0.5 FTE or less (see Figure 17). Only 28 percent said that they had more than 1 FTE devoted to MLP activities. The median staffing from the health care organization devoted to MLP activities was just 0.2 FTE.

Compared to MLP health care partners, legal organizations are more likely to account for FTEs to MLP activities and are more likely to commit a greater number of FTEs. Only 6 percent of legal partner organizations report zero FTE participation in MLP activities (see Figure 17). Three-quarters of MLP legal organizations with an MLP devote one or more FTE to MLP activities. The median FTE is 1.25.

In addition to information about FTE, we asked legal organizations about pro bono hours devoted to MLP activities. Sixty-five percent of legal organizations with an MLP reported that have pro bono partners for case handling or other activities related to the MLP. Among those MLPs with pro bono partners, the average number of pro bono hours reported in the past year was 573 per legal organization.

More MLP staffing resources originate from legal organizations than from health care organizations. As MLPs grow to meet demand and become more established across the country, health care organizations participating in an MLP may need to devote more staff time toward the coordination of MLP activities in order to be sustainable and effective.

FIGURE 17. TOTAL ANNUAL FTE REPORTED BY HEALTH CARE AND LEGAL ORGANIZATIONS WITH AN MLP



Notes: n=118 for health care partners, n=103 for legal partners.
Source: 2016 NCMLP Survey.

HIGHLIGHTS

HEALTH CARE ORGANIZATIONS THAT PARTICIPATE IN AN MLP:

- Often report very little FTE dedicated to MLP activities;
- Tend to have small budgets for MLP activities, but some are devoting pieces of their operating budget; and
- Are likely to report that they have the capacity to meet demand for MLP services.

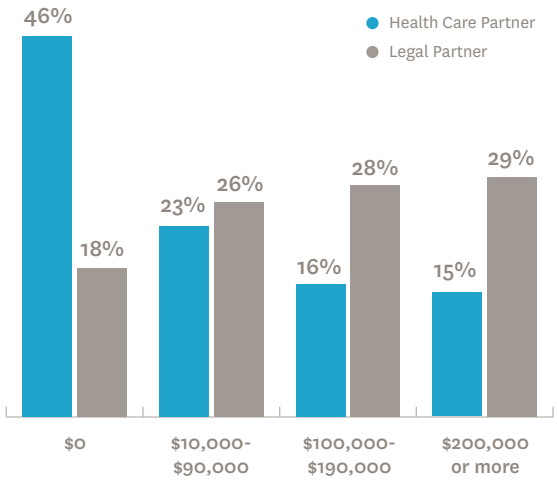
LEGAL ORGANIZATIONS THAT PARTICIPATE IN AN MLP:

- Generally commit FTE to MLP activities;
- Have dedicated budgets and varied funding sources for MLP activities; and
- Less than half report that they have the capacity to meet demand for MLP services.

FUNDING

When it comes to funding for the MLP, legal organizations are more likely than health care organizations to report a budget for MLP activities. Legal organizations also have higher budgets for MLP activities. As noted in Figure 18, the majority of legal organizations reported an annual budget of $100,000 or more for MLP activities, whereas the majority of health care organizations reported a budget of $90,000 or less for MLP.

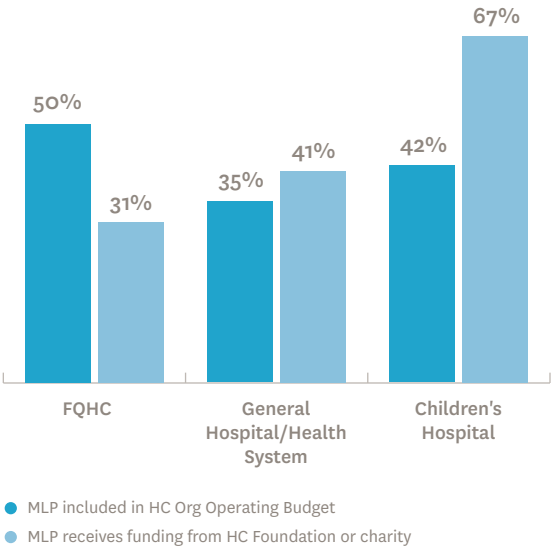
FIGURE 18. MEDIAN ANNUAL MLP BUDGET FOR HEALTH CARE AND LEGAL PARTNERS



Notes: n=115 health care partners and 94 legal partners.
Source: 2016 NCMLP Survey.

One of the funding streams that demonstrates commitment to MLP as a critical part of health care operations is the operating budget. Over a third (34 percent) of health care respondents list MLP as an item in their operating budget. Additionally, a smaller number of respondents say that they receive funding from a foundation or charity internal to their organization (13 percent), and 28 percent receive funding from an external health care foundation or charity. In Figure 19, the data show that half the federally qualified health centers that responded to the survey include funding for the MLP in their operating budget, making FQHCs the most likely organizations to support MLP with operating budget funds. Also notable is the support that children's hospitals receive for MLP from both internal and external foundations and charities. Two in three children's hospitals receive charitable support for their MLP activities.

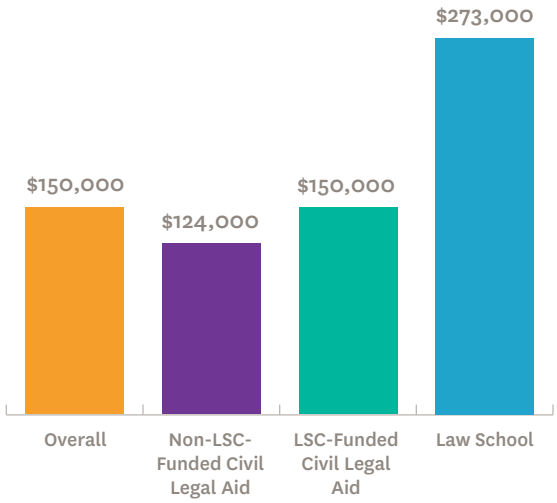
FIGURE 19. HEALTH CARE ORGANIZATIONS THAT INCLUDE MLP AS PART OF THE ORGANIZATION'S OPERATING BUDGET BY TYPE



N=113-114 overall, 37 general hospitals/health systems, 19-21 children's hospitals and 36-38 FQHCs.
Source: 2016 NCMLP Survey.

For MLP legal organizations, respondent data shows a median annual MLP budget of $150,000. MLPs that are partnered with law schools report the highest median budget by far ($273,000), followed by LSC-funded civil legal aid organizations and non-LSC funded civil legal aid organizations (see Figure 20). Because law schools serve a training function for their students, these entities may have resources to provide MLP services as part of their educational mission.

FIGURE 20. MEDIAN ANNUAL MLP BUDGET BY LEGAL ORGANIZATION TYPE

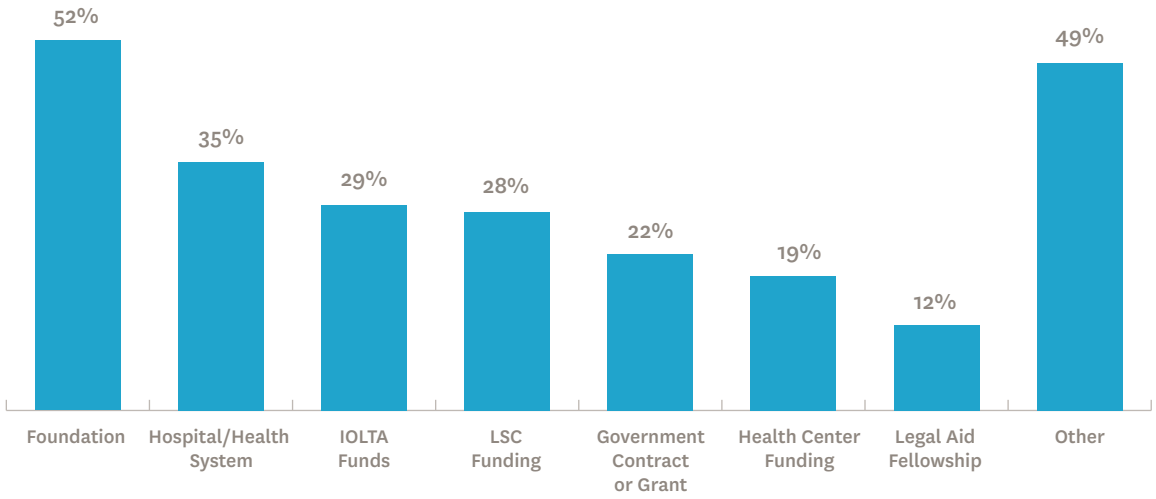


Notes: Data represent median budgets of organizations reporting an MLP budget >$0. N=77 overall, 11 for law schools, 33 for LSC-funded civil legal aid organizations, 25 for Non-LSC-funded civil legal aid organizations, and 8 for other legal organizations.
Source: 2016 NCMLP Survey.

As shown in Figure 21, half (52 percent) of MLP legal organizations receive funding from a foundation. One in three receive funding from their MLP health care partner as part of the hospital or health system's operating budget, foundation, or community benefit. IOLTA funds, LSC funding, government contracts or grants, health center funding and legal aid fellowships are all important MLP funding sources. Legal organizations with an MLP also depend on funding from law firms, law schools, private foundation grants and donations, individual contributions, corporate donations, legal fees, and other sources. It is worth noting that 28 percent of legal organizations rely on LSC funding for MLP activities given that the current administration has recommended elimination of funding for LSC.

Further research is needed to identify the factors that influence the size of MLP budgets on both the health care and legal sides as well as the challenges and opportunities for stable and diversified funding streams for sustainability and growth of MLPs.

FIGURE 21. MLP FUNDING SOURCES BY TYPE AMONG LEGAL ORGANIZATIONS



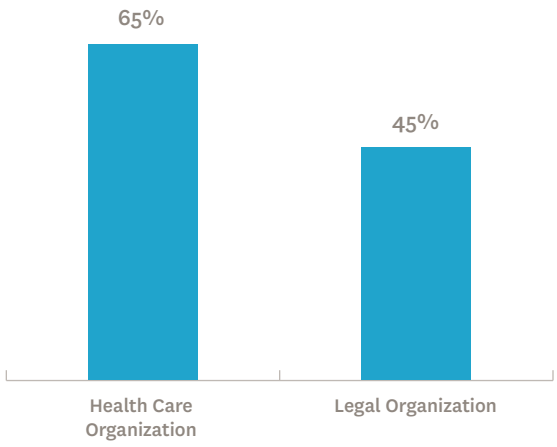
Notes: n=99. Data show any funding received by legal MLP partners and do not sum to 100%.
Source: 2016 NCMLP Survey.

PERCEIVED CAPACITY TO MEET DEMAND FOR MEDICAL-LEGAL PARTNERSHIP SERVICES

We asked health care and legal organizations with MLPs about their capacity to meet demand for MLP intervention. Our data indicate that MLPs operate on limited budgets with constrained staff resources, yet face growing demand from patients with complex legal needs. Fewer than half of legal organizations (45 percent) reported that the MLP can meet the demand associated with patients' health-harming legal needs present at their partner health care organization (see Figure 22). Eighty percent of legal organizations with an MLP report that they refer clients to other civil legal aid organizations, and 70 percent refer clients to other pro bono attorneys in order to address health-harming legal needs of MLP patients/clients who exceed their available resources or are beyond the scope of services they provide.

Surprisingly — given relatively low budgets and limited FTEs devoted to MLP activities — nearly two in three (65 percent) health care organizations with an MLP report that their legal partner organization can meet the demand for MLP services.

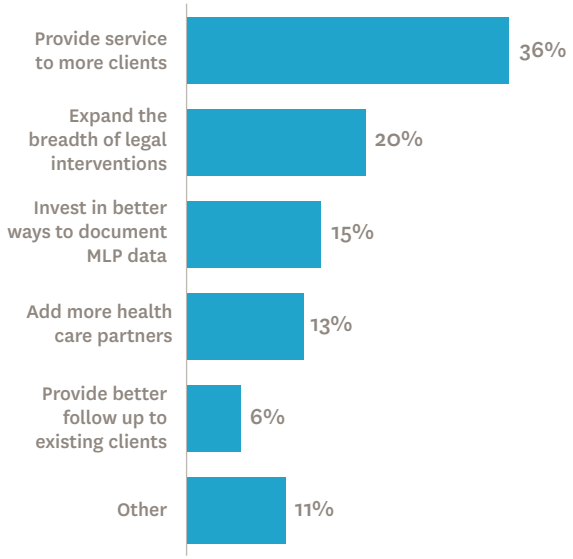
FIGURE 22. HEALTH CARE AND LEGAL ORGANIZATIONS WHO SAY THEY CAN MEET THE DEMAND FOR THEIR PATIENTS' HEALTH-HARMING CIVIL LEGAL NEEDS



Notes: n=123 for HC partner and 102 for legal partner.
Source: 2016 Annual Survey.

As seen in Figure 23, when asked where legal organizations would prioritize their efforts if given additional resources for MLP activities, the majority said that they would want to expand capacity in order to reach more patient-clients — either by providing more services to clients (36 percent), expanding the breadth of available legal interventions (20 percent), or adding more health care partners (13 percent). Few legal organizations said that they would spend additional resources to improve existing MLP activities, either on better ways to document data (15 percent) or to provide better follow up to existing clients (6 percent).

FIGURE 23. TOP PRIORITY IDENTIFIED BY MLP LEGAL PARTNERS IF ADDITIONAL RESOURCES WERE AVAILABLE



Notes: n=103.
Source: 2016 NCMLP Survey.

4. Service Integration and Information Sharing Among MLP Partners

LOCATION OF MLP SERVICES

Given that MLPs require collaboration across two organizations with different missions and organizational structure, we wanted to know how the partners negotiate where and how to provide MLP services. In keeping with best practice, the vast majority (84 percent) of legal organizations provide their services on-site at the health care partner organization, which is more convenient for patients and provides more opportunity for in-person communication and coordination between the two partners. Most health care organizations (81 percent) have a memorandum of understanding (MOU) or another formal legal agreement with their legal partner organization.

COMMUNICATING ABOUT MLP ACTIVITIES

We were interested in the extent to which MLP legal staff participate in clinical team discussions at the health care organization. We did not define what constitutes "participation in clinical team discussions", but we know from conversations in the field that these interactions can range from brief discussions or consultations with clinicians and other health care staff, to full participation of the MLP legal staff in regular clinical team meetings. However the respondents chose to define their interaction, the majority of MLP legal staff say that they regularly participate in clinical team discussions with their health care partner organization(s) (57 percent). One in five (18 percent) legal partners participate in clinical discussions on an as-needed basis. One quarter (24 percent) of legal MLPs do not participate in clinical team discussions (see Figure 24).

HIGHLIGHTS

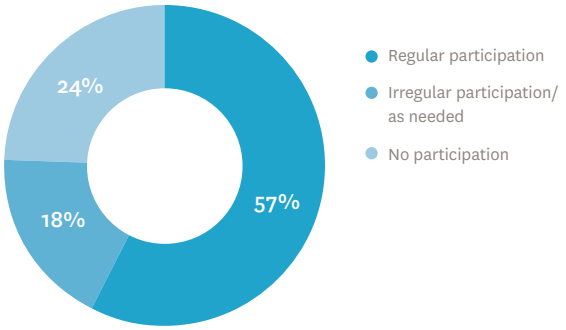
HEALTH CARE ORGANIZATIONS PARTICIPATING IN AN MLP:

- Usually provide on-site office space for MLP legal partner organizations' staff and have a memorandum of understanding in place;
- About half have a data sharing agreement with a legal partner organization;
- Have an EHR, and formally document the use of MLP services in patient records about half of the time;
- Receive information on MLP patient/client legal outcomes some or all of the time; and
- Sometimes train legal partner organization staff on social determinants of health.

LEGAL ORGANIZATIONS PARTICIPATING IN AN MLP:

- Participate in health care clinical discussions with some regularity, but may define "clinical discussions" with some variation;
- Report having data-sharing agreements with their health care partner organization(s) less than half of the time;
- Use a database to record information about their interactions with MLP patient-clients;
- Receive information from their health care partner organizations on reasons for patient/client referrals; and
- Train health care partner organization(s)' staff on MLP.

FIGURE 24. MLP LEGAL STAFF PARTICIPATION IN CLINICAL TEAM DISCUSSIONS



Notes: n=103.
Source: 2016 NCMLP Survey.

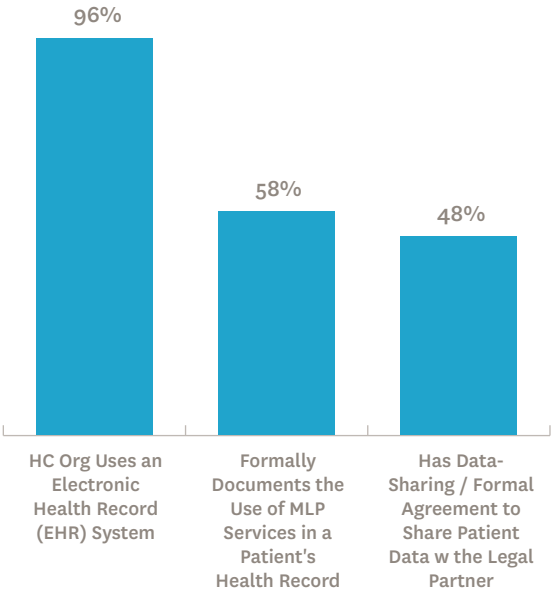
DATA SHARING

Given increased attention in leveraging electronic health record (EHR) systems to capture social determinant data, with an eye toward improving individual and population health, we asked survey respondents about how they capture and share MLP-related data. Nearly all MLP health care partner organizations have an electronic health record (EHR) system (96 percent). More than half (58 percent) formally document the use of MLP services in patients' medical records. Forty-eight percent of MLP health care partner organizations have a data-sharing agreement with their legal partner organization to share patient-level data (see Figure 25).

We also asked health care survey respondents about documentation because we know that it's a best practice in health care systems. Documentation enables data collection and sharing, which in turn helps ensure coordination and quality of care both for the individual patient and across systems of care. Widespread use of Electronic Health Records (EHRs) now makes documented information more accessible in clinical care. Some of the MLP activities formally documented through an EHR or another database include patient referrals to the MLP legal partner organization (54 percent), results of HHLN screening (46 percent), MLP interactions with the patient (34 percent), and the preparation of form letters or other similar templates for health care providers to use (28 percent) (see Figure 26).

Unfortunately, we do not know from the survey responses how consistently this documentation happens within each health care partner organization. We also do not know if there are formal fields or processes to record this information in the EHR — the data may include a range of practices, including those organizations that sometimes make a note in the EHR, to those organizations who have specific forms for legal services in the EHR. Some organizations deliberately opt to include "the bare minimum" information about legal services in the EHR to protect patient confidentiality.

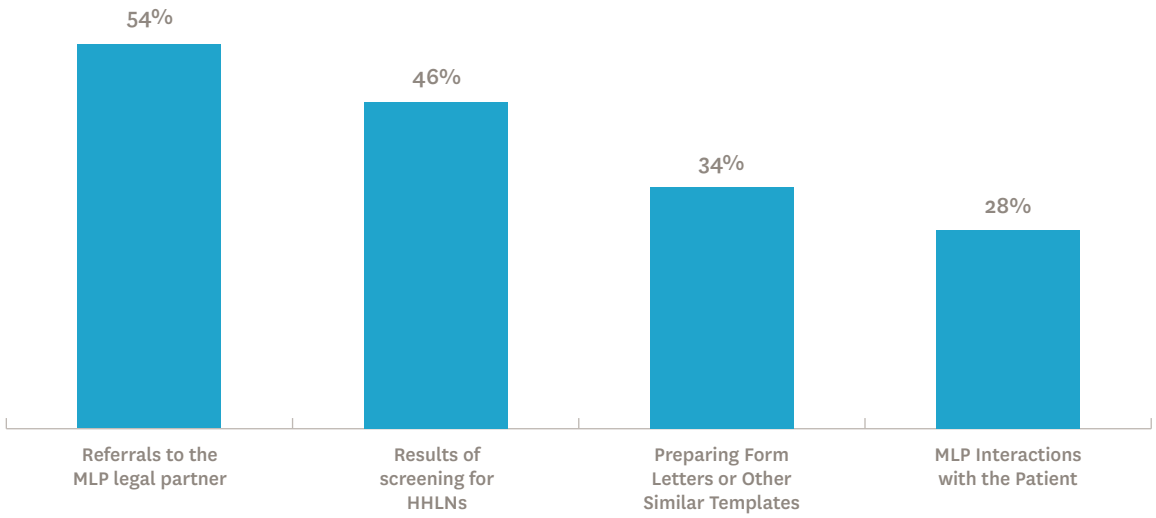
FIGURE 25. USE OF DATA SYSTEMS BY HEALTH CARE ORGANIZATIONS WITH MLPS



Notes: n=125-128.
Source: 2016 NCMLP Survey.

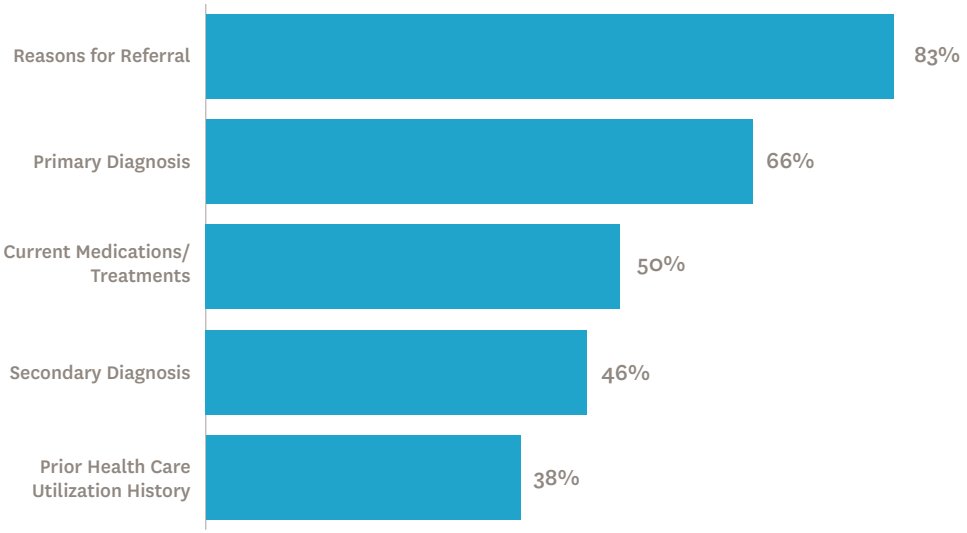
Ninety percent of legal organizations use a legal database or case management software to track information about MLP activities. During the referral process or during other interactions with health care staff, the legal organization typically receives some level of information about the patient being referred to them for legal services. The most common types of patient-level information that the legal partner organizations report receiving from their health care partners to help provide MLP services are: (1) reasons for referral (83 percent); (2) primary diagnosis (66 percent); and (3) current medications and treatments (50 percent) (Figure 27).

FIGURE 26. TYPES OF MLP ACTIVITIES FORMALLY DOCUMENTED IN HEALTH CARE ORGANIZATION EHRS



N=121-125.
Source: 2016 NCMLP Survey.

FIGURE 27. TYPES OF PATIENT-LEVEL INFORMATION LEGAL ORGANIZATIONS HAVE RECEIVED FROM HEALTH CARE PROVIDERS IN THE PAST YEAR



Notes: n=103.
Source: 2016 NCMLP Survey

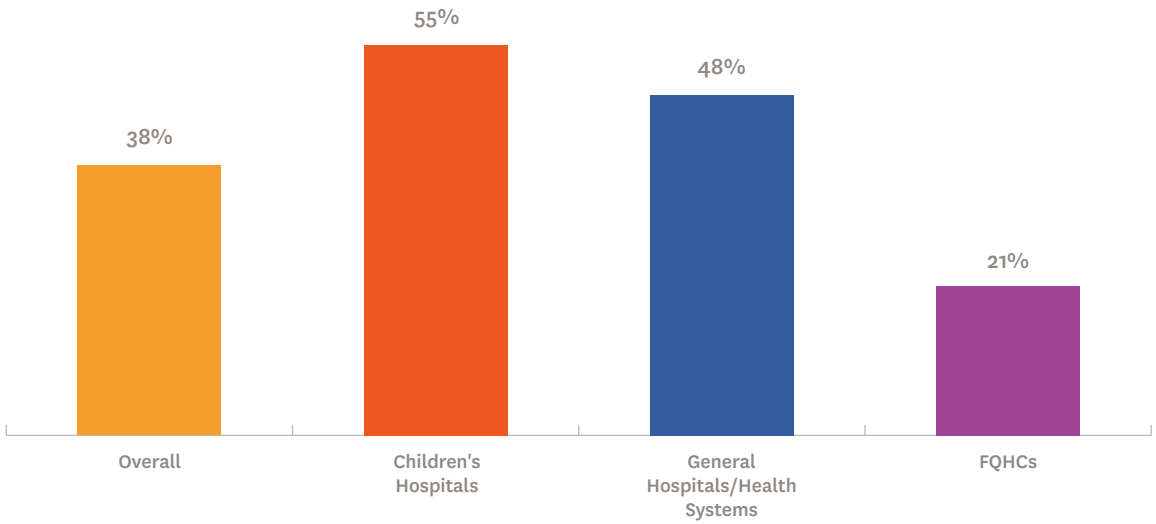
Much like a health care specialist would report back to a referring primary care physician, we also wanted to know whether health care providers at partner organizations received information about patients' legal outcomes after being referred to an MLP lawyer for a health-harming civil legal need. Most health care partner organizations do receive information from the legal partner organization on a patients' legal outcomes after an MLP intervention at least some (62 percent) or all (24 percent) of the time. Once again, there are a range of ways in which this is done — from a brief phone call to a formal note from the lawyer — and it is at the discretion of the legal staff and health care organization to figure out which approach is most appropriate for their organization(s).

TRAINING

It is common practice for legal organizations with an MLP to provide some level of training to health care partner organization staff on the concept of MLP and how to identify health-harming legal needs. These trainings can run the gamut from a brief presentation from MLP legal staff at new employee orientation, to comprehensive training modules developed with the health care organization to target key clinical staff. The average number of health care providers and staff at an MLP health care partner organization trained in MLP in the past year is 66. MLP legal partner organization respondents collectively trained 11,446 clinicians and staff at health care partner organizations during the previous year.

Additionally, as seen in Figure 28, over a third of MLP health care organizations (38 percent) train lawyers or other MLP legal staff on health topics or social determinants of health. Children's hospitals and general hospitals/health systems are more likely to do this (55 percent and 48 percent, respectively) than HRSA-funded health centers (21 percent).

FIGURE 28. PERCENT OF HEALTH CARE ORGANIZATIONS THAT TRAIN MLP LEGAL STAFF ON HEALTH TOPICS/ SOCIAL DETERMINANTS OF HEALTH



Notes: n=128 overall, 42 health centers, 42 general hospitals/health systems and 22 children's hospitals.
Source: 2016 NCMLP Survey.

5. Ways MLPs Advance Health and Wellbeing

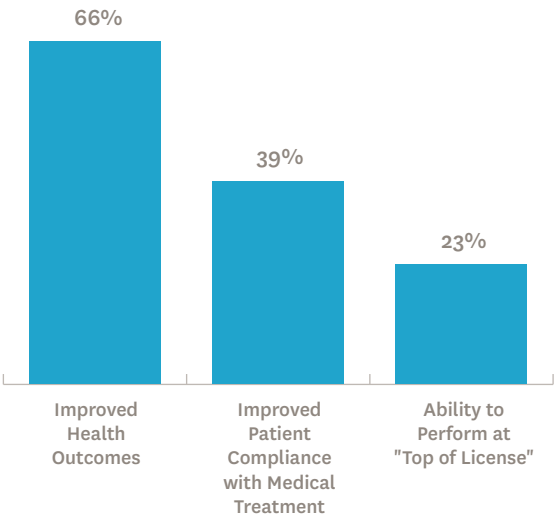
IMPROVED WELLBEING AND PATIENT CARE

Health care organizations were asked to report the impacts that health care providers most often hear from patients after they have received MLP services. The most commonly reported impacts were:

- Improved access to housing and utilities needs (noted by 82 percent of respondents)
- Reduced stress (79 percent)
- Improved access to income and insurance needs (79 percent)
- Improved access to personal and family stability needs (73 percent)
- Improved access to education and employment needs (53 percent)

We were interested in clinician perspectives on the impacts of MLP intervention. Over half of health care organizations report that clinicians have noted impacts as a result of their participation in MLPs. Sixty-six percent of health care organizations say that clinicians report improved patient health outcomes, 39 percent report improved patient compliance with medical treatment, and 23 percent report the ability to perform at "top of license" (see Figure 29). This question had obvious limitations, including the fact that several of our health care partner survey respondents were not clinicians. We hope to further probe provider opinions and perceptions of MLP in the future to get a better understanding of how providers value MLP as one approach to improved health outcomes.

FIGURE 29. IMPACTS OF MLP PARTICIPATION REPORTED ANECDOTALLY BY CLINICIANS



Notes: n=124-125.
Source: 2016 NCMLP Survey.

HIGHLIGHTS

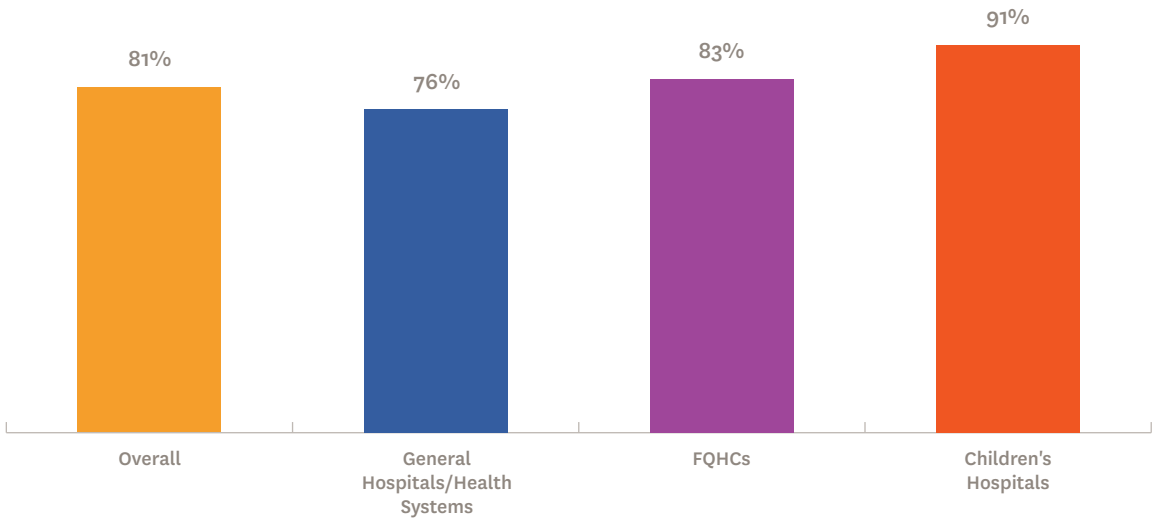
HEALTH CARE ORGANIZATIONS PARTICIPATING IN AN MLP:

- Report a variety of positive impacts by MLPs on patient wellbeing, including increased access to housing and income, reduced stress, and access to income and insurance needs;
- Report improved patient health outcomes and patient engagement; and
- Embrace the "MLP approach to patient care."

LEGAL ORGANIZATIONS PARTICIPATING IN AN MLP:

- Collect information on financial benefits to their patient-clients as a result of the MLP over half of the time;
- Few collect information on dollars recovered by the health care partner organization; and
- Note substantial recovery dollars for health care organizations when this information is collected.

FIGURE 30. HEALTH CARE ORGANIZATIONS THAT SAY THEIR "ORGANIZATION HAS FULLY EMBRACED THE MLP APPROACH TO CARE"



Notes: n=126 overall, 22 children's hospitals, 42 general hospitals/health systems and 40 FQHCs. Responses represent percent who say they strongly agree or agree.
Source: 2016 NCMLP Survey.

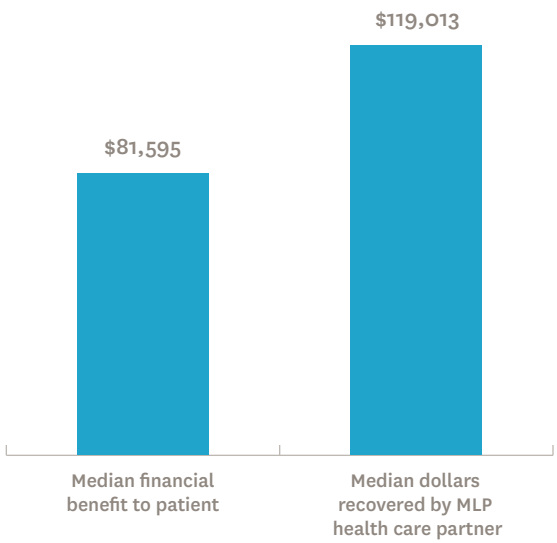
We also wanted to know whether health care organizations believe that their staff have "fully embraced the MLP approach as an important part of patient care." Eight in ten health care organizations (81 percent) say that they agree or strongly agree with that statement. Children's hospitals were most likely to answer 'yes', with nearly all respondents indicating that they had embraced the MLP approach to patient care (see Figure 30).

FINANCIAL BENEFIT TO PATIENTS AND HEALTH CARE ORGANIZATIONS

MLPs often look for ways to demonstrate the value of their services for patients and participating health care organizations. One of the most direct and quantitative approaches that MLPs use to demonstrate value is to measure the financial benefits to patients that result from MLP interventions, such as Medicaid enrollment or food stamp benefits. Over half of legal organizations (58 percent) calculate total financial benefits for patients from MLP services; however, only 11 percent calculate the health care dollars recovered by the MLP health care partner(s) or other health care organizations in the community as a result of MLP legal services.

Of the MLPs that do collect information on financial benefits, the median dollar amount of total financial benefits received by all patient-clients served by each MLP in the past year was $81,595. The median dollar amount recovered by MLP health care organization(s) as a result of MLP services over the last year was $119,013 per MLP (see Figure 31). These dollar figures should be viewed as preliminary estimates for the field, since relatively few MLPs collect this information and responses about financial benefits and dollars recovered by MLP health care organizations showed wide variation.

FIGURE 31. MEDIAN FINANCIAL BENEFITS ASSOCIATED WITH MLP IN THE PAST YEAR



Notes: N=45 and 7, respectively, and do not include those reporting $0.
Source: 2016 NCMLP Survey.

We did not ask why so few MLPs calculate health care dollars recovered for the health care organization, but anecdotally the National Center for Medical-Legal Partnership has found that there is little consensus on how to collect this data. Collecting this data also requires financial information from the health care partner organization, which may not be readily available to the legal organization. The National Center for Medical-Legal Partnership is working with a group of MLPs from across the country to better understand how to collect and use this data most effectively.

DISCUSSION AND RECOMMENDATIONS

The medical-legal partnership field is still relatively new and ripe for further growth and integration within health care settings. Most MLPs are five years old or less and many are looking to expand. Partnerships with hospitals and federally qualified health centers are driving the field, which is committed to serving people who are medically vulnerable — especially children, homeless individuals, and the elderly.

Our approach to this survey is to gather information from both health care organizations and legal organization participating in MLPs, since the traditional MLP model involves a legal organization carving out staffing resources to work with one or more health care organizations. That said, there are a few other models of MLP that involve other arrangements or partner organizations — for example, the health care organization that hires its own legal staff to do MLP work, or the primary care association or health department acts as a coordinator with a legal organization to provide MLP services to multiple health care sites. This survey is not necessarily structured to best capture the infrastructure, practices, and resources of these other MLP models.

In terms of investment and staff engagement in MLP, legal organizations appear to be more active than health care organizations. Legal organizations are more likely to commit greater amounts of FTE and larger budgets to MLP activities. Legal organizations also often partner with multiple health care organizations to form several MLPs. They invest in training health care staff about the concept of MLP and how to identify health-harming civil legal needs. They handle a significant number of referrals each year and provide services including brief advice and counseling, consultations with health care providers, limited representation, and formal representation.

Although their financial and staff commitment to MLP appear to be less than what is seen on the legal side, health care organizations appear to increasingly understand the value of legal and other social support staff to tackle the social needs of their patients. Most health care organizations are screening for health-harming legal needs among their patients. They have invited legal staff into their organizations by providing office space and often an opportunity to engage in clinical discussions. Health care partners indicate that their organizations have embraced the MLP approach to patient care, and two-thirds of MLP health care providers report improved patient health outcomes and more than one-third report improved patient compliance and engagement due to MLP interventions. And perhaps one of the most concrete signs of investment and commitment in using legal services in clinical care is the 38 percent of health care organizations that are now dedicating some part of their operating budget for MLP activities.

This survey was fielded at a time of both increased momentum for identifying social determinants of health among vulnerable patient populations, and looming uncertainty for the future of health care insurance access for the underserved. There has perhaps never been a better time to engage legal experts in health care. They can serve as a solution to the social determinants to be uncovered in patient care settings at an increasing rate, and as a means for navigating uncertain times for critical public benefits and services.

BASED ON THE RESULTS FROM THE 2016 NCMLP SURVEY, WE IDENTIFY THREE PRIMARY AREAS FOR MLPS TO REACH MORE PATIENTS IN A SYSTEMATIC WAY:

01

Establish standard practice guidelines for identifying when and where legal assistance is needed.

Currently, there are no standard practice guidelines for screening for health-harming legal needs. As such, it is unknown as to whether health care organizations truly know the need or demand for legal services among their patient populations. However, with the emergence of new standard tools for identifying social determinants in health care settings, such as PRAPARE and the CMS tool for AHC communities, the process for determining whether a patient has legal needs may become more standardized in time. Though most MLPs have some screening process in place, the protocols are varied and inconsistent; screening can often be informal, and most organizations do not screen patients for health-harming civil legal needs "all of the time," even for patients who are the MLP's target population. Who should be screened, what screening tool should be used, how patients should be screened, and how screening information should be documented are all areas that could benefit from clear direction and knowledge from the field.

02

Capture the impact of MLP services on patients and health care organizations

The impact of legal services in patient care settings is known to be anecdotally powerful. Many organizations are seeking resources to demonstrate the effect of legal intervention on health — from direct health outcomes, to decreased stress or increased self-sufficiency in managing one's own care. Health care partner organizations report that they embrace the MLP approach to care and often report improved patient outcomes and engagement. Yet the health care investment in MLP in terms of budget and paid, dedicating staffing is usually less than that of the legal organizations. The National Center for Medical-Legal Partnership has observed great interest in demonstrating the value and impact of MLP, and is working in the field to uncover how existing data can be used for this purpose. One of the aspects of legal data collection that may show some promise is the financial benefit of MLP interventions. More than half of legal organizations collect data on the financial benefits received by patients who have received an MLP intervention, but only 11 percent of MLPs report dollars recovered by the health care partner organizations as a result of the MLP. Improved data collection practices and common measurement/assessment could go a long way toward demonstrating the impact of legal services in health care.

03

Grow, improve, and sustain medical-legal partnerships

To date, there are about 300 MLPs across the country. MLPs are still young relative to other interventions in health care. MLPs have many strengths. MLP legal partners are committed, hard-working, and have tremendous expertise to offer to address health-harming legal needs. MLP health care partner organizations are influencers in the community — drawing in its most vulnerable residents and giving them important health advice and resources, including providing a pathway to civil legal aid services.

As the use of legal services in health care continues to take hold, it is important to note that growth takes time, but it also takes money. A stable and diversified funding stream is critical. MLPs are young. They operate on small budgets, and often require that staff donate time for these activities. An investment in information technology supports is needed - health care organizations do not always leverage data infrastructure to capture the need for and use of MLP services. It is promising that over one-third of health care organizations with MLPs say that they now devote a portion of their operating budget for MLP activities. We must acknowledge that these circumstances can pose substantial challenges to their long-term stability or sustainability.

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