

THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD

FINDINGS FROM THE 2015 NATIONAL CENTER
FOR MEDICAL-LEGAL PARTNERSHIP SURVEYS

AUGUST 2016

AUTHORS

Marsha Regenstein, PhD

Director of Research and Evaluation
National Center for Medical-Legal Partnership

Jessica Sharac, MSc, MPH

Senior Research Associate
National Center for Medical-Legal Partnership

Jennifer Trott, MPH

Program Advisor
National Center for Medical-Legal Partnership

THE NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP

The mission of the National Center for Medical-Legal Partnership (NCMLP) is to improve the health and well-being 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.

ACKNOWLEDGEMENT

This report is possible with support from the Robert Wood Johnson Foundation.

CONTACT INFORMATION

The National Center for
Medical-Legal Partnership
Department of Health Policy and Management
Milken Institute School of Public Health
The George Washington University

2175 K Street, NW
Suite 513A
Washington, DC 20037
www.medical-legalpartnership.org
t: (202) 994-4119

GLOSSARY

Brief advice: The provision of limited civil legal assistance to clients who are not appropriate for full or limited representation

Case: The provision of civil legal assistance to an eligible client with a legal problem or set of legal problems

Civil Legal Aid: The national system of publicly funded lawyers – supplemented by private lawyers and law firms acting in a pro bono capacity and by law school clinics across the country – who handle housing, public benefits, family law, and additional non-criminal problems for low-income and other vulnerable populations. It is the civil equivalent of the criminal public defender system.

Health-Harming Civil Legal Needs: A social, financial, or environmental problem that has a deleterious impact on a person's health and that can be addressed through civil legal aid.

I-HELP™: 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 dealt with by civil legal aid; these include Income and insurance, Housing and utilities, Education and employment, Legal status, and Personal and family stability.

High-utilization: Utilization of health care services that is above average; typically includes the use of hospital services.

HRSA: Or the Health Resources and Services Administration, is the primary federal agency charged with improving access to health care for the uninsured and vulnerable. HRSA is a major funder of primary care and other care services infrastructure and innovation in health center settings.

Limited Representation: A method of legal assistance in which an attorney and client agree to limit the scope of the attorney's involvement in a lawsuit or other legal action

Medical-Legal Partnership: An approach to health care delivery that embeds civil legal aid lawyers and paralegals alongside health care teams to detect, address, and prevent health-harming social conditions.

MLP case consultation: Sharing of legal information by the legal team to the health care team. In a typical MLP case consultation, the legal team never meets or learns the name of the patient and does not open a "case" at the civil legal aid organization.

TABLE OF CONTENTS

Executive Summary	4
Survey Methods	6
Results	
Key Characteristics of a Medical-Legal Partnership	7
MLP Health Care Partner Organizations	7
MLP Legal Partner Organizations	8
People Served by Medical-Legal Partnerships	10
Screening for Health-Harming Civil Legal Needs	11
Patient Referrals from Health Care Providers for Civil Legal Aid Services	11
Resources Associated with Operating a Medical-Legal Partnership	13
Staffing	13
Funding	14
Perceived Capacity to Meet Demand for MLP Services	14
Service Integration and Information Sharing Between Partners	18
Location of Service Delivery	18
Communicating about MLP Activities	18
Data Sharing – Health Care Partner Organizations	19
Data Sharing – Civil Legal Aid Partner Organizations	19
Training	19
Ways Medical-Legal Partnerships Advance Health and Well-Being	22
Improved Wellbeing and Patient Care	22
Financial Benefits to Patients and Health Care Organizations	23
Discussion and Recommendations	25

EXECUTIVE SUMMARY

Increasingly, the health care system strives to address the social and environmental factors that affect health through social work, case management, and navigation services deployed alongside clinical care. Yet often the services, benefits, and laws in place to help ensure economic stability, healthy housing, and access to health care are wrongfully denied, under-enforced, or do not exist. When this happens – when a woman loses her job because of employment discrimination, when her landlord threatens to illegally evict her from her apartment, or when her health insurance or disability benefits are wrongly denied – her physical and/or mental health often suffer, and she needs more help than the traditional health care team can provide. These problems are not health care problems per se, but rather are rooted in civil legal needs that profoundly affect health, and left untreated, they can have debilitating effects on individual and population health, which in turn increases health care utilization and costs.

Over the past decade, the medical-legal partnership (MLP) approach to care has taken its rightful place as a critical innovation to advance the health and wellbeing of millions of low-income and underserved individuals. Simple in design yet elegant in purpose, 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 civil 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 civil legal needs to advance local and state policy to provide safer and healthier environments.

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. Nearly 300 MLPs now 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.

In 2015, 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:

- What are the key characteristics of medical-legal partnerships?
- Whom do medical-legal partnerships serve?
- What resources are associated with operating a medical-legal partnership?
- How do health care and civil legal aid organizations integrate service delivery and information sharing to accomplish their goals?
- In what ways do medical-legal partnerships advance health and well-being?

This report presents findings from the 2015 NCMLP Survey 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 four primary areas for MLP growth and improvement based on the survey results. The recommendations include to:

1. Establish standard practices for identifying health-harming civil legal needs, including a screening process in the health care setting.

The survey data demonstrate a clear disconnect between perceived capacity and actual demand. It also shows that formal screening processes are not yet pervasive in MLP programs.

2. Improve the data collection and sharing between MLP health care partner organizations and MLP civil legal aid partner organizations.

Data sharing and feedback on patient outcomes has the potential to improve the effectiveness of MLP services, and strengthen partnership between the health care and civil legal aid organizations. The data show that this is an area for improvement among MLPs.

3. 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.

4. Grow, improve, and sustain MLPs by building out critical infrastructure elements like diverse and stable funding streams.

This survey shows that funding and staff support for MLP activities is more likely to come from the MLP legal partner organization. An investment of dollars and staff from the MLP health care partner organization to help support the activities of the MLP could bring greater sustainability and strengthened partnership.

It is the intention of NCMLP to repeat this survey annually to monitor trends in MLP, to draw upon this information to inform the work of NCMLP, and to continue to make recommendations for the field in the future.

SURVEY METHODS

Health care and legal organizations involved in an active or developing MLP were invited to participate in the 2015 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, from mid-December 2015 to mid-February 2016.

The NCMLP survey questionnaires were developed by researchers from the National Center for Medical-Legal Partnership, with input from experts at Westat Corporation. The 2015 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 405 organizations were considered eligible for the survey, meaning that they were a health care or legal organization actively engaged in an MLP. Of these, 266 were health care organizations and 139 were legal organizations. We received a total of 256 completed surveys, for an overall response rate of 63 percent. Legal organizations were more likely to complete the survey; their response rate was 92 percent, compared to 48 percent for health care organizations. Survey data was collected through Survey Monkey and analyzed using SPSS, Version 22.

Figure 1. NCMLP Survey Response Rates

TYPE OF RESPONDENT	TOTAL SURVEYED	RESPONSE RATE
All organizations	405	63 percent
Health care organizations	266	48 percent
Legal organizations	139	92 percent

Source: 2015 Annual 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 45 states and the District of Columbia. California and Illinois had the highest and second-highest number of health care, legal, and total responses, while Florida had the third-highest number of legal responses and Pennsylvania had the third-highest number of health care and total responses. The five states with no responses were Alabama, North Dakota, Nevada, South Dakota, and Utah.

Questionnaires were completed by different MLP participants, depending on the type of organization or the engagement of different staff in the MLP enterprise. (The health care and legal questionnaires are both available on NCMLP's website. [Click here](#) to view the health care partner questionnaire, and [click here](#) to view the legal partner questionnaire. In the case of legal partner organizations, 88 percent of questionnaires were completed by a lawyer. A variety of individuals responded to the questionnaire on the health care organization side. Four out of ten health care respondents were physicians – making that the most likely health care profession to respond to the survey – followed by administrators/managers (20 percent), social workers (11 percent), CEOs/Executive Directors (10 percent), nurses/nurse practitioners (7 percent), others (6 percent), and attorneys (5 percent).

RESULTS: KEY CHARACTERISTICS OF MEDICAL-LEGAL PARTNERSHIPS

HIGHLIGHTS

MLP health care partner organizations tend to be:

- Located at hospitals, health systems, or HRSA-funded health centers
- Situated in underserved areas
- Able to say that they have participated in an MLP for less than five years

MLP legal partner organizations tend to be:

- Civil legal aid organizations, split fairly evenly between organizations who receive federal Legal Services Corporation funding and those who do not receive this funding
- Actively engaged in MLPs with more than one health care organization
- Positioned to spread to additional health care organizations

MLP Health Care Partner Organizations

The field of medical-legal partnership is still in a growth phase. While early MLPs tended to be 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 2 indicates, most (84 percent) health care partner organizations engaged in MLPs are located at hospitals, health systems or HRSA-funded health centers. In fact, HRSA is actively encouraging health centers to consider the benefits of MLP for their patient populations and 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 training to improve clinical quality and operations in health centers. Currently, more than one-quarter (28 percent) of active MLPs are located at HRSA-funded health centers.

In July 2015, 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”](#)) About 30 percent of health centers surveyed indicated that they use some enabling services funding to support MLP services for their patients.

Additionally, a small but growing number of MLPs are part of the U.S. Department of Veterans Affairs (VA) Health System, reflecting the fact that the VA increasingly has recognized that matching civil legal aid interventions

with health care services has the potential to dramatically improve the lives of veterans and their families. (See issue brief: [“The Invisible Battlefield: Veterans Facing Health-Harming Legal Needs in Civilian Life”](#)) Because the MLP approach is particularly flexible and can adapt to a variety of health care settings, we expect to see partnerships cropping up in other health care organizations in the coming years.

Reflecting MLP’s mission to address health-harming civil legal needs of low-income and vulnerable populations, health care partner organizations tend to be situated in areas with high health care needs. Three-quarters of health care partner organizations with MLPs are located in underserved areas. Eighty-four (84) percent have at least a quarter of patients on Medicaid and 47 percent have at least a quarter of patients who are uninsured (see Figure 3). In addition, many MLP health care partner organizations are actively engaged in innovative practices related to the dynamic health care environment. Four in ten health care partner organizations are certified as Patient-centered Medical Homes, and a third (34 percent) are part of Accountable Care Organizations (ACOs).

Approximately 30 percent of health care partner organizations indicate that their MLP has been active for five years or longer. These more mature MLPs are the pioneers of the field. Serving as early testing grounds for much of the work that currently defines an MLP, 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 field is still quite young, with much to learn as it grows and matures. According to health care organization survey respondents, a third of MLPs are two years old or less and 37 percent are three to five years old. As Figure 4 illus-

trates, hospital-based MLPs tend to be more established (in terms of age) compared to health center-based MLPs.

MLP Legal Partner Organizations

Like MLP health care partner organizations, legal partner organizations also demonstrate diversity in terms of their organizational characteristics. Three-quarters of legal partners are true civil legal aid organizations, split between LSC-funded (44 percent) and non-LSC-funded (31 percent) entities. One in seven legal partner organizations are law schools; only about 2 percent are private law firms (see Figure 5).

Unlike health care partner organizations, which tend to be affiliated with only one legal organization, legal partner organizations often partner with more than one health care organization to provide civil legal aid services and support. Legal partner organization respondents indicated that they partner on average with 2.4 health care organizations (see Figure 6). Also indicative of growth and spread in the field, a third of MLP legal partner organizations (34 percent) are planning additional MLPs.

CHARACTERISTICS BY THE NUMBERS

Figure 2. MLP Health Care Partners by Organization Type

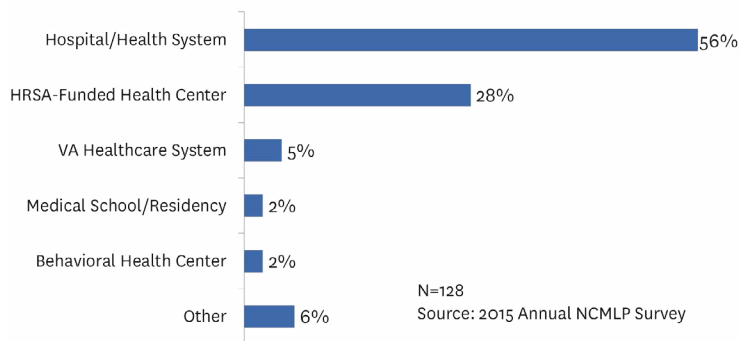


Figure 5. MLP Legal Partners by Type of Organization

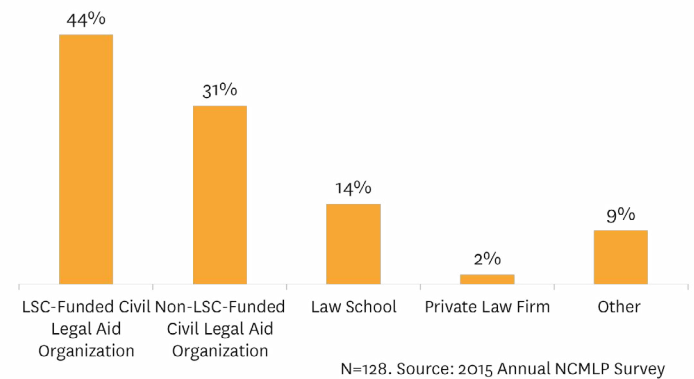


Figure 3. MLP Health Care Partners Serve Underserved Populations

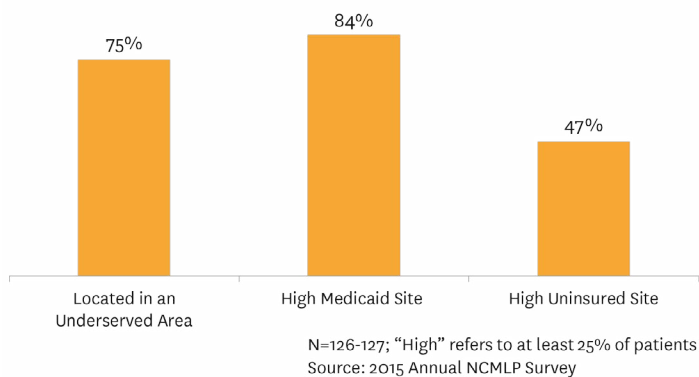
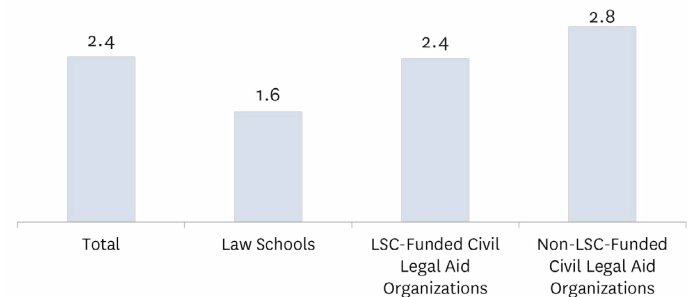
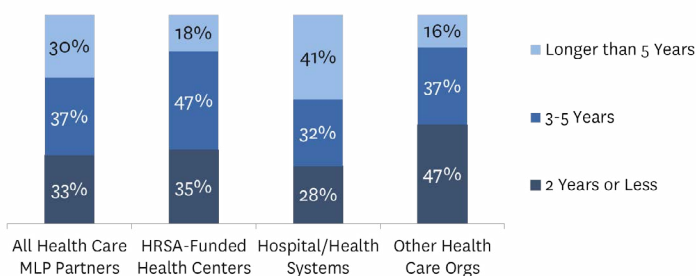


Figure 6. Average Number of Active MLPs that Legal Organizations Support



N=125 and 43 for all, 17 and 2 for law schools, 55 and 27 for LSC-funded civil legal aid organizations, and 39 and 13 for non-LSC-funded civil legal aid organizations. Means were not significantly different. Source: 2015 Annual NCMLP Survey

Figure 4. Most MLPs are Less than Five Years Old



N=122 for all, 34 for health centers, 69 for hospitals/health systems, and 19 for other organizations. Length of establishment did not significantly differ by organization type. Source: 2015 Annual NCMLP Survey

RESULTS: PEOPLE SERVED BY MEDICAL- LEGAL PARTNERSHIPS

HIGHLIGHTS

MLP health care partner organizations:

- See a variety of patient populations and conditions
- Are likely to include children among the populations served
- Screen for health-harming civil legal needs, though inconsistently

MLP legal partner organizations:

- Receive thousands of referrals from health care partner organizations
- Provide civil legal aid interventions related to all five [I-HELP™](#) needs

Health care and legal partner 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 civil legal aid interventions can provide. So too is an appreciation of the circumstances that enhance the effectiveness of MLP interventions, given scarce civil legal aid resources in the context of acute and chronic health and social service needs.

Some MLPs address a broad collection of health-harming civil legal needs, while others target a narrower population with a more focused set of civil legal aid interventions. MLPs adapt to their local surroundings, both in terms of the health care environment and organizational constraints, as well as the health-harming civil legal needs demonstrated by patients and the civil legal aid resources available to address those needs.

We asked MLP health care partner organizations to report the populations that they serve, with the understanding that many MLPs serve multiple population groups. As can be seen in Figure 7, the most common response was children, with 59 percent of MLPs reporting that they address the health-harming civil legal needs of children. Half of the respondents reported that they serve the general population (52 percent), and nearly four in ten (39 percent) reported serving patients experiencing homelessness. Substantial percentages of MLPs also serve immigrants, elderly patients, veterans, Native Americans, and patients with high-utilization rates of health services.

We also asked health care partner organizations whether they targeted specific health conditions for MLP interventions. Half of health care partner organizations (52 percent) do not target any specific conditions for services and about half target 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, about a quarter of respondents target mental health issues (24 percent), disabilities (23 percent), or chronic illness (22 percent). Sizeable numbers of MLPs target specific chronic conditions or domestic violence/abuse.

Screening for Health-Harming Civil Legal Needs

Health care organizations that participate in MLPs commonly have a process to screen their patients for health-harming civil legal needs. Eight in ten health care partner organizations (79 percent) have some type of screening process for identifying patients who would benefit from an MLP intervention. Of these organizations, nearly two-thirds (63 percent) use a formal screening protocol to screen for health-harming civil legal needs.

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. Fewer than half (44 percent) say they screen “all of the time,” regardless of the patient population of focus. The most common patient populations consistently screened for health-harming civil legal needs are patients experiencing homelessness (44 percent), high-utilizers of health care services (35 percent), veterans (31 percent), and immigrants (31 percent).

The percent of health care partner organizations indicating consistent screening by condition or patient circumstance is even lower. As Figure 9 illustrates, less than half (48 percent) of MLPs say they screen “all of the time” among patients with a history or indication of domestic violence or abuse; the percentages drop for other conditions such as disability, substance use, and other chronic health conditions.

Patient Referrals from Health Care Organizations for Civil Legal Aid Services

Even without standardized or consistent screening protocols, legal partner organizations receive numerous patient referrals for civil legal aid services from their health care

partners. Two-thirds (66 percent) of MLP legal partner organizations said they receive referrals for civil legal aid issues related to children, and nearly as many (63 percent) saw referrals related to homeless/unstably housed patients or elderly individuals (60 percent). Figure 10 illustrates the percent of MLPs who 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 dealt with by civil legal aid; these include Income and insurance, Housing and utilities, Education and employment, Legal status, and Personal and family stability. Eighty-two (82) percent of MLP legal partner organizations received referrals from health care partner organizations for income and insurance needs (82 percent); 80 percent had referrals for housing and utilities needs, and 77 percent had referrals related to family stability (77 percent). Slightly fewer had referrals for education and employment, or needs related to legal status.

Legal partner organizations document the number of patients/clients referred by their health care partners and the type of civil legal aid interventions provided. Figure 11 provides information on annual MLP caseloads on the legal partner side, including the total number of cases for brief advice, limited representation, cases opened and closed, and MLP case consultations with health care providers at their health care partner organizations over the past one-year period. Clearly, legal partner organizations provide an enormous benefit to thousands of patients and health professionals at health care partner organizations.

PEOPLE SERVED BY THE NUMBERS

Figure 7. MLPs Serve Various Populations at Health Care Organizations

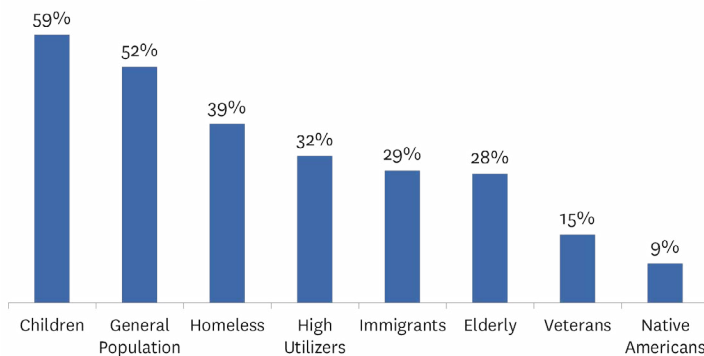


Figure 8. MLPs Target Various Health Conditions for MLP Services

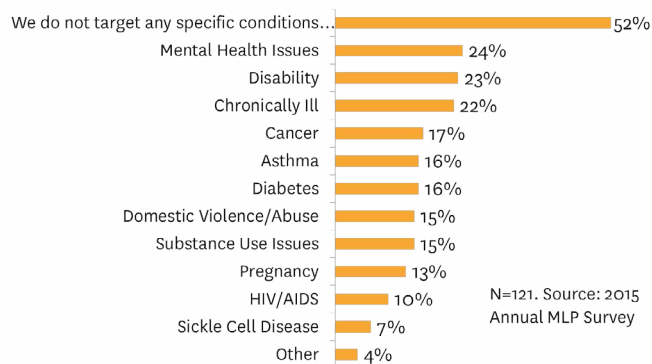


Figure 9. Percent of MLP Health Care Partners that Screen for Health-Harming Civil Legal Needs "All of the Time" (by Conditions)

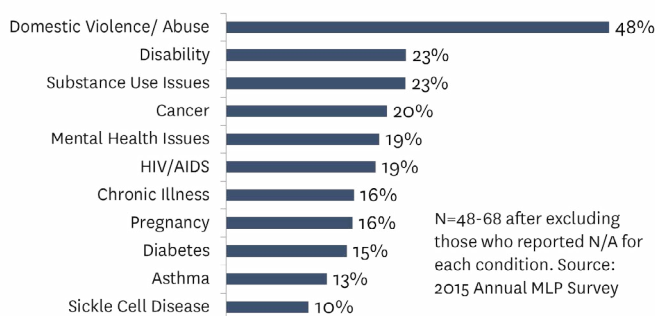


Figure 10. Distribution of MLP Referrals by I-HELP Category in the Past Year

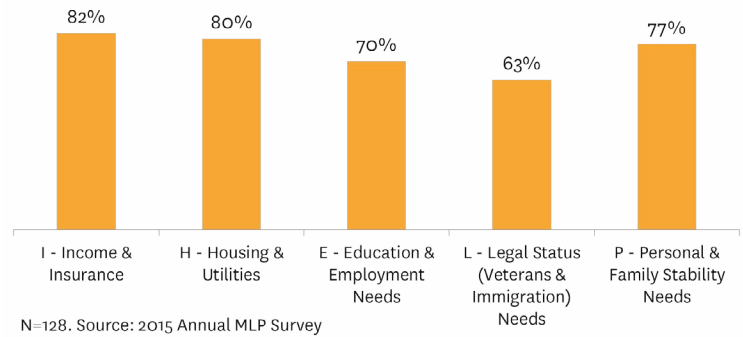
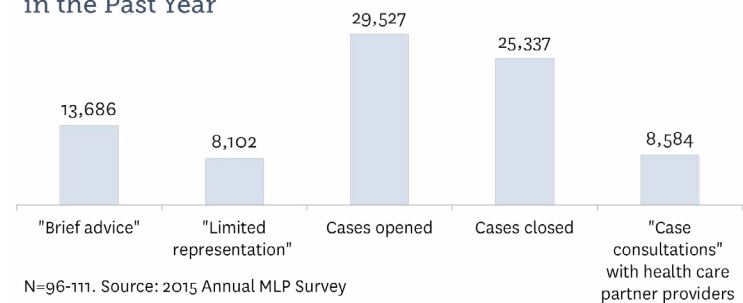


Figure 11. Total Number of MLP Legal Interaction in the Past Year



RESULTS: RESOURCES

ASSOCIATED WITH

OPERATING AN MLP

HIGHLIGHTS

MLP health care partner organizations:

- Often do not report FTEs committed to MLP activities
- Tend to have small budgets for MLP activities
- Are likely to report that they have the capacity to meet demand for MLP services

MLP legal partner organizations:

- Generally commit FTEs to MLP activities
- Have dedicated budgets and varied funding sources for MLP activities
- Are likely to report that they have the capacity to meet demand for MLP services

Staffing

Health care organizations participating in MLPs are not very likely to commit considerable amounts of full-time equivalent (FTE) staff to MLP activities. In fact, only four in ten health care partner organizations report any FTEs for MLP activities. Among the 95 respondents who say that they commit FTEs to MLP, 61 percent report one FTE or less (see Figure 12). The most common professions with FTEs committed to MLP activities on behalf of the health care partner organization are social workers (42 percent), physicians (41 percent), and administrators (38 percent).

Compared to MLP health care partner organizations, legal partner organizations are more likely to commit FTEs to MLP activities, and are more likely to commit a greater number of FTEs. Nine out of ten MLP legal partner organizations report FTE participation in MLP activities (see Figure 13). All respondents who report FTE for MLP activities claim lawyer FTEs, while 41 percent of legal partner organizations also report paralegal FTEs and 43 percent report other staff FTEs. The median FTE is 2.3. Among the 115 legal partner organization respondents who report FTEs spent on MLP activities, only 25 percent report one FTE.

It is perhaps not surprising that the MLP legal partner organization is very likely to report FTEs for MLP activities since they are responsible for executing the legal work of the MLP. However, a lack of FTEs or fewer FTEs reported by the health care partner organizations could impede effectiveness, growth, and sustainability of the partnership. More research is needed to determine the best models for supporting the operations of the MLP.

In addition to information about FTEs, we asked MLP legal partner organizations about pro bono hours devoted to MLP activities. Fifty percent reported that they used pro

bono hours to treat patients' needs. Among those MLPs, the average number of pro bono hours reported in the past year was 707 per program.

More staffing resources originate from legal partner organizations than from health care partner organizations. As MLPs grow to meet demand and become more established across the country, it is likely that health care partner organizations will need to devote more staff time toward the coordination and integration of MLP activities in order to be sustainable and effective.

Funding

When it comes to funding, the MLP legal partner organization is more likely than the health care partner to report a budget for MLP activities. As detailed in Figure 14, 61 percent of legal partner organizations report a budget above zero for MLP. Twelve percent of legal partner organizations report a “zero” budget, compared to 41 percent of health care partner organizations.

Overall, we found that the median annual budget amount was greater among legal partner organizations than health care partner organizations. The MLP health care partner organization median annual MLP budget is \$80,415, with health centers reporting the lowest median MLP budget (\$55,000). Hospitals/health systems and other health care organizations have median annual budgets of \$65,000 and \$95,000, respectively.

As shown in Figure 15, health care partner organizations that have been part of an MLP for five years or longer have a higher median budget (\$132,500) than MLPs in operation for two years or less (\$75,000). Interestingly, the smallest median budget is linked with the group of respondents reporting three to five years of MLP operation. Unfortunately, the survey captures MLPs at one point in time, limiting our understanding of how individual MLPs operate over time. As we collect additional years of survey data, we will be able to track trends in MLP funding and operations. Nevertheless, these initial findings may reflect start-up costs and moderately higher budgets associated with operating a new MLP. Budgets

may drop somewhat after the first two years of operation when the start-up phase is over and seed funding has ended. The older, more established MLPs may have larger budgets because they have had more time to establish relationships with funders and to demonstrate their value to patients, health care providers, and the communities in which they operate.

For MLP legal partner organizations, respondent data shows a median annual MLP budget of \$135,891, ranging from \$120,000-\$160,169 depending on the type of organization. MLPs that are partnered with law schools report the highest median budget, followed by LSC-funded civil legal aid organizations, non-LSC funded civil legal aid organizations, and other legal organizations (see Figure 16). Because law schools serve a training function for their students, they may have resources to provide MLP services as part of their educational experience.

Often MLPs draw on multiple sources of funding. Health care partner organizations are more likely to report a single source of funding for MLP activities than legal partner organizations. Half of MLP health care partner organizations (49 percent) reported only one source of funding as compared to 27 percent of legal partner organizations, while nearly half of legal partner organizations (45 percent) reported three or more sources of funding as compared to only 24 percent of health care partner organizations (see Figure 17). 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/opportunities for stable and diversified funding streams for sustainability and growth strategies.

Perceived Capacity to Meet Demand for Medical-Legal Partnership

One of the most interesting responses that we received was around capacity to meet demand for MLP services. We recognize that measuring demand is largely dependent on screening practices, which are inconsistent across MLP health care partner organizations. This may result in MLP health care partner organizations un-

derestimating demand for services and legal partner organizations not receiving the optimal number of referrals based on the needs of the population. Nevertheless, we wanted to know how MLP partners viewed their capacity to meet either real or potential demand for services.

Six in ten MLP legal partner organizations reported that the MLP can meet the demand associated with patients' health-harming civil legal needs present at their partner health care organization. Responses differed quite a bit by legal organization type. Three-quarters (74 percent) of LSC-funded civil legal aid organizations said they could meet the current demand, compared to 50 percent of non-LSC-funded civil legal aid organizations, and only 38 percent of law schools. While law schools had the highest median budgets dedicated to MLP activities (see Figure 18), they also tend to have the lowest capacity, owing both to the small caseloads and high turnover of law students, and the primary focus of law clinics on teaching and training.

About two-thirds of MLP legal partner organizations refer clients elsewhere – to pro bono attorneys (66 percent), to other civil legal aid organizations (66 percent), or to non-legal supports (63 percent) – in order to address health-harming civil legal needs of MLP patients/clients who exceed their available resources or are beyond the scope of services they provide. Few MLP legal partner organizations (11 percent) report placing clients on a waiting list.

We also asked MLP health care partner organizations about their capacity to meet demand for their patients' health-harming civil legal needs. Surprisingly – given relatively low budgets and limited FTEs devoted to MLP activities – three-quarters of health care partner organizations (74 percent) say that their MLP can meet the demand. Newer MLPs are more likely than more mature partnerships to indicate that they can meet patient demand associated with health-harming civil legal needs. Ninety percent of health care organizations with MLPs two years old or younger said that they could meet demand, compared to 56 percent of health care partner organi-

zations with five or more years of MLP experience (see Figure 19). The difference in response between the newer MLPs and older MLPs could be a reflection of the wisdom that accompanies experience. It could also be due to the fact that newer MLPs may be less likely to have a tested, formal screening process that provides them with a more accurate picture of demand.

RESOURCES BY THE NUMBERS

Figure 12. Total Annual FTE for MLP Activities Reported by MLP Health Care Partners

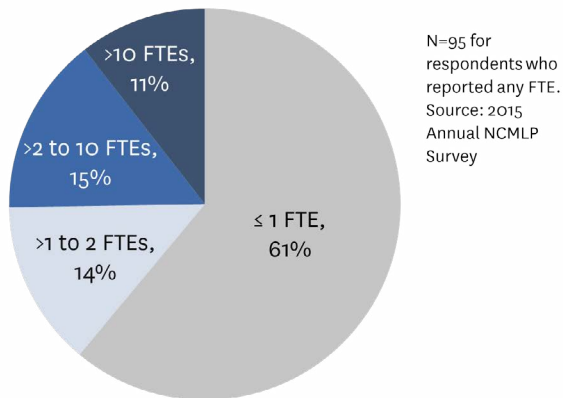


Figure 14. Percent of MLP Health Care and Legal Partners Who Reported an MLP Annual Budget

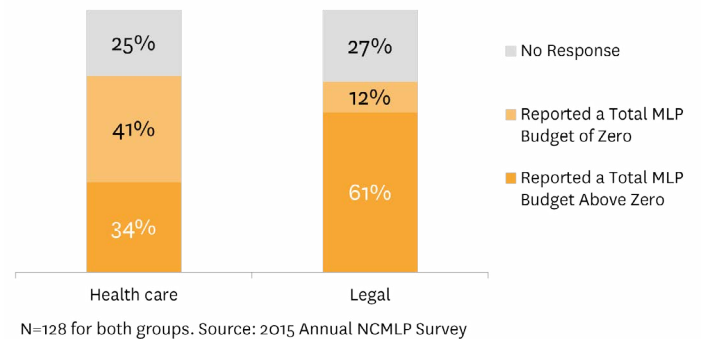


Figure 13. Total Annual FTE for MLP Activities Reported by MLP Legal Partners

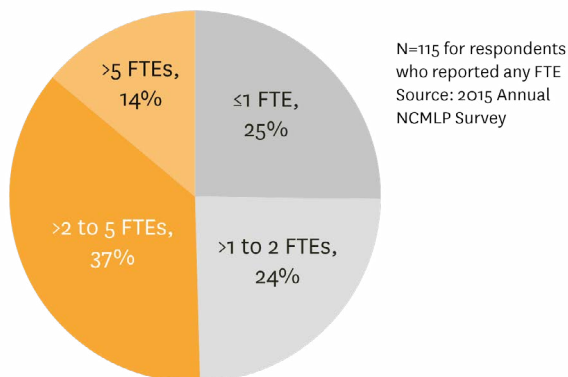


Figure 15. MLP Health Care Partners Median Annual MLP Budget, by Age of MLP

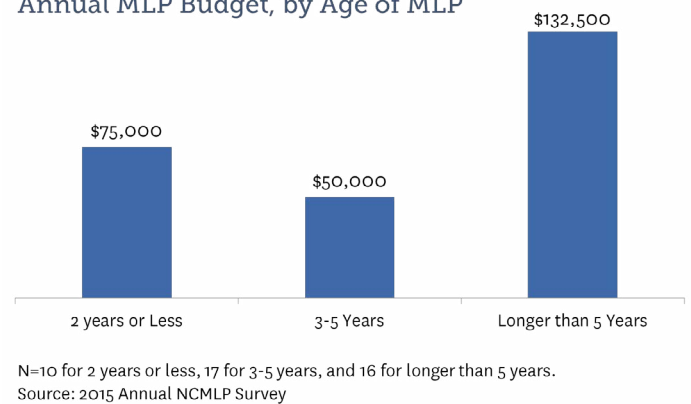
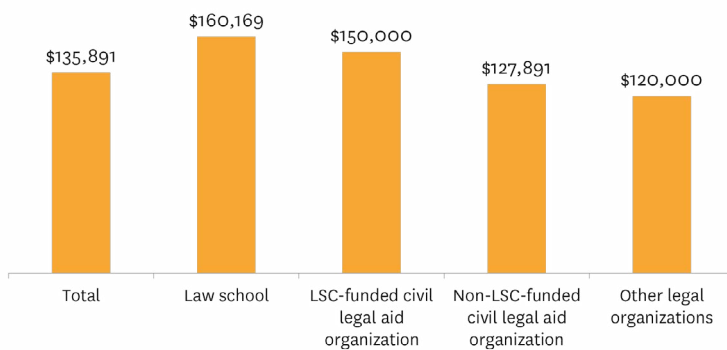
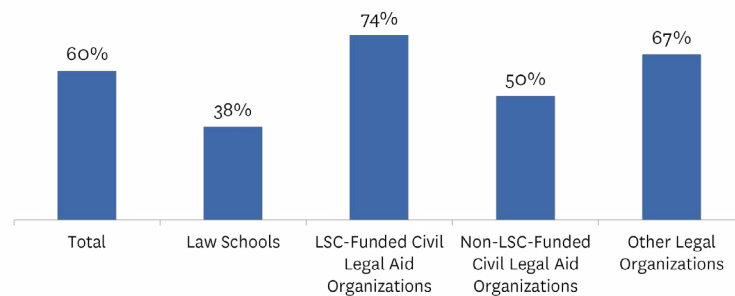


Figure 16. MLP Legal Partners Median Annual MLP Budget, by Organization Type



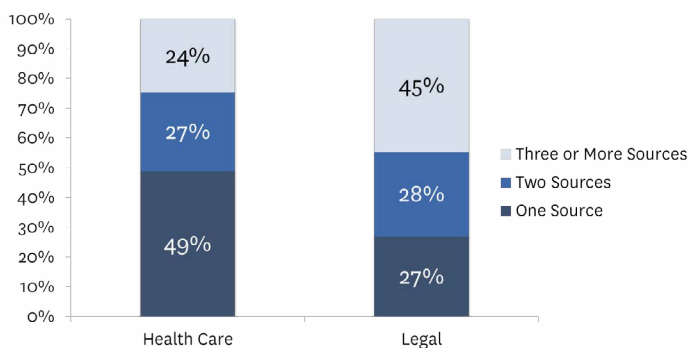
N=78 for total, 10 for law schools, 33 for LSC-funded civil legal aid organizations, 26 for Non-LSC-funded civil legal aid organizations, and 9 for other legal organizations.
Source: 2015 Annual NCMLP Survey

Figure 18. MLP Legal Partners Who Say they Can Meet the Demand for Patients' Health-Harming Civil Legal Needs



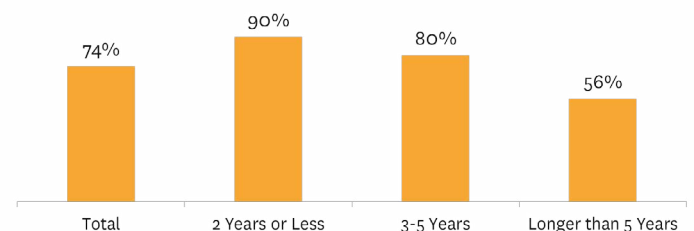
N=98 for all, 16 for law schools, 43 for LSC-funded civil legal aid organizations, 30 for non-LSC-funded civil legal aid organizations, and 9 for other legal organizations. Percentages are significantly different by type of organization. Source: 2015 Annual NCMLP Survey

Figure 17. Number of Funding Sources for MLP Health Care and Legal Partners



N=49 for health care and N=79 for legal. Source: 2015 Annual NCMLP Survey

Figure 19. MLP Health Care Partners Who Say they Can Meet the Demand for their Patients' Health-Harming Civil Legal Needs



N=100 for all, 30 for 2 years or less, 35 for 3-5 years, and 32 for longer than 5 years. Percentages by length of MLP establishment are significantly different. Source: 2015 NCMLP Annual Survey

RESULTS: SERVICE INTEGRATION AND SHARING AMONG PARTNERS

HIGHLIGHTS

MLP health care partner organizations:

- Are likely to communicate with health care leadership and civil legal aid executive directors about MLP, but less likely to meet with civil legal aid board of directors
- Usually provide on-site office space for MLP legal partner organizations' staff
- Report having data-sharing agreements with their legal partner organization 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
- Often do not train legal partner organization staff on social determinants of health

MLP legal partner organizations:

- Are likely to meet with health care leadership and civil legal aid executive directors about MLP
- Participate in health care clinical discussions at least some of the time
- Report having data-sharing agreements with their health care partner organization(s) about half of the time
- Receive information from their health care partner organizations on reasons for patient/client referrals
- Train health care partner organization(s)' staff on MLP

Location of MLP Services

Given that MLP is a partnership of two organizations, we wanted to know how the partners negotiate where and how to provide MLP services. In keeping with best practice, nearly all (94 percent) of MLP legal partner 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. There is some variation by type of legal organization, with LSC-funded organizations being the most likely to provide services on-site at the health care organization (100 percent) and law schools being less likely by comparison (83 percent). Most health care partner organizations (78 percent) have a memorandum of understanding (MOU) or another formal legal agreement with their legal partner organization.

Communicating about MLP Activities

MLP activities are a valued component of the health care and legal partner organizations. As such, we were interested to learn whether health care and legal partners discussed MLP activities with various leadership groups over the course of the previous year. About three-quarters (73 percent) of MLP health care partner organizations and 83 percent of legal partner organizations met with health care CEOs/COOs or other senior leadership in the past year. Likewise, 82 percent of legal partners met with the civil legal aid executive director or other senior leadership. Yet, while MLP professionals were accustomed to meeting with some health care and legal organizations' leadership, discussions with board members occurred much less often. MLPs may be missing an opportunity to educate board members about the benefits of MLP; only 29 percent of health care partner organizations met with their boards about MLP activities, and only one-quarter of legal organizations met with health care board members. While half (51 percent) of legal partner organizations met with members of their boards, only 15 percent of health

care partner organizations met with legal organizations' board members (see Figure 20). Given board members' control of organizational resources and role in priority setting, MLPs should actively pursue opportunities to showcase the work they do before organizational governing bodies.

We also wanted to know about regular, day-to-day communication between the health care and legal partners, as an indicator of an integrated approach to patient care. Over half of MLP legal partners (58 percent) say that they regularly participate in clinical discussions with their MLP health care partner. About one quarter of MLP legal partners (28 percent) do not participate in clinical team discussions at all (see Figure 21).

Data Sharing: MLP Health Care Partner Organizations

Nearly all MLP health care partner organizations have an electronic health record (EHR) system (94 percent), while 54 percent formally document the use of MLP services in patients' 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 22). HRSA-funded health centers were more likely to have a data sharing agreement (58 percent) than hospitals (47 percent) and other health care organizations (35 percent), but were the least likely type of health care organization to document the use of MLP services in a patient's health record.

We 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 (EHR) now makes documented information more accessible in clinical care. Some of the MLP activities formally documented through an EHR include patient referrals to the MLP legal partner organization (54 percent), MLP interactions with the patient (27 percent), and preparing form letters or other similar templates for health care provider use (24 percent) (see Figure 23). Unfortunately, we do not know from the survey responses how consistent or accurate MLP documentation processes are within each health care partner organization. We also did not ask if health care partner staff are routinely trained on documenting MLP information in the EHR.

One of the most important aspects of an MLP is its ability to integrate legal interventions and their outcomes into health care. Much like a health care specialist would report back to a referring primary care physician, we 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 some (51 percent) or all (37 percent) of the time.

Data Sharing: MLP Legal Partner Organizations

Approximately four in ten MLP legal partner organizations (42 percent) have a data-sharing agreement or other formal agreement to share patient-level data with their health care partner organizations. The most common types of patient-level information that the legal partner organizations report receiving from their health care partner organization(s) to help provide MLP services are: (1) reasons for referral (79 percent); (2) primary diagnosis (57 percent); and (3) current medications and treatments (50 percent) (see Figure 24).

We were surprised to see the results when we asked MLP legal partner organizations if they document the location where their clients receive health care services. In total, just over a quarter of MLP legal partner organizations document the location where patients receive health care services. Percentages do significantly differ by organization type, with 16 percent of LSC-funded civil legal aid organizations, 35 percent of non-LSC-funded civil legal aid organizations, 44 percent of law schools, and 38 percent of other legal organizations documenting this fact (see Figure 25). We guessed that this might be a typical practice among MLP legal partner organizations. Knowing the source of a client's referral might enable the legal partner organization to report legal outcomes back to the health care provider, or to report specific referral volumes and outcomes to leadership at the health care organization.

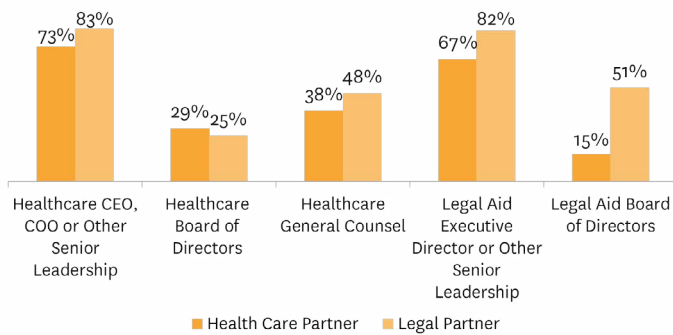
Training

MLP legal partner organizations train health care partner organization staff on the concept of MLP and how to identify health-harming civil legal needs. The average number of health care providers and staff at an MLP health care partner organization trained in MLP in the past year is 77. MLP legal partner organization respondents collectively trained 14,553 clinicians and staff at health care partner organizations during the previous year.

Additionally, a third of MLP health care partner organizations (33 percent) train lawyers or other legal staff on health topics or social determinants of health. Hospitals and other health care organizations are more likely to do this (42 percent and 45 percent, respectively) than HRSA-funded health centers (24 percent) (see Figure 26).

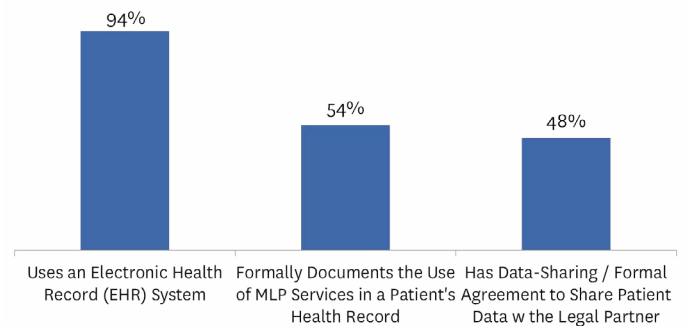
INTEGRATION BY THE NUMBERS

Figure 20. Leaders with Whom MLP Health Care and Legal Partners have Discussed MLP Activities in the Past Year



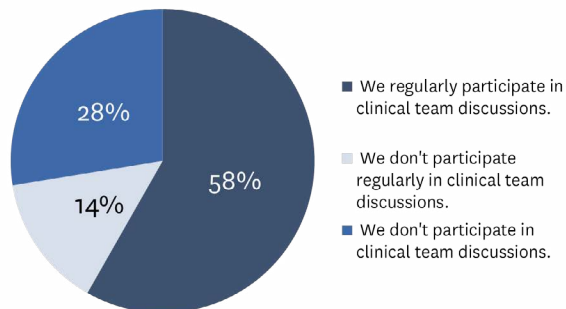
N=114-126 for MLP health care partners and N=122-125 for MLP legal partners.
Source: 2015 Annual NCMLP Survey

Figure 22. Use of Data Systems by MLP Health Care Partners



N=124-125. Source: 2015 Annual NCMLP Survey

Figure 21. MLP Legal Partner Participation in Clinical Team Discussions



N=126 for health care MLP partners and N=127 for legal MLP partners.
Source: 2015 Annual NCMLP Survey

Figure 23. Types of MLP Activities Formally Documented in Health Care Partner EHRs

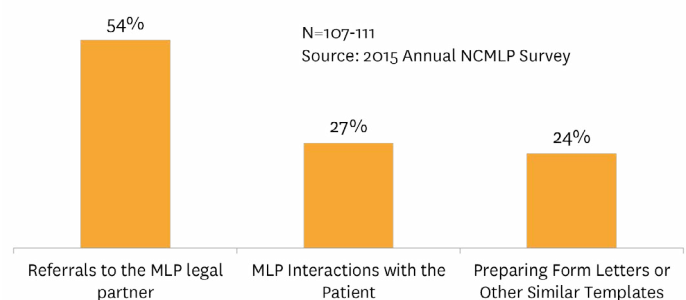


Figure 24. Types of Patient-Level Information MLP Legal Partners Have Received from Health Care Providers in the Past Year

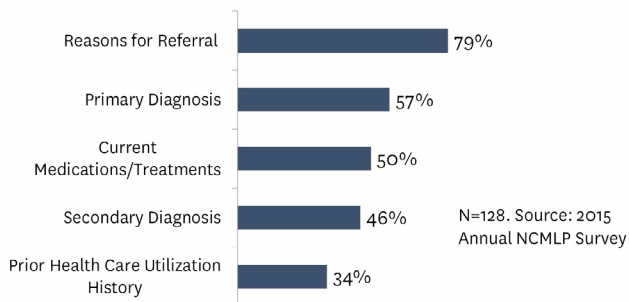
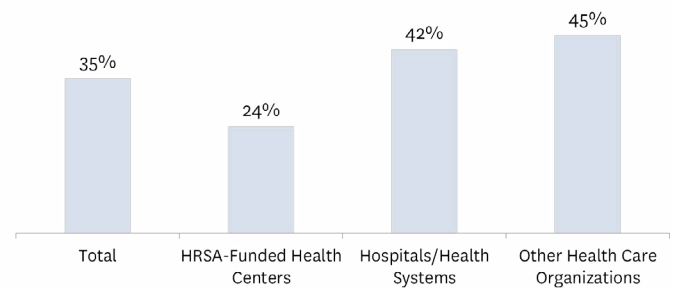
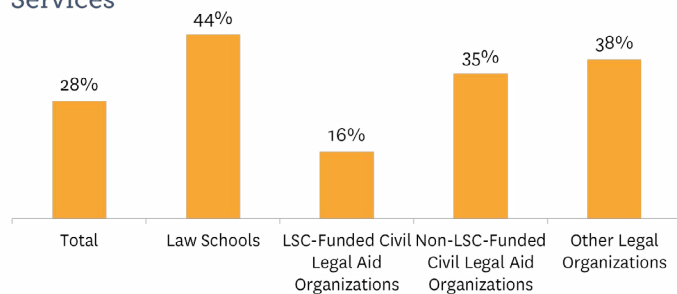


Figure 26. Percent of MLP Health Care Partners that Train MLP Legal Staff on Health Topics/SDOH



N=120 for all, 33 for health centers, 67 for hospitals, and 20 for other health care organizations. Source: 2015 Annual NCMLP Survey

Figure 25. Percent of MLP Legal Partners that Document where Patients Receive Health Care Services



N=127 for all, 18 for law schools, 56 for LSC-funded legal aid organizations, 40 for non-LSC-funded legal aid organizations, and 13 for other legal organizations. Source: 2015 Annual NCMLP Survey

RESULTS: WAYS MLPS ADVANCE HEALTH AND WELL-BEING

HIGHLIGHTS

MLP health care partner organizations:

- Engage in policy and advocacy work related to social determinants and MLP activities
- Report a variety of impacts on patient wellbeing, including increased access to housing, income, and personal and family stability needs
- Report improved patient outcomes and patient engagement
- Are in organizations that embrace the MLP approach to patient care

MLP legal partner organizations:

- Collect information on financial benefits to their patients/clients as a result of MLP about half the time
- Generally do not collect information on dollars recovered by the health care partner organization
- Note substantial recovery dollars for health care organizations when this information is collected

Improved Wellbeing and Patient Care

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

1. Improved access to housing and utilities needs (noted by 48 percent of respondents)
2. Improved access to personal and family stability Needs (48 percent)
3. Improved access to income and insurance needs (44 percent)
4. Reduced stress (39 percent)
5. Improved access to education and employment needs (32 percent)

We were interested in clinician opinions on the impacts of MLP. Over half of health care partner organizations report that clinicians have noted impacts as a result of their participation in MLPs. Fifty-nine percent of health care partners say that clinicians report improved health outcomes, 56 percent report improved patient engagement, and 42 percent report improved patient compliance with medical treatment (see Figure 27). 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.

We also wanted to know whether MLP health care partner organizations believe that their staff have “fully embraced

the MLP approach as an important part of patient care.” Three-quarters of health care partner organizations (75 percent) say that they agree or strongly agree with that statement. HRSA-funded health centers were less likely to answer yes than hospitals/health systems and other health care organizations (see Figure 28).

Financial Benefit to Patients and Health Care Organizations

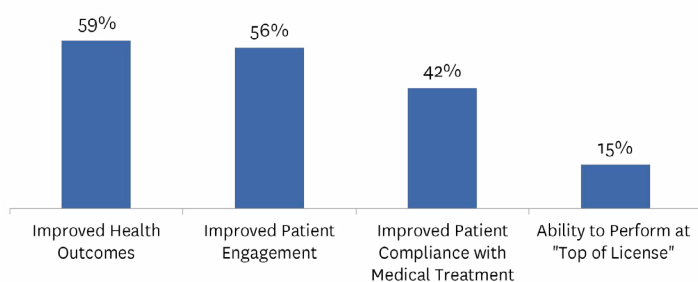
MLPs often look for ways to demonstrate the value of their services for patients and participating health care organizations. One of the most direct and quantitative approaches that MLPs use to demonstrate value is to measure the financial benefits to patients that result from MLP interventions, such as Medicaid enrollment or food stamps. Nearly half of MLP legal partner organizations (48 percent) calculate total financial benefits for patients from MLP services; however, only 16 percent calculate the health care dollars recovered by the MLP health care partner(s) or other health care organizations from MLP services.

Of the MLPs that do collect information on financial benefits, the median total benefit received by all MLP patient-clients per health care partner organization in the past year was \$181,490, and the median amount recovered by the MLP health care partner organization(s) from MLP services per site over the last year was \$150,000 (see Figure 29). These dollar figures should be viewed as preliminary estimates for the field, since relatively few MLPs collect this information and responses on financial benefits and dollars recovered showed wide variation.

We did not ask why so few MLPs calculate health care dollars recovered for the health care partner 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 partner 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.

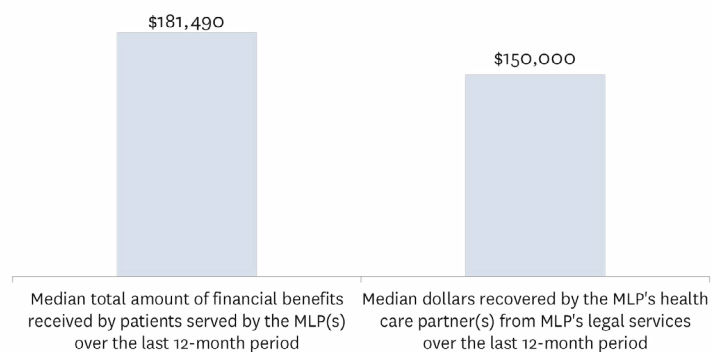
HEALTH & WELL-BEING BY THE NUMBERS

Figure 27. Impacts of MLP Participation Reported Anecdotally by Clinicians



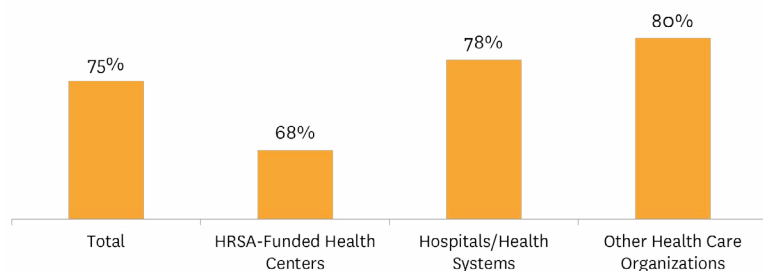
N=112-116. Source: 2015 Annual NCMLP Survey

Figure 29. Median Financial Benefits Associated with MLP



N=32 and 5, respectively, and do not include those reporting 0.
Source: 2015 Annual NCMLP Survey

Figure 28. MLP Health Care Partners that Say their "Organization has Fully Embraced the MLP Approach to Care"



N=121 for all, 34 for health centers, 67 for hospitals, 20 for other health care orgs. Responses represent percent who say they strongly agree or agree. Source: 2015 Annual NCMLP Survey

DISCUSSION

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

The core of an MLP is the partnership, which is why we survey both MLP health care partner organizations and legal partner organizations. As is the case with any relationship, each partner we surveyed brought different perspectives and responsibilities to the data. In terms of investment and engagement, the legal partner organizations clearly seem to be more active than their health care organization counterparts. MLP legal partner organizations are more likely to commit greater amounts of FTEs and budget to MLP activities. They also often partner with multiple health care organizations. They invest in training health care staff on the concept of MLP and how to identify health-harming civil legal needs. They handle thousands of referrals each year and provide services including brief advice and counseling, consultations with providers, limited representation, and formal representation.

MLP health care partner organizations also show signs of engagement and commitment to MLP. About half of MLP health care partners have forged data sharing agreements with their legal partner organization. They have invited legal staff into their organizations by providing office space and often an opportunity to engage in clinical discussions.

Health care partner organizations want to know the legal outcomes of their patients and often record the provision of civil legal aid services in the patient record. They indicate that their organizations have embraced the MLP approach to patient care, and over half of MLP health care providers report improved patient wellbeing and engagement due to MLP intervention.

RECOMMENDATIONS

Based on the results from the 2015 NCMLP Survey, we identify four primary areas for MLP growth and improvement.

01 SCREENING

Establish standard practices for identifying health-harming legal needs

Unlike other interventions in health care, there are no real guidelines for providing a high-quality MLP intervention or criteria for evaluating an MLP intervention. In the survey, we chose to ask about screening for health-harming civil legal needs as the first step in the MLP intervention process. Though most MLPs have some screening process in place, the protocols are varied and inconsistent; they are often 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. In spite of the lack of a trusted screening process, the majority of legal partner organizations and the vast majority of health care partner organizations believe that they are meeting the demand for MLP services. Who should be screened, what they should be screened with, and how they should be screened, documented, and referred to the legal partner organization are all areas that could benefit from clear direction and definition from the field. With the help of The Advisory Board Company, the NCMLP made [a screening tool available](#) and continues to collect best practices from the field and pilot new metrics for screening.

Additionally, training seems to be an area of investment for the legal partner organization. Most legal partner organizations train health care partner organization staff in MLP. Our survey does not provide information to determine whether MLPs are consistent in the content of their training, or whether there is consensus on how often and for whom training should happen. It is clear that training can help health care staff identify health-harming civil legal needs and access MLP resources to address them. Additionally, few health care partner organizations train legal partner organization staff in social determinants of health. Training is another foundational area that would benefit from additional guidance in terms of standards and preferred practices.

02

DATA SHARING

Improve data collection and sharing between health care and legal partners

Most MLP health care partner organizations have an EHR and many MLP legal partner organizations use some database for collecting information on clients, which bodes well for data collection on MLP patients and practices. We know from the survey that data sharing agreements are not yet pervasive in the field, though many MLPs do have them. In addition to building the infrastructure for data collection, there seems to be a desire to share patient information between the health care partner organizations and legal partner organizations for both patient referral and improvement related to patient care. Tracking patients from the time that they enter the health care system with health-harming civil legal needs to legal intervention and outcome is critical to identifying areas for improvement, best practices, and opportunities for efficiencies within health care and legal partner organizations that have resource constraints. Screening patients for health-harming civil legal needs, referral to MLP services, and outcome tracking are three areas targeted for data collection for the purposes of performance improvement.

03

TRACKING OUTCOMES

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

Health care partner organizations report that they embrace the MLP approach to care and often report improved patient outcomes and engagement, but their investment in MLP in terms of budget and FTEs is usually less than that of the legal partner organization. Anecdotally, the National Center for Medical-Legal Partnership has observed great interest in demonstrating the value and impact of MLP. Half of MLPs collect data on the financial benefits received by patients who have received an MLP intervention, but only 16 percent of MLPs report dollars recovered by the health care partner organizations as a result of the MLP. Improved data collection practices, measurement, and investments in patient focus groups could go a long way toward demonstrating the impact of MLPs individually and as a field, and leveraging it for investment.

04

GROWTH

Grow, improve, and sustain medical-legal partnerships

To date, there are nearly 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 health care. 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 partnerships between these two types of organizations continue 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. We must acknowledge that these circumstances can pose substantial challenges to their long-term stability or sustainability.

MLPs are generally run and served by optimistic individuals – in spite of very limited resources they claim that they have sufficient capacity to meet demand. If MLPs want to scale up to truly meet demand for their valuable services, additional resources are necessary. Data collection practices must be embedded into MLP systems that enable MLPs to know their true demand, whether demand is being met, and the financial and health impacts of their services, so that this information can be leveraged for additional growth.