



Addressing Civil Legal Needs as Part of Nurse-Led Care

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About this Report

This report is part of the “Nurse-led Medical-legal Partnership Initiative,” a project funded by the Kresge Foundation partnering the National Nursing Centers Consortium (NNCC), Philadelphia’s Legal Clinic for the Disabled (LCD), Family Practice and Counseling Network (FPCN), and the National Center for Medical-Legal Partnership (NCMLP) to expand medical-legal partnerships into the nurse-led health care setting.

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The **Family Practice & Counseling Network** is a network of three federally-qualified Nurse-Managed Health Centers that provide health services to thousands of Philadelphians. FPCN established the country’s first nurse-led medical-legal partnership, an innovative health care delivery model that integrates legal assistance as a core component of patient care. Based on the recognition that health is as dependent on social conditions as it is on accessing and receiving quality health care, MLPs place legal staff on-site at health care institutions as part of the health care team to alleviate the hardships associated with problems like unsafe housing, hunger, and income insecurity that may contribute to negative health outcomes and lower quality of life.



The **Legal Clinic for the Disabled** (LCD) provides free high-quality legal services to low-income people with physical disabilities and to the deaf and hard of hearing in Philadelphia, Bucks, Chester, Delaware and Montgomery Counties. Since 1990, LCD, a 501(c)(3) non-profit corporation with offices at Magee Rehabilitation Hospital, has helped thousands of Pennsylvanians with disabilities. LCD opened its newest MLP at St. Christopher’s Hospital for Children in spring 2011.



The **National Nursing Centers Consortium** (NNCC) advances nurse-led health care through policy, consultation, programs and applied research to reduce health disparities and meet people’s primary care and wellness needs. Comprised of more than 250 members across the country, it provides organizational, technical, and supportive services to member clinics at all stages of development.

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Introduction

The medical-legal partnership (MLP) approach naturally aligns with many aspects of the nurse-led model of care. They share philosophical and practical foundations in which teams work together to provide comprehensive, holistic care alongside high-quality clinical care in order to improve health. In particular, the interdisciplinary, whole-person orientation and almost exclusive focus on medically underserved and socially disadvantaged populations distinguishes both the nurse-led health care model and the MLP approach from more traditional health and public health models.

This guide is intended to help health care and legal institutions establish medical-legal partnerships in nurse-led health care settings. It provides information and resources specific to understanding and partnering with nurse-led health care institutions, and highlights some of the opportunities and challenges when applying the MLP approach in a nurse-led setting.

Partners interested in developing an MLP in a nurse-led setting will benefit from many of the same strategies and will experience many of the same issues as MLPs in other health care settings. Consequently, legal and health care institutions interested in exploring the possibility of a nurse-led MLP should first review and complete the Medical-Legal Partnership Toolkit, available at no cost through the National Center for Medical-Legal Partnership's website: www.medical-legalpartnership.org. This guide is intended as a companion piece to that Toolkit, which explains in detail how the MLP approach works.

Important first steps when building an MLP are to evaluate the population, health care, public health, and legal landscapes in a chosen community and geographic area, and to become familiar with the priorities, challenges, and basic framework of your potential health care or legal partner's field.

This guide is divided into three parts:

- **Part I** provides an overview of nurse-led health care settings and their role in providing and innovating care for underserved populations.
- **Part II** discusses the potential benefits for medical-legal partnerships to meet the goals of nurse-led health care.
- **Part III** addresses issues of developing and sustaining a medical-legal partnership in a nurse-led setting, with a focus on potential long-term funding streams.

Glossary of Terms

Federally Qualified Health Center (FQHC): An entity which, (i) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

FQHC Lookalike: Health centers certified by the federal government as meeting all the Health Center Program requirements, but do not receive funding under the Health Center Program.

Health-Harming Legal Need: A social problem that adversely affects a person's health or access to health care, and that is better remedied through joint legal care and health care than through health care services alone. It is a type of social determinant of health.

Legal Care: The full spectrum of interventions that address legal needs for individuals, clinics, and populations. This includes (1) training of health care team members to recognize health-harming legal needs; (2) legal screening of patients by health care team members; (3) triage, consultations, and legal representation provided to patients by legal professionals; (4) changes to clinical or health care institution policies made jointly by health care and/or legal professionals to treat and prevent health-harming legal needs; and (5) changes to local, state and federal policies and regulations made jointly by health care and/or legal professionals to improve population health.

Medical-Legal Partnership (MLP): A health care delivery approach that embeds lawyers and paralegals alongside health care teams to detect, address, and prevent [health-harming social and legal conditions](#) for people and communities.

Nurse-Led Care: Health care provided by advanced practice nurse-led health care teams.

Nurse-Led MLP: A subset of MLPs where advanced practice nurses function as clinical champions for the MLP.

Nurse-Managed Health Clinic (NMHC): A nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

Patient-Centered Medical Home: A care delivery model whereby primary care physicians coordinate patient treatment to ensure patients receive the necessary care when and where they need it, in a manner they can understand.

The Role of Nurse-Led Care in Treating Medically Underserved Populations

Brief History of Nurse-Led Care in the United States

Since the end of World War II, nurses have played an increasingly important role in providing care for underserved populations in the United States. Over the last 25 years, Nurse-Managed Health Centers (NMHCs) have emerged as an important part of the primary care safety net. The NMHC service delivery model grew out of nursing education and academic-based health professions programs as a way to meet community needs, while also training nurses. Nurse leaders have been at the forefront of innovating delivery of care. For example, recognizing health disparities among public housing communities, nurse leaders in the Philadelphia area renovated apartments in public housing complexes, turning them into small clinics that served the community. Today, many NMHCs are still academically or community-based, with a growing number receiving federal funding from the Health and Resources Services Administration (HRSA) as federally qualified health centers (FQHCs) or federally-qualified look alike.



The Work and Reach of Nurse-Managed Health Clinics

Currently, there are more than 250 NMHCs throughout the country, where Advanced Practice Registered Nurses (APRNs), specifically Nurse Practitioners (NPs), provide and manage care for more than 1.5 million patients annually. NMHCs are primarily located in medically underserved areas, such as public housing developments, churches, schools, domestic violence shelters, and correctional facilities. As a result, NMHCs serve individuals and populations with complicated health conditions and disproportionate health disparities, including low-income and homeless individuals, racial/ethnic minorities, the uninsured, survivors of violence, inmates, and public housing tenants.

NMHCs are well-positioned to both provide and manage care for the medically underserved and to address health disparities. NPs are trained at the graduate-level to diagnose and treat both physical and mental conditions through comprehensive history taking, physical exams, and ordering and interpreting diagnostic tests. The specific scope of practice for NPs varies by state, but NMHCs generally provide full primary care services through the holistic lens of nursing practice, including health promotion, disease prevention, and the management of chronic diseases. NPs have shown consistently high outcomes across a range of important measures, including outcomes of health status and physical function across health care settings (hospital, inpatient, outpatient) and populations (adults with chronic illness, well adults, children, seniors), safety, effectiveness, and patient satisfaction. NMHCs also lead innovations in health care by

building community anti-violence programs, providing pre- and post-natal care to women in their homes, and integrating behavioral health and nutrition specialists to ensure that patient care centers on the patient.

With the increased demand for primary care services nationally as a result of increased access to care, policymakers have been looking to NPs and nurse-led care as cost-effective solutions to caring for an aging population and newly-insured individuals in need of primary and preventive care. Policymakers do not expect the supply of primary care physicians to keep pace with demand, but have estimated the number of APNs to double by 2025. Health care leaders, including the Institute of Medicine, the Robert Wood Johnson Foundation, and the American College of Physicians, have advocated for the use of all qualified providers to prevent the expected shortfall and protect patients against a lack of access.

The relative cost-effectiveness of NPs compared to physicians is partly the result of lower salaries and a shorter and less-costly training program. However, even greater opportunities exist to capitalize on the preventive and holistic NMHC model by integrating it with other models of care, such as the Patient-Centered Medical Home (PCMH) and the Medical-Legal Partnership approach (MLP).

Team-based care is a core component in nurse-led care and has positioned an increasing number of NMHCs to become certified medical homes. Medical-Legal Partnerships align well within a patient-centered nurse-led model to:

- Identify and treat health-harming legal needs;
- Facilitate coordination of care across a patient's multiple health and social needs; and
- Achieve quality improvement and data tracking using electronic medical records and other technologies.

Taken together, Nurse-Managed Health Clinics, Patient Centered Medical Homes and Medical-Legal Partnerships are on track to dramatically change how primary care is delivered, utilized, and paid for, in service of improved quality and decreased costs.

Suggested Readings on Nurse-Led Health Centers

Esperat, M.C. et al. (2012). Nurse-Managed Health Centers: Safety-net care through advanced nursing practice, *Journal of the American Academy of Nurse Practitioners*, 24, 24-31.

Barkauskas, V. et al. (2011). Quality of Care in Nurse-Managed Health Centers; *Nurs Admin Q*, 35(1), 34-43.

Coddington, J. & Sands. L. (2008). Cost of Health Care and Quality Outcomes Of Patients At Nurse-Managed Clinics. *Nursing Economics*, 26(2), 75-83.

Potential Impact of Medical-Legal Partnership in Nurse-Led Health Clinics

Medical-legal partnership embeds civil legal aid lawyers alongside health care teams to improve both individual and population health. Research shows that when patients' legal problems -- such as threatened evictions, wrongful utility shut-offs, insurance disputes, and improper educational supports for children -- are solved, the ripple effects are significant. From improved access to care, increased capacity of health care team members, to reduced stress for patients, medical-legal partnership is transforming how care is delivered, especially in the most resource-strapped environments. Led by the National Center for Medical-Legal Partnership (NCMLP) at The George Washington University, the MLP movement in 2016 is reaching over 300 hospitals and health centers to help meet the needs of children, veterans, adults with chronic illness, and many others. NCMLP helps communities bridge the health care, public health, and civil legal aid sectors through medical-legal partnership, providing technical assistance and training aimed at developing common metrics and resources, and expanding funding and sustainability strategies.

The coordinated, patient-centered approach, which has been the hallmark of nurse-led care since its inception, creates a ready-made environment for MLP to thrive. In addition to health promotion, disease prevention, and chronic disease management, NPs are trained to consider and evaluate social factors that impact disease and wellness. This treatment of the "whole person" accommodates quite naturally the identification and treatment of health-harming legal needs as part of the standard of care, as well as the addition of a lawyer as a member of the health care team. The following section outlines some of the ways that MLP can help nurse-led health clinics provide comprehensive, high-quality care, while also adding value to operational and financial stability.

Examples are drawn from Abbottsford Falls Family Practice and Counseling ("Abbottsford"), a federally qualified NMHC in Northwest Philadelphia that is one of three clinics in the Family Practice & Counseling Network (FPCN). Abbottsford introduced a lawyer to the treatment team in 2009. Since then, they have worked closely with their legal partner, the Legal Clinic for the Disabled ("LCD"), to integrate legal services as a standard of patient care. Abbottsford is federally designated as Medically Underserved and a Primary Care Health Professions Shortage Area and serves a large population of public housing residents. The population is about 90% African-American and experiences severe poverty, with more than 6 of every 10 patients living below 200% of the federal poverty limit. In fiscal year 2013, the center served more than 6,000 patients, a high proportion of whom are either uninsured (20%) or covered by Medicaid (70%).

Improving the Coordination and Delivery of Holistic Patient Care:

In NMHCs, where coordinated, comprehensive care is already a priority, onsite civil legal aid services can often be the missing link.

**"Attorneys look at the world differently than health care providers,"
says the Center Director at Abbottsford Falls.**

"They approach problems from a different perspective and often come up with solutions that had not been considered. Having a different perspective at the table can be extremely helpful in working through complex problems."

A patient at Abbottsford Falls had been fighting with her employer's insurance company about disability benefits following an accident. The patient was extremely vulnerable: she had lost several close family members in a very short period of time to violence and disease, and was struggling with depression and other emotional issues that come with trauma and loss. Despite paperwork submitted by the NP indicating that the patient had a disability that prevented her from working, her benefits were denied. The NP and social worker had been helping with the appeals process for weeks, and when they reached their limit, they turned to the MLP attorney for help.

The attorney met with the patient for less than one hour, and with the help of the clinical team "ghost wrote" a strongly- and specifically-worded letter to the psychiatrist at the insurance company. The patient's disability benefits were approved within thirty days. The Center's Director, Michelle O'Connell, said, "This kind of minimal involvement from an attorney can have an incredibly powerful impact and help our providers address issues that they have been struggling with for a long time." In this situation, the onsite attorney provided critical assistance that unlocked a team-based solution.

Improving Administrative Efficiency and Effectiveness

Medical-legal partnerships can help NMHCs and their providers deal more efficiently with the non-medical issues that they already confront every day. According to the Legal Services Corporation's *Documenting the Justice Gap in America report* (2009), the average low-income individual has at least three unmet legal needs, most of which are related to basic necessities such as food, housing, and safety. Patients feel comfortable communicating these issues to NPs, medical assistants and others on the primary care team who have developed trust within the community. The MLP can help providers understand, identify, and quickly handle these issues so that they can focus on primary care with confidence that the adverse social conditions impacting the patient's health and wellbeing are being addressed.

In the MLP approach, health care providers screen for health-harming legal needs alongside behavioral health, social, and clinical problems. Electronic medical record (EMR) systems can be especially effective tools for integrating civil legal services into existing screening processes. The system at Abbottsford Falls, a four-question electronic Legal Screener administered by medical assistants to every new patient, evolved over a period of one year. The process started with a series of discussions where providers identified the most commonly occurring non-medical needs expressed by their patients. The MLP team then designed a questionnaire to systematically identify patients presenting with potential civil legal needs.

The MLP attorney conducted trainings with the full health care staff to share the function of the legal screener and the appropriate referral process for positive screens. The screener rolled out first in paper version, allowing the team to quickly adjust the questions and conduct additional trainings when referrals initially skyrocketed. Finally, the MLP team worked with the clinic's Information Technology department to add four questions to the EMR system, allowing providers to easily track patients that screened positive for a civil legal issue and easing communication and referrals to the on-site attorney.

The system created by the MLP helped health care providers at the NMHC feel prepared to handle many of the nonmedical problems they had so often encountered. In post-training questionnaires, providers at Abbottsford Falls report gains in (1) knowledge about the health impacts of social determinants of health; (2) comfort with identifying those issues; and (3) confidence asking about and referring issues concerning adverse social conditions. The system has increased legal referrals and enabled NPs to help more people in less time – creating a more efficient team with a more powerful intervention.

Value and Return on Investment for MNHCs

High-quality, comprehensive patient care is the core of any NMHC, but like any business, clinics must operate efficiently to continue delivering that care. An MLP can advance these dual goals, particularly by helping patients access health care coverage.

According to Emily Nichols, Director of Operations for the three-clinic Family Practice and Counseling Network, the MLP played a crucial role in decreasing the number of uninsured patients. Medical assistance applications in Pennsylvania require a provider-signed assessment form. Many NPs in the network expressed confusion over the documentation the application required, misunderstood certain aspects of the form, and worried that signing a form exposed them to liability. Hearing widespread concerns from the NPs across the clinic network, Emily consulted the onsite MLP attorney at Abbottsford Falls.

The attorney worked with the Director of Primary Care to draft a letter documenting and addressing provider concerns and offering information about the form to help NPs better understand its meaning and function. Following distribution of the letter to all NPs in the network, the attorney led site-specific trainings, where NPs and social workers were able to openly discuss their concerns about completing the form and receive training materials that offered guidance in applying the rules. Almost all NPs subsequently reported feeling more comfortable with the form and having a better understanding of the form's importance in getting patients covered. Importantly, the network had started fiscal year 2014 with a 25% uninsured rate. By October 2014, the rate decreased by 5%. According to Emily Nichols, *"There is no doubt that the MLP at FPCN played a critical role in reducing our uninsured by increasing the number of medical assistance forms completed by our Nurse Practitioners and assisting patients who are denied coverage, but actually qualify, get covered."*

Background on Interdisciplinary, Community-Based Care Teams Including Civil Legal Aid Services

Lawton, E., Coon, B., & Fung, A. (2010). Meeting basic needs and reducing health disparities by integrating legal services into the health care setting. *Philadelphia Social Innovations Journal*.

Regenstein, M., Teitelbaum, J., Sharac, J., Phyu, E. (2015). Medical-Legal Partnership and Health Centers: Addressing Patients' Health-Harming Civil Legal Needs as Part of Primary Care. available at www.medical-legalpartnership.org

Sandel, M., Hansen, M., Kahn, R., Lawton, E., Paul, E., Parker, V., Zuckerman, B. (2010). Medical-legal partnerships: Transforming primary care by addressing the legal needs of vulnerable populations [vulnerable populations]. *Health Affairs*, 29(9) 1697-1705.

Shin, P., Byrne, F., Jones, E., Teitelbaum, J., Repasch, L., & Rosenbaum, S. (2010). Medical-legal partnerships: Addressing the unmet legal needs of health center patients. *Policy Research Brief No. 18*.

Teufel, J., Werner, D., Goffinet, D., Thorne, W. (2012). Rural Medical-Legal Partnership and Advocacy: A Three-Year Follow-up Study. *Journal of Health Care for the Poor and Underserved*, 23(2) 705-714.

For more resources on MLP, visit <http://medical-legalpartnership.org/mlp-response/resources/>

Developing a Medical-Legal Partnership in a Nurse-Led Health Clinic

Building the Team

As with any medical-legal partnership, a nurse-led MLP team should consist of administrators and front-line providers from both the health and legal institutions. The makeup of any particular team will depend on the structure, priorities, and resources of the partner organizations, but a typical team might look as follows:

Nurse-Led MLP Organizational Chart



Funding and Planning for Sustainability

Funding and sustaining a medical-legal partnership is a critically important, and often overlooked, part of both the initial partnership process and ongoing operations. The National Center Toolkit (Phase II) addresses this issue directly in a comprehensive discussion of formalizing the relationship between a health and legal partner through a Memorandum of Understanding (MOU).

Charting the pathway from partnerships funded and supported primarily by the legal nonprofit partners, which themselves exist mainly through philanthropy, to an environment that supports diversified, sustainable resources, is a large part of the work being done by National Center for Medical-Legal Partnership. This section offers an example of a nurse-led MLP using diversified funding, followed by descriptions of several current and potential payment mechanisms and suggestions for how new partnerships might access them or help advocate for change.

Sustaining a Nurse-Led MLP: A Brief Case Study

The MLP at Abbotsford Falls Health Center (“Abbotsford”) encountered issues of sustainability from the outset. A local foundation provided generous support to fund the attorney who joined the health care team in 2009. This is a common origin story of MLPS in a variety of settings throughout the country.

Referrals to the MLP increased significantly each year since opening, as did the reach and frequency of providers trained on identifying and “treating” the health-harming legal issues impacting their patients. However, the success of the MLP quickly became its greatest challenge. Increased referrals pushed the client capacity of the onsite attorney, which created overflow cases for the already over-burdened institutional legal aid partner and staff. This systemic stress led the legal partner, which was bearing most of the financial costs of the project, to consider tough questions about reducing services or pulling out of the partnership altogether. In late 2012, leadership from both organizations responded swiftly with a joint analysis of goals, priorities, and cost-sharing for the MLP.

One of the greatest obstacles to long-term sustainability is reliable and renewable sources of funding. Ensuring proper funding of the MLP activities is the responsibility of both the health and legal partners, and can take on a range of forms. Historically, most MLPs have not successfully negotiated proper allocation of resources, and as a result legal partners have frequently borne the brunt of the operating cost of the MLP – despite the significant advantage that health care partners have in securing resources for health care innovations and interventions, alongside the basic fact that MLP programs accrue a benefit directly to health care partners and their patients – which merits an investment of resources. Ultimately, shared resources underscores buy-in and shared responsibility in all aspects of the partnership.

Abbotsford's network director, Donna Torrasi, saw that the MLP provided ongoing benefits to patients, such as healthier housing, reduced family violence, and access to public benefits, as well as help to providers and a financial return on investment to the organization through increased Medicaid-insured patients. Moreover, the organization-wide education and advocacy projects led by the onsite attorney contributed to reducing the uninsured rate and creating administrative efficiencies for providers who are constantly struggling against limitations on resources and time that hamper their ability to respond effectively to the social determinants of their patients' health.

Donna took action. She committed to the MLP's sustainability by paying 25% of the onsite attorney's salary for fiscal year 2013; specifying ongoing protected time for the project at key positions in primary care – nurse administrator, nurse-practitioner, and a medical assistant; and bringing in the director of operations as a strategic partner to help identify additional funding opportunities available only to health organizations or populations (one example is an asthma-education initiative by a large insurer that the MLP could complement and support). The plan is to increase health center funding over the next three years to support at least 50% of the onsite attorney's time. Currently, the partners are also working through the possibility of MLP as a component of Patient Centered Medical Home accreditation (of which Abbotsford is a Level 3).

Current and Potential Funding Mechanisms

Legal aid funding for MLPs, which has been effective in driving the grassroots adoption of the MLP model across the country over the past 10 years, cannot sustain its current evolution from a direct services model to a public health strategy capable of driving population health change. Health organizations, however, which accrue significant benefits through the MLP for themselves and for their patients, are uniquely positioned to marshal, identify, and obtain financial support for integrated legal care. Nurse-Managed Health Centers (NMHCs), many of which are FQHCs or FQHC look-alikes, are funded through a variety of sources, including Medicaid/Medicare, the U.S. Health Resources Services Administration (HRSA), Affordable Care (ACA), universities, grants, third-party payers, and patient fees. While there is no standard funding mix for NMHCs, there are several mechanisms that linics and networks should explore before and throughout the operation of the MLP.

Health Care System Funding

Health Care Partner Operational Revenue

Health care partner commits funds to legal aid services based on growing evidence-base that MLP improves patient care, administrative efficiencies, and bottom line.

- **Pros:** more likely that a NMHC will attract a legal partner and form a MLP; culture and structure for partnership and sustainability is set from the beginning.
- **Cons:** building the evidence base for the return on investment takes time; requires comprehensive understanding of the MLP approach from the outset.

Consideration for Patient-Centered Medical Homes

An MLP may benefit NMHCs seeking PCMH status, if the PCMH model includes civil legal aid services.

- **Pros:** corresponds to a basic theory of MLP, which is that good health may require a range of clinical and nonclinical considerations.
- **Cons:** financial benefits of achieving PCMH status may not be realized directly or easily attributable to the MLP.

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Philanthropic Investment

Leveraging Social Return on Investment with National and Local Philanthropies

For the communities served by NMHCs, ensuring the proper distribution of SNAP benefits and preventing bankruptcies, evictions, and utilities terminations all have a social impact beyond the delivery of individuals legal services. Foundations and philanthropic organizations today seek programs where small changes impact large numbers. By applying public health strategies into the delivery of civil legal aid services, MLPs can improve the lives of entire communities.

- **Pros:** attractive to funders that are interested in new strategies for delivering programs and services to individuals in need; allows funder investments to have impact beyond the specific number of services actually delivered.
- **Cons:** understanding the social return of investing in an MLP requires a thorough understanding of the MLP model; although emerging research documents how MLPs can create systems that improve patients' financial circumstances, prevent community wide heat shut-offs, and more, frequently the connection between the legal service delivered to one patient and the positive impacts felt by others in the community is too attenuated and more research is needed.

Payor Reform

As health care reform continues to take shape throughout the nation, new opportunities to support nurse-led MLPs will emerge. Of particular relevance are developments surrounding how different payor models impact the quality of health care delivery. As new models are tested and adopted, nurse-led MLPs may be able to take advantage of new funding mechanisms that support efforts to deliver care that treats the whole person.

Fee for Service Reimbursement

Fee for service is payment model where services are unbundled and paid for separately. For legal services, this would mean a fee assessed for each service provided.

- **Pros:** Each item or service provided is charged for, which generates revenue for each service provided instead of a flat fee.
- **Cons:** Legal provider gets paid per service so there is no financial incentive to keep cost down.

Value Based Payment Models

Value based payment models, or “pay for performance” models, offer financial rewards for better outcomes instead of the quantity of services rendered, making the focus of treatment the overall health of the patient, including civil legal issues associated with health concerns. This model uses a broad-spectrum approach to treatment in order to ensure the health of the patient.

- **Pros:** Recognizes the hand-in-hand relationship between medical health and the legal system; mimics the ACA shift in focus on quality outcomes over quantity.
- **Cons:** Can prevent reimbursement for additional services needed that are unforeseen at the beginning of the patient attorney relationship.

Wraparound Service Inclusion

The wraparound service delivery model aims to achieve positive outcomes by providing an individualized planning process for patients that addresses a range of life areas to improve overall health. The values associated with wraparound service inclusions require that the planning process itself should be individualized, family driven, culturally competent, and community based. Payors can execute the wraparound system through a variety of models including: the provider-implemented model (fosters collaboration between provider, state, and country funders); the public sector implemented model (should explain this); and the network-implemented model (where the country contracts for care coordination and direct services). Funding should consider the population, urgency, and nature of the host environment where the wraparound service will take place.

- **Pros:** flexibility in funding models; county and state support; numerous test programs successfully implementing a wraparound system.
- **Cons:** Due to time and resources involved, wraparound services are not intended for every patient.

Looking Ahead: The Future of Nurse-Led MLPs

Civil legal aid services can be a critical component of the interdisciplinary, patient-centered care offered in nurse-led care settings like NMHCs. Through the MLP approach, patients can access potential solutions to health-harming legal needs, and health centers can develop the resources and skills that advance systems- and population-level change.

Across the country, health care and policy leaders are taking action to bring MLP into nurse-led care settings. In the Philadelphia region alone, nurse-led MLPs can be found in FQHCs, like Abbottsford Falls and Rising Sun Health Center; in the maternal and early childhood health home-visiting program, Nurse Family Partnership; and serving the migrant farmworker population at La Comunidad Hispana. In Tennessee, the Nursing Community Health Center (NCHC) at East Tennessee State University is partnering with the Tennessee Justice Center in order to advocate for patients “in ways beyond our imagination,” says Dr. Patricia Vanhook, PhD, FNP-BD, FAAN. Vanhook says the MLP “will allow us to understand the social parameters that impact our patients. Our practitioners acknowledge they only scratch the service because if they delve too deep, then they do not have the resources to assist the patients in those areas.”

Dr. Annette Mitzel, DNP, CNS, from the University of Akron, decided to integrate “the MLP model into the health Safety Net System, extend[ing] the integrative, holistic care we provide and address social determinants of health, within the community.” The MLP site at Akron will address important issues such as Advance Care Planning and documented Advance Directives. By integrating civil legal aid services into nurse-led settings, Mitzel says health centers can better understand “social parameters impacting their patients and develop upstream strategies to prevent these issues.”

MLPs can offer practical solutions to patients’ health-harming legal problems prevalent in so many safety-net health care settings. Over fifteen other NMHCs have shared interest in or made steps toward integrating legal services into their health centers. Several nurse leaders are also working to include MLP training into academic nursing curricula—reflecting the longstanding commitment of NMHCs to not only delivering high-quality, comprehensive care but also cultivating a workforce ready to meet the needs of their patient-communities. In an ever-changing health care climate, the future of nurse-led MLP is unknown. However, it is clear that integrating legal services into the nurse-led health setting advances a nuanced, comprehensive understanding health care for patients and communities.

