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## TABLE OF CONTENTS

- 251 Introduction to the Medical-Legal Partnership Symposium Issue**  
*Susanna D. Evarts & Nathan Guevremont*

### ARTICLES

- 253 A Mental Health Checkup for Children at the Doctor's Office:  
Lessons from the Medical-Legal Partnership Movement to Fulfill  
Medicaid's Promise**  
*Yael Cannon*
- 309 Medical-Legal Partnerships with Communities: Legal Empowerment  
to Transform Care**  
*Tamar Ezer*
- 327 Ethics of Evidence: Health Care Professionals in Public Benefits and  
Immigration Proceedings**  
*Jesselyn Friley*
- 343 The Roots and Branches of the Medical-Legal Partnership Approach  
to Health: From Collegiality to Civil Rights to Health Equity**  
*Joel Teitelbaum & Ellen Lawton*



# Introduction to the Medical-Legal Partnership Symposium Issue

**Susanna D. Evarts & Nathan Guevremont, Co-Editors-in-Chief**

Since the first medical-legal partnership (MLP) opened in 1993 at the Boston Medical Center,<sup>1</sup> MLPs have increasingly become integrated into community health centers around the United States. And MLPs are in the business of growth: more than 300 MLPs are currently operating in the United States, and 59 percent of those are fewer than five years old.<sup>2</sup> MLPs are collaborations between physicians and civil attorneys in which the attorneys are integrated into the health care team, and work with the patient to address civil legal needs that impact the social determinants of a patient's health. The MLP model emerged from the recognition that many non-clinical circumstances had a direct impact on the patient's health outcomes. For example, an individual suffering from asthma will be thwarted in her quest to manage it if she lives in an apartment with a mold infestation. An attorney working with the medical team can develop legal interventions to help the patient move or get the mold treated, thereby transforming the patient's living environment into one in which she can actually heal.

In March 2017, The Solomon Center for Health Law & Policy at Yale Law School held a symposium on MLPs, featuring panels with leaders in the MLP field. This issue contains articles written by some of the symposium's panelists on the present and future of MLPs. The event provided an opportunity to reflect on the systemic factors that impact the growth and development of MLPs nationwide, and to address specific ways in which MLPs have been utilized successfully.

Yael Cannon, visiting Associate Professor at the Georgetown University Law Center and Co-Director of the Georgetown University Medical-Legal Partnership, writes about the potential for interdisciplinary collaboration to help medical providers screen children for mental health needs. As Cannon explains, children experience childhood trauma, are more likely to suffer from mental and physical ailments as adults. One way in which physicians have been able identify and help children living in abusive environments is by partnering with law-school clinics through an MLP. Collaborating with attorneys and legal professionals not only helps to provide assistance to patients at a clinic, but also provides an opportunity

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1. Barry Zuckerman et al., *Medical-Legal Partnerships: Transforming Health Care*, 372 THE LANCET 1615, 1616 (2008).

2. MARSHA REGENSTEIN ET AL., THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD: FINDINGS FROM THE 2016 NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP SURVEYS 9 (2017).

to identify and remedy systemic threats to the health of vulnerable populations. The collaboration between physicians and attorneys leverages their ability to effect change at the state levels.

Tamar Ezer, Associate Research Scholar in Law and Schell Visiting Human Rights Scholar at Yale Law School, argues that MLPs should broaden their focus to include an emphasis on community empowerment. The three core elements of MLPs—direct legal assistance, health care provider training, and policy-change advocacy—should be expanded to include an emphasis on community development and engagement. By conducting rights-literacy trainings, utilizing the power of community-based paralegals, and actively involving the community in the program design, MLPs can become a more effective tool to advance the rights of marginalized groups, and shift the framework from being needs-based to being rights-based.

Jesselyn Friley, a recent graduate of Yale Law School and participant in the school's MLP program, identifies a gap in MLP literature on the role that health care providers have by appearing as witnesses in administrative proceedings. The article provides an overview of the types of administrative proceedings in which medical professionals can provide testimony, and explains potential problems that health care providers may have when serving as expert witnesses in administrative proceedings. The article provides suggestions for how MLPs can improve collaboration with physicians.

Finally, Ellen Lawton, Lead Research Scientist and Co-Principal Investigator at the National Center for Medical-Legal Partnership at George Washington University, and Joel Teitelbaum, Associate Professor of Health Policy and of Law at George Washington University and Co-Principal Investigator at the National Center for Medical-Legal Partnership, provide a historical account of MLPs' origins, detailing collaborations, and occasional clashes, between attorneys and physicians since the 1800s. With this historical perspective, the authors argue that the law must play a central role in the modern fight to achieve health equity. They emphasize the importance of legal strategies to address structural barriers to health, arguing for increased emphasis on multidisciplinary training of medical professionals and additional funding for civil legal aid. The MLP movement and collaborations between attorneys and physicians provide a significant opportunity to integrate health care quality and civil rights perspectives on health equity.

No interdisciplinary collaboration is static, and the MLP movement is no exception. As it expands, matures, and solidifies, the tensions and opportunities that the authors identify will only become more salient. We hope that this special issue will contribute to ongoing dialogue between medical professionals, lawyers, public health researchers, and policy-makers. While the future of American health care reform is unclear, the spirit of cooperation and teamwork between attorneys and physicians embodied in the MLP model will be essential no matter what system emerges.

## ARTICLES

### **A Mental Health Checkup for Children at the Doctor's Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid's Promise**

**Yael Cannon\***

#### ABSTRACT

Traumatic childhood events and the stress they cause can negatively affect health over a lifetime. For children with Medicaid coverage, visits to the doctor's office present an opportunity to improve this trajectory. Medicaid's Early Periodic Screening Diagnostic and Treatment (EPSDT) mandate requires that children receive more than a basic physical when they see a doctor for regular "well-child checks." As part of a comprehensive look at their development, they should receive mental health check-ups that could identify childhood trauma, its impacts, and the interventions that could help improve health and mental health. Data suggests that many children do not receive these mandatory comprehensive screenings. Significant barriers to screening include lack of transportation for patients, low reimbursement rates for physicians that limit their ability to devote enough attention to screenings, and lack of access to mental health screening tools.

Medical-legal partnerships (MLPs) provide a framework for addressing these challenges. MLPs bring together civil legal services lawyers with health providers to address social determinants of health. This article argues that the MLP movement provides a three-tiered paradigm for change for physicians and attorneys to improve the trajectory for children who have suffered trauma and address the gaps in Medicaid EPSDT mental health screening: (1) collaborative advocacy to improve patient health, (2) transformation of health and legal institutions, and (3) policy change.

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\*Yael Cannon, JD, Visiting Associate Professor and Director, Community Justice Project: Health Justice Alliance, Georgetown University Law Center, Associate Professor (on leave), University of New Mexico School of Law. I would like to thank Dr. Andrew Hsi of the University of New Mexico School of Medicine and my other colleagues at the University of New Mexico Medical Legal Alliance, including Aliza Organick, Sarah Steadman, Victoria Elenes, April Land, Carol Suzuki, Camille Carey, and Sally Bachofer, as well as Tara Ford, Dr. George Davis, and other members of the J. Paul Taylor Task Force, for their collaborative efforts towards improving the lives of children who have suffered trauma. I am also grateful for the invaluable research assistance of Kirsten Schuster, Devan Zorn, Rebecca Dittrich, and Shaina Vinayek, and support from my Georgetown University Health Justice Alliance Co-Director Vicki Girard and colleagues Jane Aiken, Dr. Eileen Moore, Dr. Ana Caskin, and Dr. Deborah Perry, as well as Community Justice Project: Health Justice Alliance fellows Jessica Millward, Nicole Tuchinda, and Katherine Wallat.

TABLE OF CONTENTS

**TABLE OF CONTENTS ..... 254**

**INTRODUCTION ..... 255**

**I. EFFECT OF CHILDHOOD TRAUMA ON HEALTH ..... 259**

    A. THE ACES STUDY ..... 259

    B. UNDERSTANDING THE LINK BETWEEN CHILDHOOD TRAUMA AND POOR MENTAL AND PHYSICAL HEALTH ..... 262

    C. REDUCING THE IMPACT OF CHILDHOOD TRAUMA: THE NEED FOR EARLY IDENTIFICATION AND INTERVENTION ..... 265

**II. FULFILLING THE MEDICAID PROMISE: A ROUTE TO WIDESPREAD EARLY IDENTIFICATION AND INTERVENTION TO IMPROVE THE HEALTH AND MENTAL HEALTH WHO HAVE SUFFERED TRAUMA..... 269**

    A. MEDICAID EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES FOR CHILDREN ..... 270

    B. EARLY AND PERIODIC SCREENING FOR MENTAL HEALTH CAN DISRUPT THE TRAUMA CYCLE ..... 271

**III. MULTI-LEVEL RESPONSES BY PHYSICIANS AND ATTORNEYS TO IMPROVE IDENTIFICATION AND EARLY INTERVENTION OF CHILDHOOD TRAUMA AND MENTAL HEALTH NEEDS: LESSONS FROM THE MEDICAL-LEGAL PARTNERSHIP MOVEMENT..... 278**

    A. COLLABORATIVE ADVOCACY TO IMPROVE PATIENT HEALTH: IDENTIFYING AND SERVING CHILDREN AND FAMILIES WITH MENTAL HEALTH NEEDS ..... 279

        1. INDIVIDUAL PATIENT ADVOCACY..... 280

        2. IMPACT LITIGATION..... 284

    B. TRANSFORMING HEALTHCARE AND LEGAL INSTITUTIONS BY TRAINING THE NEXT GENERATION OF LEADERS IN LAW AND MEDICINE IN EARLY IDENTIFICATION OF CHILDREN’S MENTAL HEALTH NEEDS ..... 286

    C. MOBILIZING TOWARDS POLICY CHANGE ..... 290

        1. RESEARCH AND DATA TO EDUCATE POLICYMAKERS..... 291

        2. POLICY DEVELOPMENT THROUGH INTER-DISCIPLINARY COALITION ENGAGEMENT..... 298

**CONCLUSION..... 304**

## INTRODUCTION

Selena<sup>1</sup> was born addicted to “meth.” Her mother, Amelia, tried hard to get sober when she found out she was pregnant, but was not successful and Selena was exposed to methamphetamine in utero. Amelia ended up in a detox facility shortly after Selena was born, while Selena’s father was in prison. Fortunately, Selena recovered quickly. After a few weeks, she was discharged from the neonatal intensive care unit into the care of Amelia’s sister, Joann, while Amelia completed her detox program. Over the next couple of years, Selena bounced back and forth between her mother’s and her Aunt Joann’s home. Amelia’s boyfriend was abusive to her in front of Selena, and when things got really bad, Amelia would drop Selena off at Joann’s house. When Selena was two and a half years old, Amelia told Joann she needed to take some time to get her life together and asked Joann to care for Selena for a while. Amelia disappeared and never returned.

At age thirteen, Selena is struggling. She often feels anxious and struggles academically. Since school is so difficult for her, she regularly skips it and hangs out at a park where she smokes marijuana. She feels sad when she thinks about her mother, which is frequently. She eats to make herself feel better, and is now significantly overweight. Otherwise, Selena seems healthy. When she goes to the doctor, he talks to her about eating healthier, but gives her a clean bill of health. Joann is doing her best to keep Selena out of trouble.

Traumatic events in childhood like those experienced by Selena are known as adverse childhood experiences, or ACEs. One of the most groundbreaking epidemiological studies in our nation’s history demonstrated the high prevalence of ACEs, with more than half of the study’s respondents reporting at least one traumatic event in childhood.<sup>2</sup> The ACEs study also revealed that children who experience these forms of trauma early in life are more likely not only to experience mental health challenges, but also to face a multitude of poor health issues.<sup>3</sup> Trauma like that experienced by Selena can actually change the brain and make the body unhealthy.<sup>4</sup> This article begins in Part I by dissecting the implications of childhood trauma on an individual’s health and the types of mental health services that children with these experiences require.

Although the research paints a dire picture, it also shows that the fate it predicts for a child such as Selena can in fact be disrupted. With early identification of trauma and related mental health needs, a child and her family can gain access

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1. Selena and her family are a composite of clients commonly served by the University of New Mexico Medical Legal Alliance. *See infra*, described in Part III of this article.

2. *See* Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction of Many of the Leading Causes of Death in Adults*, 14 AM. J. PREVENTIVE MED. 245, 249 (1998).

3. *See id.* at 251.

4. *See* Jack P. Shonkoff et al., *Technical Report: The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS e232, e236–37 (2012).

to needed services and have a chance to experience a healthy life.<sup>5</sup> In Part II, the article argues that the sweeping national Medicaid program, through which children living in poverty have access to health and mental health care,<sup>6</sup> provides a structure for this critical early identification and intervention to facilitate better outcomes for traumatized children.<sup>7</sup> Medicaid law requires mental health screening and necessary treatment for all Medicaid-eligible children. In fact, the Early Periodic Screening Diagnostic and Treatment (EPSDT) mandate in federal Medicaid law and the accompanying regulations promulgated by the U.S. Department of Health and Human Services require mental health screenings as part of routine visits to the doctor, as well as referral to services that may be necessary to address identified issues.<sup>8</sup> This article argues that mental health screenings in the doctor's office have the potential to improve the health and mental health outcomes of many children who experience trauma in early childhood because they provide a gateway to needed services that can improve a child's life trajectory.

However, Medicaid-enrolled children do not always receive mandated mental health screenings as part of their doctor's visits,<sup>9</sup> evidencing a missed opportunity

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5. See Hillary A. Franke, *Toxic Stress: Effects, Prevention, and Treatment*, 1 CHILDREN 390, 394 (2014) ("If primary preventive measures are implemented during the early, sensitive windows of development, appropriate stress responses to adversity may result. Screening is a means to identify those children who would benefit from both preventive measures and, if need be, therapeutic interventions.").

6. See 42 U.S.C. §1396a(a)(43) (2012).

7. See 42 U.S.C. §1396d(r) (2012) (Requiring, at minimum, a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, and health education).

8. See *id.*

9. See, e.g., Health Res. & Servs. Admin., *The Health and Well-Being of Children: A Portrait of States and the Nation 2011-2012*, U.S. DEP'T HEALTH & HUM. SERVS. 22 (2014), <https://mchb.hrsa.gov/nsch/2011-12/health/pdfs/nsch11.pdf> [https://perma.cc/3P9L-5384] [hereinafter *Well-Being of Children*] (reporting results of the 2011–2012 National Survey of Children's Health, which found that only 31.5% of publicly insured children nationwide received a standardized developmental or behavioral health screening between the ages of ten months and five years). At the time of publication of this article, the legislative landscape remains in flux, with members of Congress having introduced multiple legislative proposals in recent months seeking to change the current Medicaid funding structure as part of Republican efforts to repeal and replace the Affordable Care Act. In two of the most significant bills, the American Health Care Act (AHCA) and the Graham-Cassidy proposal, Medicaid was targeted for restructuring. American Health Care Act of 2017, H.R. 1628, 115th Cong. (1st Sess. 2017); Graham-Cassidy-Heller-Johnson Proposed Amendment to H.R. 1628, H.R. 1628, 115th Cong. (1st Sess. 2017). Although neither the Act nor the proposal explicitly repeals or amends the EPSDT provisions, it proposes financial restructures that potentially jeopardize the continued comprehensiveness and robustness of Medicaid-based pediatric healthcare. Current EPSDT benefits require states to provide four screenings – medical, vision, dental, and hearing – and all "other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan" to Medicaid-eligible persons in the state who are under the age of twenty-one. 42 U.S.C. §1396d(r) (2012); 42 U.S.C. §1396a(4)(B) (2012). Under the proposed AHCA and Graham-Cassidy bills, federal contributions towards benefits for children under 19 years old who are not covered under the



for early identification of trauma, as well as the resulting connections to needed services. While more research is needed to understand the reasons behind these gaps, some barriers have been identified by physicians and patients. In Part III, the article calls physicians and attorneys to action to ensure that children who have suffered trauma are identified early and receive the mental health services they need to cope with that trauma effectively and thrive. Medical-legal partnerships (MLPs) provide a framework for concrete steps that lawyers and healthcare professionals can take together to change the trajectory from childhood trauma to poor health through patient services, institutional change, and policy change.

MLPs bring together lawyers and doctors who serve people living in poverty to address legal barriers to health in individual patients and improve systemic

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Children's Health Insurance Program (CHIP) would be restructured as per capita caps with a block grant option. H.R. 1628 §121(2) (proposing introduction of new §1903A to Title XIX of the Social Security Act). Children are one of only two Medicaid enrollee populations subject to the block grant option. *Id.* In opposing the AHCA, the American Academy of Pediatrics (AAP) argued that this proposed restructuring would divert costs to the states. Letter from Fernando Stein, President, Am. Acad. Pediatrics, to Chairman Kevin Brady, Chairman Greg Walden, Ranking Member Richard Neal, and Ranking Member Frank Pallone (Mar. 8, 2017), <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Documents/AAP%20Letter%20Opposing%20AHCA.pdf> [https://perma.cc/B9BQ-GFBT] [hereinafter AAP Opposition Letter]. Given the already low per-person costs, these changes are unlikely to lead to improvements in Medicaid efficiency, but instead could require states to either increase state contributions or implement changes in the scope of coverage, including "reductions in enrollment, cuts to benefits, and decreased access to physicians." *Id.*; Ctr. for Children & Families, *How Restructuring Medicaid Could Affect Children*, GEO. U. HEALTH POL'Y INST. 2 (Feb. 2017), <http://ccf.georgetown.edu/wp-content/uploads/2017/02/Medicaid-funding-caps.pdf> [https://perma.cc/5CAE-YXDC]. Potential consequences of increased spending include cuts to other child and family services such as childcare, education, child welfare, juvenile justice, and family support programs. *Id.* at 3. Since neither the AHCA nor the Graham-Cassidy proposal mentions or cites the current EPSDT requirements, it is unclear whether states could elect to cut these services. Indeed, under the AHCA and the Graham-Cassidy proposal's block grant option, the state plan must merely provide for "health care for children under 18 years of age." H.R. 1628 §121(2). This ambiguous standard creates a potential for reductions in screening, diagnosis, and access to treatment, and more variation in interpretation across states. Mara Youdelman & Jane Perkins, *AHCA's Block Grant Option and EPSDT*, NAT'L HEALTH L. PROGRAM 3 (2017), <http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00P0W00000jYT KjUAO> [https://perma.cc/B9R7-ADVK]. Both the AHCA and the Graham-Cassidy proposal failed to pass Congress. See Phil Mattingly, *GOP Takes Stock After Another Health Care Failure*, CNN (Sept. 26, 2017, 6:10 AM), <http://www.cnn.com/2017/09/26/politics/health-care-what-next/index.html> [https://perma.cc/6SSU-NTR9]. However, Medicaid restructuring appears to be a priority of the current Republican majority in Congress. Another concern articulated by the AAP in connection with such efforts is the phasing out of a provision of the Affordable Care Act that expanded Medicaid eligibility to more than half a million children from low-income families. According to the AAP, eliminating this provision can result in a confusing constellation of coverage within a family with different coverage under different programs for different family members. See AAP Opposition Letter. If additional legislative proposals emerge from Congress that propose restructuring Medicaid or eliminating the prior expansion of Medicaid under the Affordable Care Act, analysis to determine both the impact on both the substantive Medicaid EPSDT legal requirements and the availability of Medicaid to low-income children and children with disabilities will be critical.

conditions facing patient populations. In 1993, Dr. Barry Zuckerman, a pediatrician at Boston Medical Center, realized that he could not get his patients healthy without a lawyer.<sup>10</sup> He was treating children with asthma who would cycle in and out the emergency room, suffering repeated asthma attacks despite receiving high quality medical care. He learned that many of these children were living in substandard housing conditions, where mold and dust mites were exacerbating their asthma.<sup>11</sup> He could not care for those patients effectively or get them healthy without an attorney who could advocate with landlords and public housing programs for improvements in their housing conditions.<sup>12</sup> Dr. Zuckerman brought a lawyer onto his team, giving rise to the medical-legal partnership (MLP) movement, which recognizes that medicine and law can operate collaboratively and preventively in service of patients and population health.<sup>13</sup> MLPs have mobilized to create an impact on three levels: (1) collaborative advocacy to improve patient health; (2) transformation of health and legal institutions; and (3) policy change.<sup>14</sup> These tiers provide a paradigm through which attorneys and healthcare providers can serve as catalysts for change. With over half of the ACEs study population having reported a traumatic experience in childhood and one-fourth reporting two or more ACEs,<sup>15</sup> physicians and attorneys can improve outcomes for a significant portion of the next generation if they similarly mobilize through a multi-level response to ensure that childhood trauma is identified and the resulting health and mental health needs of children are addressed.

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10. See Jane R. Wettach, *The Law School Clinic as a Partner in a Medical-Legal Partnership*, 75 TENN. L. REV. 305, 307 (2008).

11. See Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224, 224–25 (2004).

12. See *id.*

13. See Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations*, 29 HEALTH AFF. 1697, 1698 (2010).

14. *The MLP Response*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlp-response> [https://perma.cc/VR5T-XAX4] [hereinafter *The MLP Response*]. As discussed by Elizabeth Tobin Tyler, a tension between individual service and social change advocacy can sometimes be seen in the legal services community, perhaps due to the fact that organizations receiving Legal Services Corporation (LSC) funding are restricted from certain activities that are historically construed as drivers of systemic change (such as class action lawsuits and legislative lobbying). Limited resources also require some legal services organizations to keep their efforts focused on individual direct services legal representation. Therefore, some legal services providers may not engage in social policy change work as a focused effort. However, Tobin Tyler argues that when possible, legal services professionals, in collaboration with clinical and public health professionals can and should embrace an integrated approach to changing system and policy factors that affect vulnerable patients. Her recommendations include identifying social, legal, and health needs as well as tracking unmet need for the purposes of achieving social policy change. See Elizabeth Tobin Tyler, *Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health*, 8 J. HEALTH & BIOMEDICAL LAW 211, 239 (2012).

15. See Felitti et al., *supra* note 2, at 245.

## I. EFFECT OF CHILDHOOD TRAUMA ON HEALTH

Selena has a strong likelihood of becoming an unhealthy adult. While it may seem intuitive that a person who experiences childhood trauma like Selena may struggle with mental illness or substance abuse later in life, a growing body of research over the past three decades has shown that childhood adversity actually takes a toll on the entire body.<sup>16</sup> Exposure to certain categories of traumatic events—ACEs<sup>17</sup>—is associated with increased risk for numerous chronic physical health conditions, mental illness,<sup>18</sup> and even early death.<sup>19</sup> Those poor health effects can begin in childhood.<sup>20</sup>

### A. The ACEs Study

In the late 1990s, researchers working with the U.S. Centers for Disease Control and Prevention and the Kaiser Family Foundation conducted a groundbreaking study of the connection between childhood exposure to emotional, physical, and sexual abuse, as well as household dysfunction and subsequent adult health risk behaviors and disease.<sup>21</sup> Over an eight-month period,<sup>22</sup> researchers mailed questionnaires to 13,949 Kaiser Health Plan members who visited the Health Appraisal Clinic.<sup>23</sup> This clinic served the general population of Kaiser patients, who did not present as a population with any particular likelihood of childhood trauma history. Each survey included questions about childhood abuse, including psychological, physical abuse, and sexual abuse, and questions about household dysfunction they experienced in childhood, including substance abuse, mental illness, and incarceration of a household member, as well as violence

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16. See Katherine B. Ehrlich et al., *Childhood Adversity and Adult Physical Health*, in DEVELOPMENTAL PSYCHOPATHOLOGY: RISK, RESILIENCE, AND INTERVENTION 1, 4–12 (Dante Cicchetti ed., 3d ed. 2016).

17. See Felitti, *supra* note 2.

18. See, e.g., Daniel P. Chapman et al., *Adverse Childhood Experiences and the Risk of Depressive Disorders in Adulthood*, 82 J. AFFECTIVE DISORDERS 217, 222–23 (2004); Shanta R. Dube et al., *Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span*, 286 J. AM. MED. ASS'N 3089, 3094–95 (2001); Charles L. Whitfield et al., *Adverse Childhood Experiences and Hallucinations*, 29 CHILD ABUSE & NEGLECT 797, 803 (2005).

19. See David Brown et al., *Adverse Childhood Experiences and the Risk of Premature Mortality*, 37 AM. J. PREVENTIVE MED. 389, 393 (2009) (finding a relationship between risk of death at any age and ACE scores greater than or equal to six).

20. See, e.g., Nadine J. Burke et al., *The Impact of Adverse Childhood Experiences on an Urban Pediatric Population*, 35 CHILD ABUSE & NEGLECT 408, 412–13 (2011); Emalee G. Flaherty et al., *Adverse Childhood Experiences and Child Health in Early Adolescence*, 167 JAMA PEDIATRICS 623, 626 (2013).

21. See Felitti et al., *supra* note 2, at 246.

22. Questionnaires were sent to members who visited the clinic between August and November of 1995 and January and March of 1996. Those seen in December were excluded. *Id.*

23. *Id.* Response rate was 70.5 percent; 9,508 completed the questionnaire. *Id.*

against the patient's mother.<sup>24</sup>

The patients, most of whom were over fifty years old, were asked to reflect on events in their childhood.<sup>25</sup> More than half of the patients surveyed reported experiencing at least one form of childhood trauma.<sup>26</sup> The prevalence of specific forms of trauma among the respondents was also surprisingly high:

- 11.1 percent reported psychological abuse;
- 10.8 percent reported physical abuse;
- 22.0 percent reported sexual abuse;
- 25.6 percent reported substance abuse by a household member;
- 18.8 percent reported mental illness of a household member;
- 12.5 percent reported violence directed against their mother or stepmother; and
- 3.4 percent reported incarceration of an adult household member.<sup>27</sup>

The reach of trauma among this general population cohort<sup>28</sup> is astounding; *more than a quarter* had a household member who engaged in substance abuse, and *more than one in five* recalled having experienced sexual abuse.<sup>29</sup> Some individuals experienced multiple traumatic events, reflected by their total ACE score, in which each experience counts as one ACE.<sup>30</sup> Using this framework, Selena experienced multiple ACEs. She was exposed to methamphetamine in utero and born with the drug still in her system, meaning that she has a parent who was a substance abuser. Her father was incarcerated, and she witnessed violence against her mother. By the age of two and a half, Selena already had an ACE score of at least three.

The Kaiser/CDC researchers sought to understand the implications of a person's ACE score. They examined the medical records of the patients and analyzed the relationship between the patients' ACE scores and the likelihood of certain disease conditions and health risk factors. They found that high ACE scores, especially where patients had four or more ACEs, were correlated with poor health conditions and behaviors, such as increased risk of ischemic heart

24. *Id.* at 248 tbl.1.

25. *Id.* at 247.

26. *Id.* at 248 tbl.1.

27. *Id.*

28. See, e.g., Michael T. Baglivio et al., *The Prevalence of Adverse Childhood Experiences in the Lives of Juvenile Offenders*, 3 J. JUV. JUST. 1, 1–23 (comparing the prevalence of ACEs among juvenile offenders in Florida to the general population group analyzed in the original Kaiser study); Yael Cannon et al., *Adverse Childhood Experiences in the New Mexico Juvenile Justice Population*, N.M. SENT'G COMMISSION 4 (2016), <https://nmssc.unm.edu/reports/2016/adverse-childhood-experiences-in-the-new-mexico-juvenile-justice-population.pdf> [<https://perma.cc/WV9G-VK56>] (comparing the prevalence of ACEs among youth in custody in New Mexico's juvenile justice population to the general population group analyzed in the original Kaiser/CDC ACEs study).

29. Felitti et al., *supra* note 2, at 248 tbl.1

30. *Id.* at 248.

disease,<sup>31</sup> cancer,<sup>32</sup> stroke,<sup>33</sup> chronic bronchitis or emphysema,<sup>34</sup> diabetes,<sup>35</sup> fair or poor self-rated health,<sup>36</sup> self-diagnosed alcoholism,<sup>37</sup> illicit drug use,<sup>38</sup> injectable drug use,<sup>39</sup> and sexual promiscuity.<sup>40</sup> Selenia's score of three ACEs by age two and a half set her on a path toward potentially devastating health and mental conditions over her lifetime.

The ACEs study has prompted interest in the connection between childhood trauma and poor health outcomes, both among health researchers and increasingly in the media and broader public health discussions.<sup>41</sup> The current body of literature in the ACEs field contains more than 450 follow-up studies and publications.<sup>42</sup> Evidence now links ACEs to an increased risk of hospitalization with a diagnosed autoimmune disease,<sup>43</sup> chronic obstructive pulmonary disease,<sup>44</sup> and liver disease.<sup>45</sup> In addition, ACEs have been associated with an increased risk of depressive disorders,<sup>46</sup> hallucinations,<sup>47</sup> and suicidality in adults.<sup>48</sup> These studies show that the entire body can suffer during adulthood as a result of childhood trauma.

Moreover, the research is increasingly drawing connections between childhood trauma and poor physical and mental health in childhood.<sup>49</sup> As part of

31. *Id.* at 254 tbl.7.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.* at 255 tbl.8.

37. *Id.* at 253 tbl.5.

38. *Id.*

39. *Id.*

40. *Id.*

41. See, e.g., Laura Starcheski, *Can Family Secrets Make You Sick?*, NAT'L PUB. RADIO (Mar. 2, 2015, 3:02 PM), <http://www.npr.org/sections/healthshots/2015/03/02/377569413/can-family-secrets-make-you-sick> [<https://perma.cc/54LJ-2968>]; *Adverse Childhood Experiences: A Collection of News, Perspectives, and Other Resources to Help Raise Awareness, Prevent ACEs, and Improve Resiliency*, ROBERT WOOD JOHNSON FOUND., <http://www.rwjf.org/en/library/collections/aces.html>.<http://www.rwjf.org/en/library/collections/aces.html> [<https://perma.cc/5EJ3-NEZ9>].

42. Yael Cannon & Andrew Hsi, *Disrupting the Path from Childhood Trauma to Juvenile Justice: An Upstream Health and Justice Approach*, 43 FORDHAM URB. L. J. 425, 445 (2017).

43. See Shanta Dube et al., *Cumulative Childhood Stress and Autoimmune Diseases in Adults*, 71 PSYCHOSOMATIC MED. 243, 246–49 (2009).

44. See Robert F. Anda et al., *Adverse Childhood Experiences and Chronic Obstructive Pulmonary Disease in Adults*, 34 AM. J. PREVENTIVE MED. 396, 401–02 (2008).

45. See Maxia Dong et al., *Adverse Childhood Experiences and Self-Reported Liver Disease: New Insights into the Causal Pathway*, 163 ARCHIVES INTERNAL MED. 1949, 1952–53 (2003).

46. See Chapman, *supra* note 18.

47. See Whitfield, *supra* note 18.

48. See Dube, *supra* note 18.

49. See, e.g., Flaherty, *supra* note 20, at 627 tbl.4.

pilot testing for an ACE screening tool, researchers demonstrated links between risk exposure and childhood-onset health and behavioral problems.<sup>50</sup> They collected data on 102 children between the ages of four and five years who received check-ups over a six month period at a doctor's office serving a low-income community.<sup>51</sup> Their mothers or other female primary caretakers were asked to report on seven child ACE measures, as well as maternal marital status,<sup>52</sup> maternal education,<sup>53</sup> and child health status.<sup>54</sup> Physician investigators verified child health status through medical chart reviews.<sup>55</sup> Ninety-four percent of the parents or adult caregivers reported that their child experienced at least one ACE.<sup>56</sup> Recent research found that forty-seven percent of the children studied had experienced three or more ACEs, and were considered at higher risk for poor health outcomes including behavioral problems, developmental delay, and acute injuries.<sup>57</sup> Other studies have found high ACE scores to be associated with fair or poor general health,<sup>58</sup> illness requiring a doctor,<sup>59</sup> and obesity among children.<sup>60</sup> By age thirteen, Selena's health already demonstrates these correlations; she is struggling with substance abuse and depression, and is at risk for obesity.

*B. Understanding the Link Between Childhood Trauma and Poor Mental and Physical Health*

The impact of trauma on the brain helps to explain the connection between the adverse experiences of a child like Selena and her increased risk for health risk behaviors and poor health conditions. Although the mechanisms underlying the

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50. See Ariane Marie-Mitchell & Thomas G. O'Connor, *Adverse Childhood Experiences: Translating Knowledge into Identification of Children at Risk for Poor Outcomes*, 13 ACAD. PEDIATRICS 14, 16–18 (2013).

51. *Id.* at 15.

52. *Id.* Maternal marital status was ascertained by self-report.

53. *Id.* No maternal high school degree or GED was considered a positive risk factor.

54. *Id.*

55. *Id.*

56. *Id.* at 16 tbl.1. The most prevalent ACE measures were single parent household (76%), low maternal education (57%), and household mental illness (41%). *Id.* at 16.

57. *Id.* at 16. Researchers often use four or more ACEs as a cut-off point for determining increased risk. Because the ACE screen in this study was less comprehensive, in that it only included one category for child maltreatment – and used a higher risk population, the authors used a cut-off score of three or more for the dichotomization between high risk and low risk. Thus, those 47% were considered to be at higher risk for experiencing for poor health outcomes. The percent of children who already expressed poor outcomes and had ACE scores greater than or equal to three was determined outcome by outcome. Moreover, contrary to expectations and previous research, accumulated risk was also associated with lower body mass index (BMI), decreased likelihood of medically reported asthma, and decreased healthcare utilization. *Id.* at 17 tbl.3.

58. Flaherty, *supra* note 20, at 627 tbl.4.

59. *Id.*

60. Burke, *supra* note 20, at 411.

biological embedding of childhood trauma are still being explored,<sup>61</sup> the correlation between traumatic experiences and increased risk of poor physical and mental health outcomes can be explained by the impact of toxic stress.<sup>62</sup> In the absence of buffering protection afforded by support from caring adults, high exposure to childhood adversity and trauma can result in strong, prolonged, or frequent activation of the body's stress response system, known as "toxic stress."<sup>63</sup> When a child starts daycare or gets a vaccine, or experiences other forms of "positive" stress, "the proverbial 'fight-or-flight response' may kick in temporarily."<sup>64</sup> However, when that stress response is prolonged and not mitigated by the stable support of a parent or other caregiver, it can become toxic, and lead to a chronically heightened stress response system, resulting in actual changes to the brain.<sup>65</sup> Persistent toxic stress can disrupt brain circuitry and other organ and metabolic systems in ways that influence not only behavior but also physiology, in the short-term and decades later.<sup>66</sup> In fact, chronic toxic stress can permanently

61. Biological embedding is defined as "the process whereby differential human experiences systematically affect the healthfulness of life across the life cycle." Clyde Hertzman, *The Biological Embedding of Early Experience and its Effects on Health in Adulthood*, 896 ANNALS N.Y. ACAD. SCI. 85, 89 (1999).

62. Toxic stress is defined as the strong, prolonged, or frequent activation of the body's stress response systems in the absence of the buffering protection afforded by support from caring adults. Nat'l Sci. Council on the Developing Child, *Excessive Stress Disrupts the Architecture of the Developing Brain* 1 (Harvard Univ. Ctr. on the Developing Child, Working Paper No. 3, 2014), [http://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress\\_Disrupts\\_Architecture\\_Developing\\_Brain-1.pdf](http://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress_Disrupts_Architecture_Developing_Brain-1.pdf) [https://perma.cc/4W7B-VS29] [hereinafter Working Paper No. 3].

63. Shonkoff et al., *supra* note 4, at e236.

64. Jennifer S. Middlebrooks & Natalie C. Audage, *The Effects of Childhood Stress on Health Across the Lifespan*, CTR. DISEASE CONTROL & PREVENTION 3 (2008), [https://www.bisccmi.org/revisitingtraumatology/childhood\\_stress.pdf](https://www.bisccmi.org/revisitingtraumatology/childhood_stress.pdf) [https://perma.cc/B3YV-V88S].

65. Shonkoff et al., *supra* note 4, at e236; see also Middlebrooks & Audage, *supra* note 65.

66. *Id.* Several mechanisms have been proposed in order to explain the biological processes by which toxic stress effects development. One of the most frequency cited mechanisms involves prolonged elevation of cortisol levels. In the face of stressors, the immune system produces proinflammatory cytokines. These cytokines in turn activates the hypothalamic-pituitary adrenal axis (HPA), which under normal conditions produces cortisol to extinguish the HPA and inflammatory response. Sarah B. Johnson et al., *The Science of Early Life Toxic Stress for Pediatric Practice and Advocacy*, 131 PEDIATRICS 319, 321 (2013). Toxic stress impedes this regulatory process and increases cortisol production. *Id.* at 321–22. Long-term effects of elevated cortisol levels include sensitized proinflammatory pathways, suppressed immune function, alterations in the architecture of brain regions responsible for learning, memory, and emotion, and contributions to metabolic syndrome, bone mineral loss, and atrophy. Working Paper No. 3, *supra* note 62, at 3. Other proposed direct effects of toxic stress include increased leukocyte telomere degradation and epigenetic activated and deactivation of specific genes. Ehrlich, *supra* note 16, at 25, 27. Childhood emotional and physical abuse has been associated with shorter telomeres in which blood cells. Telomeres are non-coding segments of DNA that act like caps to prevent DNA degradation when cells divide. When telomeres degrade, cells enter a phase known as senescence where replication ceases and functional capacity is limited. As a result, risks for morbidity and mortality from various conditions increase.

66. In addition, stress due to childhood adversity has been shown to turn some genes "on" and

affect the expression of genes involved in stress response regulation, brain development and functioning, and immune function.<sup>67</sup>

Toxic stress can also lead to unhealthy lifestyles through risky behaviors, such as Selena's frequent marijuana use and eating to make herself feel better, which people adopt as coping mechanisms.<sup>68</sup> Higher ACE exposure has been linked to higher rates of risk-taking behaviors such as tobacco use, illicit drug abuse, obesity, promiscuity, and pathologic gambling.<sup>69</sup> These behaviors are estimated to contribute to as many as forty percent of early deaths.<sup>70</sup>

Children exposed to trauma can experience a panoply of mental health challenges; they are more likely to exhibit negative affect, respond inappropriately to situations, have problematic social interactions with peers, and demonstrate ambivalence to their parents or other caregivers.<sup>71</sup> The frequent sadness that Selena feels is understandable. Over time, these reactions can evolve into psychiatric disorders, such as posttraumatic stress disorder (PTSD), separation anxiety, and depression.<sup>72</sup> As adults, children with histories of trauma and abuse are more likely to develop depression, anxiety, antisocial personality disorder, and borderline personality disorder, to attempt suicide, and to have challenges with substance abuse.<sup>73</sup> Although formal diagnoses of mental illness are most often associated with adult patients, many children who experience trauma actually begin to develop these conditions earlier in life and they often persist into adulthood.<sup>74</sup>

With fewer than 20 percent of youth with a diagnosable mental disorder receiving an evaluation or treatment services,<sup>75</sup> the toll of these conditions on our

others "off" at particular times in locations. *Id.* at 25.

67. Ross A. Thompson, *Stress and Child Development*, 24 FUTURE OF CHILDREN 41, 48 (2014). The study cited compared epigenetic changes in a group of children raised in orphanages with a group raised by their biological parents.

68. See Shonkoff et al., *supra* note 4, at e237.

69. *Id.* at e237.

70. *Id.* at e238.

71. Ann T. Chu & Alicia F. Lieberman, *Clinical Implications of Traumatic Stress from Birth to Age Five*, 6 ANN. REV. CLINICAL PSYCHOL. 469, 478 (2010).

72. *The 12 Core Concepts: Concepts for Understanding Traumatic Stress Responses in Children and Families*, NAT'L CHILD TRAUMATIC STRESS NETWORK (2012), <http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts/12-core-concepts> [<https://perma.cc/D9KQ-3RH4>].

73. Daniel P. Chapman et al., *Adverse Childhood Events as Risk Factors for Negative Mental Health Outcomes*, 37 PSYCHIATRIC ANNALS. 359 (2007).

74. According to the National Comorbidity Survey Replication study, half of all diagnosable mental illnesses began by age fourteen and seventy-five percent by age twenty-four. Vikram Patel et al., *Mental Health of Young People: A Global Public-Health Challenge*, 369 LANCET 1302, 1306 (2007). Moreover, most disorders likely to persist into adulthood had ages of onset during the 12–24 year age range. *Id.*

75. See, e.g., Joshua Breslau, et al., *Mental Disorders and Subsequent Educational Attainment in a U.S. National Sample*, 42 J. PSYCHIATRIC RES. 708, 708–716 (2008); Sheryl H. Kataoka, *Unmet Need of Mental Health Care Among U.S. Children: Variation By Ethnicity and Insurance Status*, 159 AM. J. PSYCHIATRY 1548, 1548–1555 (2002); Vander Stoep, et al., *What Proportion of Failure to*



youth is grave. Mental illness is the cause of more hospitalizations among teens than any other condition,<sup>76</sup> and suicide is the second leading cause of death in youth ages ten to twenty-four.<sup>77</sup> And the financial costs can be staggering; the Institute of Medicine in 2009 estimated the annual cost of early onset mental health disorders at more than \$247 billion per year.<sup>78</sup>

Once children begin experiencing poor mental health, they are at higher risk for many other health and developmental issues such as poor educational achievement, substance use and abuse, violence, and challenges with reproductive and sexual health.<sup>79</sup> The research similarly shows that mental illness in adolescence can also harm educational achievement<sup>80</sup> and later socio-economic status.<sup>81</sup> The spiraling effect of unaddressed children's mental health issues strains many systems, such as the educational, child welfare, and juvenile justice systems.<sup>82</sup> Selena's school avoidance and marijuana use could lead her to face school suspension or other consequences, such as involvement in the juvenile delinquency system. As the juvenile justice, child welfare, and crisis-oriented mental health services systems are highly resource intensive, the financial implications are also significant.

### *C. Reducing the Impact of Childhood Trauma: The Need for Early Identification and Intervention*

Selena's path could have improved greatly if she had been connected early on to needed mental health services to address her trauma. Early identification and interventions to address ACEs and toxic stress can help to mitigate their harmful impact so that children are given a chance to achieve more optimal mental and

*Complete Secondary School in the U.S. Population is Attributable to Adolescent Psychiatric Disorder?*, 30 J. BEHAV. HEALTH SERVS. & RES. 119, 119–24 (2003).

76. Pamela L. Owens, et al., *Care of Children and Adolescents in U.S. Hospitals*, AGENCY HEALTHCARE RES. & QUALITY (Oct. 2003), <https://archive.ahrq.gov/data/hcup/factbk4/factbk4.pdf> [<https://perma.cc/J8WN-2LZK>].

77. *WISQARS™ Leading Cause of Death Reports*, CTRS. DISEASE CONTROL & PREVENTION, <https://webappa.cdc.gov/sasweb/ncipc/leadcause.html>.

78. *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*, NAT'L RES. COUNCIL & INST. MED. (Mary Ellen O'Connell et al., eds. 2009), [https://download.nap.edu/cart/download.cgi?record\\_id=12480](https://download.nap.edu/cart/download.cgi?record_id=12480) [<https://perma.cc/6JAV-FRN9>] [hereinafter *Preventing MEB Disorders*].

79. See Patel, *supra* note 74, at 1302.

80. Ronald C. Kessler et al., *Social Consequences of Psychiatric Disorders, I: Educational Attainment*, 152 AM. J. PSYCHIATRY 1026, 1026–1032 (1995).

81. Ronald C. Kessler et al., *Individual and Societal Effects of Mental Disorders on Earnings in the United*

*States: Results from the National Comorbidity Survey Replication*, 165 AM. J. PSYCHIATRY 703, 703–711 (2008).

82. *Preventing MEB Disorders*, *supra* note 78, at 15–16.

physical health over the course of their lifetime.<sup>83</sup> The first several years of life and adolescence are especially critical years during which psychosocial factors have a disproportionately large impact on development.<sup>84</sup> Even at age thirteen, treatment to help her cope with the trauma she experienced as a child and to improve her mental health could have helped her long-term trajectory. But without access to necessary mental health treatment over time, a child's mental health status suffers as a result of trauma, as do his or her overall health outcomes.<sup>85</sup> If prevention and treatment intervention can be effectively implemented during early childhood, children will develop more appropriate stress responses and face lower risk of mental health challenges.<sup>86</sup> Later interventions are more likely to require greater intensity and cost in order to overcome well-established neural networks in the brain and routinized behavioral patterns.<sup>87</sup> If they are deployed early, interventions have the greatest impact—and also yield lower costs in such wide ranging areas as remedial education, clinical treatment, public assistance and incarceration.<sup>88</sup> If children in need of mental health services can access treatment early in life, the costs to them and to society can be reduced.<sup>89</sup>

The pathway to this early intervention begins with identification of the need.

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83. See, e.g., Michael Regalado & Neal Halfon, *Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years: Review of the Literature*, 155 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1311 (2001).

84. Sharon E. Fox et al., *How the Timing and Quality of Early Experiences Influence the Development of Brain Architecture*, 81 CHILD DEV. 28 (2010); Jack P. Shonkoff, *Leveraging the Biology of Adversity to Address the Roots of Disparities in Health and Development*, 109 PROC. NAT'L ACAD. SCI. 17302, 17304 (2012).

85. In children ages 5–14, mental illnesses cause 15 percent of the disability-adjusted life years (DALYs) lost to illness. In youths age 15–24 this number doubles; during this period, almost two-thirds of DALYs lost are due to causes strongly associated with mental illness and substance abuse. “One DALY can be thought of as one lost year of “healthy” life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.” *Metrics: Disability-Adjusted Life Year (DALY)*, WORLD HEALTH ORG., [http://www.who.int/healthinfo/global\\_burden\\_disease/metrics\\_daly/en](http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en) [https://perma.cc/X62P-236J]; *Preventing MEB Disorders*, *supra* note 78, at 17.

86. Hillary A. Franke, *Toxic Stress: Effects, Prevention, and Treatment*, 1 CHILDREN 390, 394 (2014).

87. Thompson, *supra* note 67, at 51.

88. Suggested economic effects of early rather than late intervention include lower costs in remedial education, clinical treatment, public assistance, and incarceration. Jack P. Shonkoff & Pat Levitt, *Neuroscience and the Future of Early Childhood Policy: Moving from Why to What and How*, 67 NEURON 689, 691 (2010). In a study conducted by Shirtcliff and colleagues, children brought up in orphanages but subsequently adopted into stable homes showed similar inability to keep the herpes simplex virus dormant as adolescents with recent histories of trauma. Elizabeth Shirtcliff et al., *Early Childhood Stress is Associated with Elevated Antibody Levels to Herpes Simplex Virus Type 1*, 106 PROC. NAT'L ACAD. SCI. 2963 (2009). Even rodent studies have found that offspring born to low nurturing mothers but raised in high nurturing environments develop normal endocrine and behavioral responses. Darlene Francis et al., *Nongenomic Transmission Across Generations of Maternal Behavior and Stress Responses in the Rat*, 286 SCIENCE 1155, 1156 (1997).

89. Patel, *supra* note 74, at 1306.

When children receive mental health screenings that identify trauma and related mental health needs, those children can then be referred for more in-depth psychological and psychiatric evaluations when necessary and to appropriate mental health treatment. Mental health treatment for children can include interventions focused on their families, community-based treatments, and school-based interventions.<sup>90</sup> These interventions are specifically targeted at children and are most effective when provided early in life.<sup>91</sup> Even babies who have experienced trauma, like Selena, can benefit from infant mental health services, which engage parents and caregivers like Amelia and Aunt Joann, together with the infant, to promote mental health, prevent further trauma, and treat its symptoms.<sup>92</sup> Infant mental health services could have helped to palliate Selena's mental health problems, and supported her mother and aunt in nurturing her healthy childhood development.<sup>93</sup>

Beyond infancy, there are a panoply of treatments for traumatized children like Selena and their families that are evidence-based, meaning those services have been shown through scientific research to be effective in improving outcomes.<sup>94</sup> Many of these treatments engage the child's parent or caregiver, as well as the child, to support that relationship and improve the well-being of the family. For example, treatment aimed at both a parent and child can be especially critical when both have been exposed to trauma. Because Amelia was a victim of interpersonal violence that was also witnessed by her child, treatment could have been instrumental in addressing both of their related needs. Research shows that "traumatized adults may experience post-traumatic stress symptoms such as avoidance and withdrawal, which limit their availability and responsiveness to the child. Simultaneously, exposure to a traumatic event creates in the child stress symptoms that are exacerbated by the indirect effect of the caregiver's compromised responsiveness."<sup>95</sup> Amelia and Selena could have participated in

90. *Id.* at 1182–83.

91. Kimberly Eaton Hoagwood et al., *Evidence-Based Practice in Child and Adolescent Mental Health Services*, 52 *PSYCHIATRIC SERVS.* 1179, 1181 (2001).

92. *Infant-Early Childhood Mental Health*, ZERO TO THREE (Feb. 10, 2016), <https://www.zerotothree.org/resources/110-infant-early-childhood-mental-health> [https://perma.cc/6QZG-SDBP]; see also *Infant Mental Health Journal*, WORLD ASS'N INFANT MENTAL HEALTH, <http://www.waimh.org/i4a/pages/index.cfm?pageid=3292> [https://perma.cc/X6EA-8WYJ].

93. ZERO TO THREE, *supra* note 92.

94. The American Psychological Association describes evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences," with the best available research referring to "scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields." *Policy Statement on Evidence-Based Practice in Psychology*, AM. PSYCHOL. ASS'N (Aug. 2005), <http://www.apa.org/practice/guidelines/evidence-based-statement.aspx> [https://perma.cc/GP7E-HV2P].

95. Ann T. Chu & Alicia F. Lieberman, *Clinical Implications of Traumatic Stress from Birth to*

child-parent psychotherapy, which has been shown to reduce a child's behavioral problems as well as mental health symptoms associated with trauma for both child and parent.<sup>96</sup> Play therapy could have helped to lower Selena's toxic stress response.<sup>97</sup>

As Selena came into the care of her Aunt Joann, evidence-based treatments would have engaged Joann in Selena's therapy, even though Joann herself may not have experienced trauma like Amelia. Because a child's traumatic stress responses are linked with the quality of the child-caregiver relationship, treatments like functional family therapy seek to build bonds between a traumatized child like Selena and her caregiver, Aunt Joann.<sup>98</sup> Regular home visits by a trained community health worker may have helped her to become less anxious, display fewer symptoms of depression, and have fewer disciplinary issues at school during adolescence.<sup>99</sup> As Selena began to struggle in school and turn to marijuana use, Selena and Joann could perhaps have benefited from behavioral management help from a social worker, known as multisystemic therapy.<sup>100</sup> School-based interventions can also have powerful results.<sup>101</sup>

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*Age Five*, 6 ANN. REV. CLINICAL PSYCHOL. 469, 478 (2010).

96. Child-parent psychotherapy improves the relationship between a child and her parents by reinforcing the child's perception of the parent as a competent and reliable protector and helping parents understand the meaning of a child's behavior. This type of psychotherapy is not only significantly effective in reducing children's behavioral problems and symptoms of post-traumatic stress disorder, but also can improve a mothers' symptoms of avoidance of trauma triggers, helping traumatized mothers be more responsive to their children. A 6-month follow-up found that these improvements were sustained. *Id.*

97. "Play therapy allows children to express themselves through play and activity. This theory assumes that "children will use play materials to directly or symbolically act out feelings, thoughts, and experiences that they are not able to meaningfully express through words." Sue C. Bratton et al., *The Efficacy of Play Therapy with Children: A Meta-Analytic Review of Treatment Outcomes*, 36 PROF. PSYCHOL.: RES. & PRAC. 376, 376 (2005). Combinations of play therapy and training and support for caregivers have been shown to lower the toxic stress response of children who have experienced maltreatment. Thompson, *supra* note 67, at 51.

98. Functional family therapy involves a three-stage engagement process of (1) building a therapeutic bond with family, (2) enabling adept family problem-solving, and (3) helping families generalize problem-solving skills to new scenarios.<sup>98</sup> Functional family therapy has long-term positive outcomes; for example, this service reduces recidivism in juvenile offenders with conduct disorders by 26–73%, as compared to routine services. Alan Carr, *The Effectiveness of Family Therapy and Systemic Interventions for Child-Focused Problems*, 31 J. FAM. THERAPY 3, 16 (2009)

99. Regular home visits by a trained community health worker to high risk families have led to promising results, where those babies ultimately become adolescents who are less anxious, display fewer symptoms of depression, and have improved self-esteem, as well as fewer attention problems and fewer disciplinary issues at school. Patel, *supra* note 74, at 1305.

100. Multisystemic therapy deploys a social worker or other highly qualified professional to work with youth and their families to better manage behaviors by helping an adolescent and her family draw on their strengths to develop and implement new skills as part of an action plan to disrupt problematic patterns. Carr, *supra* note 98, at 17. Families who engage in multisystemic therapy have shown "greater improvements in family problems and parent-child interaction" for treatment of physical abuse and neglect. Carr, *supra* note 98, at 17.

101. For example, Resilient Peer Treatment pairs socially withdrawn preschool children,

These and other evidence-based children's mental health treatments can serve as critical tools to disrupt the path from ACEs and other forms of early childhood trauma to poor health and mental health. If children can access these services early in life,<sup>102</sup> they are more likely to experience improved outcomes.<sup>103</sup> To facilitate access to these services early in life, systems need to be in place to screen children and identify those at high risk.<sup>104</sup> Early intervention necessarily starts with identification, and healthcare providers can play a key role in identification by screening children when they come to the doctor for a check-up.<sup>105</sup>

## II. FULFILLING THE MEDICAID PROMISE: A ROUTE TO WIDESPREAD EARLY IDENTIFICATION AND INTERVENTION TO IMPROVE THE HEALTH AND MENTAL HEALTH WHO HAVE SUFFERED TRAUMA

"[W]e make this commitment to our youth not merely at the bidding of our conscience. It is practical wisdom. It is good economics. But, most important, as Franklin D. Roosevelt said thirty years ago, because 'the destiny of American youth is the destiny of America.'"<sup>106</sup>

Through the enactment of the Medicaid program, "Congress embarked on an ambitious program to provide medical care for the country's poorest people."<sup>107</sup> In 1967, President Lyndon B. Johnson laid the groundwork for legislation to identify and treat the healthcare needs of children living in poverty as early as possible through an expansion of the services required by Medicaid. President Johnson argued that "[o]ur whole society pays a toll for the unhealthy and crippled children who go without medical care: a total of incalculable human suffering, unemployment, rising rates of disabling disease, and expenditures for special education and institutions for the handicapped."<sup>108</sup> In addition to the moral duty to

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including those with trauma histories, with a peer in the same classroom who is coached by a play supporter. With numerous play sessions over several months, research shows that this treatment results in the previously withdrawn children engaging more collaboratively in play with their peers. Chu & Lieberman, *supra* note 95, at 486.

102. Barbara J. Burns et al., *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*, 43 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 960 (2004) (stressing the importance of identifying mental health problems in children in the child welfare system early, and providing treatment quickly).

103. Carr, *supra* note 98 (noting that functional family therapy reduces recidivism in juvenile offenders with conduct disorders by 26–73%, as compared to routine services).

104. Emalee G. Flaherty & John Stirling, Jr., *The Pediatrician's Role in Child Maltreatment Prevention*, 126 PEDIATRICS 833 (2010). Currently, the American Academy of Pediatrics recommends screening for factors such as social isolation, poverty, low educational achievement, single-parent homes, history of domestic violence, young parental age, and parental mental health issues.

105. *Id.*

106. 13 CONG. REC. 2883, 2885 (Feb. 8, 1967) (statement of President Lyndon B. Johnson).

107. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 24 (D. Mass. 2006).

108. 13 CONG. REC. 2883, 2885 (Feb. 8, 1967) (statement of President Lyndon B. Johnson).

reduce the infant death rate and the number of children suffering from debilitating conditions,<sup>109</sup> policymakers were concerned by findings from Vietnam War draftee health exams<sup>110</sup> that one in four young men who were medically disqualified for service would not have been rejected by the Selective Service for orthopedic or hearing defects had they received “timely medical attention.”<sup>111</sup> Healthier children could become healthier adults better poised to serve in the military and defend our nation. With these economic and practical drivers in mind, President Johnson advocated for policies to ensure the “discover[y], as early as possible, the ills that handicap our children.”<sup>112</sup>

*A. Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services for Children*

The amendments to the Social Security Act consequently passed that year by Congress required states to provide Medicaid-enrolled children periodic screening and “health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.”<sup>113</sup> In further defining and expanding these critical components of children’s Medicaid, now known collectively as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services, Congress recognized that “adherence to clearly effective and cost-effective well-child care could be worth the immediate outlays” and that “the availability of diagnostic and treatment services is critical to [] children’s health status.”<sup>114</sup> In promulgating accompanying regulations, the U.S. Department of Health and Human Services

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109. E.g., President’s Proposals for Revision in the Social Security System: Hearing on H.R. 5710 Before the H. Comm. on Ways & Means, 90th Cong. 189 (1967) (statement of John Gardner, Sec’y of Health, Educ., & Welfare) (“Too many infants die who would have lived had they received medical attention. Too many children suffer from chronic handicapping conditions that could have been prevent, corrected, or improved by early treatment.”).

110. Sara Rosenbaum et al., *EPSDT at 40: Modernizing a Pediatric Health Policy to Reflect a Changing Health Care System*, CTR. HEALTH CARE STRATEGIES, INC. 3 (July 2008).

111. Social Security System Hearing, *supra* note 109.

112. 13 CONG. REC. 2883, 2885 (Feb. 8, 1967) (statement of President Lyndon B. Johnson).

113. Social Security Amendments of 1967, Pub. L. No. 90-248, §302, 81 Stat. 929 (1968) (amended 1989). The original text read “(B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the secretary.” *Id.*

114. Office of Tech. Assessment, *Healthy Children: Investing in the Future*, U.S. CONGRESS 23 (Feb. 1988), <http://ota.fas.org/reports/8819.pdf> [<https://perma.cc/XAE8-7VUE>]; see also SUBCOMM. ON HEALTH & THE ENV’T OF THE HOUSE COMM. ON ENERGY & COMMERCE, REPORT ON MEDICARE AND MEDICAID HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1989, at 65 (Comm. Print 1989) (citing the Office of Technology Assessment’s report and noting potential cost savings from effective screening and care). The Congressional Record for the Deficit Reduction Act of 2005 clarifies the continuing protections afforded by Medicaid EPSDT. 152 CONG. REC. H46 (daily ed. Feb. 1, 2006) (statement of Rep. Slaughter) (noting a “clear legislative intent that all children should continue to receive access to coverage of early and periodic screening, diagnostic, and treatment services”).

(H.H.S.) similarly emphasized EPSDT's purpose to "[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly."<sup>115</sup> The EPSDT children's health program is mandatory for the fifty states and territories that have agreed to participate in Medicaid.<sup>116</sup> It provides a comprehensive set of medical benefits for Medicaid-eligible children and youth who are under the age of 21.<sup>117</sup> The program's core components are those spelled out in its EPSDT title: (1) early and periodic screening, (2) diagnosis, and (3) treatment services.<sup>118</sup>

### *B. Early And Periodic Screening for Mental Health Can Disrupt the Trauma Cycle*

More than 42 million children now receive their healthcare through the Medicaid program.<sup>119</sup> With such widespread reach, Medicaid's early and period screening requirement provides a critical structure for identifying trauma early and providing necessary mental health services. For a child like Selena, her annual check-ups were an opportunity for her doctor to screen her for trauma and mental health needs and refer her for critical treatment that could have provided her with a healthier start in life and healthier outcomes down the road. Indeed, regular screening services are the foundation of EPSDT; children's health problems can only be treated if medical providers are aware of them. When a child covered by Medicaid goes to the doctor throughout childhood and adolescence for check-ups known as a well-child checks, the child should receive holistic screening that includes a mental health assessment at each appointment. Congress directed states to ensure that these doctor's visits go beyond traditional height, weight, and basic physical exams: specifically, Medicaid EPSDT requires that states ensure medical, vision, hearing, and dental screenings are regularly provided to children.<sup>120</sup> The first component, the medical screening, must include a comprehensive health and developmental history assessing both physical and mental development.<sup>121</sup> A

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115. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 5010.B [hereinafter CMS MEDICAID MANUAL].

116. See Social Security Act, 42 U.S.C. §§ 1396a(a)(10)(A) and 1396a(a)(43) (2012).

117. 42 U.S.C. § 1396d(r) (2012). State participation in Medicaid is voluntary, but once a state opts to participate, it must comply with the Act and all regulations promulgated by the federal Centers for Medicare and Medicaid Services (CMS) in order to obtain federal funds. See *Bowen v. Mass.*, 487 U.S. 879, 883 (1988).

118. See 42 U.S.C. § 1396d(r) (2012).

119. See CTRS. FOR MEDICARE & MEDICAID SERVS., *Form CMS-416: Annual EDST Participation Report* (2015). According to the latest available national data, 42,150,534 individuals aged 0–20 were eligible at some point for EPSDT. 39,723,800 were eligible for 90 continuous days. See *Early and Periodic Screening, Diagnostic, and Treatment*, CTRS. MEDICAIR & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html> [<https://perma.cc/H35D-85EN>] (describing Form CMS-416 and linking to data).

120. See 42 U.S.C. § 1396d(r)(1)–(4) (2012).

121. The medical screen must also include a comprehensive unclothed physical examination and

screening constitutes the critical first step towards identification and understanding of a child's challenges and the gateway towards the receipt of the services a child needs to get healthy. If needs are identified during a screening, a child must subsequently be provided any medically necessary healthcare, diagnostic services, treatment and other measures to "to correct or ameliorate" those conditions that were discovered,<sup>122</sup> such as more comprehensive psychological evaluations and the types of evidence-based children's mental health treatment described above.

While screenings must generally "be provided in accordance with reasonable standards of medical and dental practice,"<sup>123</sup> the Medicaid statute and regulations provide little guidance to states and providers as to how to assess a child's mental health in the doctor's office or what a mental health screening should encompass.<sup>124</sup> Guidance from the Centers for Medicare and Medicaid Services (CMS) explains that assessments should be age-appropriate and examine the social-emotional needs of young children and possible peer relation issues, substance abuse, and psychological conditions in adolescents. However, CMS guidance does not identify specific screening tools that should be used for evaluation. As a result, states and providers are still left without specificity as to which screening tools or protocols are appropriate or effective, and would satisfy Medicaid's mental health screening requirement for children.<sup>125</sup> There are a wide variety of screening tools that can be used to assess for mental health as part of a broader developmental screening or separately for trauma and mental health needs.<sup>126</sup>

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health education. 42 U.S.C. § 1396d(r)(1)(B) (2012); 42 C.F.R. §441.56(b)(1) (2016).

122. *Id.*

123. 42 C.F.R. § 441.56(b)(2) (2016).

124. 42 U.S.C. § 1396d(r)(1)(B) (2012); 42 C.F.R. §441.56(b)(1) (2016).

125. The Manual does not identify specific screening tools that should be used during the evaluation in order "to avoid any connotation that only certain tests or instruments satisfy Federal requirements," and instead directs physicians to use any information acquired to objectively evaluate whether the child is within expected developmental ranges. Although this guidance provides some additional detail, states are largely left without a federal definition of what constitutes an adequate mental health screening. See CMS STATE MEDICAID MANUAL, *supra* note 115, at § 5123.2(1)(a), (b).

126. For general developmental screening, the American Academy of Pediatrics (AAP) recommends a variety of screening tools, including the Ages & Stages Questionnaire (ASQ). The ASQ has been normed on children from diverse socioeconomic and ethnic backgrounds and has moderate to high sensitivity and specificity. Council on Children with Disabilities et al., *Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*, 118 PEDIATRICS 405, 410–13 (2006). For psychological and behavioral screenings, the AAP recommends the use of the Pediatric Symptom Checklist, Youth Report, or Strengths and Difficulties Questionnaire. *Bright Futures Tool and Resource Kit: Developmental, Behavioral, Psychosocial, Screening, and Assessment Forms*, AM. ACAD. PEDIATRICS, <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx> [<https://perma.cc/LLT2-B6CN>]; see also *Screening and Assessment*, in SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES 91 (2014), [https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf\\_NBK207201.pdf](https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf_NBK207201.pdf) [<https://perma.cc/2MJV-E22S>]; Jane Ellen Stevens, *To Prevent Childhood Trauma, Pediatricians*



Without effective tracking systems in most states, it is difficult to tell whether children receive the required comprehensive screenings, including mental health screening, when they see the doctor for a well child check.<sup>127</sup> What information has been reported by states shows that there is a wide variance among states in the frequency required for well child checks and in the screening components that should be administered at different ages.<sup>128</sup> Alarming, available data shows that

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*Screen Children and Their Parents. . . And Sometimes, Just Parents. . . For Childhood Trauma*, ACES TOO HIGH NEWS (July 29, 2014), <https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parents-and-sometimes-just-parents> [https://perma.cc/3QYL-BPEW] (describing the use of ACEs screening tools to identify trauma histories in a pediatric practice).

127. Defendants' 8/29/06 Remedial Plan Proposal at 6, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199).

128. Each state sets its own periodicity schedule for how regularly children should be seen for well-child check screens and what each visit should include, but these schedules typically involve frequent visits every few months in infancy and toddlerhood and then annual or bi-annual visits later in adolescence. *See, e.g.*, 405 IND. ADMIN. CODE 5-15-8 (2016); MD. CODE REGS. 10.09.23.01(B)(4) (2016). The American Academy of Pediatrics' recommends the Bright Futures periodicity schedule, which requires history taking, measurements, sensory screening, developmental/behavioral assessment, physical examination, procedures, oral health assessment, and anticipatory guidance, as well as body mass index (BMI) measurements, depression screenings, alcohol/drug use assessments, and the use of verified screening tools for developmental, behavioral, and psychosocial assessments. The AAP recommends screenings as a newborn; at 3–5 days; at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months; and every year thereafter. *Recommendations for Preventive Pediatric Health Care*, AM. ACAD. OF PEDIATRICS, [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) [https://perma.cc/6K38-UYK3].

At least twenty-six states have adopted the AAP's Bright Futures recommendations to some extent. *Early & Periodic Screening, Diagnostic, & Treatment Program*, ALASKA DEP'T HEALTH & HUM. SERVS., [http://dhss.alaska.gov/dhcs/Pages/epsdt\\_hcs.aspx](http://dhss.alaska.gov/dhcs/Pages/epsdt_hcs.aspx) [https://perma.cc/L825-UF4G]; *Provider Manual*, ARK. MEDICAID § 215.100 (2015), [https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/epsdt/EPSDT\\_II.doc](https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/epsdt/EPSDT_II.doc) [https://perma.cc/7MTX-NQ2Z]; *Periodicity Schedules*, CAL. DEP'T HEALTH CARE SERVS. (May 20, 2016 10:09 AM), <http://www.dhcs.ca.gov/services/chdp/Documents/HealthPeriodicity.pdf> [https://perma.cc/3ACM-MUWB]; *Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*, COLO. DEP'T HEALTH CARE POL'Y & FINANCING, <https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt> [https://perma.cc/SUC3-YDD9]; Div. of Medicaid & Med. Assistance, *Quality Management Strategy*, DEL. HEALTH & SOC. SERV. 33 (2014), [http://dhss.delaware.gov/dhss/dmma/files/draft\\_qms\\_20140401.pdf](http://dhss.delaware.gov/dhss/dmma/files/draft_qms_20140401.pdf) [https://perma.cc/2KLY-LTVL]; Div. of Medicaid, *Policies & Procedures for Early & Periodic Screening, Diagnostic, & Treatment (EPSDT) Services*, GA. DEP'T OF CMTY. HEALTH at IX-2 (2016), <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/EPSDT%20Health%20Check%20Manual%2020160926134353.pdf> [https://perma.cc/8YAL-7H3X]; *Medicaid Provider Manual: Early and Periodic Screening, Diagnosis and Treatment*, MEDQUEST HAWAII 3 (2002), <http://www.med-quest.us/PDFs/Provider%20Manual/PMChp0502.pdf> [https://perma.cc/4Q2F-9CGD]; *Idaho MMIS Provider Handbook*, IDAHO MEDICAID 50–56 (July 13, 2017), <https://www.idmedicaid.com/General%20Information/General%20Provider%20and%20Participant%20Information.pdf> [https://perma.cc/JFW4-NQAE]; *Handbook for Providers of Healthy Kids Services Chapter HK-200: Policy and Procedures for Health Care for Children*, ILL. DEP'T HEALTHCARE & FAMILY SERVS. 16 (Mar. 2017), <https://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf> [https://perma.cc/2X2R-FKM2];

more than a third of Medicaid-enrolled children are not receiving any screenings at all.<sup>129</sup> When children *are* screened, there is a dearth of data to indicate whether those screenings are comprehensive and specifically whether they include any

Div. of Health Care Fin., *KBH – EPSDT Updates*, KAN. DEP'T HEALTH & ENV'T 8-1 (Apr. 2016), <https://www.knap-state-ks.us/Documents/Content/Bulletins/16058%20-%20General%20-%20KBH-EPSDT.pdf> [<https://perma.cc/2J4Z-ZWRS>]; Cabinet for Health Servs., *EPSDT Screening Services & EPSDT Special Services Policies & Procedures*, KY. DEP'T MEDICAID SERVS. 4.1, <http://www.chfs.ky.gov/NR/rdonlyres/64EFF098-5C67-48B4-8B8B-97EE2E9005BF/0/1034.pdf> [<https://perma.cc/BU6N-NBKK>]; *Pediatric Preventive Health Screenings*, MAINECARE SERV. 2 (Dec. 7, 2016), [http://www.maine.gov/dhhs/oms/pdfs\\_doc/children\\_IHOC/Pediatric%20Preventive%20Health%20Screenings2017final.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/children_IHOC/Pediatric%20Preventive%20Health%20Screenings2017final.pdf) [<https://perma.cc/Z65F-3PJ7>]; Clarification of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Covered Services and Definition of “Medically Necessary,” MICHIGAN DEP'T HEALTH & HUMAN SERVS. 1 (Jan. 15, 2016), [http://www.michigan.gov/documents/mdhhs/MSA\\_16-01\\_510956\\_7.pdf](http://www.michigan.gov/documents/mdhhs/MSA_16-01_510956_7.pdf) [<https://perma.cc/3SW4-G4K6>]; *EPSDT Periodic Examination Schedule*, MISS. DIV. MEDICAID (Jul. 2016), <https://medicaid.ms.gov/wp-content/uploads/2016/07/EPSDT-Periodicity-Examination-Schedule.pdf> [<https://perma.cc/Y48J-6F44>]; *General Information for Providers*, MONT. DEP'T HEALTH & HUM. SERVS. 3.2 (Feb. 2017), <http://medicaidprovider.mt.gov/Portals/68/docs/manuals/General/GeneralManual02032017.pdf> [<https://perma.cc/BHC4-8WP3>]; 471 Neb. Admin. Code §33-002.03A (2016); Office of Medicaid Mgmt., *EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid)* N.Y. STATE DEP'T OF HEALTH 9–11 (2005), <https://www.emedny.org/ProviderManuals/EPSDTCTHP/PDFS/EPSDT-CTHP.pdf> [<https://perma.cc/C5SQ-T3XN>]; Div. of Med. Assistance, *N.C. Health Check Program Guide*, N.C. DEP'T HEALTH & HUM. SERVS. 5 (2016), [https://ncdma.s3.amazonaws.com/s3fs-public/Health\\_Check\\_Program\\_Guide\\_2016\\_10.pdf](https://ncdma.s3.amazonaws.com/s3fs-public/Health_Check_Program_Guide_2016_10.pdf) [<https://perma.cc/ME66-CZSM>]; *General Information for Providers: Medicaid and Other Medical Assistance Programs*, N.D. DEP'T HUM. SERVS. 111 (2012), <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf> [<https://perma.cc/3LJ4-67J4>]; *EPSDT: Rhode Island Medicaid Early Periodic Screening Diagnosis and Treatment*, R.I. DEP'T HEALTH, [https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/RI-Provider-Information/RI\\_Early\\_Periodic\\_Screening\\_Diagnosis\\_Treatment.pdf](https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/RI-Provider-Information/RI_Early_Periodic_Screening_Diagnosis_Treatment.pdf) [<https://perma.cc/7Q8P-SNQT>]; *Professional Services Billing Manual*, S.D. MEDICAID 41 (Jul. 2017), <https://dss.sd.gov/formsandpubs/docs/MEDSRVCS/professional.pdf> [<https://perma.cc/2EGQ-XM8N>]; *EPSDT Fact Sheet*, TENN. DEP'T HEALTH, <https://www.tn.gov/health/article/epsdt-fact-sheet> [<https://perma.cc/7M6T-2RM4>]; Bright Futures, *Utah*, AM. ACAD. PEDIATRICS, <https://brightfutures.aap.org/states-and-communities/Pages/Utah.aspx> [<https://perma.cc/PW5P-6379>]; *Health Care and Screening Guidelines*, VT. DEP'T HEALTH (Jan. 3, 2017), <http://healthvermont.gov/children-youth-families/health-care-children-youth/health-care-and-screening-guidelines> [<https://perma.cc/A2UP-WQRP>]; *Virginia EPSDT Periodicity Chart*, Va. DEP'T MED. ASSISTANCE SERVS., [http://dmasva.dmas.virginia.gov/Content\\_atchs/mch/mch-epsdt\\_poi2.pdf](http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf) [<https://perma.cc/6NQZ-CQQE>]; *West Virginia EPSDT/HealthCheck Program Periodicity Schedule*, W. VA. DEP'T OF HEALTH & HUMAN SERVS., <http://www.dhhr.wv.gov/HealthCheck/providerinfo/Documents/HC%20periodicity%20schedule%2002-15.pdf> [<https://perma.cc/C9AU-W8AU>].

129. In FY 2015, 33,788,843 children were eligible for at least one initial or periodic screen; only 19,732,638 (58.4%) received one. *Annual EPSDT Participation Report: Fiscal Year 2015*, CTRS. MEDICARE & MEDICAID SERVS. (Sept. 29, 2016), <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2015-epsdt-data.zip> [<https://perma.cc/L8GZ-CLHV>] [hereinafter *EPSDT 2015 Participation Report*]; see Rosie D. v. Romney, 410 F. Supp. 2d at 30-35 (“Without a clinically appropriate, detailed assessment . . . proper treatment is obviously impossible.”).

mental health screening.<sup>130</sup> A study by the HHS Office of Inspector General of a small sample of medical records across nine states found that 76 percent of children did not receive all required medical, vision, and hearing screenings and nearly 60 percent of children who did receive a medical screening were missing at least one component.<sup>131</sup> In 2001, a survey of state Medicaid programs revealed that 23 states failed to include a single question related to mental health in their EPSDT tools for primary care providers.<sup>132</sup> A national survey of parents from 2011-2012 found that only 31.5 percent of publicly insured children across the country received a standardized developmental and behavioral health screening between the ages of 10 months and 5 years.<sup>133</sup> And a review in 1998 of Minnesota's Medicaid EPSDT system found that only 27 percent of children there received a mental health or developmental screening.<sup>134</sup> The available data shows that "many children with mental health disorders are never screened, diagnosed, or offered the treatment services to which they are entitled under the Medicaid EPSDT benefit."<sup>135</sup>

130. Najeia Mention & Felicia Heider, *The Nuts and Bolts of Medicaid Reimbursement for Developmental Screening: Insights from Georgia, Minnesota, and North Carolina*, NAT'L ACAD. STATE HEALTH POL'Y 2 (Sept. 2016), <http://www.nashp.org/wp-content/uploads/2016/09/Screening-Brief-Updated.pdf> [<https://perma.cc/ZE8R-CQL9>]. As key exceptions, Massachusetts publishes quarterly reports on behavioral health screenings and North Carolina has published yearly screening rates for all Medicaid-enrolled children 0-5 years old. *Behavioral Health (BH) Screening Cumulative Quarterly Report*, MASS. EXECUTIVE OFFICE HEALTH & HUMAN SERVS., <http://www.mass.gov/eohhs/docs/masshealth/cbhi/reports/bh-screening.pdf> [<https://perma.cc/XUT7-TRF4>] [hereinafter Mass. Screening Reports]; Marian Earls & Kimmy Vuong, *Assuring Better Child Health and Development (ABCD) Program Improves Screening Rates*, COMMUNITY CARE N.C. (2016), <https://www.communitycarenc.org/media/files/data-brief-7-abcd-program-improves-screening-rates.pdf> [<https://perma.cc/4G54-LFYP>]. Because screenings are reported as a single unit rather than by component, however, this data provides no information regarding the comprehensiveness and quality of the screenings conducted. See 42 U.S.C. §1396a(a)(43)(D) (2012) (requiring states to report to the Secretary "the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year: (i) the number of children provided health screening services, (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services, (iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 1397hh(e) of this title and (iv) the State's results in attaining the participation goals set for the State under section 1396d(r) of this title").

131. U.S. Dep't of Health & Human Serv., Office of the Inspector Gen., OEI-5-08-00520, *Most Medicaid Children in Nine States are Not Receiving All Required Preventive Screening Services* (2010) [hereinafter OEI-5-08-00520] (finding that in nine states, three of four children did not receive all covered health screening services and nearly sixty percent of those who received EPSDT medical screenings lacked at least one component of a complete screening); U.S. Dep't of Health & Human Serv., Office of the Inspector Gen., OEI-05-13-00690, *CMS Needs to Do More to Improve Medicaid Children's utilization of Preventive Screening Services* (2014).

132. Rafael M. Semansky et al., *Behavioral Health Screening Policies in Medicaid Programs Nationwide*, 54 PSYCHIATRIC SERVS. 736 (2003).

133. *Well-Being of Children*, *supra* note 9, at 22.

134. FMAS Corp., *1999 External Quality Review Study Child and Teen Checkups Participation Rate Review Final Report*, MINN. DEP'T HUM. SERVS. 5 (Aug. 2000).

135. Rosie D. and *Mental Health Screening: A Case Study in Providing Mental Health Screening*

While children like Selena struggle to cope with the trauma they have experienced, available data suggests that mental health screenings that could identify their mental health needs and facilitate necessary services are not reaching many children. In examining the failure of Massachusetts' Medicaid system to provide children with both mental health screening in the pediatric setting and more intensive mental health evaluations, a federal judge noted "The simplest way to escape the challenge of serving [a seriously emotionally disturbed] child is to avoid conducting the sort of in-depth comprehensive assessment that will reveal the extent of the child's medical needs."<sup>136</sup> More research is needed to understand how often well-child checks are in fact provided and how frequently the checks that do happen are comprehensive, including the mental health screening and all other required components. The federal government should both require and support states in collecting and analyzing this data and providing it to the U.S. Department of Health and Human Services for further analysis.

While there has been no comprehensive national study of the reasons behind the failure of states to ensure that Medicaid-eligible children receive mental health screenings as part of their well child checks, there are a number of possible contributing factors. Primary care providers already struggle with low reimbursement rates for Medicaid EPSDT well child visits<sup>137</sup> and feel they have insufficient time to complete all required screening components,<sup>138</sup> especially

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at the Medicaid EPSDT Visit, TEENSCREEN: NAT'L CTR. MENTAL HEALTH CHECKUPS COLUM. U. 1 (2010), <http://www.mass.gov/eohhs/docs/masshealth/cbhi/reports/rosie-d-white-mhscreening.pdf> [https://perma.cc/3VGZ-SWEJ] [hereinafter TEENSCREEN].

136. Rosie D. v. Romney, 410 F. Supp. 2d 18, 35 (2016).

137. Diane L. Frankenfield et al., *Adolescent Patients- Healthy or Hurting? Missed Opportunities to Screen for Suicide Risk in the Primary Care Setting*, 154 ARCHIVES OF PEDIATRICS AND ADOLESCENT MEDICINE 162, 165 (2000) (reporting that most surveyed physicians indicated concerns about inadequate reimbursement for screening for mental health problems as a barrier to screening for suicidality or associated risk factors); Sarah McCue Horwitz et al., *Barriers to the Identification and Management of Psychosocial Issues in Children and Maternal Depression*, 119 PEDIATRICS e208, e212 tbl.3 (2007) (reporting on perceived barriers to providing pediatric mental health services and finding that 50.6% of physicians surveyed agreed that inadequate reimbursement was a barrier to care); Judith A. Savageau et al., *Behavioral Health Screening Among Massachusetts Children Receiving Medicaid*, 178 J. PEDIATRICS 261, 265 (2016).

138. Paul Chung et al., *Preventive Care for Children in the United States: Quality and Barriers*, 27 ANN. REV. PUB. HEALTH 491, 507 (2006) (noting that a lack of time on the part of healthcare providers as to what can be accomplished in a well-child check may be more a matter of perception, as studies show that well child visits that incorporate counseling of patients lasted only two minutes longer than visits where no counseling was provided); Horwitz et al., *supra* note 137, at e212 tbl.3 (finding that 77% of physicians surveyed agreed that lack of time to treat child/adolescent mental health problems was a barrier to care); Melissa D. Klein et al., *Can a Video Curriculum on the Social Determinants of Health Affect Residents' Practice and Families' Perception of Care?*, 14 ACAD. PEDIATRICS 159, 163 (2014); Lewis Margolis & Samuel Meisels, *Barriers to the Effectiveness of EPSDT for Children with Moderate and Severe Developmental Disabilities*, 57 AM. J. ORTHOPSYCHIATRY 424, 427 (1987) (emphasizing insufficient time due to 'inflexibility inherent in the structured session'); Savageau et al., *supra* note 137, at 165.

given the many valuable and competing priorities in a pediatric well child visit.<sup>139</sup> Some primary care providers have reported concerns about the unavailability of validated mental health screening tools,<sup>140</sup> and the need for training on how to effectively use available tools to identify child and adolescent mental health problems.<sup>141</sup> In many communities, primary care physicians are concerned about their own lack of knowledge of available mental health resources for patients with identified problems,<sup>142</sup> shortages of competent and qualified mental health providers to whom they can refer children for follow-up evaluations and services when needs are identified, and long waiting periods for children to see mental health providers.<sup>143</sup> Physicians have expressed both discomfort and a lack of confidence in providing children mental health screening in primary care visits,<sup>144</sup> and particular concerns about a lack of privacy during adolescent visits,<sup>145</sup> which can be critical to discerning mental health needs.

Moreover, many Medicaid-eligible families lack awareness about EPSDT, the screening requirements, and their rights under the law.<sup>146</sup> Logistical barriers such as lack of access to transportation and inconvenient physician office hours and locations<sup>147</sup> may keep some families from bringing their children in for Medicaid well-child visits. Cultural and family barriers can also play a role, where, for example, some parents do not think well-child visits to a primary doctor for regular screenings are necessary and instead visit their child's doctor only for acute care.<sup>148</sup>

More research is needed to understand the barriers experienced by both families and physicians that result in a system where comprehensive screening in well child checks, including mental health screening, is likely not the norm, despite

139. TEENSCREEN, *supra* 135, at 9.

140. Savageau et al., *supra* note 137, at 265.

141. *Id.* at 265; Horwitz et al., *supra* note 137, at e212 tbl.3 (finding that 65% of physicians agreed that lack of training in treatment of children's mental health was a barrier to care and 47.1% agreed that lack of training in identifying children's mental health problems was a barrier to care); Defendants' 8/29/06 Remedial Plan Proposal at 4, 6, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199); TEENSCREEN, *supra* note 135, at 8.

142. Klein et al., *supra* note 138, at 163.

143. Horwitz et al., *supra* note 137, at e212 tbl.3 (finding that 61% of physicians surveyed agreed that lack of competent or qualified mental health providers to which they could refer children/adolescents was a barrier to care); Savageau et al., *supra* note 137, at 265; TEENSCREEN, *supra* note 135.

144. Chung et al., *supra* note 138, at 506 (describing challenges with providers' perceptions of the importance of screening and the perceived inability to provide the necessary services); Klein et al., *supra* note 138, at 163; Margolis & Meisels, *supra* note 138 (emphasizing lack of confidence in the effectiveness of procedures used in Medicaid EPSDT well child checks to actually identify health problems); Savageau et al., *supra* note 137, at 265.

145. Chung et al., *supra* note 138, at 505.

146. Defendants' 8/29/06 Remedial Plan Proposal at 3, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199), at 3 (last visited Jan. 31, 2017); Margolis & Meisels, *supra* note 138, at 427.

147. OEI-5-08-00520, *supra* note 131, at 18; Margolis & Meisels, *supra* note 138, at 427.

148. OEI-5-08-00520, *supra* note 131, at 18.

Medicaid EPSDT's statutory requirement.

### III. MULTI-LEVEL RESPONSES BY PHYSICIANS AND ATTORNEYS TO IMPROVE IDENTIFICATION AND EARLY INTERVENTION OF CHILDHOOD TRAUMA AND MENTAL HEALTH NEEDS: LESSONS FROM THE MEDICAL-LEGAL PARTNERSHIP MOVEMENT

Less than twenty percent of a person's health status is actually driven by their clinical care.<sup>149</sup> In fact, over fifty percent is attributable to social determinants of health,<sup>150</sup> non-biological factors related to where people work, learn, live, eat, and play. For example, poverty, education, lack of access to employment, housing conditions, and exposure to family and community violence have a strong influence on a person's health and mortality.<sup>151</sup> These issues can manifest as unmet legal needs, which can be addressed through legal assistance by an attorney. A Legal Services Corporation study of nine states found that low-income individuals experienced on average 2-3 legal issues in the prior year.<sup>152</sup> With multiple legal challenging faced by people living in poverty, "the addition of lawyers to the medical team can promote health and address barriers to effective health care. These non-medical needs have legal solutions that, if addressed, can diminish health disparities."<sup>153</sup> For example, lawyers can advocate for improved housing conditions, safety protections for victims of domestic violence, public benefits that can help put food on the table, educational or employment accommodations for people with disabilities, or access to necessary treatment and evaluations guaranteed by Medicaid law. Through advocacy around these types of civil legal needs, MLPs integrate attorneys onto the healthcare team as an effective strategy for addressing social determinants of health.<sup>154</sup>

Health and legal professionals serving people living in poverty are increasingly collaborating through the growing medical-legal partnership movement. In 2015, MLPs provided legal assistance to more than 75,000 patients

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149. *Our Approach*, COUNTY HEALTH RANKINGS & ROADMAPS, <http://www.countyhealthrankings.org/our-approach> [<https://perma.cc/38QA-ASQS>] (summarizing research on relative contribution to health and health outcomes).

150. *Id.*

151. Edward Paul et al., *Medical-Legal Partnerships: Addressing Competency Needs Through Lawyers*, 1 J. GRADUATE MED. EDUC. 304, 304 (2009); *Using Health Center Needs Assessments to Understand and Meet Patients' Health-Harming Civil Legal Needs*, NAT'L CENTER MED.-LEGAL PARTNERSHIP (2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/07/Needs-Assessment-MLP-Fact-Sheet-FINAL.pdf> [<https://perma.cc/B2BA-BD33>]; COUNTY HEALTH RANKINGS, *supra* note 149.

152. *Documenting the Justice Gap in America*, LEGAL SERVS. CORP. 11 (2007), <http://www.lsc.gov/sites/default/files/LSC/images/justicegap.pdf> [<https://perma.cc/6FEY-LMJJ>].

153. Ellen Cohen et al., *Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities*, 25 J. GEN. INTERNAL MED. 136, 136 (2010).

154. Tobin Tyler, *supra* note 14, at 234.

to resolve issues that were impeding their health<sup>155</sup> and there are now 155 hospitals and 139 health centers across the nation with attorney partners.<sup>156</sup> These collaborations can provide a platform for early and preventive identification through “an integrated approach to health and legal services that facilitates critical, efficient, shared problem solving among health and legal teams who care for patients with complex health and legal needs.”<sup>157</sup> They also provide a platform for change among health and legal institutions, which can benefit from a more holistic, inter-disciplinary approach to all individuals, and to marginalized and vulnerable children and families in particular. Medical-legal partnerships employ a multi-level response to the complex needs of patients living in poverty that can similarly be deployed to ensure that the mental health needs of children who have suffered trauma are identified and addressed early. This multi-level response has three core components, which build upon each other to present a paradigm for individual, systems, and population level change: (1) collaborative advocacy to improve patient health, (2) transformation of health and legal institutions, and (3) policy change.<sup>158</sup>

*A. Collaborative Advocacy to Improve Patient Health: Identifying and Serving Children and Families with Mental Health Needs*

“Because the explicit integration of social and health care services is central to their mission and vision, health centers serve as an excellent entry point to civil legal aid services for low-income populations . . . . Many of these patients have “health- harming civil legal needs,” meaning that at least some of the social, financial, environmental or other problems in their lives have a deleterious impact on their health and are in fact amenable to civil legal solutions. Indeed, one study estimated that between 50 and 85 percent of health center users experience such unmet health-harming civil legal needs.”<sup>159</sup>

Through medical-legal partnerships, physicians have come to realize that healthcare delivery often necessitates legal care if disadvantaged patients are to

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155. The MLP Response, *supra* note 14.

156. *Partnerships Across the U.S.*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/partnerships> [<https://perma.cc/GJ4L-R6HL>].

157. Ellen Lawton et al., *Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations*, in

POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL-LEGAL PARTNERSHIP 71, 72 (Elizabeth Tobin Tyler et al. eds., 2011).

158. Tobin Tyler, *supra* note 14, at 234–238 (describing the 3 core components of the MLP response).

159. Marsha Regenstien et al., *Medical-Legal Partnership and Health Centers: Addressing Patients’ Health-Harming Civil Legal Needs as Part of Primary Care*, NAT’L CTR. MED.-LEGAL PARTNERSHIP, at 1 (Feb. 2015), <http://medical-legalpartnership.org/wp-content/uploads/2015/08/Medical-Legal-Partnership-and-Health-Centers.pdf> [<https://perma.cc/2D6L-KUYJ>].

avoid health crises, as well as legal crises.<sup>160</sup> For example, in 1996, out of concerns regarding the legal barriers facing some of the most vulnerable patients of University of New Mexico (UNM) community-based health clinics in Albuquerque, Dr. Andrew Hsi, MD, MPH, of the UNM School of Medicine and Professor Michael Norwood of the UNM School of Law founded the UNM Medical Legal Alliance (MLA).<sup>161</sup> Seeking to reach children and families with intensive health and legal needs, the MLA integrated law students taking part in the law school's Community Lawyering Clinic into neighborhood pediatric and family medicine clinics in low-income communities.<sup>162</sup> When those patients come to see the doctor, they can also see a law student to pursue legal assistance.<sup>163</sup>

### 1. Individual Patient Advocacy

The "medical-legal partnership" model of advocacy involves a "train and treat" approach.<sup>164</sup> Attorneys train healthcare professionals to identify potential legal issues among their patients and refer them to lawyers, just as they would make referrals to other specialists to expand the treatment team. Then those lawyers, integrated into the healthcare setting, "treat" the patients through legal advocacy.<sup>165</sup> Under the MLA at UNM, law students and faculty train healthcare providers to identify and refer patients to the UNM Community Lawyering law clinic for free legal assistance.<sup>166</sup> Each semester, approximately sixteen Community Lawyering Clinic law students represent patients under faculty supervision in a broad range of legal areas such as family law, domestic violence, kinship guardianships, immigration, property disputes, disability law, and education.<sup>167</sup> By bringing health and legal professionals together to identify legal issues in a health clinic setting, the model often allows these providers to identify patients in need of assistance before crisis situations arise and the effects on health

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160. See generally Lisa Pilnik, *Practicing Preventive Law: A Day in the Life of a Medical-Legal Partnership Attorney*, 27 CHILD L. PRAC. 14 (2008), <http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/mlp.authcheckdam.pdf> [https://perma.cc/4SUC-JJJP].

161. Cannon & Hsi, *supra* note 42, at 48; see also *UNM Medical-Legal Alliance: 2013 Snapshot*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/wp-content/uploads/2014/02/UNM-Medical-Legal-Alliance-2013-Albuquerque-NM.pdf> [https://perma.cc/4ZYX-EYC7]. Although the collaboration began informally in 1996, the MLAC was formally established in January 2007. *Medical-Legal Alliance for Children*, UNM LAW, Spring 2007, at 8. The MLAC is also known in shorthand as the UNM Medical Legal Alliance (MLA), which is how this Article refers to the partnership.

162. *Id.*

163. Cannon & Hsi, *supra* note 42, at 519.

164. Lawton et al., *supra* note 157, at 75.

165. *The MLP Response*, *supra* note 14.

166. April Land, "Lawyering Beyond" Without Leaving Individual Clients Behind, 18 CLINICAL L. REV. 47, 53 (2011).

167. *Id.*; Cannon & Hsi, *supra* note 42, at 64.



are worsened.<sup>168</sup>

Many families like Selena's are patients of one of the MLA's core healthcare partners, the FOCUS clinic. FOCUS treats children born with positive drug toxicologies. Because those children have a parent who is a substance abuser, a form of trauma that is one of the ACE categories, those babies come into this world with an ACE.<sup>169</sup> The team screens each baby for other forms of childhood trauma, and for health and mental health needs. The team also screens the entire family for health and mental health needs, as well as legal needs. This type of comprehensive screening not only encompasses the core components of a Medicaid EPSDT well child check, but looks even more broadly at legal issues implicating the health and well-being of families who have suffered trauma. Once needs are identified, the MLA wraps health, developmental, mental health, and legal services around the child and family in the health clinic and the home, and refers the child for any additional needed services.<sup>170</sup>

Similarly reflecting the inter-disciplinary medical-legal partnership model, the new Georgetown University Health Justice Alliance teams law students, fellows, and faculty with a health and behavioral health community pediatrics team to bring together diverse legal, mental health, and medical services to support families. The Alliance brings its holistic services directly to children who are a high risk of trauma, by locating health clinics and legal services directly where those families live and learn, in Washington, D.C.'s large emergency homeless shelter for children and families, within high schools in highly underserved neighborhoods, and through a mobile health clinic van that parks directly in communities where poverty and neighborhood are high.<sup>171</sup>

For Selena and her family, the medical-legal partnership model would have provided a very different experience at the doctor's office, one in which her well-child checks provided a gateway towards comprehensive screening of her holistic needs and connections to needed services early in life. At the UNM Medical Legal Alliance's FOCUS health clinic, for example, her healthcare team would have taken advantage of frequent Medicaid EPSDT well child checks to screen her comprehensively, including for mental health and developmental needs, using evidence-based screening tools as well as discussions with the family that reflect the healthcare team's training around issues of trauma, toxic stress, and their implications. Through these checks, the team would have identified the various forms of trauma that she experienced, such as the parental substance abuse in her

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168. See Sandel et al., *supra* note 13, at 1698; Ellen M. Lawton & Megan Sandel, *Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEGAL MED. 29, 38 (2010).

169. Cannon & Hsi, *supra* note 42, at 512–13.

170. *Id.* at 513–14.

171. Kat Zambon, *Doctors and Lawyers Speak Out for Health Justice Alliance*, GEO. U. MED. CTR. (Sept. 22, 2017), <https://gumc.georgetown.edu/news/Doctors-and-Lawyers-Speak-Out-for-Health-Justice-Alliance> [<https://perma.cc/SF86-Z5FL>].

household and the absence of her father due to incarceration. The team would have also identified developmental and mental health needs, such as any attachment challenges with which Selena is struggling as a result of being passed among family members frequently, which may necessitate mental health treatment. Her healthcare providers would have referred Selena for any more in-depth evaluations she may have required, such a comprehensive mental health evaluation by a psychologist.

Because FOCUS uses an inter-generational approach to care of these high-needs children, the healthcare team would have also assessed the needs of Joann and Amelia, and developed a holistic, multi-disciplinary plan for the family's care.<sup>172</sup> If Amelia was still involved in Selena's life at the time, the team would have provided her with needed care, such as medication-assisted substance abuse treatment and referrals to counseling services to support her recovery from drug addiction. The team would have provided Joann and Amelia with support in parenting skills and home-based early intervention services to address any developmental delays experienced by Selena.<sup>173</sup>

The healthcare team would also have referred the family to the Community Lawyering Clinic for legal services. Law students and faculty have trained the MLA's FOCUS team to identify potential legal issues that may arise for their patients, such as legal needs related to child custody, special education, and Medicaid appeals. When the FOCUS healthcare team spots a potential legal issue, they make a referral to the law clinic, and a law student, sometimes in partnership with a medical student, conducts a legal intake to assess the family's legal needs. If a need is identified, the law student might provide the family with legal advice, refer them to a legal services organization, or directly provide the family with legal representation.

For Selena's family, the legal services of the MLA may have been deployed in a number of ways to address their legal needs. For example, if the family experienced barriers like transportation that kept them from bringing Selena to the doctor for well-child checks or other appointments, the MLA could have advocated to ensure that transportation was provided for the family through Medicaid. If Amelia was unavailable to care for Selena, MLA law clinic students could have advocated for Joann to become Selena's legal guardian in order to achieve family stability and ensure that Joann could make educational and medical decisions on Selena's behalf during Amelia's absence.<sup>174</sup> The MLA could have advocated for appropriate special education services to address Selena's social-emotional needs and any other developmental needs that might necessitate special education programming as Selena entered school.<sup>175</sup> And as the healthcare team

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172. *Id.*

173. *Id.* at 514.

174. See Kinship Guardianship Act, N.M. STAT. ANN. § 40-10B-1 *et seq.* (2016).

175. See Yael Cannon et al., *A Solution Hiding in Plain Sight: Special Education and Better*

recommended any medically necessary health or mental health services, law students could have advocated to ensure that those services were timely provided or appealed any denials of recommended services through an administrative hearing pursuant to Medicaid EPSDT law.<sup>176</sup> These forms of legal advocacy would have helped to provide stability and access to necessary services for Selena that could have set her on a better path towards improved physical health, mental health, educational, and family outcomes.

The different experience Selena would have had as a medical-legal partnership patient exemplifies the promise that collaborative patient advocacy can have to identify and address the complex needs of children who have suffered trauma. All children living in poverty should have access to attorney-physician teams. Attorneys should train healthcare providers on the Medicaid EPSDT rights of their patients and think collaboratively with healthcare teams about how to ensure that pediatric patients are screened comprehensively and connected to medically necessary treatment, including mental health treatment. Medical-legal partnerships provide a holistic, preventive framework that embraces early identification and intervention as problem-solving approaches for people living in poverty.<sup>177</sup> Consequently, health clinics that have adopted the MLP approach can provide leadership and best practices models for comprehensive screening for Medicaid-eligible children not only for health and mental health needs, as required by Medicaid EPSDT, but also for legal needs, which are often closely connected for children who have suffered trauma, like Selena.

Moreover, physicians discouraged from mental health screening of children by waitlists and scarcities of the mental health services they would ultimately recommend may feel more confident conducting the necessary screening for mental health services if they have access to attorneys who could help patients pursue any further evaluations or medically necessary services the physicians recommend. For example, the Medicaid EPSDT appeals process provides a concrete structure for this type of legal advocacy through a fair hearing.<sup>178</sup> Indeed, “[d]octors, who are in an ideal position to ask about systemic problems that affect the health of their patients are more likely to do so ‘if they have the support and expertise of a lawyer who can offer solutions or training in available remedies.’”<sup>179</sup>

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*Outcomes for Students with Social, Emotional, and Behavioral Challenges*, 41 *FORDHAM URB. L.J.* 403 (2015).

176. See 42 U.S.C. §1396a(a)(3) (2012) (requiring that Medicaid state plans “provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness”).

177. Sandel et al., *supra* note 13, at 1699 (“The first core component is providing legal advice and assistance to patients, with a focus on the early detection of legal problems and the prevention of legal crises and health consequences.”).

178. 42 U.S.C. §1396a(a)(3) (2012).

179. Monica Carmean, Note, *Medical-Legal Partnerships: Unmet Potential for Legislative Advocacy*, 19 *GEO. J. ON POVERTY L. & POL’Y* 499, 505 (2012)

When lawyers learn of these problems, they can advocate for the timely provision of required evaluations and services for individual patients. Those interventions by lawyers in individual cases can also help to ensure accountability for children's mental health systems and spur improvements as a result where state Medicaid systems and managed care organizations adopt improved practices in order to avoid further appeals.

## 2. Impact Litigation

When Medicaid EPSDT systems are broken, attorneys and physicians can take action not only through individual patient advocacy, but through broader impact litigation as well. Lawsuits to enforce Medicaid EPSDT in both the District of Columbia<sup>180</sup> and Massachusetts<sup>181</sup> revealed a failure to provide eligible children with comprehensive screens. Citing the number of children not receiving screening services as evidence of noncompliance, the court in each case ordered the development of expansive monitoring systems to ensure that every child receives the screening services and follow-up care required. Focusing on the defendants' lack of "procedures to determine whether children receive the full battery of EPSDT screening services," the judge in D.C. ordered the city to "design and employ policies and methods to assure that children receive rescreening and treatment when due."<sup>182</sup> Similarly, the court in Massachusetts focused on the need to monitor and assure that children with serious emotional disturbance "will necessarily receive these pediatric assessments at any particular time or in any consistent form."<sup>183</sup> Both courts also sought to ensure that providers had the necessary training to implement the required screens.<sup>184</sup>

In Massachusetts, the attorneys who advocated on behalf of the aggrieved families partnered with physician experts to ensure that the court understood the unmet needs for mental health screening and medically necessary community-based mental health treatment for Medicaid-eligible children.<sup>185</sup> As a result of

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180. *Salazar v. D.C.*, 954 F. Supp. 278, 304 (D.D.C. 1996), *amending* 938 F. Supp. 926 (D.D.C. 1996). For subsequent case history, see *Salazar v. D.C.*, No. CA-93-452(GK), 1997 WL 306876 (D.D.C. Jan. 17, 1997) (issuing remedial plan to ensure state compliance with EPSDT screening and informing requirements); *Salazar v. D.C.*, No. CA-93-452(GK) (D.D.C. Sept. 17, 2001) (ordering compliance with screening, adolescent targeting, provider outreach, and tracking requirements of settlement agreement); *Salazar v. D.C.*, 729 F. Supp. 2d 257 (D.D.C. 2010) (finding § 1396a(a)(43) enforceable under § 1983 and refusing to vacate consent decree).

181. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52 (D. Mass. 2006) ("For the majority of SED children in the Commonwealth, assessments take place in name, or not at all.")

182. *Salazar*, 954 F. Supp. at 307 (quoting CMS MEDICAID MANUAL, *supra* note 115, at §5310(A)).

183. *Rosie D.*, 410 F. Supp. 2d at 34.

184. *Id.* at 35; *Salazar*, 954 F. Supp. at 313, 328.

185. See Plaintiffs' Proposed Findings of Fact and Conclusions of Law, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (citing the testimony of healthcare providers in support of the proposed factual findings); Plaintiffs' Revised Witness List, *Rosie D. v.*

policy changes stemming from the Massachusetts litigation,<sup>186</sup> the state promulgated new EPSDT regulations to require providers to use one of a number of evidence-based behavioral health screening tools as part of a well child check.<sup>187</sup> Data suggests that this approach has increased both the rates at which Massachusetts Medicaid-eligible children receive behavioral health screenings<sup>188</sup> and behavioral health related outpatient services.<sup>189</sup>

Medical-legal partnerships—when they have the resources and expertise and are not restricted by their funding sources<sup>190</sup>—are well-poised to bring to light endemic issues in Medicaid EPSDT systems and improve children’s health and mental health systems through impact litigation cases like those brought in Massachusetts and D.C. As “[h]ealthcare providers are armed with clinical stories and medical evidence” that can support legal deficiencies in Medicaid EPSDT systems, such as inadequate screening and treatment programs, insufficient reimbursement rates for well-child checks, failures by state Medicaid agencies to ensure that physicians receive the necessary training and tools to conduct mental health screening, medical-legal partnerships can turn patterns identified in the examination room into systemic change. Physicians bring expertise, information, and credibility as witnesses when they collaborate with lawyers in litigation. In

Romney, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (listing many healthcare providers).

186. *Rosie D.*, 410 F. Supp. 2d at 22. Plaintiffs also charged defendants with violation of the “reasonable promptness” provision, the “equal access” provision, and “managed care provision” of the Medicaid Act. *Id.*

187. Defendants’ 8/29/06 Remedial Plan Proposal at 3, *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (2007) (No. 01-30199).

188. Mass. Screening Reports, *supra* note 130 (showing the percent of physician visits that included behavioral screenings increased from 14.22% in early 2008 to 68.01% in mid 2016); Karen Kuhlthau et al., *Increases in Behavioral Health Screening in Pediatric Care for Massachusetts Medicaid Patients*, 165 ARCHIVES PEDIATRICS & ADOLESCENT MED. 660, 662 (2011).

189. Karen Hacker et al., *The Impact of the Massachusetts Behavioral Health Child Screening Policy on Service Utilization*, 68 PSYCHIATRIC SERVS. 25, 29 (2017) (finding that the adjusted rate of behavioral health-related outpatient service utilization rose from approximately 35 per 1,000 youths per month to approximately 50 per 1,000 youth per month following implementation of the screening mandate); Sharon Rignwalt, *Developmental Screening and Assessment Instruments with an Emphasis on Social and Emotional Development for Young Children Ages Birth Through Five*, NAT’L EARLY CHILDHOOD TECHNICAL ASSISTANCE CTR. 5 (2008), <http://www.nectac.org/~pdfs/pubs/screening.pdf> [<https://perma.cc/R6FH-CMFR>] (finding increased formal screening rates were associated with a 10.1 percent increase in the number of children receiving behavioral health services within 6 months of a well-child visit).

190. “Because of Legal Services Corporation (‘LSC’) funding restrictions on certain activities that focus on systemic change (including prohibitions against class action lawsuits and legislative lobbying), some programs that accept LSC funding may not engage in social change advocacy at all.” Tobin Tyler, *supra* note 14, at 240 (discussing the challenges facing legal services programs in engaging in social change advocacy to address social determinants of health). In New Mexico, attorneys from some legal advocacy organizations have expressed concerns about the need for Medicaid EPSDT systems change to ensure mental health screenings and treatment are provided as required by law and have been trying to work collaboratively with state agencies to improve the system without yet resorting to impact litigation as a strategy.

individual patient cases and larger impact cases alike, MLPs “bring a uniquely powerful clinical voice to the advocacy process”<sup>191</sup> to ensure that Medicaid-eligible children receive the mental health screenings and treatment to which they are entitled.

*B. Transforming Healthcare and Legal Institutions by Training the Next Generation of Leaders in Law and Medicine in Early Identification of Children’s Mental Health Needs*

“Concerns that traditional legal and medical education have emphasized technical skill and practice management over problem-solving and the professional relationship have led to calls for major reforms in the way we educate doctors and lawyers . . . medical-legal partnership in the academy can offer a rich opportunity to bring future doctors and lawyers together to explore issues of social justice and professional ethics, as well as to practice interdisciplinary collaboration and problem-solving.”<sup>192</sup>

MLPs transform health care practice by training providers to both understand and identify social determinants of health and to play an active role in addressing unmet legal needs.<sup>193</sup> Physicians feel empowered to ask questions about social determinants of health because they finally have a solution to the problems they uncover in the form of integrated legal care. Legal institutions are also transformed because the model allows for early detection of legal barriers in the examination room, when they may still be burgeoning, rather than in the courthouse, for example, when crises have typically escalated. In this way, the MLP model reflects the early identification ethos of Medicaid EPSDT and indeed of primary care as a whole.<sup>194</sup>

The adoption of this approach not only allows attorneys to be more preventive, but presents a unique access to justice model, where “legal services are delivered to vulnerable populations by identifying legal needs within a trusted health care setting, rather than waiting for potential clients to seek out assistance at a local legal aid office.”<sup>195</sup> The same way that many health clinics have become part of the fabric of communities in order to create improved access to healthcare, by

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191. Sandel et al., *supra* note 13, at 1699.

192. Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL’Y 249, 276 (2008).

193. Tobin Tyler, *supra* note 14, at 235.

194. Ellen Lawton et al., *supra* note 157, at 72 (“A patient might not have enough food, which is frequently seen as a ‘social’ need. But when that patient is wrongly denied Supplemental Nutrition Assistance (SNAP) benefits- formerly known as food stamps- what was a social need becomes a legal need because access to the benefit is prescribed by law . . . . With a focus on early detection of legal problems and prevention of legal and health crises, MLP legal practice is frequently understood as analogous to primary care.”)

195. *Id.* at 236.

embedding in community-based health clinic settings, legal aid offices are creating even greater access to justice by taking legal services to clients in clinics where they already go to seek out healthcare.

MLPs also provide a broader paradigm shift for health and legal institutions in the way that they approach the people they serve; rather than operating in silos, lawyers and doctors serving people living in poverty can come together to holistically identify patient/client needs and develop collaborative solutions. Services that were fragmented become coordinated, and the patient/client now has a team in their corner. And patient and client care takes on new meaning when both health and justice implications are considered with individuals and families as they make critical decisions and seek out supports from both legal and health institutions.

Academic medical-legal partnerships present great promise for health and legal institution transformation by influencing and changing the way providers in both realms are trained from the beginning, before they even take on their first patient or client. In university-based MLPs, law students come together with students of health disciplines such as medicine, nursing, public health, and social work to learn collaboratively about social determinants of health and the potential for collaboration to address those barriers.<sup>196</sup> Through the UNM MLA, law and medical school faculty train their students and medical residents—future leaders in law and medicine, many of whom will shape policy in their careers—to understand the ACEs research, including the prevalence of childhood trauma and the poor health and legal outcomes that the data indicates are likely. Law students engage in an exercise called “ACEs in Your Cases,” in which law and medical school faculty guide them through screening individuals in their cases for trauma histories, considering the health and justice implications, and developing plans for advocacy on behalf of their clients that are informed by an understanding of trauma and mental health needs. Students and residents also learn about Medicaid EPSDT and the platform it provides for screening for mental health needs and access to medically necessary treatment.<sup>197</sup>

At Georgetown University’s Health Justice Alliance, medical students and

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196. Elizabeth Tobin Tyler et al., *Medical-Legal Partnership in Medical Education: Pathways and Opportunities*, 35 J. LEGAL MED. 149, 164 (2014). Note that while some academic MLPs like those at Georgetown University and University of New Mexico bring law and medical students together, some academic MLPs engage law students with healthcare providers at community health centers or hospitals, but not medical students, such as where a university has a law school but no medical school with which to partner. Other MLPs engage medical students and residents with attorneys at legal services organizations, but do not engage law students through a law school course.

197. The Toledo Medical-Legal Partnership for Children has also created a PowerPoint to train healthcare providers on EPSDT, including how they can identify when a patient has a legal need for services as a result of, for instance, a lack of necessary prior authorization. See David Koeninger et al., *Current State of Health Coverage for Kids: What You Should Know About the ACA, EPSDT, and How to Get Pediatric Patients the Care They Need*, TOLEDO MED.-LEGAL PARTNERSHIP CHILD (on file with author).

law students participate in a joint seminar to learn about the long-lasting effects of childhood trauma on health and justice outcomes, and consider how physicians and attorneys can collaborate to disrupt that path.<sup>198</sup> They also learn about childhood trauma and the structure of Medicaid EPSDT law. At a free clinic located in a family homeless shelter, medical students provide patients with a legal check-up as part of their health visit. When legal issues are identified, law and medical students address those legal barriers to health for the highly traumatized population at the shelter, and work to ensure that holistic health and legal needs are identified and timely addressed to prevent further crises in the lives of these parents and children.<sup>199</sup>

The UNM MLA also immerses medical and law students intensively in the classroom and the field advocating on behalf of traumatized families. Fourth year medical students participate in community ambulatory clinical rotations in the law school's Community Lawyering Clinic. The medical students join classroom discussions on advocacy skills, ethics, and social justice values. They participate in legal intakes, transforming the legal interview into a collaborative, holistic problem-identification and problem-solving session by a medical student/law student team. Medical students come to court and participate in and observe other case events. And law and medical students come together for a type of troubleshooting and problem-solving critical to both law and medical education—case rounds.<sup>200</sup> In case rounds in the Community Lawyering Clinic, law and medical students discuss the challenges facing traumatized children and families in their cases, work through various dimensions of the problem, develop possible solutions, and begin to make a plan for next steps.<sup>201</sup> Students from the law and medical schools work to improve the lives of traumatized children and their families by advocating to remove legal barriers to health, ensuring family stability and access to necessary health, disability, and educational services.

In addition to furthering patient wellbeing, academic MLPs provide these unique benefits to the students and ultimately to the communities they will serve. By learning to understand the connection between patients' health problems and social determinants, future physicians learn how to show socioeconomic and

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198. See *Georgetown University Health Justice Alliance*, GEO. U. L., <https://www.law.georgetown.edu/academics/centers-institutes/health-justice-alliance> [<https://perma.cc/PDN4-2BW2>].

199. See *HOYA Clinic*, GEO. U. MED. CTR., <https://hoyaclinic.som.georgetown.edu> [<https://perma.cc/UUA9-TES3>].

200. Muhammad Ali Abdool & Don Bradley, *Twelve Tips to Improve Medical Teaching Rounds*, 35 MED. TCHR. 895, 895 (2013) (noting that bedside rounds, senior clinician-guided reviews and presentation of patients' notes, signs and symptoms, teach students the clinical and communication skills necessary to be a doctor); Elliot S. Milstein, *Clinical Legal Education in the United States: In-House Clinics, Externships, and Simulations*, 51 J. LEGAL EDUC. 375, 377 (2001) (describing case rounds as student presentations of cases either in preparation for group decision-making or as updates on the status of active cases).

201. Milstein, *supra* note 200, at 377.



cultural sensitivity, communicate effectively to a diverse patient population, become patient advocates, and work as members of an inter-professional team – all skills that could benefit Selena and other traumatized children and their families in the examination room and on a policy level.<sup>202</sup> By connecting theory and practice through direct client interaction, law students gain experience in translating medical and technical information into legal standards<sup>203</sup> and learn the importance of social justice values, cross-cultural competence, and effective communication.<sup>204</sup> As a result, they can better advocate on behalf of families like Selena’s through individual representation and inter-professional collaboration to develop policy solutions that disrupt the trajectory from trauma to poor health.<sup>205</sup>

Through training the next generation of leaders in law and medicine to understand childhood trauma and its implications and the promise of Medicaid EPSDT to address these issues preventively, we can begin to transform policies and systems. Many law and medical students will go on to become key policy and decision-makers in their roles leading government agencies, serving as judges and legislators, and running healthcare systems and hospitals, for example. Both medical and legal education are often heavily focused on developing technical skills. Academics collaborations such as the MLA challenge students to consider health and justice problems in their social contexts and broaden their concepts of professional roles and limits.<sup>206</sup>

When these medical and law students graduate and move into their respective professions, medical and legal institutions will be transformed by their more holistic approaches to complex patient problems. Learning about the effect of childhood trauma and lifelong outcomes can prompt a nurse, a physician, an attorney, or a judge to ask not “what’s wrong with this person?” but instead “what happened to this person?”<sup>207</sup> This change in perspective that should be cultivated in law and medical education represents a critical shift in the way that hospitals and courts may think about some of the most complex people who come through their doors. Perpetrators of crime and super-utilizers of medicine may in fact have been traumatized children whose trajectory could have been improved by earlier identification and intervention around mental health needs. Medical students will think about trauma and mental health in the patient room, and may feel more empowered to embrace the holistic vision of Medicaid EPSDT or to voice the barrier they face in its implementation. Lawyers will become more trauma-

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202. Paul et al., *supra* note 151, at 206 tbl.1.

203. Wettach, *supra* note 10, at 311.

204. Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education*, 35 J. LEGAL MED. 113, 138 (2014).

205. Tobin Tyler et al., *supra* note 196, at 161.

206. Tobin Tyler, *supra* note 192, at 271.

207. See Nadine Burke Harris, *How Childhood Trauma Affects Health Across a Lifetime*, TED: IDEAS WORTH SPREADING, [https://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime) [https://perma.cc/Q62A-J3WD].

informed and push government systems like Medicaid and school districts in the direction of early identification and intervention. Engaging with these complex issues in the classroom and advocating on behalf of families in the field allows for students to bring health and justice perspectives to policy gaps and begin their careers with an eye towards collaborative and holistic problem-solving at the individual and population levels.

### *C. Mobilizing Towards Policy Change*

“Individual cases develop a practitioner’s sense of broader concerns or trends in a community. It is often a recurrent problem seen as a pattern across many patients that triggers the need for policy action rather than individual attention. MLP develops both perspective and relationships that can facilitate the steps to influence policy.”<sup>208</sup>

In addition to the direct legal care provided to patients, medical-legal partnerships are well-situated to advocate more systemically for changes to policies that result in injustice and poor health for underserved patients.<sup>209</sup> MLPs are uniquely positioned to effectuate policy change because they combine the understanding on the part of medical professionals of the adverse health implications of specific conditions and policies with the capacity of lawyers to navigate decision-making systems and develop and advocate for proposed policy changes.<sup>210</sup> For example, attorneys and physicians in Boston saw many patients after with critical health issues, who were dependent on electricity for oxygen tanks and insulin refrigeration, suffering from utilities shut-offs in their homes. They worked together to successfully reform public benefit and utility regulations to protect patients from these harmful utility shut-offs.<sup>211</sup> By collaborating with attorneys, medical providers can gain insight into the laws and policies that affect patient health and develop legal and policy remedies. Similarly, by partnering with health professionals, lawyers learn to reframe their advocacy in terms of health and

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208. Manel Kappagoda et al., *Public Health Crisis: Medical-Legal Partnership Approaches to Obesity Prevention*, in *POVERTY, HEALTH, AND LAW* 601, 636 (Elizabeth Tobin Tyler et al. ed., 2011).

209. See, e.g., Daniel Atkins et al., *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEGAL MED. 195 (2014); Barry Zuckerman et al., *From Principles to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCHIVES DISEASE CHILDHOOD 100 (2007).

210. See Zuckerman et al., *supra* note 209, at 101. Despite the growing body of literature discussing the impact of MLPs through the individual legal representation of patients provided by attorneys in healthcare settings, there has been relatively little written about the impact of MLPs on policy change. There is a need for more scholarship exploring the role of MLPs in systemic advocacy towards policy change. Tishra Beeson et al., *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, NAT’L CTR. MED.-LEGAL PARTNERSHIP 8 (Feb. 2013), <http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf> [<https://perma.cc/D8CZ-VN7U>].

211. Beeson et al., *supra* note 210, at 4; Zuckerman et al., *supra* note 12, at 226; Sandel et al., *supra* note 13, at 1701–02.

well-being and rely on the science-based perspectives—and credibility—of their medical partners to substantiate their arguments.<sup>212</sup>

### *1. Research and Data to Educate Policymakers*

While teaching and supervising law and medical students in advocacy on behalf of traumatized children and their families, MLA co-founder Dr. Hsi and I, along with other law and medical school faculty members, confronted repeatedly a challenge that we sought to better understand. Young children like Selena would come through our doors, and we would see before our eyes the pathway from childhood trauma to poor health, mental health, and justice outcomes. As they grew older, young children like Selena who had experienced trauma would get in trouble at school, and quickly get entangled in the school-to-prison pipeline,<sup>213</sup> facing punishment at school and in the juvenile justice system. Many of their older siblings were involved in the delinquency and criminal justice systems as well. And the inter-generational nature of these cycles was striking; many of their parents had experienced trauma in childhood and now were struggling with addiction, mental health needs, and involvement with various legal systems. The Community Lawyering Clinic law students also represent youth in delinquency matters in the county's Children's Court<sup>214</sup> through a partnership with the public defender office's juvenile division. In that work, my students, my colleagues, and I also got a glimpse into the trauma histories of many of these teenagers, who were now in court facing charges in the delinquency system. We witnessed firsthand the pathway from early childhood trauma to poor health and delinquency outcomes.<sup>215</sup>

Along with our medical school colleagues, we hoped that New Mexico, a state consistently ranked at the bottom of the nation in childhood well-being,<sup>216</sup> could prioritize the issue of childhood trauma and develop policies to disrupt the trauma-to-juvenile and criminal justice pipeline through more preventive and early intervention approaches. Dr. Hsi and I resolved to find a way to educate policymakers in New Mexico about these critical unmet needs and unmask the dimensions of these problems in our state. We collaborated with Dr. George Davis,

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212. Megan Sandel et al., *Medical-Legal Partnership: Strategies for Policy Change, in Poverty, Health and Law*, in *POVERTY, HEALTH, AND LAW: READINGS & CASES FOR MEDICAL-LEGAL PARTNERSHIP* 581, 594 (Elizabeth Tobin Tyler et al. eds., 2011).

213. The phrase "school-to-prison pipeline" refers to the increasingly punitive school systems that push minority students out of school and the parallel shift in juvenile justice that make it easier to try juveniles as adults, strengthen sanctions, and reduce confidentiality provisions for juveniles. Johanna Wald & Daniel Losen, *Defining and Redirecting a School-to-Prison Pipeline*, 99 *NEW DIRECTIONS STUDENT LEADERSHIP* 9, 11 (2013).

214. N.M. STAT. ANN. §§ 32A-2-1 to -33 (West 2016).

215. See Cannon & Hsi, *supra* note 42.

216. *Kids Count Data Book: State Trends in Child Well-Being*, ANNIE E. CASEY FOUND. 19 (2016), <http://www.aecf.org/m/resourcedoc/aecf-the2016kidscountdatabook-2016.pdf> [<https://perma.cc/K5DN-CXLF>].

MD the director of psychiatry for the state's Children, Youth, and Families Department (CYFD), the executive branch agency charged with overseeing both the state's child protective services and juvenile justice systems, and with Alexandra Bochte, a recent Community Lawyering Clinic law student graduate, to examine the trauma histories of youth incarcerated in the state's juvenile justice facilities. We knew from our collective work that youth incarcerated in state juvenile justice facilities in New Mexico—those for whom community-based interventions had failed or were deemed insufficient for safety or other reasons<sup>217</sup>—were in fact some of the most traumatized youth in the state. Our individual cases, which were identified in the health setting, served “as diagnostic tools for failed policies.”<sup>218</sup> We resolved to study the problem to provide an evidence base to inform policy change. The unmet needs of our patients and clients informed our thinking about policy reform. Decision-makers in all three branches of government needed to know that without early identification and intervention, traumatized children were becoming incarcerated youth, at great cost to them, their families, and taxpayers.<sup>219</sup>

Dr. Davis' team had developed a process for providing psychosocial evaluations to every youth committed to the custody of the state's CYFD juvenile justice facilities during their intake at the state's Youth Development and Diagnostic Center. The evaluation involved independent intake interviews of the youth by psychological diagnosticians and information gathered from juvenile justice, medical, educational, and child protective services records, as well as from guardians and probation officers.<sup>220</sup> These evaluation reports provided great insight into the trauma histories of those who had been deemed the state's most serious juvenile offenders. Building on MLP principles, our collective law, pediatric, and psychiatric backgrounds brought a unique analysis to this problem of childhood trauma and its connected outcomes. Working together, our various perspectives could enrich the development of policy solutions, and we sought to employ a multi-disciplinary framework that draws on the medical-legal partnership approach to understanding health and justice inequities not only on the ground but at the policy level.<sup>221</sup> By partnering health care providers and lawyers in our study and analysis

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217. N.M. STAT. ANN. § 32A-2-19(B) (2016) (describing the court's authority under the New Mexico Children's Code to commit youth who have been adjudicated delinquent to a facility for their care and rehabilitation).

218. Lawton & Sandel, *supra* note 168, at 38.

219. In 2015, the cost of confinement per youth in a state juvenile facility was \$182,000. State of N.M. Legislative Fin. Comm., Report No. 16-06, Program Evaluation: Effectiveness of Juvenile Justice Facilities and Community-Based Services 21 (2016), <https://www.nmlegis.gov/handouts/ALFC%20082416%20Item%204%20Program%20Evaluation%20-%20%20Effectiveness%20of%20Juvenile%20Justice%20Facilities%20and%20Community-Based%20Services.pdf> [<https://perma.cc/3ZBC-N2FS>].

220. Cannon et al., *supra* note 28, at 4.

221. See Kappagoda, *supra* note 208, at 636 (describing how the origins of medical-legal partnerships “lie in providing individual patients and clients with integrated medical and legal care

of this problem, we hoped to shine a spotlight on policy failures that were otherwise going undetected.<sup>222</sup>

The New Mexico Sentencing Commission was a unique and important partner for the research and publication of the study. The Commission assists the executive, legislative, and judicial branches of state government, as well as concerned citizens, in the analysis and development of “criminal and juvenile justice policy.” The Commission is comprised of representatives from the executive and judicial branches of state government, “legislators’ appointees, law enforcement officials, criminal defense attorneys, and citizens.”<sup>223</sup> As a result, the Commission’s reports gain the attention of key stakeholders and decision-makers, and the entity is a critical player in criminal and juvenile justice policymaking in New Mexico. The Sentencing Commission brought another disciplinary perspective, with staff skilled in statistical analysis, as well as juvenile justice policy analysis. It also provided a platform for our research to go beyond an academic exercise to draw upon our unique inter-disciplinary analysis of these challenges and our patient/client stories from our medical-legal partnership work to inform policymakers across the three branches of government about the problems we had identified on the ground.

The resulting study, *Adverse Childhood Experiences in the New Mexico Juvenile Justice Population*, aimed to (1) define the relationship between early childhood trauma and juvenile delinquency, (2) evaluate ways in which the law and medicine can facilitate better health and delinquency outcomes for children with ACEs, and (3) compare the prevalence of ACEs in New Mexico’s juvenile justice population with national prevalence in similar populations.<sup>224</sup> We reviewed the psychosocial evaluations of all 220 youth aged thirteen to eighteen committed for incarceration in New Mexico in 2011,<sup>225</sup> and applied the ACEs framework described above in Part I, assessing those youth for prevalence of the following nine ACEs: emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, household substance abuse, household mental illness, parental separation or divorce, and having an incarcerated household member.<sup>226</sup>

The data revealed that *all* female, and nearly all male, juvenile offenders were traumatized in childhood, having each experienced at least one ACE. Both male and female youth had a very high likelihood of having experienced physical neglect, emotional neglect, household substance abuse, and parental divorce or

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to address the social determinants of health. However . . . both lawyers and healthcare providers can play a very powerful role as agents for policy change. Individual cases develop a practitioner’s sense of broader concerns or trends in the community.”)

222. Tobin Tyler, *supra* note 14, at 237.

223. *New Mexico Sentencing Commission*, U.N.M., <https://nmsc.unm.edu/index.html> [<https://perma.cc/63S3-TUGB>].

224. Cannon et al., *supra* note 28, at 1.

225. *Id.* at 4.

226. *Id.* at 1, 4.

separation.<sup>227</sup> Ninety-four percent of the youth had experienced physical neglect, which included one hundred percent of the females studied.<sup>228</sup> The study also concluded that youth in the New Mexico sample had a much greater probability of experiencing at least one ACE, and greater than four ACEs, as compared to their peers in other states.<sup>229</sup> Twenty-three percent of females in particular experienced *all nine* ACEs (compared to only three percent of males).<sup>230</sup> As described above, the field of ACEs research shows that those who have experienced more ACEs in childhood are more likely to have poor health conditions and exhibit risk behaviors. Specifically, most research stemming from the original ACEs study by the Kaiser Foundation and the CDC looks at the rates of health risks and poor health outcomes among individuals who experiences four or more ACEs, who are much more likely to experience depression or alcoholism, for example.<sup>231</sup> The ramifications for a person who has experienced *nine* ACEs, like many of the youth in our New Mexico juvenile justice study, seem potentially astounding.

With 86% of incarcerated youth in New Mexico having experienced four or more ACEs (rates seven times higher than the general population group studied by the CDC and Kaiser), it is not surprising that the youth studied in New Mexico experienced very high rates of psychological and substance abuse disorders.<sup>232</sup> For example, more than ninety-nine percent of the incarcerated youth (nearly every single one) met criteria for a mental health diagnosis and a substance abuse disorder.<sup>233</sup> Depression in particular was widespread.<sup>234</sup>

With these findings in hand, we made recommendations for policy solutions to address these issues. We recommended that the state build on ongoing efforts to develop a strong, well-organized process to screen juvenile offenders entering the justice system for trauma, mental health conditions, and substance abuse disorders to help identify needs and target assistance.<sup>235</sup> At the very least, such screening would fill the gap where Medicaid EPSDT well child checks had failed to catch those needs. We also recommended that the state employ evidence-based trauma treatment modalities for youth in the juvenile justice system, as well as youth returning home from state facilities, and train its juvenile justice system staff and community providers in trauma-informed care.<sup>236</sup> Trauma screenings and trauma-informed treatment are increasingly common recommendations nationally, given the growing recognition of trauma and maltreatment histories among youth

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227. *Id.* at 6 fig.3.

228. *Id.* at 5.

229. *Id.* at 6.

230. *Id.* at 6 fig.3.

231. *Id.* at 3.

232. *Id.* at 1.

233. *Id.* at 11 tbl.1.

234. *Id.*

235. *Id.* at 8.

236. *Id.* at 9.

involved in the juvenile justice system.<sup>237</sup>

We could not ignore our experience engaging in health and legal care in the community and our understanding of gaps in early identification and treatment of trauma and mental health needs. Therefore, we also recommended that the state enact policies to ensure that trauma, and the related physical and mental health needs of families and children, are identified early to decrease overall ACE rates and resultant negative health consequences.<sup>238</sup> We described our MLA work in the primary care health setting as an example of a collaborative best practice towards trauma identification and improved health and justice outcomes, and explained the importance of mental health screening during Medicaid EPSDT well child checks.<sup>239</sup>

In addition to making our recommendations in writing in the New Mexico Sentencing Commission's publication, we took our findings and proposed solutions to all three branches of government. In regards to the executive branch, the Children, Youth, and Families Department (CYFD) joined our study as a formal partner in the project, supporting Dr. Davis' examination of the trauma needs of the state's juvenile justice population. We drew on our medical-legal partnership expertise in trying to inform the state agency's policies, especially as MLPs "have had substantial impact in improving regulatory implementation of health-related policy when both medical and legal practitioners meet with agency administrators."<sup>240</sup> We testified alongside the Secretary of CYFD before the state's Legislative Health and Human Services Committee to discuss our findings and recommendations. Our testimony provided a unique opportunity to educate lawmakers about this problem, especially as we were able to draw on our interdisciplinary patient/client experiences and perspective, as well as concrete data from the study, to raise awareness of the serious depth of the trauma histories of our juvenile justice population and the implications of this trauma. Finally, we met with judges from Bernalillo's County Children's Court, a court which hears many of the juvenile justice cases in New Mexico and commits some of the state's most serious juvenile offenders to the custody of CYFD for incarceration in state facilities. We shared our findings and recommendations, and discussed policy implications for the judicial branch as well as for broader systemic changes the state could embrace.

With all three branches of government, our research—validated and analyzed by the New Mexico Sentencing Commission, which itself is connected to all three branches of government—was critical to gaining the attention and respect of policymakers. In line with MLP principles, the interdisciplinary nature of our team also helped to establish our credibility, as well as our combined academic and

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237. Cannon & Hsi, *supra* note 42, at 36–38

238. Cannon et al., *supra* note 28, at 7.

239. *Id.*

240. Sandel et al., *supra* note 13, at 1699.

community-based experiences. The research findings set the stage for our policy recommendations aimed at early and regular screening and intervention to curve the dire trajectory painted by the statistics. As part of our testimony, we discussed the work of the MLA in addressing these issues in primary care settings. We described the power of Medicaid EPSDT well child visits to ensure an avenue for screening and identification of treatment needs for a large population in New Mexico, the state with the highest rates of children born into Medicaid families in the nation.<sup>241</sup>

The study and resulting policy recommendations caught the eye of Raúl Torrez, the District Attorney (D.A.) for Bernalillo County, where Albuquerque, the largest metropolis in the state, is located. The data demonstrated to the D.A., who oversees the county's criminal prosecutors, that early childhood trauma is a "driver of crime in the community."<sup>242</sup> Citing to the study's findings, D.A. Torrez launched a partnership with the private and nonprofit sectors to work towards "the prevention and mitigation of early childhood trauma as part of a long-term strategy to improve not only public health, but public safety."<sup>243</sup> The initiative, known as Mission Families,<sup>244</sup> involves a collaboration with the United Way of Central New Mexico to identify and stabilize families more preventively and through early interventions "to help our most vulnerable children stay in school, stay out of the criminal justice system and become productive members of the community."<sup>245</sup> An Advisory Council will develop "strategies that will increase prospects for secure and stable homes for children, improve children's safety and well-being, and support working families and student success from cradle to career."<sup>246</sup> The D.A. encouraged other elected officials, leaders in the business community, and citizens to look at the data and "do more for traumatized children who need our help today, before they give rise to the public safety crisis of tomorrow."<sup>247</sup>

The MLP strategy of inter-disciplinary research to inform policy worked: the

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241. Seventy-two percent of children born in New Mexico are born into families covered by Medicaid. See *Births Financed by Medicaid*, KAISER FAM. FOUND., <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22%25%20Births%20Financed%20by%20Medicaid%22,%22sort%22:%22desc%22%7D> [https://perma.cc/VF3L-RVE5]; Rick Nathanson, *New Mexico Has Highest Rate of Medicaid-Covered Births*, ALBUQUERQUE J. (Mar. 28, 2017), <https://www.abqjournal.com/977267/nm-has-highest-rate-of-medicaidcovered-births.html> [https://perma.cc/LEH4-5VBQ].

242. Raúl Torrez, *Securing the City: Broad Strategy Can Improve Law Enforcement and the Legal System*, ALBUQUERQUE J., November 19, 2017, [http://ejournal.abqjournal.com/popovers/dynamic\\_article\\_popover.aspx?artguid=b99ebed9-bb3e-48cf-8ee8-21f62cca2003](http://ejournal.abqjournal.com/popovers/dynamic_article_popover.aspx?artguid=b99ebed9-bb3e-48cf-8ee8-21f62cca2003) [https://perma.cc/2233-5WA4].

243. *Id.*

244. Bernalillo County DA, *Mission: Families*, Vimeo (Nov. 2017), <https://vimeo.com/240023183?ref=em-v-share> [https://perma.cc/ZL4Z-36A4].

245. Torrez, *supra* note 242.

246. Bernalillo County DA, *supra* note 244.

247. Torrez, *supra* note 242.



prosecutors' office charged with enforcing law and order in a city with rising property and violent crimes<sup>248</sup> began to pay attention to childhood trauma and change policy as a result of findings identifying significant ACEs histories among incarcerated youth and agreement with the authors' recommendations for a prevention focus. It is remarkable to see a prosecutors' office adopt a holistic approach accounting for public health needs, a further reflection of the power of the MLP paradigm. Indeed, the first program the D.A. intends to focus on cultivating as part of this new initiative is a new component of the UNM Medical Legal Alliance focused on serving youth in the juvenile justice system holistically, with an eye towards their health *and* behavioral health, developmental, and educational needs.<sup>249</sup>

We also incorporated our study findings into our teaching of law students, medical students, residents, and other healthcare professionals connected to the MLA. The study provides our students with a concrete understanding of the health and justice implications of trauma in New Mexico, and a platform for considering policy initiatives aimed at addressing the related problems, including the ways in which Medicaid EPSDT could provide an opportunity to identify these issues and intervene early on in a child's life. One of our law students who helped us with important research on the health and justice implications of childhood trauma ended up playing a key role as a recent law graduate as a co-author of the study.

As we explain to our students, our study confirmed our anecdotal experiences working with patients and clients on the ground, that our "delinquent" youth are in fact our traumatized youth. As a lawyer, I helped my pediatrician and psychiatrist partners to see the power of their voice and their patient stories in the advocacy process. Indeed, "as advocates, health care providers are armed with clinical stories and medical evidence of the impact of [social determinants of health] on patient health. Their voice in policy debates may be critical to convincing policymakers that change is needed."<sup>250</sup> Our research, which built upon the advocacy on behalf of patients and clients discussed above in Part III(A), allowed us to pursue a core MLP strategy—providing evidence to support our recommendations for policy improvements.<sup>251</sup> Collaborative inter-disciplinary research efforts are needed to understand the impact of childhood trauma, gaps in Medicaid EPSDT implementation, and barriers for patients and physicians to the implementation of mental health screening in well child checks. Research across disciplines can yield concrete ideas for policy changes needed to close those gaps, such as increased

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248. *Rising New Mexico Crime Rates Propelled by Albuquerque*, U.S. News and World Report at <https://www.usnews.com/news/best-states/new-mexico/articles/2017-09-26/rising-new-mexico-crime-rates-propelled-by-albuquerque> [<https://perma.cc/6X8V-CYGQ>].

249. Interview with Raul Torrez, Dist. Atty., Bernalillo Cty., in Washington, D.C. (Nov. 13, 2017).

250. Tobin Tyler *supra* note 14, at 237

251. *Id.* at 236

reimbursement rates and training for primary care providers in mental health screening, transportation services to well-child checks, and evidence-based mental health services that must be made more available for particular populations when treatment needs are identified, and can spark discussion and ultimately change among policy-makers and courts.

## 2. Policy Development through Inter-Disciplinary Coalition Engagement

Physicians and attorneys can also engage in coalitions in their communities to inform thoughtful policy change. For example, a judge in the District of Columbia provides oversight of the children's Medicaid system as a result of that long-running lawsuit alleging, among other legal violations, that the city has failed to provide children with required Medicaid EPSDT screenings.<sup>252</sup> Unfortunately, court oversight has had little effect on the city's fulfillment of its EPSDT screening requirements.<sup>253</sup> More recently, however, an interdisciplinary coalition has spearheaded significant change. In 2012, the D.C. Collaborative for Mental Health in Pediatric Primary Care (D.C. Collaborative) was established, which is a public-private partnership<sup>254</sup> that has worked to ensure that pediatricians get reimbursed for the extra time involved in conducting a mental health screening.<sup>255</sup> The D.C. Collaborative spent 15 months training the pediatric providers that serve 80 percent

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252. *Salazar v. D.C.*, 954 F. Supp. 278 (D.D.C. 1996), *amending* 938 F. Supp. 926 (D.D.C. 1996).

252. *Salazar*, 954 F. Supp. at 280.

253. For fiscal year 2015, the District's participation ratio – the number of Medicaid-eligible children who received at least one initial or periodic screening service divided by the number of Medicaid-eligible children who should have – was 63 percent, a 1-point decrease from pre-trial rates. *EPSDT 2015 Participation Report*, *supra* note 129. It should be noted that there was some improvement in the intervening years. The District achieved an 81 percent participant ratio in both 2010 and 2011. *Annual EPSDT Participation Report: Fiscal Year 2010*, CTRS. MEDICARE & MEDICAID SERVS. (Nov. 19, 2014), <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2010-epsdt-data.zip> [<https://perma.cc/HR4M-8K7V>]; *Annual EPSDT Participation Report: Fiscal Year 2011*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 7, 2014), <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2011-epsdt-data.zip> [<https://perma.cc/F8NM-P3KB>].

254. The D.C. Collaborative includes that includes the Children's National Health System, MedStar Georgetown University Hospital, the Children's Law Center, the D.C. Chapter of the American Academy of Pediatrics, the D.C. departments of Behavioral Health and Health Care Finance, and a community advisory board. *Evaluating DC's Progress in Meeting Children's Mental Health Needs: 2016 Children's Mental Health*, CHILD. L. CTR. 2 (May 2016), [http://www.childrenslawcenter.org/sites/default/files/Childrens\\_Law\\_Center\\_MH\\_Update\\_2016.pdf](http://www.childrenslawcenter.org/sites/default/files/Childrens_Law_Center_MH_Update_2016.pdf) [<https://perma.cc/2FJG-A6C6>] [hereinafter *2016 Update*]. It should also be noted that this increase coincided with a 2015 change in billing guidance that increased the rate for components of a well-child visit, including separately billed mental health screens. Memorandum from Claudia Schlosberg, Acting Senior Deputy Medicaid Dir., to D.C. EPSDT/HealthCheck Providers, EPSDT Well-Child Visits: New Billing Requirements and Rate Changes, Transmittal #14-29 (Oct. 2, 2014), <https://www.dchealthcheck.net/documents/Transmittal%2014-29.pdf> [<https://perma.cc/TXH6-43DA>].

255. *2016 Update*, *supra* note 254, at 2.

of all low-income children on Medicaid in D.C. on how to conduct mental health screenings. They also launched the Mental Health Access in Pediatrics project (DC-MAP) to give pediatricians the tools necessary to themselves treat some children with mental health issues and to provide quality referrals for those who require additional services.<sup>256</sup> In part through provider training and the implementation of standardized mental health screening tools into 10 primary care practices, this coalition, funded in part by the D.C. government, was able to increase the mental health screening rate amongst the practices by over 70%.<sup>257</sup>

In 2014, the District also amended its billing requirements and reimbursement rates for well-child visits.<sup>258</sup> In order to improve the documentation and tracking of EPSDT visit components, the new guidelines mandate that health care providers bill for the age-specific preventive medicine visit and bill for each screening component separately.<sup>259</sup> Accordingly, providers now have a monetary incentive to conduct screenings as part of the well-child visits.<sup>260</sup> Between 2013 and 2015, the number of developmental and behavioral health screens of children in D.C. rose more than four-fold from 5,020 to 22,762.<sup>261</sup> The policy changes in D.C. and the inter-disciplinary coalition that helped to achieve them draw upon the MLP

256. *Id.*

257. See Children's National, *Mental Health Screening in Pediatric Primary Care: Results from a Quality Improvement Learning Collaborative* (April 2016), [https://www.sbm.org/UserFiles/file/Symposium50\\_Godoy.pdf](https://www.sbm.org/UserFiles/file/Symposium50_Godoy.pdf) [<https://perma.cc/84B6-73N3>] (finding the percent of mental health screenings completed using an approved tool increased from 1% to 74%).

258. Memorandum from Claudia Schlosberg to D.C. EPSDT/HealthCheck Providers, *supra* note 254.

259. *Id.*

260. The current reimbursement rate for developmental and behavioral screenings (CPT code 96110) is \$8.65. Providers are allowed to submit claims for 2 screens per well-child visit. *Medical Fee Schedule*, D.C. MEDICAID, [https://www.dc-medicaid.com/dcwebportal/nonsecure/getFeeSchedule?filename=Medical\\_Fee\\_Schedule\\_Current.csv](https://www.dc-medicaid.com/dcwebportal/nonsecure/getFeeSchedule?filename=Medical_Fee_Schedule_Current.csv) [<https://perma.cc/ME6C-8SFU>].

261. 2016 Update, *supra* note 254, at 1. These numbers are based on data from the DC Collaborative for Mental Health in Pediatric Primary Care. According to the District of Columbia's Department of Health Care Finance, the number of screens billed to DC Medicaid increased from 4,632 to 20,728 during the same time period. Memorandum from Claudia Schlosberg, Senior Deputy Dir. & State Medicaid Dir., to D.C. Medicaid EPSDT/HealthCheck Providers, National Children's Mental Health Awareness Week and Mental Health Screening in Pediatric Primary Care, Transmittal #16-17 (May 24, 2016), [http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DG852345\\_KT0000002801\\_1.pdf](http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DG852345_KT0000002801_1.pdf) [<https://perma.cc/4UQ9-G5CX>]. Assuming one screen per child, this translates into an increase in screening rates from approximately 5 percent in 2013 to 22.8 percent in 2015. In FY 2013, the number of children enrolled in D.C. Medicaid/CHIP was approximately 101,000. *FY 2013 Number of Children Ever Enrolled in Medicaid and Chip*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/chip/downloads/fy-2013-childrens-ever-enrolled-report.pdf> [<https://perma.cc/B4GZ-K58C>]. In FY 2015, the number of children enrolled in D.C. Medicaid/CHIP was approximately 100,000. *FY 2015 Number of Children Ever Enrolled in Medicaid and Chip*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/chip/downloads/fy-2015-childrens-enrollment-report.pdf> [<https://perma.cc/LWC6-LFZN>].

approach of bringing health and legal advocates together to identify challenges in the examination room and collaborate to remove those legal and policy barriers to health.

An interdisciplinary coalition in Connecticut also had a similar impact. The Connecticut Department of Social Services convened a task force comprised of experts from diverse disciplines, such as physicians and lawyers from the Connecticut Center for Children's Advocacy Medical-Legal Partnership Project, to review behavioral health regulations and make recommendations about screening, treatment and reimbursement protocols.<sup>262</sup> Drawing on the work of the task force, the Connecticut legislature drafted the Connecticut Behavioral Health Plan for Children, with a goal that "[a]ll children will receive age-appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services."<sup>263</sup> Moreover, Connecticut's Medicaid agency changed the state's billing procedures to require that providers use a standardized tool and include a modifier (indicating whether the screen was positive or negative) to be reimbursed for developmental or behavioral health screenings.<sup>264</sup> The MLP played a critical role in providing the "'patient to policy' perspective that may be missed in public health approaches more divorced from the clinical setting."<sup>265</sup>

In New Mexico, an interdisciplinary, public-private coalition housed at the University of New Mexico's Health Sciences Center (the medical center institutional partner of the MLA), is also tackling the gap in early identification of trauma and mental health needs. The J. Paul Taylor Early Childhood Task Force is made up of stakeholders from the public and private sectors who are working to develop policies to provide for the early identification and treatment of trauma and mental health among the state's children,<sup>266</sup> including physician, attorney, and student representatives from the MLA. Created in 2013 by the New Mexico legislature to memorialize the work of Representative J. Paul Taylor, a life-long advocate of coordinated systems of care for children, the Task Force aims to create

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262. Lisa Chedekel, Study Pushes Early Identification of Kids' Mental Health Problems, CONN. HEALTH I-TEAM (September 14, 2012), [http://c-hit.org/2012/09/14/study\\_pushes\\_early\\_identification\\_of\\_kids\\_mental\\_health\\_problems](http://c-hit.org/2012/09/14/study_pushes_early_identification_of_kids_mental_health_problems) [<https://perma.cc/P66V-JEJ4>].

263. *Connecticut Children's Behavioral Health Plan*, CHILD HEALTH & DEV. INST. CONN. 13 (Oct. 1, 2014), [http://www.plan4children.org/wp-content/uploads/2014/10/CBH\\_PLAN\\_FINAL-2\\_.pdf](http://www.plan4children.org/wp-content/uploads/2014/10/CBH_PLAN_FINAL-2_.pdf) [<https://perma.cc/F5XQ-UDA9>].

264. *Provider Bulletin 2014-43: Developmental and Behavioral Health Screens in Primary*, CONN. MED. ASSISTANCE PROGRAM (Jul. 2014), [http://www.huskyhealthct.org/providers/provider\\_postings/PB%202014-43%20Developmental%20and%20Behavioral%20Health%20Screens.pdf](http://www.huskyhealthct.org/providers/provider_postings/PB%202014-43%20Developmental%20and%20Behavioral%20Health%20Screens.pdf) [<https://perma.cc/8R4W-QR5D>].

265. Tobin Tyler et al., *supra* note 14, at 236.

266. H.M. 75, 51st Leg., 1st Sess. (N.M. 2013).

an early childhood system of behavioral healthcare that involves the prevention and identification of childhood maltreatment and other forms of trauma.<sup>267</sup> With the explicit recognition of high rates of trauma among New Mexico's children and an understanding that early childhood experiences ultimately shape an individual's health, education, and socio-economic status, the Task Force seeks to connect at-risk children with the required mental health services support to stymie the enormous social and financial costs stemming from the failure to improve outcomes for these children.<sup>268</sup> The Task Force also has a core mission related to the advancement of Medicaid EPSDT policy and practice through its founding principle that primary care providers—who, with the rights tools, can identify these issues, provide relevant diagnoses, and make recommendations for treatment—must play a critical role in the development of a comprehensive prevention, intervention, and treatment plan to target at-risk families.<sup>269</sup>

Reflecting the MLP framework, the Task Force explicitly aims to build bridges across disciplines, serving as a collaborative force for diverse early childhood development stakeholders.<sup>270</sup> Child-serving systems often operate in silos, despite their explicit collaborative policy goals.<sup>271</sup> The Task Force seeks to bring representatives from these systems, including on-the-ground providers, together to enrich the policy development process with their diverse perspectives. This approach reflects the inter-disciplinary values that the UNM Health Sciences Center also brings to the MLA and its problem-solving approaches on behalf of MLA patients. The Task Force's membership typically includes representatives from the infant mental health, early childhood development, mental health, medical, social service, academic research, public education, disability, and child welfare systems and provider communities.<sup>272</sup> A dynamic and growing body, the membership of the Task Force has expanded to include, for example, state legislative finance committee staff, representatives from managed healthcare organizations, and the medical assistance division of the Human Services Department that oversees Medicaid for the state, providing an opportunity for analysis of the unmet potential of Medicaid EPSDT well child checks.<sup>273</sup>

Moreover, the Task Force provides an important platform for physicians and

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267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.*

271. See, e.g., Yael Cannon, *There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 DEPAUL L. REV. 1049, 1051–52 (2011).

272. H.M. 75, 51st Leg., 1st Sess. (N.M. 2013).

273. S.M. 5, 51st Leg., 2d Sess., (N.M. 2014); H.M. 13, 51st Leg., 2d Sess., (N.M. 2014). The New Mexico legislature specifically called on the Task Force to engage legal experts, which is how I became its co-chair, along with Tara Ford, co-founder of a children's legal advocacy organization, Pegasus Legal Services for Children, in 2015. H.M. 47, 52d Leg., 1st Sess. (N.M. 2015); S.M. 69, 52d Leg., 1st Sess. (N.M. 2015).

attorneys to engage collaboratively with policymakers, a core tenet of MLP impact. The Task Force has the imprimatur of the state legislature, which has reconvened the Task Force annually since its creation, and includes representatives from government agencies like the state child welfare and education departments, providing MLA representatives and other non-governmental stakeholders an important forum to engage with the various branches of state government. The legislature charged the Task Force with developing a process for identification of the broad spectrum of underserved at-risk infants and young children in the state.<sup>274</sup> Because three-quarters of New Mexican children qualify for Medicaid and all of them are entitled to well child checks, Medicaid EPSDT mental health screenings can reach a significant portion of the state's children. In 2014, the Task Force sought to advance policy to fulfill the promise of Medicaid EPSDT as an identification tool for needed mental health services for traumatized children. The Task Force issued a comprehensive report highlighting the national ACEs research and its screening framework as a means for understanding the prevalence of childhood trauma and its lifelong impact.<sup>275</sup> The report recommended that Medicaid managed care organizations and their contracts with the state include coverage of ACE questions as part of Medicaid EPSDT well child checks in order to promote early risk-factor identification.

In 2014 and 2015, the Task Force worked with legislators to introduce bills to require that healthcare professionals providing Medicaid EPSDT services screen patients for ACEs and refer for necessary mental health services those children identified as having experienced at least two ACEs.<sup>276</sup> By incorporating the ACEs framework into the Medicaid EPSDT well child check and adding other forms of trauma such as homelessness and persistent poverty to the list of ACEs,<sup>277</sup> the Task Force hoped to fulfill the potential of Medicaid EPSDT to provide an opportunity for screening and identification of trauma and related mental health needs and referrals for medically necessary services. Ultimately, a Fiscal Impact Report by legislative staffers suggested that the legislation would have a significant fiscal impact, and it did not become law.<sup>278</sup>

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274. S.M. 5, 51st Leg., 2d Sess., (N.M. 2014); H.M. 13, 51st Leg., 2d Sess., (N.M. 2014).

275. *J. Paul Taylor Early Childhood Task Force: Report 2014*, J. PAUL TAYLOR EARLY CHILDHOOD TASKFORCE (2014), <https://www.nmaeyc.org/sites/default/files/files/JPT%20Final%20REPORT%2012-04-14.pdf> [<https://perma.cc/NR2Y-9V63>].

276. Adverse Childhood Event Screening and Referrals, S.B. 73, 51st Leg., 2d Sess. (N.M. 2014), <https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=73&year=14> [<https://perma.cc/HV83-32QD>]; HSD Child Screening, S.B. 244, 52d Leg. 1st Sess. (N.M. 2015), <https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=244&year=15> [<https://perma.cc/T24R-34YB>].

277. S.B. 73, 51st Leg., 2d Sess. (N.M. 2014).

278. LEGISLATIVE FIN. COMM., FISCAL IMPACT REPORT, S.B. 244/a, 52d Leg., 1st Sess. (N.M. 2015), <https://www.nmlegis.gov/Sessions/15%20Regular/firs/SB0244.PDF> [<https://perma.cc/PSQ9->

The Task Force tried a different in approach in 2016, attempting to pass legislation to effectuate the Medicaid EPSDT mental health screening components of federal law at the state level through an approach similar to the one promulgated by Massachusetts, through which providers would be required to include comprehensive behavioral, substance use, and social-emotional development assessments as part of each Medicaid EPSDT well child check.<sup>279</sup> Providers would need to use an evidence-based, approved screening tool to ask age-appropriate questions and to create a schedule recording the services provided to each recipient as a prerequisite for reimbursement.<sup>280</sup> The bill addressed some of the concerns that primary care providers have raised locally and nationally about a lack of access to evidence-based mental health screening tools and to the training needed to use them effectively.<sup>281</sup> For example, the bill directed the state's Human Services Department to create a program to train primary care and behavioral health service providers for individuals under five-years old on screening, access to medically-necessary services, and documenting service needs.<sup>282</sup> Bills developed by the Task Force in partnership with legislators have also called for the collection of data on completed mental health and trauma screenings in Medicaid EPSDT visits and referrals resulting from those screens.<sup>283</sup>

While these legislative efforts have not yet succeeded, they have educated the legislature about unmet needs and set the stage for further policy discussions to improve the trajectory for at-risk children. A number of Task Force members are now exploring further policy development opportunities in this area with Envision New Mexico, a department of the UNM Health Sciences Center that trains professionals to improve the delivery of quality healthcare for children.<sup>284</sup> Through a partnership with the national Alliance for Early Success, Envision New Mexico is studying the "barriers, opportunities, current practices, policy changes, gaps in care, and benefits to New Mexico in implementing socio-emotional screening for young children from birth to age 5."<sup>285</sup> These efforts can provide a platform for physicians and other stakeholders to have a voice in articulating the barriers to implementation of the Medicaid EPSDT requirement of mental health screening in well child checks. Such initiatives can trigger discussions to address physician

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279. S.B. 24, 52d Leg., 2d Sess. (N.M. 2016), <https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legType=B&legNo=24&year=16> [https://perma.cc/5A85-LPKS].

280. *Id.*

281. *See supra* Part II.

282. S.B. 24, 52d Leg., 2d Sess. (N.M. 2016).

283. S.B. 244, 52d Leg., 1st Sess. (N.M. 2015); S.B. 24, 52d Leg., 2d Sess. (N.M. 2016).

284. *About Envision*, ENVISION N.M., <http://envisionnm.unm.edu/index.php/about> [https://perma.cc/7ZK6-6NYK].

285. *See About Us*, ALLIANCE FOR EARLY SUCCESS, <http://earlysuccess.org/about-us>. The initiative is beginning with focus groups to better understand the relevant issues. *See* Univ. of N.M. Health Scis. Ctr., Consent Cover Letter for Focus Group Early Success-NM (on file with author).

concerns raised locally and nationally about Medicaid reimbursement rates, limited time and competing priorities in well child checks, and a scarcity of children's mental health providers to follow through on referrals, especially in more rural areas.

Inter-disciplinary coalitions like the J. Paul Taylor Task Force can also consider as next steps policy developments to remove some of these barriers.<sup>286</sup> For example, advocacy at the federal level could try to promote more detailed regulations or policy guidance from the U.S. Department of Health and Human Services (or legislation from Congress if the political will was there) to require states to collect data to show that comprehensive well-child checks are occurring and to provide training and evidence-based screening tools to primary care physicians to effectuate mental health screening as part of those doctor's appointments. Advocacy at the state level could push for funding through state Medicaid agencies to support the collection of data on mental health screening and referrals for services, provision of training and screening tools to physicians, the development of mental health services for children in certain communities where the services are scarce, and financial incentives for primary care physicians to complete mental health screenings as part of their well child checks, a policy approach that has been adopted in some states.<sup>287</sup> Increases in reimbursements for well child checks would allow doctors to spend more time with their patients, and learn about their trauma histories and mental health needs. All of these ideas have been generated in robust discussions among the diverse public and private stakeholders who comprise the Task Force, which has mobilized physicians and attorneys from within the MLA and from other health and legal partners, as well as many other inter-disciplinary stakeholders, to thoughtfully inform policymakers as they seek to improve the lives of New Mexico's children and families. Families like Selena's can only benefit from the medical and legal professions mobilizing through research, coalition-building, and other engagement with government stakeholders to spur policy change as a means of achieving improved health and mental health outcomes for children who have suffered trauma.

## CONCLUSION

Selena deserves a chance to live a healthy life. Without fault, she experienced significant trauma at a very early age. As Selena enters her teen years, identification of her mental health needs can open the door to provision of the services she and her family need to set her on a path towards improved mental

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286. H.M. 75, 51st Leg., 1st Sess. (N.M. 2013).

287. For a map detailing which of the 50 states (plus D.C.) pay an additional fee to providers for conducting developmental screenings, see *EPSDT Resources to Improve Medicaid for Children and Adolescents*,

NAT'L ACAD. STATE HEALTH POL'Y (December 2013), <http://www.nashp.org/resources-improve-medicaid-children-and-adolescents> [<https://perma.cc/YKP3-AJT6>].



health and ultimately improved overall health. Even earlier identification and intervention as a younger child could have helped to steer her towards improved mental health and overall health earlier. Federal law provides an optimum structure for this early identification, a structure that is already supposed to be in place each time one of the millions of children enrolled in Medicaid visits the doctor for a well child check.

Without assurance that children are receiving their required mental health screens when they visit the doctor, however, we will continue to see children like Selena travel a path from childhood trauma to poor health. We will also see them confront poor legal outcomes like those experienced by the juvenile offenders in New Mexico who had rates of trauma in early childhood that are literally off the national ACEs study charts.

Medical-legal partnerships provide an important multi-level paradigm for change that can—through patient advocacy, institutional transformation, and policy change—inform future efforts to address the failure to ensure implementation of this key provision of children’s Medicaid law. First, in the examination room, pediatric providers can screen children comprehensively whenever possible and identify children with unmet health, mental health, and legal needs. They can collaborate with legal services attorneys to ensure that families are connected with the requisite services. When they see problematic patterns and have law partners who can bring impact litigation, their stories and expertise should inform those larger legal strategies.

Building on these advocacy efforts on behalf of individual patients and groups of patients, lawyers and physicians should collaborate to transform their respective institutions to take interdisciplinary approaches to problem identification and solving. If we educate the next generation of attorneys, physicians, and other healthcare professionals through this framework, our impact will be even more transformative; future leaders in law and medicine will enter their practices armed with a more holistic, collaborative, and upstream approach to helping the most marginalized among us. The next generation of leaders in law and medicine should be trained to understand trauma and its implications and the Medicaid system’s structures for early intervention as they prepare to play a role in developing improved health care practices and policies. These efforts can change the life trajectory for traumatized children.

The implications of this type of culture shift are highly promising. When physicians screen holistically for mental health and developmental needs, as well as for social determinants of health in the form of legal barriers and lawyers start thinking about the implications of legal challenges for health and well-being,<sup>288</sup> we will have come out of our silos and realized that our institutions, both meant to

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288. Wettach, *supra* note 10, at 312 (“Working in a partnership also gives clinic students an understanding of how the legal problems faced by a child and his family are interrelated with other issues affecting the child’s overall well-being.”)

“heal” through “care,” can achieve better health and justice if we work together. We can begin to speak the same language, translating medical information into legal standards, and injustices into health inequities, and create a shared culture of advocacy.<sup>289</sup> After all, we are serving the same families, families like Selena’s, who can benefit from our partnership. Together, we can identify the needs of children like Selena early and mobilize collaboratively to help them obtain needed services.

Physicians and attorneys can go beyond transformations to healthcare and legal institutions and mobilize collaboratively in pursuit of broader policy change. Through the recognition of patterns in the examination room and the courthouse that are representative of policy failures, participation in research efforts to collect and analyze data to educate policymakers about policy problems, and engagement in local, state, and national coalitions to identify gaps and pursue policy solutions, physicians and attorneys can serve as catalysts for policy change, an important MLP response mechanism towards broader population health.<sup>290</sup> Lawyers and doctors, and their nursing, behavioral health, and public health partners, should conduct research into the local, state, and national dimensions of childhood trauma—and its costly outcomes—to persuasively awaken policymakers to the problem and its nuances in particular communities. Finally, physicians and attorneys should come together with stakeholders from across disciplines and across the public and private sectors to develop thoughtful policies based on shared values, such as policies that remove barriers for patients and physicians to implementation of Medicaid EPSDT’s well-child check mental health screening requirements.

The efforts of the MLA, the Georgetown University Health Justice Alliance, and other health provider/attorney collaborations show that mobilizing towards policy change is an important response for our professions, allowing us to practice law and medicine “at the health care and community levels”<sup>291</sup> with inextricably intertwined goals of health and justice. MLPs can harness their collective experiences with patients and their holistic professional expertise to empower health and legal providers to “shine a spotlight on policy failures” to address social determinants of health.<sup>292</sup> Lawyers can help doctors and other healthcare providers become educated patient advocates, who can then enter the political arena in order

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289. *Id.* at 311 (noting that MLPs benefit law students because they help them to develop the ability to translate medical charts into legal standards); Ellen M. Lawton, *Medical-Legal Partnerships: From Surgery to Prevention?*, MGMT. INFO. EXCHANGE J., Spring 2007, at 37, 40 (“Learning activities in the clinical setting are distinct from those in the legal setting, and part of creating a culture of advocacy entails adapting training to the medical model.”).

290. See Tobin Tyler et al., *supra* note 14, at 240–45 (discussing the importance of enforcement of legal rights for the health of individuals and populations and MLP as community health promotion and a forum for research and evaluation).

291. Tobin Tyler et al., *supra* note 14, at 237.

292. Tobin Tyler, *supra* note 14, at 237.

to correct these deficiencies.<sup>293</sup> Armed with concrete expertise and informed by their interprofessional collaboration, lawyers and healthcare providers can submit testimony before legislative bodies,<sup>294</sup> ensure compliance with existing laws and regulations,<sup>295</sup> draft proposed regulations,<sup>296</sup> work with professional lobbyists,<sup>297</sup> and garner public support for reform through the media.<sup>298</sup> The MLP movement, growing in size and scope across the nation, should harness physicians, nurses, other healthcare providers, and attorneys to advocate for policy change at the local, state, and federal level to improve outcomes for children with mental health needs, including consideration of how Medicaid EPSDT law and regulations can be improved to better improve lifelong outcomes for children with mental health needs.<sup>299</sup>

In 1966, Dr. Martin Luther King, Jr. asserted that “of all the forms of inequality, injustice in health is the most shocking and inhumane.”<sup>300</sup> Inequities in social determinants of health, such as those connected to the trauma suffered by Selena and the challenges faced by her mother and aunt, are both initiated and institutionalized by policies and systems outside the realm of medicine, but contribute greatly to “pervasive and persistent” health disparities.<sup>301</sup> Health and justice cannot be divorced, and medicine and law should come together as professions to improve the lives of the most disenfranchised among us, including children who have suffered childhood trauma. In sum, we need a movement of current and future leaders in law, medicine, and policy to propel implementation of the vision that President Johnson and Congress articulated fifty years ago. The next time Selena visits the doctor, she should receive a mental health check-up too.

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293. Carmean, *supra* note 179, at 511.

294. E.g., Sandel et al., *supra* note 13, at 1702 (describing the Boston MLP’s success in testifying before the Massachusetts’s Department of Public Utilities regarding proposed changes to the medical documentation requirements for utility protection benefits).

295. E.g., Daniel Atkins et al., *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEGAL MED. 195, 207 (2014) (citing HELP: MLP attorney success in “correcting a systematic failure by the local welfare office that was providing notices to non-English-speaking benefit recipients in English”).

296. Robert Pettignano et al., *The Health Law Partnership: A Medical-Legal Partnership Strategically Designed to Provide a Coordinated Approach to Public Health Legal Services, Education, Advocacy, Education, Research, and Scholarship*, 35 J. LEGAL MED. 57, 75 (2014).

297. *Id.*

298. Paul et al., *supra* note 151, at 304, 305.

299. While changes to federal law and regulations are outside the scope of this article, more research is needed on those possibilities, the barriers to such federal policy change, and ways to address those barriers (questions for a future article).

300. *Dr. Martin Luther King on Health Care Injustice*, PHYSICIANS NAT’L HEALTH PROGRAM (October 14, 2014), <http://www.pnhp.org/news/2014/october/dr-martin-luther-king-on-health-care-injustice> [<https://perma.cc/E6FV-Q8NA>].

301. See Laura K. Brennan Ramirez et. al., *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*, CTRS. DISEASE CONTROL & PREVENTION 4 (2008), <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf> [<https://perma.cc/MK58-QZRQ>].



# **Medical-Legal Partnerships with Communities: Legal Empowerment to Transform Care**

**Tamar Ezer\***

## **ABSTRACT**

Medical-legal partnerships (MLPs) integrate legal services into health care settings to provide holistic care and address the social determinants of health. This article brings a legal-empowerment lens to MLP work, arguing for a stronger focus on communities. It examines the application to MLPs of bringing services to communities, investing in rights literacy, and partnering with community-based paralegals. It then outlines the potential for a transformation in health and legal services to a rights - rather than needs-based framework where communities are active partners in program design and development.

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TABLE OF CONTENTS

**TABLE OF CONTENTS ..... 310**

**INTRODUCTION ..... 311**

**I. TAKING A LEGAL EMPOWERMENT APPROACH..... 313**

    A. BRINGING SERVICES TO COMMUNITIES..... 315

    B. INVESTING IN RIGHTS LITERACY ..... 317

    C. PARTNERING WITH COMMUNITY-BASED PARALEGALS ..... 319

**III. TRANSFORMING MLPs TO COMMUNITY-CENTERED CARE..... 323**

## INTRODUCTION

A medical-legal partnership (MLP) is defined as “a health care delivery model that integrates legal assistance into health care institutions serving the most vulnerable patient populations to address the social determinants of health.”<sup>1</sup> Lawyers serve as part of a health care team to tackle issues such as housing conditions, access to social benefits, and physical safety. MLPs aim to provide holistic care and “treat” legal issues early to avoid crises.<sup>2</sup> While the MLP model dates back to 1993, the national MLP movement only took off a decade later,<sup>3</sup> and there are currently MLPs in 294 health care centers across forty-one states.<sup>4</sup>

The growing popularity of MLPs demonstrates the draw of this concept. MLPs have unleashed the power of partnership by two professions. As explained by Ellen Lawton, a founder of the MLP movement,<sup>5</sup> and colleagues, the core of the MLP “innovation” is that “lawyers have the skills to remedy the social determinants of health, while clinicians can address biological determinants” needed to keep communities healthy.<sup>6</sup> The two professions can play complementary and mutually reinforcing roles. Health care providers are the first to spot the health consequences of unenforced laws and regulations, lack of access to benefits and services, and social injustice.<sup>7</sup> Additionally, due to their position of trust and regular contact with patients, providers are well placed to screen for these issues.<sup>8</sup> Lawyers bring the skills and knowledge to address them through an understanding of legal authority, ability to effectively navigate decision-making

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1. Elizabeth Tobin Tyler, *Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health*, 8 J. HEALTH & BIOMED. L., 211, 233–34 (2012); see also Megan Sandel et al., *The MLP Vital Sign: Assessing and Managing Legal Needs in the Healthcare Setting*, 35 J. LEGAL MED. 41, 47 (2014) (“MLP is a healthcare delivery model that serves to improve the health and well-being of low-income and other vulnerable populations by addressing unmet legal needs that impede health.”).

2. Ellen Lawton et al., *Disparities in Health, Disparities in Law: The Global Potential of Individual Advocacy*, in HEALTH CAP. & SUSTAINABLE SOCIOECONOMIC DEV. 419, 431–32 (Patricia A. Cholewka & Mitra M. Motagh, eds. 2007); see also David I. Schulman et al., *Public Health Legal Services: A New Vision*, 15 GEO. J. POVERTY L. & POL’Y 729, 759–60 (2008) (“Lawyers are able to bring a new type of expertise to the healthcare setting, so patients will be treated more holistically than in a typical medical exam room and they will be seen earlier than in a traditional legal services office.”).

3. Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations*, 29 HEALTH AFF. 1697, 1698–99 (2010).

4. NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org> [https://perma.cc/3A5E-C97X].

5. Staff, NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/national-center/staff> [https://perma.cc/43YH-3QYS].

6. Lawton et al., *supra* note 2, at 427.

7. *Id.* at 420; Elizabeth Tobin Tyler, “Small Places Close to Home”: Toward a Health and Human Rights Strategy for the US, 15 HEALTH & HUM. RTS. 80, 89 (2013) (“[H]ealth care providers bear witness daily to what might be defined as human rights abuses in the US.”).

8. Schulman et al., *supra* note 2, at 759.

systems, and a mastery of advocacy and persuasion.<sup>9</sup> Moreover, legal arguments are strengthened by medical opinion and documentation from health care providers.<sup>10</sup> Providers have access to the clinical stories and evidence of what impact the laws, regulations, policies, and practices have on patient health.<sup>11</sup> Together, the two professions have the powerful potential to tackle social systems that cause illness and interfere with recovery, while ensuring government accountability for violations.<sup>12</sup> MLPs thus leverage an alliance of two influential professions in service of social change and “to assist the most vulnerable members of the community.”<sup>13</sup> In recent years, this has further developed to include the various members of the health care team, such as nurses, care managers, behavior health specialists, and social workers.<sup>14</sup>

This paper argues for a stronger focus on communities within the MLP movement and an explicit expansion of the concept of MLP partnership to embrace communities. Real social change requires a shift in power and is only possible when led by communities. MLPs are generally considered to have three core components: (1) providing direct legal assistance to patients; (2) training health care providers to address social determinants of health and recognize legal issues; and (3) engaging in advocacy for law and policy change.<sup>15</sup> Change is therefore

9. Lawton et al., *supra* note 2, at 432; see also Barry Zuckerman et al., *From Principle to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCHIVES DISEASE CHILDHOOD 100, 101 (2007).

10. See, e.g., Tina Rosenberg, *When Poverty Makes You Sick, a Lawyer Can Be the Cure*, N.Y. TIMES (July 17, 2014), <http://opinionator.blogs.nytimes.com/2014/07/17/when-poverty-makes-you-sick-a-lawyer-can-be-the-cure> [https://perma.cc/6RPF-TDA5] (quoting Ellen Lawton, who notes that having medical evidence when writing a legal demand letter allows the lawyer to “resolve the issue much more rapidly,” since the issue “goes from ‘this is the law and you have to comply’ to a conversation that’s about community well-being and health”); Marcia M. Boumil et al., *Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model*, 13 J. HEALTH CARE L. & POL’Y 107, 114 (2010) (“Since advocating for patients’ legal needs often requires documentation from medical providers, the MLP model streamlines administrative processes and helps patients to obtain more quickly the public benefits and legal entitlements for which they are eligible.”).

11. Tyler, *supra* note 1, at 237.

12. Hilary Waldman, *Dream Team Helps Poor Families: Doctors and Lawyers Work Together to Solve Problems that Harm Health*, HARTFORD COURANT (Oct. 4, 2005), [http://articles.courant.com/2005-10-04/news/0510040689\\_1\\_medical-school-children-s-health-landlord](http://articles.courant.com/2005-10-04/news/0510040689_1_medical-school-children-s-health-landlord) [https://perma.cc/G3J7-SFGN]; Lawton et al., *supra* note 2, at 428.

13. Fiona Hum & Jennifer Faulkner, *Medical-Legal Partnerships: A New Beginning to Help Australian Children in Need*, 17 J.L. & MED. 105, 107 (2009).

14. Jeffrey Martin et al., *Embedding Civil Legal Aid Services in Care for High-Utilizing Patients Using Medical-Legal Partnership*, HEALTH AFF. BLOG (April 22, 2015), <http://healthaffairs.org/blog/2015/04/22/embedding-civil-legal-aid-services-in-care-for-high-utilizing-patients-using-medical-legal-partnershi> [https://perma.cc/MV7M-M3TP]; Randy Retkin et al., *Medical-Legal Partnerships: A Key Strategy for Mitigating the Negative Health Impacts of the Recession*, 22 HEALTH L. 29, 32 (2009).

15. TISHA BEESON ET AL., MAKING THE CASE FOR MEDICAL LEGAL PARTNERSHIPS: A REVIEW OF THE EVIDENCE 3 (2013); Rebecca L. Huston et al., *Virtual Mentor*, *Heath Law: Medical-Legal Partnerships*, 13 AMA J. ETHICS 555, 556 (2011); Sandel et al., *supra* note 3, at 1699; Edward Paul



measured at the level of the patient, clinic, and legal environment.<sup>16</sup> This paper argues that community engagement should be a fourth core activity, and that change should also be measured at the level of the community. Community engagement can take place through rights-literacy initiatives that train communities on rights and legal protections, employment of community-based paralegals, and involvement of communities in program design. Moreover, community partners would strengthen the third component focused on systemic advocacy, and community organizing can complement more legal approaches to address health disparities and social injustice. If MLPs aim to advance the rights of marginalized groups, adopting a community-centered approach is particularly critical.

The following section brings a legal-empowerment lens to MLP work. It lays out the basic principles of legal empowerment and examines the application of three key elements to the MLP context: (1) bringing services to communities; (2) investing in rights literacy initiatives; and (3) partnering with community-based paralegals. Part III discusses the potential for a second transformation in health and legal services provided by MLPs to a community-centered approach. Such a transformation would rethink service delivery so that it is less institutional and conceives of communities as active partners and participants in program design and development, rather than mere passive recipients of care. It also calls for a shift from a needs-based to a rights-based framework.

## I. TAKING A LEGAL EMPOWERMENT APPROACH

MLPs would benefit from a legal-empowerment lens, recognizing and supporting the agency of communities. The concept of legal empowerment was defined in 2008 by an independent commission supported by the United Nations Development Program as “a process of systemic change through which the poor and excluded become able to use the law, the legal system, and legal services to protect and advance their rights and interests as citizens and economic actors.”<sup>17</sup> Stephen Golub, the Franklin and Betty Barr Professor of Economics at Swarthmore

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et al., *Medical-Legal Partnerships: Addressing Competency Needs through Lawyers*, J. GRADUATE MED. EDUC. 304, 305 (2009).

16. Lynn Hallarman et al., *Blueprint for Success: Translating Innovations from the Field of Palliative Medicine to the Medical-Legal Partnership*, 35 J. LEGAL MED. 179, 183 (2014) (“MLP integrates legal care directly into patient healthcare using three levels of legal intervention: (1) directly with the patient, (2) at the clinic level, and (3) through policy advocacy.”); BEESON ET AL., *supra* note 15, at 8 (“The National Center for Medical-Legal Partnership . . . has promulgated a three-level model for the impacts generated by MLPs, including (1) changes in the health and wellbeing of patients; (2) improvements in the institutions services and practices; and (3) improvements in the policies, laws, and regulations that affect vulnerable populations.”).

17. 1 COMM’N ON LEGAL EMPOWERMENT OF THE POOR, U.N. DEVELOPMENT PROGRAMME, MAKING THE LAW WORK FOR EVERYONE 3 (2008).

College,<sup>18</sup> has further developed this concept, defining it as “the use of legal services and related development activities to increase disadvantaged populations’ control over their lives” and differentiating it from rule of law orthodoxy.<sup>19</sup> He explained that unlike traditional top-down approaches, under legal empowerment, “attorneys support the poor as partners, instead of dominating them as proprietors of expertise,” and “the disadvantaged play a role in setting priorities.”<sup>20</sup>

The Open Society Foundations has additionally embraced the legal-empowerment concept and has dedicated several initiatives to its advancement.<sup>21</sup> The Open Society Public Health Program defined legal empowerment as the “transfer of power from the usual gatekeepers of the law—lawyers, judges, police, and state officials—to ordinary people who make the law meaningful on a local level and enhance the agency of disadvantaged populations.”<sup>22</sup> To increase access to justice for socially excluded groups in the context of health, it found standard approaches to legal aid inadequate since they “typically rely on external professionals who tend to monopolize legal expertise and lack incentives to transfer knowledge or decision-making to their clients.”<sup>23</sup> Rather, the program sought to operate within a framework of participation and inclusion regarding communities “as vital actors in the justice system, rather than as its victims or passive beneficiaries.”<sup>24</sup>

This paper analyzes three critical elements of community engagement under the legal-empowerment approach and their applicability to MLPs. The first is bringing services to communities, an area where MLPs have already made significant headway. The second is providing communities with basic rights literacy, and the third is involving communities in the delivery of legal services—

18. See *Stephon Golub*, WORLD BANK BLOGS, <https://blogs.worldbank.org/team/stephen-golub> [https://perma.cc/TUT3-8UD4]

19. Stephen Golub, *Beyond Rule of Law Orthodoxy: The Legal Empowerment Alternative 5* (Carnegie Endowment for Int’l Peace, Working Paper No. 41, 2003), <http://carnegieendowment.org/files/wp41.pdf> [https://perma.cc/8XJB-N94E] (emphasis removed).

20. *Id.* at 6.

21. See, e.g., Zaza Namoradze, *Scaling Up on Legal Empowerment*, OPEN SOC’Y FOUND. (Apr. 22, 2016), <https://www.opensocietyfoundations.org/voices/scaling-legal-empowerment> [https://perma.cc/RLX6-3VYL]; *Projects: Legal Empowerment*, OPEN SOC’Y FOUND. (Sept. 15, 2014), <https://www.opensocietyfoundations.org/projects/legal-empowerment> [https://perma.cc/V935-JSZV].

22. *Bringing Justice to Health: The Impact of Legal Empowerment Projects on Public Health*, OPEN SOC’Y FOUND. 1 (2013), [https://www.opensocietyfoundations.org/sites/default/files/bringing-justice-health-20130923\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/bringing-justice-health-20130923_0.pdf) [https://perma.cc/N8UX-23DZ].

23. Ryan Quinn & Tamar Ezer, *Justice Programs for Public Health: A Good Practice Guide*, OPEN SOC’Y FOUND. 8 (2015), [https://www.opensocietyfoundations.org/sites/default/files/justice-programs-public-health-20150701\\_1.pdf](https://www.opensocietyfoundations.org/sites/default/files/justice-programs-public-health-20150701_1.pdf) [https://perma.cc/SHB6-K65R]; see also Meena Jagannath et al., *A Rights-Based Approach to Lawyering: Legal Empowerment as an Alternative to Legal Aid in Post-Disaster Haiti*, 10 NW. J. INT’L HUM. RTS. 7 (2011) (“[T]raditional legal assistance to marginalized communities tends to be top-down and exclusionary.”).

24. Quinn & Ezer, *supra* note 23, at 7.

both areas MLPs can generally strengthen. The sections below address each of these in turn.

### *A. Bringing Services to Communities*

MLPs understand the importance of leaving the law office and engaging in outreach to best provide legal services to communities. Based in health care settings, they are proactive in identifying legal needs, rather than waiting for clients to seek them out.<sup>25</sup> MLPs recognize that in resource-poor settings, people “will often forgo either medical or legal assistance if they must travel to two different places” for services.<sup>26</sup> The MLP model further builds on established trust between patients and health care providers.<sup>27</sup> As Dr. Laurie Harkness, the former director of the Errera Community Care Center, the site of an MLP serving veterans, explained, “The veteran sees the legal team as part of our team, which makes the trust much easier to establish,” and helps veterans feel comfortable engaging with the lawyers.<sup>28</sup>

However, not all health facilities are well-integrated into communities. Additionally, community members may be distrustful of the medical establishment and see providers as merely “proprietors of expertise.”<sup>29</sup> Recognizing these dynamics, MLPs can benefit from engaging in additional outreach and pursuing partnerships with community organizations, such as tenant associations. Some MLPs are pioneering these strategies. For instance, MLPs collaborating with the Association of Asian Pacific Community Health Organizations (AAPCHO) bridge community and health resources to provide culturally integrated care and assistance for Asian Americans, Native Hawaiians, and other Pacific Islanders.<sup>30</sup>

Increased access and trust are particularly critical when serving marginalized communities. MLPs serving the mentally ill and homeless have found that many would have had difficulty traveling to a legal-service organization or even identifying their legal needs.<sup>31</sup> At times, transportation to a health facility may also

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25. Tyler, *supra* note 1, at 236.

26. Zuckerman et al., *supra* note 9, at 101.

27. Retkin et al., *supra* note 14, at 32.

28. Rishi Manchanda et al., *The Invisible Battlefield: Veterans Facing Health-Harming Legal Needs in Civilian Life*, OPEN SOC’Y FOUND. 15 (2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/06/The-Invisible-Battlefield.pdf> [<https://perma.cc/ES5B-E8WE>].

29. Golub, *supra* note 19, at 6.

30. *Providing Civil Legal Aid Through Medical-Legal Partnerships: A Critical Enabling Service for Health Centers Serving Asian Americans, Native Hawaiians and Pacific Islanders*, ASS’NS ASIAN PAC.COMMUNITY HEALTH ORGS. 10 (2016), [http://www.aapcho.org/wp/wp-content/uploads/2016/10/AAPCHO-Hawaii-MLP-Case-Study-FINAL\\_100416.pdf](http://www.aapcho.org/wp/wp-content/uploads/2016/10/AAPCHO-Hawaii-MLP-Case-Study-FINAL_100416.pdf) [<https://perma.cc/2ZUE-NYH5>] (“In the beginning, I used to hear a lot of, ‘She’s not that kind of lawyer,’ because low-income families rarely get lawyers unless something bad is happening. But within six months, families were saying, ‘Hey, the lawyer lady is here!’” (quoting Dina Shek, a lawyer at the Medical-Legal Partnership for Children in Hawaii)).

31. Catherine F. Wong et al., *Helping Veterans with Mental Illness Overcome Civil Legal*

be a barrier. The AIDS Project of Pennsylvania, an MLP serving people with HIV, is located within a few blocks of the state's largest HIV/AIDS health care clinic and social-service agency.<sup>32</sup> Additionally, it makes regular home and hospital visits<sup>33</sup> and provides legal services at the city's needle-exchange program.<sup>34</sup> Similarly, the New York Legal Assistance Group provides services at home for cancer patients.<sup>35</sup>

Moreover, the key to good care is more than just physical access, but also adopting a community-centered approach and a nonjudgmental, harm-reduction philosophy.<sup>36</sup> The AIDS Project of Pennsylvania considers it "critically important to provide services by meeting people where they are."<sup>37</sup> OSF has defined a "lawyering for the marginalized approach," which entails a commitment to learning about the groups served and gaining their trust, working outside regular office hours, engaging in outreach, and meeting clients with openness and acceptance.<sup>38</sup> It is also important to respect the agency of community members. As Christine Zuni Cruz, a pioneer of the community-lawyering movement articulates, "[L]awyering which respects those who comprise the community as being capable and indispensable to their own representation and which seeks to understand the community yields far different results for the community and the lawyer."<sup>39</sup>

When MLPs work well, they strengthen relations with communities and attract people to services. Not only do MLPs connect people at a health facility with legal help they otherwise may not have sought, but the legal services also draw people to the health facility. This is the case with a veterans MLP at the Errera Community Care Center in West Haven, Connecticut, which, according to the former director, "[s]ees more people come off the street looking for legal services who then realize the other services offered here, such as mental health, primary

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*Issues: Collaboration Between a Veterans Affairs Psychosocial Rehabilitation Center and a Nonprofit Legal Center*, 10 PSYCHOL. SERVS. 73, 74 (2013).

32. Ronda B. Goldfein & Sarah R. Schalman-Bergen, *From the Streets of Philadelphia: The AIDS Law Project of Pennsylvania's How-To Primer on Mitigating Health Disparities*, 82 TEMP. L. REV. 1205, 1214–15 (2010).

33. *Id.* at 1214.

34. *Id.* at 1215.

35. *LegalHealth: Cancer Advocacy*, N.Y. LEGAL ASSISTANCE GRP., <http://nylag.org/units/legalhealth/projects/cancer-advocacy> [<https://perma.cc/W4AK-Z4XN>].

36. Harm reduction is social-justice movement, rooted in respect for the rights of people who use drugs, and a set of practical strategies meeting people who use drugs "where they're at" with the aim of reducing the negative consequences of drug use. See generally *Principles of Harm Reduction*, HARM REDUCTION COAL., <http://harmreduction.org/about-us/principles-of-harm-reduction> [<https://perma.cc/PRC2-5JFH>].

37. Goldfein & Schalman-Bergen, *supra* note 32, at 1214.

38. Quinn & Ezer, *supra* note 23, at 9; see also Tamar Ezer, *Injustice is Bad for Your Health*, OPEN SOC'Y FOUND. BLOG (July 8, 2015), <https://www.opensocietyfoundations.org/voices/injustice-bad-your-health> [<https://perma.cc/LY9L-UC9Y>].

39. Susan L. Brooks & Rachel E. Lopez, *Designing a Clinic Model for a Restorative Community Justice Partnership*, 48 WASH. U. J. L. & POL'Y 139, 140 (2015).

care, or job training, fit their needs.”<sup>40</sup> MLPs can thus serve as important gateways to services and support for communities.

### *B. Investing in Rights Literacy*

As Vivek Maru, a legal-empowerment pioneer and founder of an organization dedicated to its global expansion,<sup>41</sup> states, “[e]ducation is a critical first step in giving people power.”<sup>42</sup> If MLPs truly aim to achieve social change and address disparities, integrating rights literacy-- or training on rights and legal protections for community members-- is essential. This can build on trainings MLPs already conduct with health care providers, enabling them to recognize legal issues and address social determinants of health. Rights-literacy initiatives can take different forms, including workshops, pamphlets, posters, and documentaries that further rights awareness.<sup>43</sup> Rights literacy should teach about the formal legal system, as well as provide practical guidance on how to claim rights.<sup>44</sup>

Rights literacy can both stimulate greater community engagement and help justice programs be most effective. Conducting rights trainings is a way to invest in communities and build trust and relationships. Moreover, people are also more likely to benefit from legal services when they can connect their experiences with the law and available remedies.<sup>45</sup> Rights literacy also equips people with the tools to take steps on their own to improve their condition<sup>46</sup> and engage in systemic advocacy.<sup>47</sup>

Rights literacy should do more than merely convey knowledge to communities. It is also an opportunity to engage in dialogue and learn from communities about their concerns to ensure MLPs best meet their needs. For instance, the Community Lawyering Clinic at Drexel University’s Law School has found “Law Days,” where lawyers provide community trainings on various legal issues, to be valuable forums through which they can connect with community members and learn about their needs.<sup>48</sup> Furthermore, it is important to recognize that communities are not homogenous and to provide space for diverse voices.

40. MANCHANDA ET AL., *supra* note 28, at 14.

41. See Vivek Maru, NAMATI, <https://namati.org/people/vivek-maru> [<https://perma.cc/D9KR-CC32>].

42. Vivek Maru, *Between Law and Society: Paralegals and the Provision of Justice Services in Sierra Leone and Worldwide*, 31 YALE J. INT’L L. 427, 428 (2006).

43. Quinn & Ezer, *supra* note 23, at 74.

44. *Id.* at 75.

45. *Id.* at 8; Ezer, *supra* note 38.

46. OPEN SOC’Y FOUNDS., *supra* note 22, at 3.

47. Tyler, *supra* note 7, at 87 (“[A] key component of advocacy is educating people in a given community about their rights, human rights principles, and the potential for using law as a tool to promote those rights.”).

48. Brooks & Lopez, *supra* note 39, at 168 (noting, for example, that the first Law Day highlighted the need to offer “a continuum of legal services”).

Communities are multi-dimensional, with regard to geography, culture, politics, and power, and “an awareness of the complexity of the tensions that exist within communities, as well as . . . the connections—both self-identified and externally imposed” is critical.<sup>49</sup>

While MLPs can generally expand and strengthen work on rights literacy for communities, some MLPs already provide good examples in this area, and there are important lessons to draw from the HIV field. The Austin MLP, a collaboration between Texas Legal Services Center and People’s Community Clinic (PCC), has prioritized rights literacy.<sup>50</sup> For 2016, they proactively set a goal of at least two “know your rights” projects a year at the primary PCC clinic, and they are currently aiming to make those trainings quarterly. Additionally, starting in the fall of 2017, a dedicated attorney posted at PCC’s Center for Women’s Health will develop and provide know-your-rights sessions as part of group prenatal visits. Each know-your-rights project consists of training for both patients, as well health care providers and/or staff, and is accompanied by onsite legal assistance.<sup>51</sup> For instance, a fall 2016 training focused on supported decision making under Texas law, a spring 2017 training helped Medicare beneficiaries learn more about Medicaid eligibility, and recent trainings have focused on the interaction between federal immigration policy and Medicaid systems, as well as immigration rights for patients.<sup>52</sup> Moreover, patients had access to a panel of immigration attorneys available onsite with the capacity for representation.<sup>53</sup> Another example of an MLP engaged in rights literacy is a project with the University of California San Francisco, which serves patients facing dementia and makes good use of rights-literacy handouts.<sup>54</sup>

The HIV crisis in the 1980s highlighted the need for legal services for people to cope with social and economic factors related to illness.<sup>55</sup> HIV legal services pioneered a partnership between lawyers and health care providers and are, in fact, one of the “historical antecedents” for MLPs.<sup>56</sup> Now included in the broader MLP

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49. Brooks & Lopez, *supra* note 39, at 151.

50. Elizabeth Tobin Tyler, Issue Brief, *Improving Outreach and Enrollment Efforts in Health Centers through Medical-Legal Partnership*, NAT’L ASS’N CMTY. HEALTH CTRS., Feb. 2017, at 13, <http://www.nachc.org/wp-content/uploads/2015/11/O-E-MLP-Feb-2017-Issue-Brief-FINAL-for-website.pdf> [<https://perma.cc/UG3W-3YUG>].

51. Email from Keegan Warren-Clem, Attorney, Austin MLP (AMLP), to author (April 9, 2017, 9:12 PM) (on file with author).

52. *Id.*; see also Tyler, *supra* note 50, at 15.

53. Email from Keegan Warren-Clem, *supra* note 51.

54. For an example, see *Who Can Make Financial Decisions for Me?*, YUKON PUB. LEGAL EDUC., <http://ylea.com/seniors-education/who-can-make-financial-decisions-for-me-2> [<https://perma.cc/T2V5-NPYV>] (developed by YUKON Public Legal Education Association and used by the University of California San Francisco MLP focused on dementia).

55. Schulman et al., *supra* note 2, at 769–70; Stewart B. Fleishman et al., *The Attorney As the Newest Member of the Cancer Treatment Team*, 24 J. CLINICAL ONCOLOGY 2123, 2123 (2006).

56. Hallarman et al., *supra* note 16, at 184; Hum & Faulkner, *supra* note 13, at 105.

movement, they also bring distinct lessons. HIV legal services typically involve a client-and-community-education component, which empowers people to solve many problems themselves.<sup>57</sup> The AIDS Project of Pennsylvania, for instance, heavily invests in training and education for people with HIV, their friends and family, social workers, and health care providers.<sup>58</sup> It offers free monthly seminars on topics, such as leaving a job, returning to work, landlord-tenant law, confidentiality of medical records, and access to social benefits.<sup>59</sup>

### *C. Partnering with Community-Based Paralegals*

At the heart of a legal empowerment project are community-based paralegals. As Vivek Maru, explains, “Paralegals are often closer to the communities they serve. They tend to be ‘of’ those communities while lawyers are frequently outsiders and elites.”<sup>60</sup> Moreover, paralegals can bring “a wider and more flexible set of tools, including community education, mediation, and community organizing.”<sup>61</sup> The Open Society Foundations supports projects that train paralegals who are from the marginalized groups they serve.<sup>62</sup> These community-based paralegals are well-situated to provide rights education, address multiple legal and non-legal needs, and deliver “legal first aid” by responding quickly as issues arise and connecting their peers to any further support they may need.<sup>63</sup> Additionally, these paralegals have their community’s trust, better access to the groups they serve, and a deeper understanding of a community’s needs and challenges. As one sex worker working as a community-based paralegal put it, “We speak the same language.”<sup>64</sup> Community-based paralegals can thus serve as an important link between lawyers and marginalized groups.<sup>65</sup>

In turning to community-based paralegals, MLPs can learn from the health

57. David I. Schulman, *Making a Difference with HIV Legal Checkups*, 31 HUM. RTS. 18, 18 (2004); Goldfein & Schalman-Bergen, *supra* note 32, at 1223.

58. Goldfein & Schalman-Bergen, *supra* note 32, at 1223.

59. *Id.*

60. Maru, *supra* note 42, at 470; see also Zachary H. Zarnow, *Obligation Ignored: Why International Law Requires the United States to Provide Adequate Civil Legal Aid, What the United States is Doing Instead, and How Legal Empowerment Can Help*, 20 J. GENDER SOC. POL’Y & L. 273, 301 (2011) (“Distinctive among [legal empowerment’s] features is a belief in community-based organizing and a bottom-up approach to problem solving that uses locally-based actors to effect locally-controlled change. . . . This often means using non-lawyers, such as community-based paralegals, to provide legal services.”).

61. Maru, *supra* note 42, at 470; see also OPEN SOC’Y FOUNDS., *supra* note 22, at 3 (“[L]egal empowerment projects reveal the powerful role to be played by paralegals, who facilitate access to government agencies, assist with litigation in civil disputes, promote alternative forms of conflict resolution, and mobilize the broader community to attend to the human rights issues around them.”).

62. OPEN SOC’Y FOUNDS., *supra* note 22, at 46; Quinn & Ezer, *supra* note 23, at 8.

63. Quinn & Ezer, *supra* note 23, at 8; Ezer, *supra* note 38.

64. Quinn & Ezer, *supra* note 23, at 34; Ezer, *supra* note 38.

65. OPEN SOC’Y FOUNDS., *supra* note 22, at 46; Quinn & Ezer, *supra* note 23, at 34.

profession, which has improved quality of and access to care through the use of community health workers—also known as patient navigators and health coaches. Access-to-justice advocates in the United States have already turned to the health profession to explore possible models “to combine the expertise of lawyers with the lower cost of nonlawyers in ways that can increase affordable access while ensuring an adequate level of competence to protect consumers.”<sup>66</sup> Legal-empowerment programs themselves have taken inspiration from health care, and envision “a small corps of lawyers with a larger frontline of community paralegals who, like primary health workers, are closer to the communities in which they work and employ a wider set of tools.”<sup>67</sup>

The success of community health workers stems from their “strong ties with the communities they serve,” facilitating communication.<sup>68</sup> For instance, patient-navigator programs have been lauded for their effectiveness in assisting cancer patients by employing cancer survivors who “can relate directly to the patient experience and provide comfort and guidance.”<sup>69</sup> A randomized controlled trial in a New Haven clinic that serves patients who were recently released from prison showed that support from a community health worker “with a personal history of incarceration”<sup>70</sup> could lead to a fifteen percent absolute reduction in the proportion of patients with any Emergency Department visits and a fifty-one percent drop in the frequency of Emergency Department visits among other patients.<sup>71</sup> These community health workers aided patients in navigating medical and social services, such as accompanying patients to appointments; provided referrals to

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66. Laurel A. Rigertas, *Collaborations Between Lawyers and New Legal Professionals: A Path to Increase Access to Justice and Protect Clients*, 24 KAN. J.L. & PUB. POL’Y 539, 553 (2015).

67. Vivek Maru, *Allies Unknown: Social Accountability and Legal Empowerment*, 12 HEALTH & HUM. RTS. 83, 83 (2010); see also Zarnow, *supra* note 60, at 303 (“To provide an adequate level of access and service, the medical community has embraced levels of specialization and care that include community health workers, EMTs, nurses, nurse practitioners, physician assistants, doctors, and specialists. Community health workers, which are the most analogous to community-based paralegals, have made dramatic contributions to the health of the communities they serve.”); Maru, *supra* note 42, at 476 (“Paralegals relate to lawyers and the formal legal system not unlike the way primary health workers relate to doctors and the formal medical system: a dynamic force at the frontline, with a wider set of tools and aims; a force which, when necessary, facilitates communication between the people and the experts.”).

68. Peter Shin et al., *Medical-Legal Partnerships: Addressing the Unmet Legal Needs of Health Center Patients*, 18 GEIGER GIBSON/RCHN COMMUNITY HEALTH FOUND. RES. COLLABORATIVE 12 (2010); see also Ankita Rao, *How Community Health Workers Dramatically Improve Healthcare*, THE ATLANTIC, Feb. 4, 2014, <https://www.theatlantic.com/health/archive/2014/02/how-community-health-workers-dramatically-improve-healthcare/283555> [<https://perma.cc/95D9-T49K>] (“The area where community health workers catch on is where they retain their community identity and their advocacy for their community and yet have a sharply defined role in their health care system.” (quoting Dr. Prabhjot Singh, chairman of the One Million Health Worker Campaign)).

69. Shin et al., *supra* note 68, at 12.

70. Emily Wang et al., *Engaging Individuals Recently Released From Prison Into Primary Care: A Randomized Trial*, 102 AM. J. PUB. HEALTH e22, e23 (2012).

71. *Id.* at e27.



social services; and assisted with chronic-disease management, including support for medication adherence through home visits.<sup>72</sup> A program in Atlantic City found that employing health coaches, mainly from patient communities, who spoke the patients' languages and who had personal experience with chronic illness, led to a host of health improvements: emergency room visits and hospital admissions dropped by forty percent, surgical procedures decreased by a quarter, patients with high cholesterol had an average fifty-point drop in their levels, and sixty-three percent of smokers with health and lung disease quit smoking.<sup>73</sup> Community health workers can thus effectively prevent disease complications and emergency-room visits, in turn curbing health care costs.<sup>74</sup> For example, one study focusing on using community health workers to assist underserved men in Denver showed that using community health workers actually saved \$2.28 for each dollar spent by avoiding hospital expenses.<sup>75</sup>

Just as legal empowerment is a global phenomenon with links to development,<sup>76</sup> the community-health-worker movement in the United States has also drawn inspiration and models from abroad. As of 2014, India had more than 800,000 "accredited social health activists," Malawi had 11,000 "health extension workers," and Ethiopia had 38,000 "health extension workers," all playing integral roles in those countries' health care systems.<sup>77</sup> The idea for health coaches in the Atlantic City program came from the "promotoras" in the Dominican Republic, who work with doctors but see patients more often.<sup>78</sup> The health-coach program in Harlem drew inspiration from a South African model, which seeks to address the shortage in doctors, widespread mistrust of the health system, and poverty by working with trusted community leaders.<sup>79</sup> The United States now has about 38,000 community health workers, and Massachusetts and Minnesota have led the way in developing legislation defining their role in the health care system.<sup>80</sup>

As with community-based paralegals, community education is a critical component of the work of community health workers. In Florida and Texas, community health workers specialize in managing chronic disease and engaging in community education.<sup>81</sup> In Ethiopia, community health workers hold coffee

72. *Id.* at e23.

73. Atul Gawande, *The Hot Spotters: Can We Lower Medical Costs By Giving The Neediest Patients Better Care?*, THE NEW YORKER, Jan. 24, 2011, at 49.

74. Rao, *supra* note 68.

75. Elizabeth M. Whitley et al., *Measuring Return on Investment of Outreach by Community Health Workers*, 17 J. HEALTH CARE FOR POOR & UNDERSERVED 6, 10 (2006).

76. Golub, *supra* note 19, at 3.

77. Rao, *supra* note 68.

78. Gawande, *supra* note 73, at 47.

79. Sarah Varney, *An Idea Borrowed from South Africa: Ordinary Citizens Fill Gaps in Health Care*, KAISER HEALTH NEWS (Oct. 20, 2016), <http://khn.org/news/an-idea-borrowed-from-south-africa-ordinary-citizens-fill-gaps-in-health-care> [<https://perma.cc/24PN-VJ5V>].

80. Rao, *supra* note 68.

81. *Id.*

ceremonies “to bring people together to discuss health issues.”<sup>82</sup> In South Africa, health coaches “conduct classes in garages and visit people in their homes.”<sup>83</sup> In Harlem, health coaches help patients keep track of appointments and questions for their doctor. They see “teaching patients to be better advocates for themselves” as an integral part of their job.<sup>84</sup>

Additionally, incorporating community-based paralegals more broadly as part of MLPs has the exciting potential to further increase access to justice and civil legal services. In fact, access to justice advocates in the United States have argued for decades that paralegals should be increasingly used.<sup>85</sup> MLPs are already making use of non-lawyers and partnering with various staff at the health facility, including nurses, care managers, behavior health specialists, community health workers, and social workers to help secure legal rights for patients. For instance, some MLPs have trained social workers and medical staff on what certification requirements seriously ill patients must meet to avoid having their utilities shut off.<sup>86</sup> There is an opportunity to build on these efforts by hiring paralegals from the communities they serve, who could assist their peers in a range of ways, including providing basic legal knowledge, navigating administrative systems, drafting documents, mediating disputes, documenting rights violations, and mobilizing community members by leading roundtable discussions and know-your-rights campaigns.<sup>87</sup> Community-based paralegals can also help lead advocacy on issues identified through the MLP, such as housing problems affecting health.

One promising initiative of potential interest to MLPs is the introduction of “court navigators,” echoing patient navigators, who help patients navigate housing courts. While these navigators are non-lawyers and cannot argue cases, they can help tenants fill out paperwork and participate effectively in proceedings.<sup>88</sup> According to a 2016 study by the American Bar Foundation and National Center for State Courts, navigators in a Brooklyn court were “highly successful” in preventing evictions, obtaining court orders for needed repairs from landlords, and enabling tenants “to tell their side of the story to the court.”<sup>89</sup> MLPs can experiment

82. *Id.*

83. Varney, *supra* note 79.

84. *Id.*

85. Zarnow, *supra* note 60, at 302; see also Richard Zorza & David Udell, *New Roles for Non-Lawyers to Increase Access to Justice*, 41 *FORDHAM URB. L.J.* 1259, 1263–64 (2014).

86. Martin et al., *supra* note 14.

87. Quinn & Ezer, *supra* note 23, at 36.

88. Beth Fertig, *For Tenants in Housing Court, Study Finds ‘Navigators’ Can Be Good Alternatives to Lawyers*, WNYC NEWS (Dec. 13, 2016), <http://www.wnyc.org/story/tenants-housing-court-study-finds-navigators-can-be-good-alternatives-lawyers> [<https://perma.cc/D8DP-FGZZ>]; see also Rigertas, *supra* note 66, at 542–43; Angie M. Dorsch, *Examining the Role of Non-Lawyers in the Legal System*, 39 *WYO. LAW* 30, 32 (2016) (describing the court-navigator program in New York City and the legal-technician program in Washington state).

89. Fertig, *supra* note 88; see also REBECCA L. SANDEFUR & THOMAS M. CLARKE, *ROLES BEYOND LAWYERS* (2016) (providing a detailed report of the results of the study).

with integrating initiatives of this sort.

### III. TRANSFORMING MLPs TO COMMUNITY-CENTERED CARE

MLPs already brought a transformation in medical and legal services. As Elizabeth Tobin Tyler, an MLP leader,<sup>90</sup> describes, “By partnering lawyers and physicians to address the broader context affecting the health and stability of families and children, practitioners become holistic problem-solvers, not narrow specialists. In a sense, doctors become advocates for their patients and lawyers become healers for their clients.”<sup>91</sup> MLPs have not only shifted medicine to a more holistic outlook, but have also shifted legal work to a more preventive approach. As a number of MLP founders explain, “For lawyers, it presented an opportunity to change the way legal services are typically delivered, away from crisis-generated litigation toward *preventive law*.”<sup>92</sup> This is a perspective borrowed from medicine, which seeks to “resolve problems ‘upstream’ before they turn into crises ‘downstream.’”<sup>93</sup>

It is time now for a second transformation in care to a community-centered approach. MLPs should be proactive in partnering with communities, and communities can play a critical role as active partners and agents of change. This would strengthen individual care, as well as enforce a model of systemic advocacy envisioned as part of the MLP concept. Community engagement and grassroots mobilization can complement more legal approaches.

Such a transformation may require a rethinking of service delivery. The Errera Community Care Center, the site of the an MLP serving veterans in West Haven, Connecticut, did exactly that. They moved services from the hospital and into the community. By taking veterans out of an institutional setting, they hoped to foster their social integration and independent living.<sup>94</sup> As the Center’s director explained:

You co-locate programs, and you get the veterans out of the institutional setting because, when they’re in the institution, everybody feels they are a patient. What are the hallmarks of a patient? Let’s see—passive, helpless, things are done sequentially, and well, and that is not how people recover. That is not how people

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90. Elizabeth Tobin Tyler, HEALTH AFF. BLOG, <http://healthaffairs.org/blog/author/tyler> [https://perma.cc/MCP4-88ER] (describing Tyler as “a national expert in the development of medical-legal partnerships”).

91. Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL’Y 249, 254 (2008).

92. Schulman et al., *supra* note 2, at 759.

93. Mallory Curran, *Preventive Law: Interdisciplinary Lessons from Medical-Legal Partnership*, 38 N.Y.U. REV. L. & SOC. CHANGE 595, 602 (2014).

94. ELIZABETH BRADLEY & LAUREN TAYLOR, THE AMERICAN HEALTH CARE PARADOX: WHY SPENDING MORE IS GETTING US LESS 131 (2013).

learn to live the lives they want or dream of.<sup>95</sup>

Additionally, the Errera Community Care Center employs veterans, who make up almost half of the staff, and clients participate in the organization's governance, helping draft and co-sign policies.<sup>96</sup> Although MLPs are based in health care settings, both physical space and governance can have greater community orientation, recognizing members as more than just passive recipients of care. This is a principle various MLPs located in community health centers already embrace, serving as hubs of community support.<sup>97</sup>

Community involvement in MLP governance further points to a role for communities in program design and development. This starts with community participation in a needs assessment. A needs assessment can be a helpful tool for determining the type of services that should be provided and how these services can be provided most effectively, clarifying both the problems to be addressed and the context in which a program will operate. A needs assessment can also serve as a baseline against which to measure a program's progress.<sup>98</sup> Community participation through interviews, group discussions, and surveys is critical to ensure the accuracy and usefulness of the assessment. It enables an understanding of the priorities of the program's intended beneficiaries, their experiences with the legal and policy framework, and potential partnerships and resources. It is also an opportunity to connect and build trust with communities.<sup>99</sup> However, it is important to recognize that communities are not monolithic and collect disaggregated data.<sup>100</sup>

Community partners can further provide critical guidance as the program develops. Interview participants can become long-term partners.<sup>101</sup> A community advisory board can provide essential input not only at the program's inception, but throughout its operation. When starting its Community Lawyering Clinic, Drexel University's law school hosted an "open house" for community members to help shape its work. Recognizing the value of this engagement, they decided to make the open house an annual event "to solicit the community's feedback on the

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95. *Id.*

96. *Id.*

97. For instance, this is a core principle for MLPs working with the Association of Asian Pacific Community Health Organizations. See ASS'N OF ASIAN PACIFIC CMTY. HEALTH ORGS., *supra* note 30; see also INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE, <http://www.ipfcc.org> [https://perma.cc/9DUR-UANK] (providing resources on which MLPs can draw).

98. Quinn & Ezer, *supra* note 23, at 70. Such needs assessments were conducted by the Open Society Public Health Program before rolling out a project on Roma health rights in Macedonia, Romania, Serbia and by the African Palliative Care Association before integrating legal services into palliative care in Uganda. *Id.* at 71, 72.

99. Quinn & Ezer, *supra* note 23, at 70, 72.

100. *Id.* at 71.

101. *Id.* at 72.

effectiveness of [the legal] programs as well as their future direction.”<sup>102</sup> As the Open Society Public Health Program explained, “It is important to partner with socially excluded groups by involving them in the design, delivery, and evaluation of access to justice programs intended to support and benefit them.”<sup>103</sup> This method of partnering “helps ensure the work responds to the needs and priorities of these groups. It is also a key marker of a human rights–based approach.”<sup>104</sup>

A transformation in service delivery further calls for a shift from a needs-based to a rights-based approach. MLPs generally operate from a needs framework. As MLP theory sets out, “MLPs are built on the understanding that social determinants of health often manifest in the form of legal needs, and that attorneys have special tools and skills to address these needs.”<sup>105</sup> MLPs traditionally then bring together health teams and lawyers “to address the needs of vulnerable patients and communities by identifying, solving, and preventing health-harming legal needs.”<sup>106</sup> In this depiction, communities are “vulnerable” and passive objects with needs, rather than subjects with rights or partners who can create change.

MLP leaders, however, are already taking some promising steps to explore a rights framework. In a 2013 article looking at MLPs through a health-and-human-rights lens, Elizabeth Tobin Tyler writes: “The ultimate goal is systems accountability and change. This will only come with lawyers and health care providers partnering with and empowering communities to enforce and articulate their rights as human rights.”<sup>107</sup> MLPs would benefit from taking these words to heart and investing in efforts to develop this approach.

In this way, the MLP movement can build on examples of good work, moving beyond the confines of the doctor-patient or lawyer-client relationship and partnering with communities to revamp care. If the goal is social change and addressing disparities, MLPs would benefit from adopting a legal-empowerment approach and expanding their community engagement. This would require greater

102. Brooks & Lopez, *supra* note 39, at 148.

103. Quinn & Ezer, *supra* note 23, at 8.

104. *Id.*

105. Ellen M. Lawton & Megan Sandel, *Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEGAL MED. 29, 33 (2014); see also Tyler, *supra* note 1, at 234 (“The premise of MLP is that unmet legal needs are social determinants of health: ‘A legal need is an adverse social condition with a legal remedy—that is, an unmet basic need that can be satisfied via laws, regulations, and policies. Unmet legal needs, which can lead to poor health outcomes, are critical social determinants of health.’” (quoting Ellen Lawton et al., *Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations*, in POVERTY, HEALTH & L. 71, 72 (Elizabeth Tobin Tyler et al. eds., 2011))).

106. Curran, *supra* note 93, at 595.

107. Tyler, *supra* note 7, at 88; see also *id.* at 92 (“To be an effective human rights strategy, however, advocates must engage and mobilize affected individuals and communities to give voice to the indignities and rights violations that occur every day across the US and to challenge the social conditions which harm their health.”).

investment in rights-literacy programs, integration of community-based paralegals, partnership with communities in program design and development, and adoption of a rights- rather than needs-based framework. MLPs have the exciting potential to strengthen both care and advocacy, contributing to systemic change and building a more just and healthy society.

# Ethics of Evidence: Health Care Professionals in Public Benefits and Immigration Proceedings

Jesselyn Friley\*

## ABSTRACT

This Article discusses the role of health care professionals in applications for public benefits and immigration relief. Medical-legal partnerships (MLPs) often represent patients who are applying for disability or veterans benefits, or who are seeking asylum based on past persecution. The strength of a patient's medical evidence often determines whether their claim succeeds or fails. Many health care professionals provide corroborating evidence for their patients, but even when they do not, their opinions appear in the proceedings through medical records. Furthermore, health care professionals are not ordinary witnesses: Like lawyers, they are bound by their own ethical codes. This Article describes the role of medical evidence in public benefits and immigration proceedings; identifies the ethical rules that shape health care professionals' participation in these proceedings; and provides brief suggestions for MLP lawyers seeking the best medical evidence for their clients.

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TABLE OF CONTENTS

**TABLE OF CONTENTS ..... 328**

**INTRODUCTION..... 329**

**I. MLPS AND ADMINISTRATIVE ADVOCACY ..... 331**

**II. HEALTH CARE PROFESSIONALS’ ROLES IN ADMINISTRATIVE**

**ADVOCACY..... 333**

    A. SSI AND SSDI ..... 334

    B. VETERANS BENEFITS ..... 335

    C. ASYLUM ..... 336

**III. HEALTH CARE PROFESSIONALS AS WITNESSES AND ADVOCATES..... 337**

    A. MEDICAL ETHICS AND PROFESSIONAL CULTURE ..... 338

**IV. SUGGESTIONS FOR LAWYERS SEEKING PHYSICIAN TESTIMONY ..... 340**

**CONCLUSION ..... 342**



## INTRODUCTION

Health care professionals play a crucial role in the vast administrative bureaucracy that gives people access to public benefits and immigration relief.<sup>1</sup> For example, individuals applying for programs such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) must submit medical opinions as evidence of their disabilities.<sup>2</sup> Veterans seeking compensation for injuries connected to their military service use their medical records to trace their current conditions to events that occurred in service.<sup>3</sup> Asylum applicants can make a stronger case for past persecution if they have an affidavit from a psychiatrist or psychologist describing trauma symptoms or connecting physical and mental scars to past persecution.<sup>4</sup> In the proceedings associated with each of these benefits, an administrative agency weighs medical opinions about the client's medical condition against legal standards.<sup>5</sup> Given the high volume of disability and immigration decisions each year,<sup>6</sup> administrative proceedings like these are the main settings where health care professionals play a role in advocating for their patients.

Medical-legal partnerships (MLPs) play an important role in this ecosystem. Usually housed within health care facilities, MLPs connect lawyers with medical patients who have legal needs that impact their health.<sup>7</sup> Although MLPs have different legal practices, lawyers at MLPs often help their clients apply for public benefits and immigration relief.<sup>8</sup> Many health care professionals participate

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1. Throughout this paper, I use "health care professionals" as a shorthand for all types of clinicians that interact with MLP clients, including psychiatrists and other mental health professionals, nurses, and specialists.

2. See Amy Killelea, Note, *Collaborative Lawyering Meets Collaborative Doctoring: How a Multidisciplinary Partnership for HIV/AIDS Services Can Improve Outcomes for the Marginalized Sick*, 16 GEO. J. POVERTY L. & POL'Y 413, 439 (2009); Cathryn Miller-Wilson, *Medical-Legal Partnerships: Origins and Ethical Lessons*, 93 NEB. L. REV. 636, 644 (2015).

3. Rishi Manchanda et al., *The Invisible Battlefield*, NAT'L CTR FOR MEDICAL-LEGAL PARTNERSHIP 11, (2016).

4. Sabrineh Ardalan, *Constructive or Counterproductive? Benefits and Challenges of Integrating Mental Health Professionals into Asylum Representation*, 30 GEO. IMMIGR. L.J. 1, 14–15 (2015).

5. See, e.g., *Garrison v. Colvin*, 759 F.3d 995, 1008-09 (9th Cir. 2014); *Gambill v. Shinseki*, 576 F.3d 1307, 1310 (Fed. Cir. 2009); *Morgan v. Mukasey*, 529 F.3d 1202, 1206 (9th Cir. 2008).

6. See, e.g., *Asylum Statistics*, U.S. DEP'T JUST., <https://www.justice.gov/eoir/file/asylum-statistics/download> [<https://perma.cc/3B7P-C4E4>]; *Outcomes of Applications for Disability Benefits*, SOC. SEC. ADMIN. (2015), [https://www.ssa.gov/policy/docs/statcomps/ssi\\_asr/2015/sect10.html](https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2015/sect10.html) [<https://perma.cc/K8KQ-ZC8Y>].

7. See Bharath Krishnamurthy et al., *What We Know and Need to Know About Medical-Legal Partnership*, 67 S.C. L. REV. 377, 377 (2016).

8. See *How Legal Services Help the Health Care System Address Social Needs*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlp-response/i-help> [<https://perma.cc/2BNS-TKYN>] (listing public benefits and asylum applications as civil legal aid interventions that impact health); *Partnerships Across the U.S.*, NAT'L CTR. MED.-LEGAL

actively in their patients' benefit applications,<sup>9</sup> but even when they do not directly advocate for their patients, their words appear in administrative proceedings through medical records. These records are a significant source of corroborating evidence for applications for disability and veterans benefits.<sup>10</sup> While not every asylum proceeding involves medical evidence, records are often used to corroborate stories of torture and trauma, and to bolster an applicant's credibility.<sup>11</sup> Thus, any medical professional who comes into contact with a patient can affect the outcome of their applications for public benefits or immigration relief simply by contributing to their medical records. These are an important nexus between the medical side and the legal side of an MLP.

In administrative proceedings and elsewhere, health care professionals are not ordinary witnesses. They are bounded by codes of professional ethics that emphasize independent judgment and honesty.<sup>12</sup> Meanwhile, lawyers are also bounded by ethics rules that compel them to advocate for their clients as vigorously as they can.<sup>13</sup> The interaction between these tenets of medical and legal ethics can be a source of conflict in MLPs.<sup>14</sup> For instance, a lawyer may push a physician to tailor his treatment notes to match legal standards. In making such a request, the lawyer is fulfilling his obligation to secure the best outcome for his client. But, in going along with the request, the physician may have to compromise his ethical duty of professional independence.<sup>15</sup> This type of overreach, while often motivated by the lawyer's good-faith desire to achieve the best outcome for her client, can damage the physician's trust in the lawyer and willingness to help. In some cases, a health care professional's testimony can even damage a client's prospects for making a successful claim for public benefits or immigration relief.<sup>16</sup> A health care professional who expresses doubt about a patient's candor, symptoms, or past

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PARTNERSHIP, <http://medical-legalpartnership.org/partnerships> (listing centers for immigration law, disability law, veterans, and general civil legal aid among national MLPs).

9. See, e.g., Ardalet, *supra* note 4 at 15; Manchanda, *supra* note 3 at 16; *LegalHealth: SSI/SSD Application Assistance*, N.Y. LEGAL ASSISTANCE GROUP (2017), <http://nylag.org/units/legalhealth/projects/ssissd-application-assistance> [<https://perma.cc/8WU9-B3FX>].

10. See, e.g., 38 U.S.C. § 5103A (2012) (requiring the VA to make reasonable efforts to find records relevant to a veteran's claim); Miller-Wilson, *supra* note 2 at 649.

11. See, e.g., *Tadesse v. Gonzales*, 492 F.3d 905, 911 (7th Cir. 2007); DEBORAH E. ANKER, *LAW OF ASYLUM IN THE UNITED STATES* § 3:10 (2016).

12. See, e.g., *Code of Medical Ethics*, AM. MED. ASS'N, <https://www.ama-assn.org/about-us/code-medical-ethics> [<https://perma.cc/8YBK-M5DA>].

13. See, e.g., *Model Rules of Professional Conduct*, AM. BAR ASS'N (2017), [http://www.americanbar.org/groups/professional\\_responsibility/publications/model\\_rules\\_of\\_professional\\_conduct.html](http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct.html) [<https://perma.cc/U96P-WH97>].

14. See, e.g., Miller-Wilson, *supra* note 2, at 649.

15. See, e.g., Donald Irvine, *The Performance of Doctors. I: Professionalism and Self Regulation in a Changing World*, 314 *BRIT. MED. J.* 1540, 1540–41 (1997) (discussing the importance of independence in the medical profession).

16. See, e.g., *infra* note 73 and accompanying text

injuries can derail the application entirely.<sup>17</sup>

This symposium Article explores a gap in the MLP literature on the role of health care professionals as witnesses in administrative adjudication and on the ethical considerations surrounding that role.<sup>18</sup> The nature of an MLP requires that the same health professionals and lawyers collaborate repeatedly to bring the same types of claims on behalf of different clients. It is critical that health care professionals and lawyers work well together in this environment. Furthermore, unlike other contexts in which health care professionals appear as expert witnesses, an MLP lawyer usually does not have the luxury of sending the patient to another physician for a second opinion—the patient’s treating physicians are likely to be the only source of testimony.<sup>19</sup>

Part I provides background on MLPs and describes the following three forms of administrative proceedings—social security disability hearings, service-connected compensation for veterans, and asylum proceedings. Part II describes the role of health care professionals in these proceedings, using statutory, regulatory, academic, and case law sources to show how medical corroboration can make or break a claim. Part III provides an account of the reasons why health care professionals may hesitate to provide corroboration for their patients, including the medical profession’s tradition of independence and the differing roles of information in medicine and in law. Part IV offers suggestions for lawyers in MLPs seeking to improve their relationships with health care professionals and to secure the best possible outcomes for their clients.

## I. MLPs AND ADMINISTRATIVE ADVOCACY

As a brief primer, the first MLP was established in 1993.<sup>20</sup> MLPs connect

17. See Rand, *supra* note 16 at 30.

18. There is, however, already a literature on possible conflicts between legal and medical ethics in the realms of confidentiality, mandatory reporting, and privilege. See, e.g., Rand, *supra* note 16, at 35; Scott, *supra* note 5; Killelea, *supra* note 2.

19. See Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for their Patients*, 12 IND. HEALTH L. REV. 1, 7 (2015). Some patients, especially veterans, may struggle to get any appointment with a physician, much less a second opinion. See, e.g., Curt Devine & Scott Bronstein, *VA Inspector General Admits Wait Times Contributed to Vets’ Deaths*, CNN (Sept. 18, 2014), <http://www.cnn.com/2014/09/17/politics/va-whistleblowers-congressional-hearing> [<https://perma.cc/BXH3-L82K>]; Gregg Zoroya, *VA Scandal Probe Targets Potential Obstruction of Justice*, USA TODAY (Aug. 26, 2014), <http://www.usatoday.com/story/news/nation/2014/08/26/va-veterans-affairs-scandal-mcdonald-phoenix/14620397> [<https://perma.cc/BEU8-7XJV>]; see also Stacey-Rae Simcox, *Lightening the VA’s Rucksack: A Proposal for Higher Education Medical-Legal Partnerships to Assist the VA in Efficiently and Accurately Granting Veterans Disability Compensation*, 25 CORNELL J.L. & PUB. POL’Y 141, 142–43 (2015) (“The VA is a titanic bureaucracy that is unlikely to deliver benefits to veterans efficiently or effectively in its current state.”).

20. Ellen Lawton, *A History of the Medical-Legal Partnership Movement*, COMM. HEALTH FORUM 12 (2014), <http://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-A-History-of-the-Medical-Legal-Partnership-Movement.pdf> [<https://perma.cc/F3DB-P2UT>].

health care professionals with lawyers who can help their patients with legal needs.<sup>21</sup> Civil legal aid can alleviate many of the social, financial, and environmental causes of poor health and, in turn, health care providers can be a referral source for legal services organizations.<sup>22</sup> MLPs help patients with legal needs involving their income (e.g., government benefits), housing and utilities, education, employment, legal status, and personal and family stability.<sup>23</sup> A lawyer representing an MLP client may give advice, write a letter on the client's behalf, file forms with a government agency, or provide full representation in front of a tribunal.<sup>24</sup> Health care professionals at MLPs can be doctors, nurses, community health workers, or mental health practitioners, and they attend to medical needs from acute conditions to chronic mental and physical illnesses.<sup>25</sup> The legal and medical sides of the MLP usually co-locate at health care facilities, but there are many variations on the model.<sup>26</sup> By combining the efforts of lawyers and health care professionals, all MLPs aim to offer better services to clients with interrelated health and legal needs.<sup>27</sup>

Some of the most important legal needs can only be solved through administrative proceedings. For instance, many MLPs have clients with disabilities or other barriers to earning income. Lawyers can help these clients apply for public benefits programs, such as SSDI and veterans benefits, which are managed by an extensive administrative bureaucracy. Similarly, MLPs may also have clients who are undocumented, but may be eligible for immigration relief, such as asylum or withholding of removal. Such relief can only come from asylum officers and immigration judges, who are also part of a vast system of administrative proceedings. An applicant whose claims for benefits or immigration relief is denied can appeal to the relevant administrative agency, and then to the federal courts.<sup>28</sup>

An MLP client's application for benefits will likely give him the opportunity to present evidence before a neutral decision-maker. For example, the Social Security Administration relies on administrative law judges (ALJs) who conduct SSDI and SSI hearings and make initial decisions on benefits applications.<sup>29</sup> The

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21. See Krishnamurthy et al., *supra* note 7, at 377.

22. *Id.* at 377–378; James Teufel et al., *Legal Aid Inequities Predict Health Disparities*, 38 *HAMLINE L. REV.* 329, 355 (2015) (“A growing body of evidence supports that legal representation results in improved health outcomes.”).

23. NAT'L CTR. MED.-LEGAL PARTNERSHIP, *supra* note 8.

24. *Id.* (listing civil legal aid interventions of the forms described above).

25. See Krishnamurthy et al., *supra* note 7, at 381.

26. Marcia M. Boumil et al., *Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model*, 13 *J. HEALTH CARE L. & POL'Y* 107, 108 (2010).

27. See J. Michael Norwood & Alan Paterson, *Problem-Solving in a Multidisciplinary Environment? Must Ethics Get in the Way of Holistic Services?*, 9 *CLIN. L. REV.* 337, 362 (2002).

28. See *supra* note 8 and accompanying text.

29. 5 U.S.C. § 3105 (2012); Kent Barnett, *Against Administrative Judges*, 49 *U.C. DAVIS L.*

Executive Office of Immigration Review (EOIR) employs immigration judges (IJs) to review applications for asylum and other forms of immigration relief.<sup>30</sup> For initial benefits determinations, the Department of Veterans Affairs relies on ratings specialists at local offices and has veterans law judges (VLJs) decide any appeals of these decisions on an open record.<sup>31</sup> Lawyers at MLPs help their clients through these proceedings, just as they would help them through a trial in a federal or state court.

## II. HEALTH CARE PROFESSIONALS' ROLES IN ADMINISTRATIVE ADVOCACY

While lawyers usually handle written and oral advocacy, health care professionals contribute a significant portion of the evidence in the administrative proceedings described above. All of these proceedings give applicants the opportunity to present evidence, including medical records, declarations, and other documents, in support of their claims.<sup>32</sup> Applications for asylum, disability benefits, and service connected compensation for veterans all either require or benefit from some form of positive testimony from a health care professional.<sup>33</sup> For instance, asylum applicants can make a stronger case for past persecution if they submit medical evidence of physical or mental trauma.<sup>34</sup> Veteran law judges decide applications for discharge upgrades and service connected compensation based on evidence from medical records of a veteran's health before, during, and after service.<sup>35</sup> Applicants for disability benefits have better odds if a health care professional provides compelling testimony that they can no longer engage in activities required by their work due to a severe medical condition.<sup>36</sup> In these types of benefit applications, an administrative decision-maker weighs testimony about the client's medical condition and history against legal standards. This section will briefly describe the role that health professional testimony plays in each of these types of proceedings, from the perspective of the legal standards and regulations that govern them.

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REV. 1643, 1656 (2016).

30. See *Ethics and Professionalism Guide for Immigration Judges*, U.S. DEP'T JUST. (Jan. 31, 2011), <https://www.justice.gov/sites/default/files/eoir/legacy/2013/05/23/EthicsandProfessionalismGuideforIJs.pdf> [<https://perma.cc/62K6-QY3R>].

31. *Board of Veterans Appeals*, U.S. DEP'T VET. AFF. (Jan. 25, 2017), <http://www.bva.va.gov> [<https://perma.cc/QL9Y-WWDP>].

32. See Jonathan Krisch, *Judge, Jury, and the Gatekeeper: Admitting and Weighing Expert Testimony in Veterans' Claims Adjudication and the Federal Courts*, 4 VET. L. REV. 41, 57 (2012).

33. See *infra* notes 34–36.

34. See *Morgan v. Mukasey*, 529 F.3d 1202, 1206, 1211 (9th Cir. 2008); *Tadesse v. Gonzales*, 492 F.3d 905, 911 (7th Cir. 2007); *Ardalen*, *supra* note 4 at 14–15.

35. Manchanda et al., *supra* note 9, at 11.

36. See Miller-Wilson, *supra* note 2, at 644, 649.

*A. SSI and SSDI*

The Social Security Administration (SSA) offers two disability benefit programs. The Supplemental Security Income (SSI) program supports people who are both indigent and disabled.<sup>37</sup> Meanwhile, a person who is insured and disabled—but need not necessarily be indigent—is eligible for SSDI.<sup>38</sup> The two programs use the same process to determine whether an individual is disabled.<sup>39</sup> Health care professionals' testimony and medical records are important parts of the process, because an individual must have a severe physical or mental impairment or combination of impairments to qualify for benefits.<sup>40</sup> ALJs also have a duty to develop the record, assessing the value and credibility of each medical opinion presented by both sides.<sup>41</sup>

Disability proceedings are adversarial, and almost 80% of applicants are represented by an attorney.<sup>42</sup> Both sides have the opportunity to present evidence and to contest the evidence put forth by the other side.<sup>43</sup> Usually, the applicant will submit medical records and other evidence from a treating physician.<sup>44</sup> The SSA will then send the applicant to at least one consultative medical examiner for an outside assessment of the applicant's impairments.<sup>45</sup> Medical records also play a role because an ALJ must discount any physician conclusions that are not supported by medical evidence.<sup>46</sup> As one commentator has noted, these records are "often, at best, unhelpful with regard to the legal question of whether the client is disabled and at worst they unintentionally undermine the client's application."<sup>47</sup>

Concerns about the subjectivity of medical evidence abound throughout the system.<sup>48</sup> Even the Supreme Court has acknowledged that a consulting physician may have an incentive to make a finding of not disabled, while a treating physician may favor a finding of disabled in a close case.<sup>49</sup> Courts have attached different amounts of deference to the opinions of treating physicians versus those of

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37. Harold J. Krent & Scott Morris, *Inconsistency and Angst in District Court Resolution of Social Security Disability Appeals*, 67 HASTINGS L.J. 367, 373 (2016).

38. *Id.*

39. *Id.*

40. See 20 C.F.R. § 404.1520 (2017).

41. Krent & Morris, *supra* note 37, at 376.

42. *Id.* at 375.

43. Miller-Wilson, *supra* note 2, at 659.

44. *Id.* at 661.

45. *Id.*

46. See, e.g., *Mays v. Colvin*, 739 F.3d 569, 575 (10th Cir. 2014).

47. Miller-Wilson, *supra* note 2 at 649.

48. *Id.* at 664, 667 ("Courts . . . realized that physicians' sworn statements—viewed as sacrosanct because of their reliability—were in fact neither more or less reliable than any other type of opinion evidence.").

49. See *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 829 (2003).

consultative physicians,<sup>50</sup> but, in any event, physicians' words have stronger weight than applicants' words. For instance, a claimant can testify as to the extent of her pain and other symptoms, but a physician's description of symptoms—even if they are entirely subjective—is given more weight under the regulations.<sup>51</sup>

### B. Veterans Benefits

The Department of Veterans Affairs (VA) administers a number of benefits programs, the largest of which compensates veterans for injuries incurred or aggravated by their military service.<sup>52</sup> Unlike SSA benefits, service-connected compensation is awarded according to a non-adversarial process.<sup>53</sup> The VA rates the severity of service-connected disabilities on a scale from 0 to 100 percent.<sup>54</sup> Veterans with more than one disability receive a single combined rating, and a rating of 10 percent or higher entitles a veteran to compensation.<sup>55</sup> Ratings specialists are not doctors and are not permitted to make their own medical judgments.<sup>56</sup> By statute, the VA has a duty to assist veterans in making their claims for compensation.<sup>57</sup> Usually, this means that the VA will make reasonable efforts to obtain and analyze the veteran's medical records, but occasionally, the VA must also provide a non-partisan medical opinion at no cost to the veteran.<sup>58</sup> This opinion need not involve a personal examination, but it must (1) involve a thorough and contemporaneous examination of records, (2) take into account prior medical treatment, and (3) fully inform the reviewer about the disability.<sup>59</sup>

Similar to ALJs working for the SSA, VA reviewers must weigh medical records and opinions that are inconsistent or inconclusive.<sup>60</sup> Aside from these rare VA-ordered examinations, a veteran's medical records form the backbone of her application for service-connected compensation. These records may include

50. Miller-Wilson, *supra* note 2 at 662–63.

51. 20 C.F.C. § 404.1527(c)(2); *Garrison v. Colvin*, 759 F.3d 995, 1012, 1014 (9th Cir. 2014) (describing the standards for discrediting treating physician testimony, and the comparatively less strict standards for rejecting a patient's symptom testimony).

52. *Board of Veterans Appeals*, *supra* note 31.

53. See Krisch, *supra* note 32, at 57 (2012).

54. L. Scott Muller et al., *Veterans Who Apply for Social Security Disabled-Worker Benefits After Receiving a Department of Veterans Affairs Rating of "Total Disability" for Service-Connected Impairments: Characteristics and Outcomes*, 74 SOC. SEC. BULLETIN No. 3 (2014), <https://www.ssa.gov/policy/docs/ssb/v74n3/v74n3p1.html> [<https://perma.cc/KH3G-MN4L>].

55. *Id.*

56. Krisch, *supra* note 53, at 64 (citing *Gambill v. Shinseki*, 576 F.3d 1307, 1310 (Fed. Cir. 2009) (Moore, J. concurring)).

57. 38 U.S.C. § 1110(a), (b) (2012).

58. See, e.g., *Cook v. Principi*, 318 F.3d 1334, 1336 (Fed. Cir. 2002).

59. Krisch, *supra* note 32, at 63.

60. See 38 C.F.R. § 4.2 (2017) ("Different examiners, at different times, will not describe the same disability in the same language. . . . It is the responsibility of the rating specialist to . . . reconcile[] the various reports into a consistent picture . . .").

additional commentary from a variety of medical professionals who have treated the veteran over many years. Older medical evidence is relevant to the question of whether a veteran's service caused or aggravated his disability, and the backwards-looking nature of the inquiry can lead to further inconsistencies.<sup>61</sup> An additional challenge for veterans is that the VA prefers to see medical conclusions stated in probabilistic terms—for example, whether a certain disability is “mostly likely” or “at least as likely as not” caused by an event that occurred during a veteran's service.<sup>62</sup> Health care professionals may be reluctant to make such conclusions, let alone to state them in these terms, for reasons that I will discuss below, especially if they are unaware that doing so would help their patient satisfy the relevant legal standards.<sup>63</sup> Failure to do so can lead to a decision denying service connection.<sup>64</sup>

### C. Asylum

Asylum is a form of immigration relief that grants legal status to individuals who have experienced past persecution, or who have a well-founded fear of future persecution, in their home countries.<sup>65</sup> Under the REAL ID Act of 2005, applicants must be credible.<sup>66</sup> Immigration judges review asylum applications and conduct hearings with the applicant and with any witnesses she might want to call.<sup>67</sup>

Although not every asylum claim requires medical evidence, health care professionals can be highly effective witnesses for two main reasons.<sup>68</sup> First, a physician or a psychologist may be able to corroborate a torture victim's story by diagnosing and treating scars and wounds caused by weapons, physical abuse, or other trauma.<sup>69</sup> Even when past persecution does not leave a physical mark on an applicant's body, he may submit medical records indicating a diagnosis of posttraumatic stress disorder (PTSD) or other mental condition.<sup>70</sup> A health care professional's second role in an asylum proceeding is to defend against an adverse credibility finding. Medical experts can explain the causal relationship between an

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61. See, e.g., *Wagner v. Principi*, 370 F.3d 1089, 1096 (Fed. Cir. 2004).

62. Krisch, *supra* note 32, at 70–71.

63. *Id.* at 71.

64. See, e.g., *Fagan v. Shinseki*, 573 F.3d 1282, 1290 (Fed. Cir. 2009) (“[B]ecause the report did not state that the veteran's disability was likely service connected, [it] was insufficient to establish service connection.”).

65. See 8 U.S.C. §§ 1101(a)(52); 1158(b)(1)(B) (2012).

66. See 8 U.S.C. § 1158(b)(1)(B)(iii) (2012); *Shrestha v. Holder*, 590 F.3d 1034, 1039–40 (9th Cir. 2010).

67. See *EOIR at a Glance*, U.S. DEP'T JUSTICE (Jan. 8, 2016), <https://www.justice.gov/eoir/eoir-at-a-glance> [<https://perma.cc/GK4V-NYWV>].

68. ANKER, *supra* note 11, at § 3.10; Caitriona Palmer & Kerri Sherlock, *Doctors and Lawyers: Fighting for Immigrant Rights*, HUM. RTS. 23 (1998).

69. Palmer & Sherlock, *supra* note 68, at 23.

70. See, e.g., *Morgan v. Mukasey*, 529 F.3d 1202, 1206 (9th Cir. 2008); *Tadesse v. Gonzales*, 492 F.3d 905, 911 (7th Cir. 2007); *Mukamusoni v. Ashcroft*, 390 F.3d 110, 122–23 (1st Cir. 2004).



applicant's past persecution and her current inability to remember events or to explain them in a coherent, consistent narrative.<sup>71</sup> In a treatment setting, medical professionals can also help asylum seekers recount episodes of past persecution in a "coherent and linear manner, understandable to U.S. adjudicators."<sup>72</sup> A number of cases have acknowledged the importance of physician or mental health expert testimony in asylum cases.<sup>73</sup>

To summarize, testimony from health care professionals is a crucial part of the administrative proceedings that determine who get disability benefits and service-connected compensation, and can play a vital role in some asylum cases as well. Health care professionals participate directly in Social Security proceedings by providing treating physician testimony, and they may submit affidavits on behalf of veterans seeking service-connected compensation. They may also serve as experts in asylum proceedings, testifying as to an applicant's injuries from past persecution and explaining the effects of past trauma on memory and other aspects of an applicant's presentation. In all three types of proceedings, however, health care professionals help build the medical records that the applicant will use as a primary source of evidence to support their application. Whether they want to or not, health care professionals exert significant control over their patients' fates in administrative proceedings.

### III. HEALTH CARE PROFESSIONALS AS WITNESSES AND ADVOCATES

If a physician were like any other witness, a lawyer would try to help him craft his testimony in ways that would be most helpful to the client. The lawyer would instruct the physician to describe the patient's symptoms in ways that align closely or exactly with the legal standards most relevant to the application. For physicians treating veterans, this preparation would mean identifying a causal relationship between an event in service and a current diagnosis and using probabilistic terms to discuss that relationship. For asylum applicants, it would mean stating that the applicant's account of persecution is credible and that it fits with the applicant's physical and mental manifestations of trauma. For disability applicants, it would mean tailoring a description of symptoms to legal standards and emphasizing the relationship between an impairment and the tasks required by the applicant's job. In any of these proceedings, a health care professional can provide insight into any inconsistencies between the different medical opinions that appear in an applicant's medical records. A medical professional who treats a patient over a long period can use medical records to build up a case for a particular public benefit over time. A lawyer who regularly works on these types of claims—and especially

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71. ANKER, *supra* note 11, at § 3.10; Ardalen, *supra* note 4, at 6.

72. Ardalen, *supra* note 4, at 13; Rand, *supra* note 16, at 20–21.

73. See, e.g., Zeru v. Gonzales, 503 F.3d 59, 73–74 (1st Cir 2007); Lopez-Umanzor v. Gonzales, 403 F.3d 1049, 1050 (9th Cir. 2005).

an MLP lawyer who works with a relatively constant set of medical professionals—can improve his client’s position by asking a clinician to formulate his medical records, affidavits, and letters to the court in these ways.

But, a lawyer cannot treat a physician like any other witness. Like many other professionals, including lawyers, health care professionals are bounded by ethical codes.<sup>74</sup> Although these codes allow health care professionals to take on advocacy roles, professional values and cultures can conflict with a lawyer’s means of advocating on behalf of a client.<sup>75</sup> For instance, many physicians recognize the importance of public benefits programs in improving their patients’ health.<sup>76</sup> But, they may be reluctant to help their patients obtain those benefits if doing so requires them to compromise their professional independence.<sup>77</sup> Zealous advocacy is no longer an ethical requirement of the legal profession,<sup>78</sup> but a lawyer’s efforts to “maximize the client’s advantage and minimize any disadvantage” can easily make a physician feel uneasy about her own ethical obligations.<sup>79</sup>

The rest of this section provides a brief background on the American Medical Association’s Code of Medical Ethics, which is representative of the various codes governing health care professionals and describes how its principles can lead to two forms of conflicts between lawyers and physicians working with MLP clients. One of these conflicts stems from values that both professions share: professional independence. Another conflict reflects differing conceptions in the two professions: the role of information in medicine is very different from the role of information in a procedure-bound, adversarial legal profession.

### *A. Medical Ethics and Professional Culture*

Like the legal profession, the medical profession adheres to a code of ethics.<sup>80</sup> While legal ethics are the province of state law and bar associations, the American Medical Association (AMA) centrally governs medical ethics.<sup>81</sup> The AMA’s Code of Medical Ethics consists of a set of nine principles and a series of ethical opinions and reports put forth by the Council on Ethical and Judicial Affairs.<sup>82</sup> The principles have been revised several times since they were first adopted in 1847,<sup>83</sup>

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74. Boumil et al., *supra* note 26, at 119; AM. MED. ASS’N, *supra* note 12.

75. See Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL’Y 331, 335, 340 (2008).

76. See, e.g., Manchanda, *supra* note 3, at 11.

77. See, e.g., Miller-Wilson, *supra* note 3, at 649.

78. See Scott, *supra* note 75, at 354–55.

79. Norwood & Paterson, *supra* note 27, at 363.

80. See Frank A. Riddick, *The Code of Medical Ethics of the American Medical Association*, 5 OSCHNER J. 6, 6 (2003).

81. *Id.* at 7.

82. *Id.* at 6.

83. AM. MED. ASS’N, *supra* note 12.

and in their current form, they emphasize that a physician should uphold standards of competence, respect patients' privacy rights, and support access to medical care for all people, among other things.<sup>84</sup> Like the law, medicine also has an uncoded "professional culture" that influences the values and analytical approaches that physicians act on every day.<sup>85</sup>

Of the many ethical rules and cultural norms that govern the medical profession, two aspects in particular affect a physician's participation in administrative proceedings. First, the medical profession has a strong culture of independence—indeed, earlier versions of the Principles of Medical Ethics explicitly stated: "A physician should not dispose of his services under terms of conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill . . ."<sup>86</sup> Second, medicine is rooted in science, and medical professionals seek "the whole truth" about every aspect of a patient's condition and to avoid distorting their opinions.<sup>87</sup> I will refer to this second principle as an information value.

The medical profession's interrelated norms about independence and information conflict with the legal profession's own norms in different ways. The medical profession's independence value has a parallel in the legal profession, which has a rule that emphasizes lawyers' professional independence.<sup>88</sup> When two members of different professions work with the same client and each comes from a profession that values independent judgment, there may be a clash of roles or cultures.<sup>89</sup> Conversely, the medical and legal professions conceptualize truth in different ways.<sup>90</sup> Lawyers have a duty of candor to the court—they may not hide bad facts or bad law<sup>91</sup>—but they are specifically trained to minimize any weak

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84. *AMA Code of Medical Ethics: AMA Principles of Medical Ethics*, AM. MED. ASS'N (2016), <https://www.ama-assn.org/sites/default/files/media-browser/principles-of-medical-ethics.pdf> [<https://perma.cc/JZ7B-7AMH>].

85. Norwood & Paterson, *supra* note 27 at 363.

86. Riddick, *supra* note 80, at App'x A (providing the full text of the 1957 AMA Principles of Medical Ethics).

87. See Charles C. Dike, *Ethics Case: The Treating Psychiatrist and Worker's Compensation Reporting*, 15 AM. MED. ASS'N J. ETHICS 840, 841 (2013).

88. See *Rule 5.4: Professional Independence of a Lawyer*, AM. BAR ASS'N (2016), [http://www.americanbar.org/groups/professional\\_responsibility/publications/model\\_rules\\_of\\_professional\\_conduct/rule\\_5\\_4\\_professional\\_independence\\_of\\_a\\_lawyer.html](http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_5_4_professional_independence_of_a_lawyer.html) [<https://perma.cc/K4HS-E3VA>]; see also Amy T. Campbell et al., *How Bioethics Can Enrich Medical-Legal Collaboration*, 38 J. LAW, MED. & ETHICS 847, 849 (2010) (describing the independence of professional judgment as one of the "basic principles of legal ethics that pertain to the representation of clients in a MLP").

89. See Boumil et al., *supra* note 74, at 124.

90. See, e.g., Norwood & Paterson, *supra* note 27, at 363–64 (emphasizing that understanding, trust, and clear delineation of roles can help overcome cultural conflict).

91. See *Rule 3.3: Candor Toward the Tribunal*, AM. BAR ASS'N (2016), [http://www.americanbar.org/groups/professional\\_responsibility/publications/model\\_rules\\_of\\_professional\\_conduct/rule\\_3\\_3\\_candor\\_toward\\_the\\_tribunal.html](http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_3_3_candor_toward_the_tribunal.html) [<https://perma.cc/9UUB-SLZF>]; Elaine Bucklo, *The Temptation Not to Disclose Adverse Authority*, 40 LITIGATION 26, 26 (2014).

spots in their arguments.<sup>92</sup> A doctor diagnosing a patient or assessing the prognosis for a given procedure is unlikely to act in this manner.<sup>93</sup>

To summarize, lawyers and physicians are bound by ethical codes that can come into conflict when they work together on behalf of a client. Both professions emphasize independent professional judgment, which inherently leads to clashes. Each profession has a different relationship to information and truth, which can lead to different approaches to describing patients' conditions. These conflicts can impair medical-legal collaborations on behalf of people applying for disability benefits, service-connected compensation, and asylum. The stakes are especially high in MLPs because of the potential for repeated interactions between physicians and lawyers involving the same types of claims but different patients.

#### IV. SUGGESTIONS FOR LAWYERS SEEKING PHYSICIAN TESTIMONY

Although some level of conflict is inevitable in a multidisciplinary environment, lawyers can take steps to minimize its effects on clients in administrative proceedings.<sup>94</sup> The two sources of conflict I have identified, independence and information, require different mitigation approaches on the lawyer's part. This section offers insights about how lawyers can use these approaches to improve relationships with health care professionals at MLPs and to obtain better testimony for their clients.

Recall that informational conflicts arise when lawyers attempt to omit, repackage, or de-emphasize information in a piece of evidence or in prepping a witness for oral testimony. As the AMA Code of Medical Ethics establishes, a physician has a more obvious duty to provide "the whole truth" than a lawyer does.<sup>95</sup> This obligation can work to the client's advantage in administrative proceedings. The right approach is not for the lawyer to persuade the physician to gloss over inconsistencies in medical records: instead, lawyers should encourage health care professionals to express their uncertainty explicitly.

In all three of the administrative proceedings discussed here, a health care professional's opinion that expresses uncertainty can be structured so that it helps, rather than harms, a client's chances. In social security disability proceedings, ALJs must acknowledge and assign credibility ratings to all physician opinions. An opinion that expresses some level of uncertainty may garner an advantageous credibility determination, especially if its conclusions are supported by the record.

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92. See, e.g., Maureen Aidasani & Osamudia Guobadia, *What Do You Mean "There's More than One Way to Do It"? Selecting Methods of Legal Analysis That Work Best*, WRITING CTR. AT GEO. U. L. CTR. 2 (2004), <https://www.law.georgetown.edu/academics/academic-programs/legal-writing-scholarship/writing-center/upload/legalanalysismethods.pdf> [https://perma.cc/8WBP-XRZR].

93. See Dike, *supra* note 87, at 841.

94. Norwood & Paterson, *supra* note 27, at 363–64.

95. See Dike, *supra* note 87, at 841.

In service-connection proceedings, conclusions stated in probabilistic terms are welcome. In asylum cases, any corroboration from a health care professional—even a letter that says: “These scars are consistent with torture, but I cannot be certain that it actually occurred”—is likely to weigh in the applicant’s favor.<sup>96</sup> In all of these proceedings, the health care professional’s expressions of uncertainty are not likely to be news to the judge or decision-maker, who is probably very familiar with the difficulties of assessing causation using only current disabilities, mental illnesses, or physical scars.

As discussed above, conflicts stemming from cultures of professional independence are inevitable when health care professionals and lawyers collaborate. Independence will always stand in the way when a member of one profession seeks to influence the way that a member of another profession does her job. A lawyer who is diligently representing his client will try to exert this type of influence every time he encounters a professional who could help a client’s legal case, but is not inclined to do so on her own. Health care professionals, from the perspective of their ethical code and professional norms, are right to resist this pressure. What, then, should a lawyer do to help secure the most helpful testimony he can?

Lawyers at MLPs are well-positioned to solve this problem. They can engage in advanced coordination and collaboration with physicians in a way that is disconnected from any particular client’s situation. This assertion is particularly salient where the medical side and legal sides of the MLP are closely knit—i.e., where the MLP’s legal clients are likely to be treated by one of a defined set of MLP-affiliated health care professionals. In such situations, an MLP lawyer knows that he is likely to seek corroborating testimony from these professionals at some point. This set of health care professionals is also likely to contribute to the medical records of his clients. As part of building up a collaborative medical-legal practice, medical professionals and lawyers should proactively discuss the aspects of their professional cultures that influence the ways that they advocate for patients. Lawyers can outline best practices for building medical records, testifying in hearings, and writing letters and affidavits on behalf of patients. This way, health care professionals will have the information they need to advocate strongly for patients, and their professional independence will not be compromised by a lawyer’s request to intervene on behalf of a specific patient.

No amount of advance coordination will eliminate the need for such requests entirely. Once a lawyer and her client decide to pursue a certain type of claim, the lawyer may need to ask for additional evidence, or a repackaging of existing evidence, from clinicians. Lawyers who face resistance to such requests may use forms that include legal standards—for example, “In your opinion, is it more likely than not that Client’s disability was aggravated by her military service?”—to pin

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96. See, e.g., *Morgan v. Mukasey*, 529 F.3d 1202, 1206 (9th Cir. 2008).

down the health care professional's perspective on the client without putting words into his mouth. MLPs should also consider setting aside physician time and resources for clients who, for whatever reason, could benefit from a second opinion.<sup>97</sup>

#### CONCLUSION

This paper has described MLPs and the forms of administrative advocacy they take on for their clients. Emphasizing the importance of health care professionals' testimony in those proceedings, I have identified sources of lawyer-physician conflict as they relate to that testimony. Finally, I have offered insights about the ways that lawyers should approach their relationships with health care professionals at MLPs in order to reach the best outcomes for their clients without intruding on professional boundaries. Health care professionals' duties are first and foremost to their patients, just as lawyers' duties are to their clients. This uniting principle makes MLPs possible, and it can also give clients a better chance of obtaining the public benefits and immigration relief that they seek.

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97. See Mehlman, *supra* note 19 and accompanying footnote text.

# **The Roots and Branches of the Medical-Legal Partnership Approach to Health: From Collegiality to Civil Rights to Health Equity**

**Joel Teitelbaum & Ellen Lawton\***

## **ABSTRACT**

This Article traces the roots of the medical-legal partnership (MLP) approach to health as a way of promoting the use of law to remedy societal and institutional pathologies that lead to individual and population illness and to health inequalities. Given current forces at work – the medical care and public health systems’ focus on social determinants of health, the increased use of value-based medical care payment reforms, and the emerging movement to train the next generation of health care and public health professionals in structural competency – the time is ripe to spread the view that law is an important lens through which we should view health promotion, disease prevention, and overall well-being. Specifically, this Article describes examples of the ways in which doctors and lawyers have meaningfully collaborated, the origins and growth of medical-legal partnerships, and how the MLP approach to health can help usher in a modernized health system premised on the underpinning concept of health equity.

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TABLE OF CONTENTS

**TABLE OF CONTENTS ..... 344**

**INTRODUCTION..... 345**

**I. THE RELATIONSHIP BETWEEN THE MEDICAL AND LEGAL PROFESSIONS:  
A HISTORY MARKED IN TURN BY COLLEGIALLY, ANIMOSITY, AND  
PERIODIC COLLABORATION ..... 350**

    A. NINETEENTH CENTURY PHYSICIAN-ATTORNEY RELATIONS ..... 350

    B. EARLY- TO MID-TWENTIETH CENTURY RELATIONS..... 352

    C. THE CIVIL RIGHTS ERA: CLINICIANS TEAM WITH LAWYERS TO  
        COMBAT HEALTH-HARMING RACE DISCRIMINATION ..... 353

        1. AMERICAN COLLEGE OF LEGAL MEDICINE..... 353

        2. MEDICAL COMMITTEE FOR HUMAN RIGHTS ..... 354

        3. FEDERAL HEALTH CENTER PROGRAM ..... 355

        4. AMERICAN SOCIETY OF LAW, MEDICINE AND ETHICS ..... 356

        5. WHITMAN-WALKER HEALTH..... 356

        6. PHYSICIANS FOR HUMAN RIGHTS..... 357

**II. MEDICAL-LEGAL PARTNERSHIP: A HEALTH INTERVENTION  
PREMISED ON COLLABORATION AND HOLISTIC PATIENT CARE..... 357**

    A. THE EARLY MEDICAL-LEGAL PARTNERSHIPS..... 357

    B. THE EMERGING NATIONAL MEDICAL-LEGAL PARTNERSHIP  
        MOVEMENT..... 358

    C. BRIDGING SECTORS: MEDICAL-LEGAL PARTNERSHIP VIEWED  
        THROUGH THE LENSES OF LEGAL NEEDS, MEDICAL CARE, AND  
        PUBLIC HEALTH..... 360

        1. THE LEGAL SECTOR ..... 361

        2. THE MEDICAL CARE SECTOR ..... 362

        3. THE PUBLIC HEALTH SECTOR..... 365

    D. MEDICAL-LEGAL PARTNERSHIP RESEARCH AND EVALUATION ..... 366

        1. INDIVIDUAL PATIENT BENEFITS..... 367

        2. INSTITUTIONAL AND PROFESSIONAL BENEFITS..... 367

        3. COMMUNITY BENEFITS ..... 368

**III. MEDICAL-LEGAL PARTNERSHIP AS A HARBINGER OF A 21<sup>ST</sup> CENTURY  
HEALTH SYSTEM GROUNDED IN HEALTH EQUITY ..... 371**



## INTRODUCTION

Except in the minds of those of us who work or teach in the specific field of health law, the law's role as a determinant of the nation's health is perhaps one of the most underappreciated. Over the past several years medical care providers and administrators, health care payors, medical training programs, policymakers, private health foundations, and others have recognized and detailed how population health outcomes are more often determined by social factors than by genetics and access to and receipt of medical services;<sup>1</sup> however, discussions of these "social determinants of health"<sup>2</sup> often tend to exclude law as a factor.<sup>3</sup>

This exclusion is deeply unwarranted: The law and legal system are vitally important to the health of individuals and populations. For example, the *de jure* segregation and discrimination that plagued our country until the 1950s resulted in separate and unequal systems of care for African-Americans and for Whites, the consequences of which (both in terms of relative overall health and mistrust of government-sponsored health programs by populations of color) still reverberate today;<sup>4</sup> the way in which facially neutral laws (such as those prohibiting the use of illicit drugs) are enforced inequitably across populations can result in

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1. See Laura McGovern et al., *Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes*, HEALTH AFF. 4-5 (August 21, 2014), [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_123.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf) [<https://perma.cc/FS3M-8XN8>] (describing multiple research studies that show that approximately sixty percent of health is determined by social/environmental/behavioral factors, twenty percent by genetics and twenty percent by medical care).

2. According to the World Health Organization, social determinants of health are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." *Social Determinants of Health*, WORLD HEALTH ORGANIZATION (2017), [http://www.who.int/social\\_determinants/en](http://www.who.int/social_determinants/en); see also Lauren A. Taylor et al., *Leveraging the Social Determinants of Health: What Works?*, BLUE CROSS BLUE SHIELD FOUND. 8 (2015), [http://bluecrossfoundation.org/sites/default/files/download/publication/Social\\_Equity\\_Report\\_Final.pdf](http://bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf) [<https://perma.cc/TQM4-ERWD>] (describing social determinants of health as the "social, behavioral, and environmental influences on one's health").

3. For example, the Centers for Disease Control and Prevention has a fairly typical and oft-cited list of health-affecting social factors, which fails to include the law: "how a person develops during the first few years of life (early childhood development); how much education a person obtains; being able to get and keep a job; what kind of work a person does; having food or being able to get food (food security); having access to health services and the quality of those services; housing status; how much money a person earns; discrimination and social support." *NCHSTP Social Determinants of Health, Frequently Asked Questions*, CTRS. FOR DISEASE CONTROL & PREVENTION, (last visited April 11, 2017), <https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#a> [<https://perma.cc/6UPN-TKFK>].

4. See, e.g., W. MICHAEL BYRD & LINDA A. CLAYTON, *AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE* (2000); Christopher Kuzawa & Elizabeth Sweet, *Epigenetics and the Embodiment of Race: Developmental Origins of U.S. Racial Disparities in Cardiovascular Health*, 21 AM. J. HUMAN BIOLOGY 2 (2009).

relatively poorer health among the affected groups;<sup>5</sup> the lack of enforcement of many types of laws (think, for example, of local housing codes) can be health-harming;<sup>6</sup> the way in which courts interpret statutes and regulations can have an enormous effect on population health (the Supreme Court's decision that it was unlawful for Congress to include a *mandatory* Medicaid expansion in the Affordable Care Act led many states to reject the coverage expansion);<sup>7</sup> and, finally, there are a litany of federal and state laws whose specific aim are to improve health through disease prevention, anti-poverty programs, discrimination remediation, marketplace reform, and more—a list that includes societal pillars such as state public health codes, the Public Health Service Act,<sup>8</sup> the Health Center Program,<sup>9</sup> Title VI of the 1964 Civil Rights Act,<sup>10</sup> Medicare,<sup>11</sup> Medicaid,<sup>12</sup> and the Children's Health Insurance Program.<sup>13</sup>

Shifting how those outside the field of health law understand and view the law's role in shaping individual and population health could not be more timely. In addition to both the increased focus by multiple stakeholders on the importance of social and environmental factors to health and the movement toward value-

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5. Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, 20 STAN. L. & POL'Y REV. 257, 269-276 (2009).

6. See Samiya Bashir, *Home Is Where the Harm Is: Inadequate Housing as a Public Health Crisis*, 92 AM. J. PUB. HEALTH 733 (2002); Gary Evans, Nancy Wells & Annie Moch, *Housing and Mental Health: A Review of the Evidence and a Methodological and Conceptual Critique*, 59 J. SOC. ISSUES 475 (2003); James Krieger & Donna Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758 (2002).

7. See *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2608 (2012) (upholding the constitutionality of Affordable Care Act's "individual mandate," but determining the Act's Medicaid expansion plan, which conditioned significant federal funding on a state expanding Medicaid, was unconstitutionally coercive). The decision to morph the ACA's Medicaid expansion from close to mandatory to voluntary has allowed nineteen states (as of the time of this writing) to decline expanding Medicaid, leaving more than two-and-a-half million low-income, uninsured adults uninsured. See Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. 2 (2016), <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid> [<https://perma.cc/6JFD-ZQDW>].

8. 42 U.S.C. §§ 201–300kk (2012).

9. 42 U.S.C. §§ 254b to 254c-19 (2012).

10. 42 U.S.C. §§ 2000a to 2000a-6; see, e.g., Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y, POLITICS & L. 1 (describing the importance of Title VI's prohibition of discrimination on the basis of race, color, or national origin in federally-funded programs in the context of health programs and services).

11. 42 U.S.C. §§ 1395–1395III (2012).

12. 42 U.S.C. §§ 1396 to 1396w-5 (2012).

13. 42 U.S.C. §§ 1397aa–1397mm (2012).

based financing of medical-care services that expects clinical institutions to monitor and improve population health,<sup>14</sup> an emerging medical and public health educational movement<sup>15</sup> lends itself to thinking critically about the law's influence

14. While a full description of these value-based payment models are beyond the scope of this Article, a couple examples are helpful. First, Accountable Care Organizations (ACOs) are a model in which groups of individual clinicians, hospitals, and other health-care providers agree to share responsibility for both the quality and costs of their patients' care. By collaborating in this fashion—and in so doing reducing duplicative services, coordinating care transitions, etc.—they aim to improve the quality of care provided, reduce overall costs, and share in any resulting savings. A first-of-its-kind version of the ACO approach is Vermont's all-payer ACO, in which all health-care payers in the state—Medicare, Medicaid, and commercial—are piloting a prospective, value-based reimbursement system that aims to improve population health outcomes state-wide. See *Vermont All-Payer ACO Model*, CTRS. MEDICARE & MEDICAID SERVS. (Feb. 13, 2017), <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model> [<https://perma.cc/KDC9-QQVG>]. Specifically, Vermont's all-payer ACO is focused on increasing access to primary care, reducing deaths attributable to suicide and drug overdose, and reducing the prevalence of chronic disease. See Ena Backus et al., *The All-Payer Accountable Care Organization Model: An Opportunity for Vermont And An Exemplar For The Nation*, HEALTH AFF. (Nov. 22, 2016), <http://healthaffairs.org/blog/2016/11/22/the-all-payer-accountable-care-organization-model-an-opportunity-for-vermont-and-an-exemplar-for-the-nation> [<https://perma.cc/FFA7-JEMA>]. For a general description of how ACOs approach population health and the social determinants of health, see Taressa Frazee et al., *Housing, Transportation, and Food: How ACOs Seek to Improve Population Health By Addressing Nonmedical Needs Of Patients*, 35 HEALTH AFF. 2109 (2016). A second relatively recent payment model to approach health care from a value, rather a volume, perspective, is called the primary care medical home (PCMH). See *Defining the PCMH*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <https://www.pcmh.hhrq.gov/page/defining-pcmh> (last visited Sept. 13, 2017). One example of this model is called Comprehensive Primary Care Plus (CPC+), a federally-sponsored program that approaches primary care through a regionally-based, multi-payer payment system. See *Comprehensive Primary Care Plus*, CTRS. MEDICARE & MEDICAID SERVS., <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus> (last updated Sept. 9, 2017). The model provides up-front primary care payments to allow doctors to deliver care more flexibly, supported by monthly care management fees that allow primary care providers to serve patient needs outside of the office visit and to coordinate with other care providers. See Backus et al., *supra*. It is noteworthy that as of October 2016, private and public health plans and programs covering approximately 200 million Americans were spending nearly a quarter of their health care dollars through these and other forms of value-based payment methods. See *HHS FACT Sheet: Delivery System Reform: Progress and the Future*, DEP'T HEALTH & HUM. SERVS. (Oct. 25, 2016), <https://wayback.archive-it.org/3926/20170129142543/https://www.hhs.gov/about/news/2016/10/25/hhs-fact-sheet-delivery-system-reform-progress-and-future.html> [<https://perma.cc/LEC3-2E8N>]. But see Rachel Dolan, *The Demise Of The Part B Demo: Doom For Value-Based Payment?*, HEALTH AFF. (Dec. 27, 2016), <http://healthaffairs.org/blog/2016/12/27/the-demise-of-the-part-b-demo-doom-for-value-based-payment> [<https://perma.cc/6LDX-LER9>] (describing how the Obama Administration has canceled a demonstration project designed to test payment changes for drugs covered under Part B of the Medicare program); Elizabeth Whitman, *HHS Finds Social Risk Factors Affect Patient Outcomes and Provider Performance*, MOD. HEALTHCARE (Dec. 22, 2016), <http://www.modernhealthcare.com/article/20161222/NEWS/161229967> [<https://perma.cc/5DAH-5HBY>] (explaining how value-based purchasing could lead some providers to decide against serving individuals with social risk factors, since those factors could affect patient health outcomes in ways that may cause physicians to suffer financial penalties).

15. For example, Academic Medicine and the Journal of Bioethical Inquiry, have published special issues on structural competency for clinical, public health and bioethics audiences. Special Issue, *A Collection of Articles About Structural Competency*, 92 ACAD. MED. 271 (2017); Symposium, *Structural Competency in the U.S. Healthcare Crisis: Putting Social and Policy Interventions*

over health. This unfolding pedagogy, termed “structural competency,” focuses on better understanding the relationships among race, class, social structures and, ultimately, downstream symptom expression and community well-being.<sup>16</sup> In this way, the structural competency paradigm expands beyond traditional ideas about and training in “cultural competency,” which emphasizes mere recognition by clinicians and allied health professionals of their patients’ diverse sociocultural backgrounds and the influence those backgrounds may have on individual health outcomes.<sup>17</sup> As one leading structural competency scholar puts it, the movement

challenges the basic premise that having a culturally competent or sensitive clinician reduces patients’ overall experience of stigma or improves health outcomes. [Instead,] [t]his movement contends that many health-related factors previously attributed to culture or ethnicity also represent the downstream consequences of decisions about larger structural contexts, including health care and food delivery systems, zoning laws, local politics, urban and rural infrastructures, structural racisms, or even the very definitions of illness and health. Locating medical approaches to racial diversity solely in the bodies, backgrounds, or attitudes of patients and doctors, therefore, leaves practitioners unprepared to address the biological, socioeconomic, and racial impacts of upstream decisions on structural factors such as expanding health and wealth disparities.<sup>18</sup>

As co-directors of the National Center for Medical-Legal Partnership (NCMLP),<sup>19</sup> we have an abiding interest in helping to drive the structural competency conversation—and conversion—forward. The mission of NCMLP is “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.”<sup>20</sup> Indeed, as described more fully below in Part II, the various clinicians, civil legal aid lawyers, and social workers who practice

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into *Clinical Practice*, 13 J. BIOETHICAL INQUIRY 167 (Jun. 2016). Several other publications have also recently published on the topic. See, e.g., Jonathan M. Metzl, *Structural Competency*, 64 AM. Q. 213 (2012); Jonathan M. Metzl & Helena Hansen, *Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality*, 103 SOC. SCI. & MED. 126 (2014); Jonathan M. Metzl, D Roberts, *Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge*, 16 AMA J. ETHICS 674 (2014); Rebecca K. et al., *Bringing Home the Health Humanities: Narrative Humility, Structural Competency, and Engaged Pedagogy*, 90 ACAD. MED. 1462 (2015).

16. See *About*, STRUCTURAL COMPETENCY, <https://structuralcompetency.org/about-2> [<https://perma.cc/3WXN-R48J>].

17. Elizabeth A. Carpenter-Song et al., *Cultural Competence Reexamined: Critique and Directions for the Future*, 58 PSYCHIATRIC SERVS. 1362 (2007).

18. Jonathan M. Metzl & Dorothy E. Roberts, *Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge*, 16 VIRTUAL MENTOR 674 (2014).

19. See NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org> [<https://perma.cc/3A5E-C97X>].

20. *About Us*, NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/about-us> [<https://perma.cc/Z26X-HWYX>].

the medical-legal partnership (MLP) approach to health have for many years been engaged in training one another to recognize the social drivers of their patients'/clients' health,<sup>21</sup> transforming institutional behaviors and protocols, and collaborating to reduce the health-harming effects of upstream social structures—all of which are, essentially, tenets of the structural competency movement.

This Article aims generally to accomplish two things. First, it introduces readers unfamiliar with medical-legal partnerships to the MLP approach to health and well-being. While much has been written about medical-legal partnership,<sup>22</sup> nothing in the literature to date traces the historical roots of MLP and uses those roots to try to create a new tendril that twines around the notion of health equity. Second, and relatedly, it endeavors to promote the use of law as a way to remedy societal and institutional pathologies that lead to individual and population illness and to health inequalities. Given the current forces at work—the medical care and public health systems' focus on social determinants of health, the medical care payment reforms underway, and the emerging movement to train the next generation of health care and public health professionals in structural competency—the time is ripe to spread the view that law is an important lens through which we should view health promotion, disease prevention, and overall well-being to stakeholders in fields as diverse as health care administration, business, technology, communications, transportation, consumer protection, criminal justice and corrections, education, and others.<sup>23</sup>

Specifically, Part I of this Article disabuses readers of the notion that the legal and medical professions are nothing more than long-standing adversaries by describing examples of the ways in which they have meaningfully collaborated, and

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21. Incidentally, research indicates that clinicians, for their part, are interested in this kind of training—for example, a majority of surveyed U.S. physicians express frustration that they do not have the tools to address the social causes of disease. *2011 Physicians' Daily Life Report*, HARRIS INTERACTIVE (Nov. 15, 2011), <http://www.rwjf.org/content/dam/web-assets/2011/11/2011-physicians-daily-life-report> [https://perma.cc/TC4R-FM82].

22. See, e.g., Tishra Beeson et al., *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, NAT'L CTR. MED. LEGAL PARTNERSHIP (Feb. 2013), <http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf> [https://perma.cc/5DG8-QXRH].

23. “It’s still news to many people who don’t have the word ‘health’ in their title that they can make a big impact. . . . When I talk to people in housing, urban development or education, they don’t typically think of themselves as health agencies, but their policies have direct impacts on health.” Tamara Rosin, *Addressing Social Determinants of Health: 3 Considerations from U.S. Surgeon General*, BECKER’S HOSP. REV. (Dec. 8, 2016), <http://www.beckershospitalreview.com/population-health/3-imperatives-to-address-social-determinants-of-health-from-us-surgeon-general.html> [https://perma.cc/PY3L-UZTZ] (quoting former U.S. Surgeon General Dr. Vivek Murthy). Also interesting in this context is the American Institute of Architects’ Design & Health Research Consortium, which is comprised of experts from both design and public health disciplines who are “expected to improve the usefulness and quality of research linking design to health outcomes through deliberative partnership with other entities.” See *Design & Health Research Consortium*, AM. INST. ARCHITECTS, <https://www.architectsfoundation.org/health/aia-design-health-research-consortium> [https://perma.cc/4A6B-4X9V].

in so doing paved the way for the MLP approach to take hold. Part II describes the origins and growth of medical-legal partnerships, the way they function, and the ways they benefit patients, practitioners, and the broader community. The description of partnership benefits explains how MLPs offer patients and their families the opportunity to become successful advocates for themselves, while allowing lawyers to come into contact with clients before developing legal problems have triggered a health crisis. Part II also describes how MLP provides a positive return on investment for health care institutions, and influences policies and laws that protect vulnerable populations across the country. Finally, in Part III we conclude with a discussion about how the MLP approach to health can help usher in a modernized health system premised on the underpinning concept of health equity, which hinges on the belief that all people should be provided an equal opportunity to attain their highest level of health, regardless of socioeconomic status, geography, and the like. Because law is the overarching mechanism by which we structure and organize society, it is a *sine qua non* to achieving health equity, and medical-legal partnership is an example of the type of intervention that can be employed in furtherance of this goal.

#### I. THE RELATIONSHIP BETWEEN THE MEDICAL AND LEGAL PROFESSIONS: A HISTORY MARKED IN TURN BY COLLEGIALLY, ANIMOSITY, AND PERIODIC COLLABORATION

In the nineteenth and early twentieth centuries, the relationship between physicians and attorneys in the United States shifted from one of mutual collegiality premised on background, class, and professional status to one of distrust and disrespect, in part due to the emergence and relatively rapid increase in the incidence of medical malpractice litigation. In the mid-to-late twentieth century, however, professional collaboration between physicians and attorneys strengthened through joint efforts to address war crimes following World War II, to address the unique medical and legal concerns of activists in the civil rights movement, to address systemic issues of poverty and socioeconomic status-related health disparities through the formation of local health centers, and to respond to the HIV/AIDS crisis of the early 1980s.

##### *A. Nineteenth Century Physician-Attorney Relations*

Relations between physicians and attorneys prior to the 1850s appear relatively stable, if not downright collegial; one physician, in a treatise on medico-legal relations, referred to lawyers as practicing a “noble sister profession.”<sup>24</sup> Between 1820 and 1850, attorneys and physicians worked side by side to develop the

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24. Kenneth De Ville, *Medical Malpractice in Twentieth Century United States: The Interaction of Technology, Law and Culture*, 14 INT’L J. TECH. ASSESSMENT HEALTH CARE 197, 198 (1998).

field of medical jurisprudence, a separate field concerned with a broad range of medical, legal, and ethical issues, including the rights of patients.<sup>25</sup> The demand for medical expertise in lawsuits involving injury, death, rape, and paternity, among other issues, made physicians' knowledge a crucial element within legal practice, with physicians serving as experts or simply as advisors to legal professionals.<sup>26</sup> The two professions were in many ways interdependent—physicians' expertise strengthened attorneys' arguments in court, while physicians were able to legitimize their profession through providing medical testimony.<sup>27</sup>

However, the emergence and growth of medical malpractice litigation fueled antagonism between the professions.<sup>28</sup> Up until the 1840s, patients brought relatively few malpractice suits, and initially some physicians who were sued for negligence did not feel threatened by medical malpractice suits; rather, many regarded malpractice suits as a way to purge the profession of incompetent doctors.<sup>29</sup> Furthermore, physicians did not unilaterally blame attorneys for the earliest malpractice claims, believing that attorneys "usually discouraged rather than caused suits[.]"<sup>30</sup>

Once the 1840s arrived, however, the relationship between the two professions began to fray under the weight of increased medical malpractice litigation.<sup>31</sup> Indeed, the sharp rise in the number of suits near the mid-nineteenth century—a period deemed the nation's first "medical malpractice crisis"—souring relations between the professions.<sup>32</sup> Although a generalized anti-professional attitude on the part of lay people and the dissipation of a strong community ethos were contributory causes of the surge in malpractice suits,<sup>33</sup> the bond between physicians and lawyers was bound to rupture. This was so, according to one leading health law scholar, because "confrontation over conflicting medical testimony. . . was virtually unavoidable in the context of a medical malpractice trial."<sup>34</sup> Physicians took

25. PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA* 27.

26. *Id.*

27. *Id.* at 28.

28. Andrew Jay McClurg, *Fight Club: Doctors vs. Lawyers—A Peace Plan Grounded in Self-Interest*, 83 TEMP. L. REV. 309, 318 (2011).

29. JAMES C. MOHR, *DOCTORS AND THE LAW: MEDICAL JURISPRUDENCE IN NINETEENTH CENTURY AMERICA* 113 (1993); McClurg, *supra* note 28, at 316.

30. De Ville, *supra* note 24, at 198.

31. George J. Annas, *Doctors, Patients, and Lawyers—Two Centuries of Health Law*, 5 NEW ENG. J. MED. 445, 448 (2012).

32. McClurg, *supra* note 28, at 316. It is perhaps not a coincidence that the American Medical Association formed during this period, in 1847. According to the AMA's website, the association established a board in 1849 "to analyze quack remedies and nostrums and to enlighten the public in regard to the nature and danger of such remedies." *AMA History*, AM. MED. ASS'N, <https://www.ama-assn.org/ama-history> [<https://perma.cc/8U4U-83QM>].

33. De Ville, *supra* note 24, at 198–199.

34. JACOBSON, *supra* note 25, at 29.

offense at attorneys' and courts' roles in evaluating their medical judgment,<sup>35</sup> while attorneys identified malpractice suits as a potential area for the growth of their profession. Taken together, these factors formed the basis for a major breach that opened between the professions in the 1840s and 1850s.<sup>36</sup> In fact, by 1860 a book review of one of the first treatises on medical law suggested that the law and medicine had become "mutually incompatible professions,"<sup>37</sup> and one expert on the social history of medicine notes that "[i]t would be easy to fill several hundred pages full of vituperative, anti-legal rhetoric from medical journals after mid-[19<sup>th</sup>] century."<sup>38</sup>

### *B. Early- to Mid-Twentieth Century Relations*

Generally speaking, anti-professional attitudes among the lay public showed signs of weakening by the late 19<sup>th</sup> century.<sup>39</sup> By 1900, physicians' status had improved, and by 1940, it had "skyrocketed[.]"<sup>40</sup> In particular, physicians' status improved as licensing for the medical profession grew more standardized and as scientific technology and knowledge improved, increasing patients' trust in the medical system.<sup>41</sup>

The first half of the twentieth century saw a dominance on the part of the medical profession that was "aided by the legal system in establishing primacy[.]"<sup>42</sup> Institutionally, the legal system supported physicians' independence, giving them control over the medical care decision-making and costs, and generally deferring to physicians' judgment.<sup>43</sup> Whereas attorneys had enjoyed greater overall social recognition for their profession's status in the nineteenth century, by the mid-20<sup>th</sup> century physicians had actually surpassed attorneys in terms of both economic and social stature, coming to dominate both health care delivery and policy.<sup>44</sup>

The Nuremberg trials that followed World War II provided the two professions a powerful opportunity to collaborate. Many physicians from the Allied countries provided input on the development of medical war crimes, a concept that straddled traditional war crimes and medical ethics.<sup>45</sup> Many physicians served as

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35. *Id.*

36. JACOBSON, *supra* note 25, at 28.

37. McClurg, *supra* note 28, at 316.

38. MOHR, *supra* note 29, at 116.

39. De Ville *supra* note 24, at 200.

40. *Id.*

41. JACOBSON, *supra* note 25, at 39.

42. *Id.*; Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004).

43. JACOBSON, *supra* note 25, at 42.

44. JACOBSON, *supra* note 25, at 205.

45. Paul Weindling, *The Origins of Informed Consent: The International Scientific Commission on Medical War Crimes, and the Nuremberg Code*, 75 BULL. HIST. MED. 37 (2011).



advisors to the prosecution before and during the trials, with several prominent physiologists contributing to the specific language that eventually became the Nuremberg Code,<sup>46</sup> an internationally recognized template for medical ethics during times of war and conflict that remains influential within the field of medical ethics and international legal practice.<sup>47</sup> This influence is particularly strong in the area of informed consent, a concept of which has essentially been universally accepted and delineated in international law.<sup>48</sup>

### *C. The Civil Rights Era: Clinicians Team with Lawyers to Combat Health-Harming Race Discrimination*

The professional collaboration that occurred post-World War II laid the groundwork for additional cooperation between doctors and lawyers, both here in the U.S. and abroad, as the movement for human and civil rights took hold. Below we briefly describe a handful of organizations and programs that represent the collaborative spirit that gripped the two professions during the latter half of the 20<sup>th</sup> century.

#### *1. American College of Legal Medicine*

One of the earliest national, formal partnerships between the medical and legal professions is represented by the American College of Legal Medicine (ACLM), which was incorporated in 1960. Several physicians with law backgrounds, recognizing the rising influence of legislative and judicial decisions on the medical profession and of legal medicine on society, came together to form ACLM, a society focused on interdisciplinary education, research, and professional development for professionals at the intersection of medicine and law.<sup>49</sup> The organization remains robust nearly 60 years later, educating health care and legal professionals, shaping health policy, promoting research, filing amicus briefs in state and federal courts, co-sponsoring the National Health Law Moot Court Competition, and publishing (among other things) the influential *Journal of Legal Medicine*, first published in 1973.<sup>50</sup>

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46. *Id.* To read the Code itself online, see Office of History, *The Nuremberg Code*, NAT'L INSTS. HEALTH <https://history.nih.gov/research/downloads/nuremberg.pdf> [<https://perma.cc/NP7K-6C4P>].

47. Evelyn Shuster, *Fifty Years Later: The Significance of the Nuremberg Code*, 337 NEW ENG. J. MED. 1436, 1439 (1997).

48. *Id.*

49. *History*, AM. C. LEGAL MED., <http://www.aclm.org/?page=history> [<https://perma.cc/JYW9-GJMZ>].

50. Cyril H. Wecht, *The History of Legal Medicine*, 33 J. AM. ACAD. PSYCHIATRY & L. 245, 249 (2005).

## 2. Medical Committee for Human Rights

In response to the civil rights movement's "Freedom Summer" of 1964, a number of physicians began recruiting health care providers to care for people living in southern states, and specifically for civil rights activists on the ground in the South.<sup>51</sup> In order to facilitate this operation, a group of approximately 100 physicians, nurses, psychologists, and social workers formed the Medical Committee for Human Rights (MCHR) and traveled to Mississippi to serve activists' physical and mental health needs.<sup>52</sup>

During the Freedom Summer, MCHR worked alongside other social justice and civil rights organizations providing legal advocacy to activists, including the Lawyers Constitutional Defense Committee and the Law Students Civil Rights Research Council.<sup>53</sup> The former group, a coalition of civil rights organizations that then-ACLU director Jack Pemberton organized during the Freedom Summer, provided legal aid to civil rights activists in the South.<sup>54</sup> The latter organization, an interracial coalition of law students, provided legal research and support to activists.<sup>55</sup> These advocacy organizations and MCHR fell under the purview of the Council of Federated Organizations; this council organized and oversaw the multiple smaller advocacy organizations doing work on the ground during the Freedom Summer.<sup>56</sup>

Following the "Freedom Summer," the health care professionals who had traveled to the South chose to make MCHR a permanent organization, headquartered in New York and creating chapters in other cities.<sup>57</sup> As civil rights activities waned nationally in the late 1960s, MCHR turned its attentions to other political and social change; for example, MCHR's social workers and other professionals were vocal in the 1970s in their opposition to the Vietnam War as well as in their support for access to legal abortions and for single-payer health care.<sup>58</sup> By 1980,

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51. Christopher Segal, *Medical Committee for Human Rights Records*, U. PA. LIBRARIES (Jun. 28, 2016), [http://dla.library.upenn.edu/dla/ead/detail.html?id=EAD\\_upenn\\_rbml\\_MsColl641](http://dla.library.upenn.edu/dla/ead/detail.html?id=EAD_upenn_rbml_MsColl641) [https://perma.cc/34A8-QP4B].

52. John Dittmer, *The Medical Committee for Human Rights*, 16 VIRTUAL MENTOR 745, 745 (2014).

53. Segal, *supra* note 51.

54. *A Bond Forged in Struggle*, AM. C.L. UNION, [https://www.aclu.org/files/pdfs/racialjustice/bond\\_forged.pdf](https://www.aclu.org/files/pdfs/racialjustice/bond_forged.pdf) [https://perma.cc/5AWQ-ZJF3].

55. *Organizational Structure of Freedom Summer, 1964*, C.R. MOVEMENT VETERANS <http://www.crmvet.org/tim/fs64orgs.htm> [https://perma.cc/SCJ3-QCX8]; *Law Students Will Aid Civil Rights Lawyers*, HARV. CRIMSON (May 6, 1964), <http://www.thecrimson.com/article/1964/5/6/law-students-will-aid-civil-rights> [https://perma.cc/2RDD-GPKM]; *Law Schools. Learning by Doing*, TIME (May 21, 1965), <http://content.time.com/time/subscriber/article/0,33009,901712-1,00.html> [https://perma.cc/4KWS-UR8J].

56. *Id.*

57. *Id.*

58. Dittmer, *supra* note 52, at 747.

however, MCHR's own internal struggles took their toll, and the organization was dissolved.<sup>59</sup>

### 3. Federal Health Center Program

Neighborhood health centers were federally authorized for the first time under the Economic Opportunity Act of 1964,<sup>60</sup> a center point in President Lyndon Johnson's War on Poverty program. The first two health centers opened a year later in Mound Bayou, Mississippi, and Boston, Massachusetts.<sup>61</sup> The founders of these two centers were doctors H. Jack Geiger and Count Gibson,<sup>62</sup> both pioneers in community health practice and advocates for civil and human rights.<sup>63</sup> In fact, both participated in the MCHR trips described above, and they harnessed the momentum of the times to persuade the federal Office of Economic Opportunity to fund the original two health centers.<sup>64</sup>

The Delta Health Center (the Mississippi-based center noted above) operated as a clinic that served its patients both on a clinical level and with regard to the overall health of the community. With this operating principle in mind, the center hired an attorney on staff in the late 1960s to aid community members who came to the clinic suffering from food, housing, and discrimination issues. The clinic's goal in maintaining an attorney on staff (as well as social workers and community organizers, among others) was to address not only patients' medical barriers to health, but the socioeconomic ones, as well.<sup>65</sup> Technically speaking, the Delta Health Center of the 1960s could fairly be viewed as the first medical-legal partnership, well ahead of its time.<sup>66</sup>

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59. *Id.*

60. Pub. L. No. 88-452 (codified as amended at 42 U.S.C. § 2991, 2992, 2996).

61. *History of America's Health Centers*, NAT'L ASS'N OF COMMUNITY HEALTH CENTERS <http://www.nachc.org/about-our-health-centers/history-americas-health-centers> [https://perma.cc/9N4Y-QZA2]. The federal health center program has grown from these two original health centers to nearly 1,400 centers operating over 9,800 clinic sites in every U.S. state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. *Health Center Program: Impact and Growth*, HEALTH RESOURCES & SERVS. ADMIN <https://bphc.hrsa.gov/about/healthcenter-program/index.html> [https://perma.cc/X3SR-9RP3].

62. *Geiger Gibson Program in Community Health Policy*, GEO. WASH., <https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> [https://perma.cc/3ZBE-7TZN]

63. In the interest of disclosure, Dr. Geiger serves on the Advisory Committee of the National Center for Medical-Legal Partnership.

64. Dittmer, *supra* note 58, at 747

65. THOMAS WARD, *OUT IN THE RURAL: A MISSISSIPPI HEALTH CENTER AND ITS WAR ON POVERTY* (2017).

66. In his keynote speech at the 2013 Community Health Institute of the National Association of Community Health Centers, Dr. Geiger remarked: "I'd like to see a lawyer at every community health center and public hospital, and see them become the agent that goes to all the other agencies in town—transportation, public health, housing—to figure out what kinds of projects health centers can collaborate on to work on the barriers that our neediest populations face and make them sick. If

#### 4. American Society of Law, Medicine and Ethics

Attorneys and physicians continued to partner professionally in the 1970s; in 1972, a physician and two attorneys founded the American Society of Law and Medicine (later renamed the American Society of Law, Medicine and Ethics (ASLME)), a professional society that aimed to bring together physicians, attorneys, and ethicists with varied interests in health law.<sup>67</sup> The organization's founding president, Dr. Elliot Sagall, co-instructed a law and medicine course alongside an attorney at Boston College Law School.<sup>68</sup>

The society developed into a prominent medico-legal organization. It remains very active today, among other things publishing two leading journals: the *Journal of Law, Medicine, and Ethics* (JLME) and the *American Journal of Law and Medicine*.<sup>69</sup> From 1980 to 1982, the organization also published a *Nursing Law and Ethics* journal, which eventually merged with JLME.<sup>70</sup> Contemporarily, ASLME aims to foster conversations between medical professionals and legal practitioners regarding issues of public health, racial and economic health disparities, and other emerging medico-legal challenges.<sup>71</sup>

#### 5. Whitman-Walker Health

The HIV/AIDS crisis that emerged in the early 1980s proved a fertile opportunity for close collaboration between physicians and attorneys to address the end-of-life needs of people living with HIV. One organization that led this cooperation—and does still to this day, employing nearly a dozen lawyers on staff and another dozen paralegals—is the Washington, D.C.-based Whitman-Walker Health clinic. Officially incorporated in 1978 as an outgrowth of the Gay Men's VD Clinic and the Washington Free Clinic,<sup>72</sup> Whitman-Walker Health embedded legal care into their health services in the mid-1980s to address patient issues ranging from estate planning and disability requirements.<sup>73</sup>

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we do this, we [health centers] will once again become the instruments of social change as well as the instruments of health care that we were originally envisioned to be." Ellen Lawton, *A History of the Medical-Legal Partnership Movement*, COMMUNITY HEALTH FORUM, Fall/Winter 2014, <http://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-A-History-of-the-Medical-Legal-Partnership-Movement.pdf> [<https://perma.cc/G6SH-5JAT>].

67. Wecht, *supra* note 50, at 249.

68. *Id.*

69. *Id.*

70. American Society of Law, Medicine, and Ethics, FACEBOOK, <https://www.facebook.com/ASLME/photos/pb.117566440837.-2207520000.1468840382./10153838878130838/?type=3&theater> [<https://perma.cc/622Z-GYM9>].

71. *About Us*, AM. SOC'Y., MED. & ETHICS, [http://www.aslme.org/About\\_Us](http://www.aslme.org/About_Us) [<https://perma.cc/4JDA-3HUY>].

72. *Our History*, WHITMAN-WALKER HEALTH, <https://www.whitman-walker.org/our-mission-values/our-history> [<https://perma.cc/DW3Y-XFJZ>].

73. *Id.*

## 6. *Physicians for Human Rights*

In 1983, Dr. Jonathan Fine, after witnessing firsthand the psychological trauma of torture survivors under Chilean dictator Augusto Pinochet's regime,<sup>74</sup> formed the American Committee for Human Rights.<sup>75</sup> This human rights advocacy organization—which claims a large contingent of lawyers on its Board of Directors, staff, and roster of consultant experts—aimed to use direct reporting on human rights violations as a way to combat such violations, fostering solidarity across professions and internationally.<sup>76</sup> By 1986, a number of other physicians involved in direct human rights advocacy, some of whom had witnessed human rights violations in their professional and personal lives, joined Dr. Fine to form Physicians for Human Rights.<sup>77</sup>

In summary, contrary to popular belief physicians and lawyers have collaborated in various ways to address human and civil rights abuses, the legal needs that attend specific illnesses, and the manifest ways in which poverty results in health disparities. It is against this historical backdrop that medical-legal partnerships took hold in the 1990s.

## II. MEDICAL-LEGAL PARTNERSHIP: A HEALTH INTERVENTION PREMISED ON COLLABORATION AND HOLISTIC PATIENT CARE

### *A. The Early Medical-Legal Partnerships*

Close on the heels of the HIV/AIDS crisis, and with organizations such as Whitman-Walker Health providing a blueprint for action, like-minded medical care professionals and public interest lawyers began forming the earliest medical-legal partnerships, with the aim of achieving a new standard of health for low-income, vulnerable populations. In 1993, clinicians at Boston Medical Center (BMC) noticed that pediatric asthma patients were returning to the hospital repeatedly and not responding to medical treatments. Providers traced the problem to moldy apartments in which landlords were out of compliance with local and state sanitary codes, and the physicians subsequently reached out to Greater Boston Legal Services for help.<sup>78</sup> This turn of events led to the first formation of what we think of today as a medical-legal partnership. In the ensuing years at BMC, legal and health professionals worked side-by-side to develop the core components of

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74. *Our History*, PHYSICIANS HUM. RTS., <http://physiciansforhumanrights.org/about/history.html> [https://perma.cc/S7WQ-5CC9?type=image].

75. *Id.*

76. *Id.*

77. *Id.*

78. Ellen M. Lawton, *Family Advocacy Program: A Medical-Legal Collaborative to Promote Child Health & Development*, MGMT. INFO. EXCHANGE J., Summer 2002, at 12; see also Ellen M. Lawton, *Medical-Legal Partnerships: From Surgery to Prevention?*, MGMT. INFO. EXCHANGE J., Spring 2007, at 37 [hereinafter *From Surgery to Prevention*].

early MLPs. Grounded in clinical and patient experience, the BMC MLP team focused on *joint training*, *direct patient services*, and *policy change* as the initial “three-legged stool” of medical-legal partnership.<sup>79</sup> Around the same time, a handful of entrepreneurial legal aid leaders in other cities sparked similar health interventions in their own communities, motivated by their own insights, word of mouth, and a few short academic publications.<sup>80</sup>

In 2001, an article in *The New York Times* about the BMC partnership<sup>81</sup> dramatically increased the number of people who were aware of the MLP concept. Almost overnight, the BMC program was fielding calls from dozens of other institutions interested in replicating its collaborative work. In the ensuing five years, nearly 75 medical-legal partnerships took root around the country. However, because this replication remained a localized effort—in which leaders were essentially recreating from scratch an intervention that was responding to problems and conditions that were hardly local in nature—it quickly became evident that if the health care and civil legal aid sectors were going to scale their coordinated approach to health, technical assistance, convening opportunities, and other resources would be needed to ensure effectiveness and sustainability.<sup>82</sup>

### *B. The Emerging National Medical-Legal Partnership Movement*

As interest in the MLP approach gained momentum nationally, the National Center for Medical-Legal Partnership (NCMLP or National Center) was launched in 2006 to help the civil legal aid, health care, and public health sectors align their

79. *Id.*; see also Monisha Cherayil et al., *Lawyers and Doctors Partner for Healthy Housing*, 39 CLEARINGHOUSE REV. J. POVERTY L. & POL’Y 65 (2005); Paul R. Tremblay et al., *The Lawyer is in: Why Some Doctors are Prescribing Legal Remedies for Their Patients, and How the Legal Profession can Support This Effort*, 12 B.U. PUB. INT. L.J. 505 (2003); Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224 (2004).

80. See Randye Retkin et al., *The Attorney as the Newest Member of the Cancer Treatment Team*, J. Clinical Oncology (May 2006); Robert Pettignano et al., *The Health Law Partnership: A Medical-Legal Partnership Strategically Designed to Provide a Coordinated Approach to Public Health Legal Services, Education, Advocacy, Evaluation, Research, and Scholarship*, 35 J. Legal Med. 57 (2014); see generally Randye Retkin et al., *Attorneys and Social Workers Collaborating in HIV Care: Breaking New Ground*, 24 FORDHAM URBAN L.J. 533 (1997) (discussing broad themes on medical-legal collaboration strategies).

81. See Carey Goldstein, *Boston Medical Center Turns to Lawyers for a Cure*, N.Y. TIMES (May 5, 2001), <http://www.nytimes.com/2001/05/16/us/boston-medical-center-turns-to-lawyers-for-a-cure.html> [<https://perma.cc/88JR-WV88>].

82. Furthermore, the emerging MLP field sought to apply the MLP approach to a range of populations beyond pediatrics, which was the logical population choice for many of the early MLPs based on the success of BMC’s pediatric-based MLP. This type of expansion also required new ideas around training and appropriate partners. Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing The Legal Needs Of Vulnerable Populations*, 29 HEALTH AFF. 1697 (2010); see also Joanna Theiss et al., *Applying the Medical-Legal Partnership Approach to Population Health, Pain Points and Payment Reform*, NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/wp-content/uploads/2016/10/Applying-the-MLP-Approach-to-Population-Health-October-2016.pdf> [<https://perma.cc/TPX7-RUVJ>].

collaborative efforts. With investments from the Kellogg and Robert Wood Johnson Foundations and initially housed at Boston Medical Center, NCMLP began as a technical assistance center, conducting site visits, conference calls, and webinars to help MLP partners navigate various planning and implementation challenges. After seven years at BMC—during which another 175 medical-legal partnerships achieved varying levels of lift-off<sup>83</sup>—NCMLP moved its activities to Washington, D.C.<sup>84</sup> in order to allow it to connect with potential new public and private partners (e.g., government agencies and relevant associations) and broaden the implementation of MLP to additional health settings, patient populations, and geographies. The goal, in the end, was to give NCMLP a more national foothold so that it could help MLP practitioners in the field scale and sustain their efforts.

Today, NCMLP's work is focused in four areas. First, it aims to transform policy and practice across sectors. In addition to the synchronizing strategies and cross-sector work described *infra* in II(C), NCMLP assists federal agencies, including the Departments of Justice, Health & Human Services (HHS), and Veterans Affairs, to develop MLP agendas within their ranks. Second, NCMLP undertakes various convening activities, including gathering leaders and practitioners from the public and private medical, legal, public health, and business sectors to accelerate MLP growth and provide technical assistance. Third, the National Center endeavors to build an evidence base for the MLP approach to health, including national field surveys, pilot demonstrations, and the development and testing of data collection and quality improvement measures.<sup>85</sup> Finally, NCMLP works to catalyze investment in the MLP approach to health. The most important recent success on this front involves the National Center's collaboration with HHS's Health Resources and Services Administration (HRSA) to clarify that civil legal aid is included in the types of "enabling" or "wrap around" health services that are eligible for federal funding under Section 330 of the Public Health Service Act,<sup>86</sup> the authorizing statute for the health center program overseen by HRSA.<sup>87</sup>

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83. Medical-legal partnership growth was steady between 2006 and 2013. For example, by 2010, enough MLPs were operating to provide legal assistance to some 13,000 patients and their families and to train approximately 10,000 medical care providers to recognize the connections between unmet legal needs and patient health. TOBIN TYLER ET AL., *POVERTY, HEALTH & LAW: READINGS & CASES FOR MEDICAL-LEGAL PARTNERSHIP* 71–97 (2011).

84. NCMLP is located at the Milken Institute School of Public Health at The George Washington University.

85. For detailed accounting of these measures and how to use them, see *Medical-Legal Partnership Performance Measures Handbook*, NAT'L CTR. MED. LEGAL PARTNERSHIP (Apr. 2016), <http://medical-legalpartnership.org/wp-content/uploads/2015/08/MLP-Performance-Measures-Handbook-Apr-2016.pdf> [<https://perma.cc/E6EQ-H5Q3>].

86. 42 U.S.C. § 254b (2012); 42 C.F.R. § 51c (2017); 42 C.F.R. § 56.201–56.604 (2017).

87. See *HRSA Recognizes Civil Legal Aid as "Enabling Service" for Health Centers*, NAT'L CTR. MED. LEGAL PARTNERSHIP (Oct. 27, 2014), <http://medical-legalpartnership.org/enabling-services> [<https://perma.cc/JXW2-BRB8>]; Bureau of Primary Health Care, *Service Descriptors for Form 5A: Services Provided*, HEALTH RESOURCES & SERVS. ADMIN., <https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf> [<https://perma.cc/7TEK-DT4L>]; see also Press Release,

In part through the national efforts of NCMLP, medical-legal partnerships have been successfully integrated within a variety of settings and for a variety of populations and conditions, including health centers, veterans, family and internal medicine, behavioral health, cancer care, and, most recently, tribal communities.<sup>88</sup> MLPs also partner with a multiplicity of groups and organizations, including health insurers, pro bono attorneys, law and medical schools, and state health departments. According to the most recent numbers available, there are now over 300 health institutions in 41 states that are partnered with public interest legal organizations to practice MLP, with dozens more in development.<sup>89</sup>

*C. Bridging Sectors: Medical-Legal Partnership Viewed Through the Lenses of Legal Needs, Medical Care, and Public Health*

A core principle of the medical-legal partnership approach to health is to embed public interest lawyers in holistic health care teams to improve individual and population health, and research demonstrates that resolution of individual legal problems—threatened evictions, wrongful utility shut-offs, health insurance disputes, and the like—can lead to improved health, lower stress, reduced medical care costs and increased healthcare team efficacy. As a result, the key sectors of law, medical and allied health care, and public health have sought to better understand and define their roles in the MLP approach to health.<sup>90</sup>

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Dep't of Justice, White House Legal Aid Interagency Roundtable Issues First Annual Report to the President (Nov. 30, 2016), <https://www.justice.gov/opa/pr/white-house-legal-aid-interagency-roundtable-issues-first-annual-report-president> [<https://perma.cc/QMJ5-KRQ6>] (describing the increase in the number of health centers that screen patients for legal needs and partner with civil legal aid agencies to improve patient well-being).

88. On the topic of tribal communities, see *New Medical-Legal Partnership Provides Free Counsel to ANMC Patients*, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM (May 12, 2017), <https://anthc.org/news/new-medical-legal-partnership-provides-free-counsel-to-anmc-patients> [<https://perma.cc/5D3W-3D9V>]. Regarding veterans and medical-legal partnership, see generally Rishi Manchanda et al., *The Invisible Battlefield: Veterans Facing Health Harming Legal Needs in Civilian Life*, NAT'L CTR. MED. LEGAL PARTNERSHIP (Jun. 2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/06/The-Invisible-Battlefield.pdf> [<https://perma.cc/Q95H-DUKM>].

89. Marsha Regenstien et al., *State of the Medical-Legal Partnership Field*, NAT'L CTR. MED. LEGAL PARTNERSHIP (Aug. 2017), <http://medical-legalpartnership.org/wp-content/uploads/2016/08/2015-MLP-Site-Survey-Report.pdf> [<https://perma.cc/84NL-8M9K>].

90. Professional associations affiliated with the health, legal, and public health sectors have publicly supported the MLP approach as a best practice. In 2007, the American Bar Association adopted an MLP resolution, Health Law Section, *Report to Delegates*, AM. BAR ASS'N (Aug. 2007), <http://medical-legalpartnership.org/wp-content/uploads/2014/02/American-Bar-Association-MLP-Resolution.pdf> [<https://perma.cc/6CM2-8PZA>], and the American Academy of Pediatrics followed suit later that year, Benjamin Gitterman, *Medical-Legal Partnership: Promoting Child Health Through Preventative Law* (Dec. 11, 2007), <http://medical-legalpartnership.org/wp-content/uploads/2014/02/American-Academy-of-Pediatrics-MLP-Resolution.pdf> [<https://perma.cc/SK7A-KZ47>]. In 2010, the American Medical Association exhorted physicians to develop MLPs and physician groups to educate providers on the health impact of unmet legal needs. In 2014, the American Association of Medical Colleges invested in a multi-year MLP initiative to examine the impact of



## 1. The Legal Sector

The legal profession has a long history of dedicating resources to address the needs of low-income and otherwise vulnerable populations, yet studies repeatedly conclude that vital legal assistance does not reach most of the people and communities who most need it.<sup>91</sup> According to the Legal Services Corporation (LSC), the independent not-for-profit entity established by Congress in 1974 to provide financial support for civil legal aid to low-income Americans, 80 percent of legal needs experienced by individuals who qualify for LSC services are not being met.<sup>92</sup> Today, the supply-demand gulf between legal aid programs and the low-income people who need their services is, in relative terms, larger than ever. While the private legal community has sought to build complementary legal resources in the form of strong and comprehensive *pro bono* standards and infrastructure, those resources are, unfortunately, still deeply insufficient to meet current needs.<sup>93</sup>

Frequently, the quantity and quality of unmet legal needs an individual experiences is associated with income level and varies from urban to rural areas. Nationally, 47% of low-income and 52% of moderate-income households have at any given time at least one unmet legal need, and 14% of low-income households typically have three or more persistent unmet legal needs.<sup>94</sup> Typically, fewer than 1 in 5 legal problems experienced by low-income people are addressed with help from a private or legal aid lawyer, leaving most legal problems unmet or unresolved.<sup>95</sup>

Given the paucity of legal aid resources in many communities, medical-legal partnership presents an opportunity for the legal sector to join forces with the medical and public health sectors, which have resources of their own, and to consider a more upstream, preventive approach to their work. Indeed, these sectors are decades ahead of the legal profession in terms of thinking about preventive strategies for their respective work. A helpful analogy likens surgery to litigation—both require intensive, costly services that are inefficient in the sense that (class-action lawsuits aside) they are focused on a single individual in the most downstream

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MLP on a range of institutional and patient-related factors. See Kim Krisberg, *Medical-Legal Partnerships Help Patients Address Barriers to Health*, AM. ASS'N MED. COLLEGES: NEWS, <https://news.aamc.org/patient-care/article/medical-legal-partnerships-help-patients> [<https://perma.cc/S47L-8EF8>].

91. *Legal Needs and Civil Justice: Major Findings from the Comprehensive Legal Needs Study*, AM. BAR ASS'N (1994), [http://www.americanbar.org/content/dam/aba/administrative/legal\\_aid\\_indigent\\_defendants/downloads/legalneedstudy.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/legal_aid_indigent_defendants/downloads/legalneedstudy.authcheckdam.pdf) [<https://perma.cc/PCA9-UT2F>] [hereinafter *ABA Legal Needs Study*].

92. *Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low Income Americans*, LEGAL SERVS. CORP. 9–12 (2009), <http://www.americanbar.org/content/dam/aba/migrated/marketresearch/PublicDocuments/JusticeGapInAmerica2009.authcheckdam.pdf> [<https://perma.cc/4KSQ-96DQ>].

93. *ABA Legal Needs Study*, *supra* note 91.

94. *Id.*

95. *Id.*

position possible. Both surgery and litigation will always be necessary in some cases, but prevention strategies can help ensure that reliance on surgery or litigation is lessened by reallocating resources toward upstream, population-based activities.<sup>96</sup>

In an MLP context, the ideal scenario is for civil legal aid organizations and law school clinics to join forces to (a) train their medical partners to screen patients for health-harming civil legal needs in health centers and hospitals,<sup>97</sup> (b) meet the specific legal needs of patients found to require legal assistance, and (c) undertake an effort with their medical, allied health, and public health counterparts to understand at a population level those socio-legal factors that are most frequently triggering health problems. Again in an ideal setting, this type of enterprise would be bolstered by law firms and corporate law offices that provide a small amount of *pro bono* wrap-around legal research and assistance.<sup>98</sup>

## 2. The Medical Care Sector

As has been described in multiple descriptive studies, medical-legal partnerships often reveal for health care teams the “invisible” problem of their patients’ legal needs, in addition to the heretofore “invisible” skilled workforce of the civil legal aid community.<sup>99</sup> As health care providers increasingly embrace social determinants as factors that influence patient and community health, lawyers have naturally evolved as important capacity-builders for health care institutions serving low-income or otherwise vulnerable populations.

Indeed, for the health care institutions that predominately take care of 60 million low-income Americans, the prospect of a new and effective strategy to tackle the persistent negative health effects of poverty and other social ills has, oftentimes, been welcomed. On the academic medicine side, for example, over 30 programs have MLP components that support training students, residents, and faculty.<sup>100</sup> Federally funded community health centers, which have a longstanding commitment to holistic patient care, are accelerating adoption of the MLP approach at both the local and state level, with approximately 110 health clinics

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96. *From Surgery to Prevention*, *supra* note 78.

97. See *Screening Tool*, NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/screening-tool> [<https://perma.cc/2FT3-JH4Q>].

98. For description of MLP components and approach, see TOBIN TYLER ET AL., *supra* note 83; NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/resources/landscapes> [<https://perma.cc/87LH-E8K6>]; and *The Medical-Legal Partnership Toolkit*, NAT’L CTR. MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlptoolkit> [<https://perma.cc/YXE4-Y4DM>].

99. Ellen M. Lawton & Megan Sandel, *Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEGAL MED. 29 (2014).

100. Regenstein et al., *supra* note 89; see also Edward G. Paul et al., Paul, *The Medical-Legal Partnership Approach to Teaching Social Determinants of Health and Structural Competency in Residency*, 92 ACAD. MED. 292 (2017).

claiming MLP activities, with more in the planning stages.<sup>101</sup> Through MLP curricula, residents, faculty, medical students, and other healthcare team members learn not only to screen, triage, and diagnose health-harming legal needs, but also to collaborate directly with lawyers who function as part of the health care team.

**Figure 1. Legal Interventions for Addressing the Social Determinants of Health<sup>102</sup>**

Population-Relevant Health-Harming Legal Needs (I-HELP® Issue)	Common Social Determinant of Health	Civil Legal Aid Intervention	Impact on Health and Health Care
Income	Availability of resources to meet daily basic needs	Appeal denials of food stamps health insurance, cash benefits, and disability benefits	1. Increasing someone's income means he or she makes fewer trade-offs between affording food and health care, including medications.  2. Being able to afford enough healthy food helps people manage chronic disease and helps children grow and develop.
Housing and Utilities	Healthy physical environments	Secure housing subsidies; improve standard conditions; prevent eviction; protect against utility shut-off.	1. Stable, decent, affordable home helps a person avoid costly emergency room visits related to homelessness.  2. Consistent housing, heat, and electricity helps people follow their medical treatment plans.

101. See generally NAT'L CTR. MED. LEGAL PARTNERSHIP, [www.medical-legalpartnership.org](http://www.medical-legalpartnership.org) [perma]; <http://medical-legalpartnership.org/healthcenters/> see also Joanna Theiss et al., *Building Resources to Support Civil Legal Aid Access in HRSA-funded Health Centers*, NAT'L CTR. MED. LEGAL PARTNERSHIP (JUL. 28, 2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/07/Building-Resources-to-Support-Civil-Legal-Aid-at-Health-Centers.pdf> [HTTPS://PERMA.CC/FG3G-W8HX].

102. Adapted from Kate Marple, *Framing Legal Care as Health Care*, NAT'L CTR. MED. LEGAL PARTNERSHIP 3 (Jan. 2015), <http://medical-legalpartnership.org/wp-content/uploads/2015/01/Framing-Legal-Care-as-Health-Care-Messaging-Guide.pdf> [https://perma.cc/75ZZ-WMHM]

<b>Education and Employment</b>	Access to opportunity to learn and work	Secure specialized education services; prevent and remedy employment discrimination and enforce workplace rights	<p>1. A quality education is the single greatest predictor of a person's adult health.</p> <p>2. Consistent employment helps provide money for food and safe housing, which also helps avoid costly emergency health services.</p> <p>3. Access to health insurance is often linked to employment.</p>
<b>Legal Status</b>	Access to opportunity to work	Resolve veteran discharge status; clear criminal/credit histories; assist with asylum applications	<p>1. Clearing a person's criminal history or helping a veteran change his or her discharge status helps make consistent employment and access to public benefits possible.</p> <p>2. Consistent employment provides money for food and safe housing, which helps people avoid costly emergency health care services</p>
<b>Personal and Family Stability</b>	Exposure to violence	Secure restraining orders for domestic violence; secure adoption, custody, and guardianship for children	<p>1. Less violence at home means less need for costly emergency health services.</p> <p>2. Stable Family relationships significantly reduce stress and allow for better decision-making, including decisions related to health care</p>

Taking cues from legal aid lawyers who help train front-line medical providers on health-harming legal needs, innovative professors and administrators in academic medical settings have developed courses that cover both social determinants of health content and skill sets.<sup>103</sup> Students and residents who have been

103. See TOBIN TYLER ET AL., *supra* note 83, at 97–123; see also Elizabeth T. Tyler, *Allies Not*

trained to understand the full range of social factors and public systems that bear on the health of their low-income patient populations will be better prepared to practice medicine in continually evolving health care delivery and payment systems, particularly in primary care settings.<sup>104</sup>

### 3. *The Public Health Sector*

While much of the early MLP practice has focused on uniting the health and legal professions to address specific legal problems that afflict individual patients and families, there is no question that medical-legal partnership has the potential to tackle broader health issues in the manner of a public health intervention. Indeed, legal issues are embedded in most social determinants of health, making lawyers a necessary part of any strategy to address them, whether at the individual, local, or national level. Ultimately, MLP can be a cornerstone of a public health prevention capacity to target the social factors that influence health, positioning lawyers alongside community health workers and other public health specialists who work at the local level to promote public health.

An excellent example of how MLP dovetails with crucial public health objectives can be found in the federal government's Healthy People 2020 initiative. Healthy People "provides science-based, 10-year national objectives for improving the health of all Americans. For 3 decades, Healthy People has established benchmarks and monitored progress over time in order to encourage collaborations across communities and sectors; empower individuals toward making informed health decisions; and measure the impact of prevention activities."<sup>105</sup>

The medical-legal partnership approach aligns closely with Healthy People 2020's framework on social determinants of health, which uses a "place-based" organizing framework, reflecting five key areas of social determinants of health: economic stability, education, social and community context, health and health care, and neighborhood and built environment. It is easy to see where these domains overlap with MLP domains.<sup>106</sup>

Increasingly, the public health community uses the term population health to describe costly medical episodes for low-income individuals with chronic illness. In this era of payment reform, MLPs can help health care organizations meet their

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*Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL'Y 249 (2008).

104. Tyler, *supra* note 103; Mary E. Kennelly, *Does Your Healthcare Team Include a Lawyer? Attorneys Can Help Clinics and Communities Address the Social Determinants of Health*, OFF. DISEASE PREVENTION & HEALTH PROMOTION (Mar. 23, 2016), <https://health.gov/news/blog/2016/03/does-your-health-team-include-a-lawyer-attorneys-can-help-clinics-and-communities-address-the-social-determinants-of-health> [https://perma.cc/T5EQ-EGT8]

105. Office of Disease Prevention & Health Promotion, *About Healthy People*, DEP'T HEALTH & HUM. SERVS. <https://www.healthypeople.gov/2020/About-Healthy-People> [https://perma.cc/WVP3-QKKT].

106. See Fig. 1, *supra*.

goals by helping health care organizations uncover the health-harming social and civil legal needs that plague quality care and drive up medical costs for millions of low-income individuals.<sup>107</sup>

#### *D. Medical-Legal Partnership Research and Evaluation*

Given the four broad goals of MLP practice—train health care, legal, and public health partners to work collaboratively to create environments in which people can achieve maximum health; treat individuals' health-harming social and legal needs with legal remedies; transform institutional practice and policies to better reflect the socio-legal barriers to good health; and prevent health-harming legal needs broadly by detecting upstream patterns and improving policies and regulations that in their current form serve as structural barriers to individual and population wellness—it is critical for the MLP field to evaluate its impact on the well-being of the people and communities it assists.

Over the years, individual MLP sites (and, relatively recently, staff at NCMLP) have undertaken research and evaluation efforts to develop an understanding of successes and challenges related to MLP program design, returns on investment, relationships among partnering organizations, program financing, patient-client characteristics and outcomes, data collection and evaluation activities, and MLP sustainability.<sup>108</sup> What emerges generally from this work is a picture of a field that is (a) “expertise-rich” and “commitment-rich”, with immensely passionate, highly skilled, and deeply dedicated leaders and front-line practitioners; (b) very diverse in terms of staffing, organizational relationships, size and demographics of the patient-client population, services delivered, program financing, and data collection activities; (c) frequently “resource-poor” and struggling to attract and maintain sufficient resources to grow capacity; and (d) sufficiently far along in its development to provide a solid platform on which to build both additional research studies and innovative collaborations outside the legal, medical, and public health sectors.<sup>109</sup>

Much of the extant MLP research is focused on describing the MLP model and its function in various populations and settings, with very few published articles providing systematically derived evidence of the benefit of MLP services on patients, provider institutions, and communities at large. Even so, these preliminary and often small-scale programmatic data demonstrate that MLP is a promising intervention for addressing health-harming legal and social challenges that disproportionately affect underserved and vulnerable patients. We describe below some of these findings in the areas of patient benefits, institutional and professional benefits, and community benefits.

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107. Theiss et al., *supra* note 82.

108. Beeson et al., *supra* note 22.

109. *Id.*

### 1. Individual Patient Benefits

Medical-legal partnerships offer patients and their families the opportunity to become better informed and to become successful advocates for themselves. One such example involves a patient named Robert Jackson (not his real name), a 42-year-old Pennsylvania resident, who was spending almost as much time in the hospital as he was spending at home.<sup>110</sup> He was admitted to Lancaster General Hospital three times in seven months due to problems with his lungs and kidneys.<sup>111</sup> Each time he went to the hospital, bills piled up from procedures and medications for which he had no insurance coverage.<sup>112</sup> Depressed from the mounting debt, Mr. Jackson stopped taking some of his pills, and his health worsened.<sup>113</sup> Fortunately for Mr. Jackson, Lancaster General Hospital participated in an MLP and, relying on medical information provided by his doctors, an MLP lawyer helped Mr. Jackson get some of his medical debt covered retroactively.<sup>114</sup> The MLP lawyer also discovered that Mr. Jackson's Social Security benefits had been unlawfully garnished, and helped reinstate 95 percent of his original benefit.<sup>115</sup> This meant Mr. Jackson had more money not only for health care, but also for food and housing. With better health insurance and more money, Mr. Jackson's depression lessened, and he moved his family into better housing.<sup>116</sup> He started taking his medications regularly, lost over 150 pounds, and experienced enormously improved health.<sup>117</sup>

### 2. Institutional and Professional Benefits

Providing legal support to patients in the health care setting and partnering with frontline health care providers allows lawyers to come into contact with clients *before* incipient legal problems have triggered a health crisis, thereby increasing the likelihood that those concerns can be addressed without engaging in stressful and time-consuming litigation. Lawyers practicing in this context are also better able to tap health care professionals for their expertise over the course of the legal intervention, which creates significant efficiencies for the patient-client. For example, at the Errera Center in West Haven, Connecticut, where an on-site legal team works with veterans who are being treated for a range of health and behav-

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110. Jeffrey Martin et al., *Embedding Civil Legal Aid Services in Care for High Utilizing Patients Using a Medical-Legal Partnership*, HEALTH AFF. BLOG (Apr. 22, 2014), <http://healthaffairs.org/blog/2015/04/22/embedding-civil-legal-aid-services-in-care-for-high-utilizing-patients-using-medical-legal-partnership> [https://perma.cc/2EBA-64YS].

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

ioral health issues, the co-location and shared work environment promotes interdisciplinary work. “Legal staff, nurses, physicians, psychiatrists, psychologists, and social workers combine their expertise for the veteran’s benefit. This team-based approach also allows each member to work at the top of their ability and contribute their specialized knowledge to solve complex problems.”<sup>118</sup> For example, patients like Ms. Leonard (not her real name), who was being treated for depression, benefited from Errera Center’s team-based approach because it allowed her caregivers to home in on the reason for her most recent depression spike—her potential eviction—and rapidly resolve the issue. Additionally, multiple pilot studies demonstrate that MLPs provide a positive return on investment for health institutions.<sup>119</sup> Through successful appeals of improperly denied Medicaid or Social Security disability benefits, MLP attorneys can bring new funds to partner health institutions. A study in Health Promotions Practice evaluated the effectiveness of a legal assistance and community healthcare center partnership program in Carbondale, Illinois. The study determined that the partnership was cost-effective and therefore sustainable. In the particular program explored, the healthcare institution received a return on investment that was 149 percent more than the amount it had originally invested in the MLP, largely through Medicaid and other insurance reimbursements.<sup>120</sup>

Separately, active and nascent MLP programs are examining pilot qualitative data that reveal the cost reductions and health benefits that flow from MLP interventions, including reduction of emergency department visits, increased adherence to clinical regimens for chronically ill patients, and more rapid discharge for patients with historically unstable housing situations.<sup>121</sup>

### 3. Community Benefits

Finally, MLPs have taken important steps to influence policies and laws that protect vulnerable populations across the country. Through joint testimony given by health and legal professionals and other coordinated policy efforts, MLPs have

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118. See Manchanda et al., *supra* note 88, quoting physician Dr. David Rosenthal: “Having legal services at the Errera Center expands the capacity for medical intervention. In the same vein of social workers being an important and critical aspect of medical care, I would argue that the legal assistance, having legal representation for real world legal problems, plays a tremendous role in my ability to care for vulnerable patients.” Similarly, lawyers from the Connecticut Veterans Legal Center help the health care team address the social and legal factors that impact health, and the health care partners contribute their medical expertise to help with legal cases. Doctor Rosenthal now asks about legal issues when taking his patients’ social history, which he explains is not something he learned to do in medical school or during his medical residencies. But by asking these questions, he allows patients to discuss issues, and can refer them for civil legal services. *Id.*

119. See Beeson et al., *supra* note 22.

120. James A. Teufel et al., *Rural Medical-Legal Partnership and Advocacy: A Three Year Follow up Study*, 23 J. HEALTHCARE POOR & UNDERSERVED 705 (May 2012).

121. Stewart B. Fleishman et al., *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLINICAL ONCOLOGY 2123 (2006).



petitioned to see an increased alignment of public policy activities with healthcare priorities, and more effective enforcements of laws and regulations that affect the health of low-income people. Examples include improved disability eligibility requirements, housing and fuel assistance programs, and immigration relief visas.<sup>122</sup> More recently, an MLP active in a community health center in Chicago was instrumental in amassing the clinical evidence and legal advocacy to significantly improve federal regulations pertaining to lead levels in federally funded public housing.<sup>123</sup> This was a prime example of what is possible when clinical, public health, and legal sectors join together to solve problems at the individual and community level.<sup>124</sup>

Despite these promising indications of MLP successes at the local level, there is room for additional research and evaluation efforts in the four key areas that were identified through our review of the existing literature. We invite health services and social science researchers and MLP practitioners to undertake their own research to evaluate the MLP approach in these key areas. The first gap concerns assessing patient need. With MLP programs operating in more than 300 hospital and health centers across the U.S., there is tremendous potential for best-practice and information-sharing across programs, particularly with regard to the mechanisms through which MLPs learn about their patients' legal needs, assess their own capacity, and connect their patients with integrated legal services. A standardized legal needs assessment tool that could be implemented in clinical settings may lend itself to this process and provide an effective and efficient means to collect patient need data, inform legal and health providers, and guide MLP growth and expansion.

Furthermore, there is no uniform benchmark across MLP programs for what constitutes a "legal need." While some publications define legal needs in a general sense,<sup>125</sup> the question remains, at what point should an MLP lawyer begin working with a specific patient on a specific problem? Identifying this threshold may be particularly helpful to MLPs as they look to improve their services and enhance their capacity to meet patients' needs. Likewise, consensus around an indicator of legal need may help MLP providers identify unmet legal needs in their communities and organize their services to reach more patients.

The second evidence gap concerns the evaluation of MLP service quality. The quality of MLP services has not been a particular focus of the literature on medical-legal partnership. Much of the data collected and reported in the empirical evidence

122. TOBIN TYLER ET AL., *supra* note 83.

123. Emily A. Benfer & Amanda Walsh, *When Poverty is the Diagnosis: The Impact of Living Without*, 4 INDIANA J.L. & SOC. EQUALITY 1 (2016).

124. See Emily Benfer, *Blame HUD for America's Lead Epidemic*, N.Y. TIMES (Mar. 4, 2016) <http://www.nytimes.com/2016/03/05/opinion/blame-hud-for-americas-lead-epidemic.html> [<https://perma.cc/SH5V-MAJW>].

125. See TOBIN TYLER ET AL., *supra* note 83, at 73.

is often preliminary in nature and generally small-scale. Furthermore, there are no existing common measures or metrics of quality, outcomes, or processes of care for MLPs. This challenge is related directly to the linkage between legal services professionals and clinical professionals, who often use different terminology and have distinct ways of measuring achieved outcomes. A common set of metrics for MLP service quality would guide both clinicians and lawyers in their interdisciplinary work in addressing patients' health and legal needs and provide a baseline with which to evaluate improvements in quality and outcomes at the patient, system, and policy level.

The third evidence gap regards how to advance system- and policy-level change through MLPs. The National Center for Medical-Legal Partnership has promulgated a three-level model for the impacts generated by MLPs, including (1) changes in the health and well-being of patients; (2) improvements in institutions, services, and practices; and (3) improvements in policies and laws that affect vulnerable populations.<sup>126</sup> One prominent MLP practitioner and instructor acknowledges that a tension between individual service and social change advocacy persists in the legal services community, perhaps due to the fact that organizations receiving federal LSC funding are restricted from certain activities that are historically construed as drivers of systemic change (such as class action lawsuits and legislative lobbying).<sup>127</sup> In this regard, some legal services providers may not engage in social policy change work as a focused effort. However, Tobin Tyler also argues that legal services professionals, in collaboration with clinical and public health professionals can and should embrace an integrated approach to changing system and policy factors that affect vulnerable patients.<sup>128</sup> Her recommendations include identifying social, legal, and health needs as well as tracking unmet need for the purposes of achieving social policy change.<sup>129</sup> Despite the emphasis on policy-level efforts, there is limited evidence of such activities taking place within most existing MLPs. However, the few examples of MLP programs influencing and leading public policy changes on a local level provide strong justification for exploring the role of MLPs in effecting policy change in a systematic manner.<sup>130</sup>

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126. Megan Sandel et al., *Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations*, 29 HEALTH AFF. 1697 (2010).

127. Elizabeth Tobin Tyler, *Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health*, 8 J. Health & Biomed L. 211 (2012).

128. *Id.*

129. *Id.*

130. See TOBIN TYLER ET AL., *supra* note 83. Examples include electronic health record (EHR) prompts that direct providers to screen for unmet legal needs; pre-formatted letters in EHRs addressing clinical implications of noncompliance with laws (e.g., housing code violations for asthmatic patients); "calculators" to help pediatricians stay on top of school timelines when advising families of children with special needs about compliance with the Individuals with Disabilities Education Act; and policies and protocols for partner healthcare institutions (in collaboration with the office of general counsel) that support provider engagement with safety net protections connected to health (for

Finally, a fourth evidence gap concerns scaling the MLP approach to improve population health. Since their emergence as a delivery system model to address social determinants of health, MLPs have continued to expand across the country. As the movement continues to grow, there is a need to develop empirical evidence to support the expansion of the model and to understand the components that contribute to its success. The outcomes presented in these studies such as (stress level, health care recovery dollars, financial return on investment, training and knowledge of providers) could be utilized in a larger-scale collective evaluation of MLP services and their impact on population health. Developing common process metrics and outcome measures, as well as utilizing standardized data collection tools, will be key strategies to demonstrating the collective impact of MLPs.

### III. MEDICAL-LEGAL PARTNERSHIP AS A HARBINGER OF A 21<sup>ST</sup> CENTURY HEALTH SYSTEM GROUNDED IN HEALTH EQUITY

The roots of the MLP approach to health are both discernable and deep, tracing back as they do some 50 years to the civil rights era. And there is little question that lawyers (and paralegals) have the unique training and skills needed to address certain social, economic, and political factors that in the end manifest as health-harming legal needs. What is less apparent are the branches of the MLP approach to health—i.e., will civil legal aid programs and the legal profession more broadly become normative discussion points and levers in the health care and public health systems among those not commonly prone to think about the law as a driver of individual and population health and, if so, in what ways?

At the time of this writing, there is enormous uncertainty concerning the future of national health reform generally<sup>131</sup> and the Affordable Care Act (ACA)<sup>132</sup> specifically. But regardless of whether the ACA is merely “repaired” or “repealed and replaced” in whole or in part (in the case of the latter, for example, Congress and

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example, in Massachusetts, only certain healthcare providers can certify that a household qualifies for protection from utility service shutoff due to medical reasons). *Id.*

131. For example, the Republican-controlled Congress spent the first half of 2017 contemplating a major shift in the Medicaid program, which insures almost 75 million low-income individuals. *House Republicans Weighing Key Medicaid Change as Part of Health Law Overhaul*, KAISER HEALTH NEWS, <http://khn.org/morning-breakout/house-republicans-weighing-key-medicaid-change-as-part-of-health-law-overhaul> [<https://perma.cc/2FA5-PDCJ>]. Since its inception, Medicaid has been a legal entitlement program, meaning that there is no cap on spending for individuals who qualify for coverage (the program is jointly funded by the federal government and states, with the federal government paying a varied percentage of program expenditures in each state based on criteria such as per capita income). Many congressional Republicans are pushing to transform Medicaid’s financing mechanism to a block grant, which would end individuals’ legal entitlement to services by sending fixed federal grants to states. See Edwin Park, *Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured*, CTR. BUDGET & POL’Y PRIORITIES (2016), <http://www.cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave> [<https://perma.cc/B3P3-SGPR>].

132. Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001 et seq. (2012).

the President could keep in place certain features such as guaranteed issue<sup>133</sup> and the ability of parents to keep dependent children on their own health policies until the dependents reach the age of 26), it is our hope that the health system transformation already underway—including the ways we pay for, collaborate around, and teach about individual and population health—will outlive any one president or law. Indeed, there is nothing about political transitions that must by necessity stifle innovation and collaboration, and recent work around the social determinants of health suggests that there is much value in innovative, cross-sector partnerships.<sup>134</sup>

To that end, while the MLP approach to health shows what is possible in the context of on-the-ground health care-legal collaboration, it also represents more broadly a starting point for thinking about the role of law in creating health systems and environments that are premised on—and can help create—health equity. Health equity refers to an environment in which all people are afforded the opportunity to attain the highest level of health, irrespective of social position or circumstance,<sup>135</sup> and our nation's health inequities are the result of more than individual choice or simple randomness: "They are the result of the historic and ongoing interplay of inequitable structures, policies, and norms that shape lives."<sup>136</sup>

Because achieving health equity requires remediating longstanding discriminatory structural systems and practices and also encompasses the notion that the quality of health care received should not vary based on patient characteristics such as race, gender, location, or socioeconomic status, health equity is properly viewed through both a civil rights and health care quality lens.<sup>137</sup> While using

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133. This refers to a health insurance rule in which insurers must enroll applicants regardless of any preexisting conditions from which they might suffer.

134. See, e.g., Vivian L. Towe et al., *Cross-Sector Collaborations And Partnerships: Essential Ingredients To Help Shape Health And Well-Being*, 35 HEALTH AFF. 1964 (2016).

135. See, e.g., Lisa K. Brennan Ramirez et al., *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*, CTDS. DISEASE CONTROL & PREVENTION (2008), <https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf> [<https://perma.cc/KJ9S-GME4>].

136. *Communities in Action: Pathways to Health Equity*, NAT'L ACADS. SCIS., ENGINEERING & MED. (2017), <http://nationalacademies.org/hmd/~media/Files/Report%20Files/2017/Promote-Health-Equity/coh-report-highlights.pdf> [<https://perma.cc/T7B2-AGAB>]. Health inequities also have significant financial and societal repercussions, affecting, among other things, medical care expenditures, the overall U.S. economy, and national security. See *id.*

137. See, e.g., Donald M. Berwick, *Era 3 for Medicine and Health Care*, 315 JAMA 1329 (2016) (discussing the moral imperative that should underpin health system transformation); Joseph R. Betancourt, *Ushering in the New Era of Health Equity*, HEALTH AFF. (Oct. 31, 2106), <http://healthaffairs.org/blog/2016/10/31/ushering-in-the-new-era-of-health-equity> [<https://perma.cc/W5SJ-25UJ>]; Wendy K. Mariner & George J. Annas, *A Culture Of Health and Human Rights*, 35 HEALTH AFF. 1999 (2016); Angela K. McGowan et al., *Civil Rights Laws as Tools to Advance Health in the Twenty-First Century*, 37 ANN. REVS. 185 (2016); Sara Rosenbaum, *Viewing Health Equity Through a Legal Lens: Title VI of the 1964 Civil Rights Act*, 42 J. HEALTH POL., POL'Y & L. 771 (October 2017); Roger Magnusson et al., *Advancing the Right to Health: the Vital Role of Law*, WORLD HEALTH ORG. (2017), <http://apps.who.int/iris/bitstream/10665/252815/1/9789241511384-eng.pdf>

these lenses to bring the problem of health inequity into focus has been underway among certain factions for many years, these efforts received increased visibility and broader acceptance in the early 2000s when the then-called Institute of Medicine (“IOM”; now called the National Academy of Medicine) released *Crossing the Quality Chasm: A New Health System for the 21st Century*<sup>138</sup> and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,<sup>139</sup> two important reports that effectively ended the discussion about *whether* health disparities (at least disparities based on race and ethnicity) existed and forced health care stakeholders to confront the question of *why* they existed. The problem of health disparities had suddenly gone mainstream.<sup>140</sup>

Passage of the Affordable Care Act in 2010 signaled the next phase in the effort to address the issue of health inequity.<sup>141</sup> With its promise of health insurance coverage for millions of uninsured individuals, its redistribution of resources toward disproportionately low-income individuals and families, its focus on value over volume in the delivery of health care services, and its incentives to drive innovations (including the use of electronic health records), the ACA pressed the idea that “[i]mproving quality, addressing disparities, and achieving equity was not just the right thing to do, but also the smart thing to do, given the new financial structures developed to drive quality and value.”<sup>142</sup> The ACA’s focus on value-based payments had another consequence as well: It forced payors and providers to consider those determinants of health that influenced patient health outside the walls of medical care institutions.

At least up until the federal elections in 2016, efforts aimed at achieving health equity continued apace in the wake of the ACA. Upstream social and environmental drivers of population health became the focus of many health foundation and government programs,<sup>143</sup> and the idea of disparities was ex-

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[<https://perma.cc/MP77-JCL2>]; Vivek A. Murthy, Build the Great American Community, Remarks at the Commission and Change of Command for the 19th Surgeon General of the United States (Apr. 22, 2015), <https://www.surgeongeneral.gov/swearing-in-murthy.html> [<https://perma.cc/8SSL-LX5F>]; Amanda Moore, *Tracking Down Martin Luther King, Jr.’s Words on Health Care*, BLOG: HUFFINGTON POST (Jan. 18, 2013, 4:00 PM), [http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care\\_b\\_2506393.html](http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care_b_2506393.html) [<https://perma.cc/LP6V-HD2M>].

138. INST. OF MED., COMM. ON QUALITY OF HEALTH CARE IN AM., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001).

139. *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson, eds., 2003).

140. Betancourt, *supra* note 137.

141. *Id.*

142. *Id.*

143. See, e.g., *Building a Culture of Health*, ROBERT WOOD JOHNSON FOUND., <http://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html> [<https://perma.cc/8QKS-PW8C>]; *CMS Equity Plan for Medicare*, CTR. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/equity-plan.html> [<https://perma.cc/X3MR-NZ4T>].

panded to include inequities premised on gender and sexual orientation. Furthermore, researchers documented the effects of implicit bias on physician-patient relationships,<sup>144</sup> and many hospitals began to orient their practices around notions of equity.<sup>145</sup> It is worth noting that over the 15 or so years that span the release of the IOM's two key reports and current day—i.e., the time period just summarized—two things stand out: a shift in the way that clinicians think about the quality of the care they provide and the use of law to drive or incentivize these changes.

Now we stand at a crossroads. Will, in fact, the health system transformation already underway continue regardless of the fate of the Affordable Care Act? Or will society permit a return to the earliest days of the “health equity era,” when we spent most of our time deliberating whether health disparities—and broader health inequities—were a cause worth combatting, while more than 50 million of our fellow Americans lacked even basic health insurance coverage (and many other basic needs). Indeed, as a nation that is alarmingly good at cultivating the fertile ground that allows poverty to take root and flourish,<sup>146</sup> the signposts at our crossroads do not read “Affordable Care Act” in one direction and “ACA Replacement” in the other. Rather, one signpost indicates a path that focuses on efficient and collaborative models that leverage the power of law and draw on community resources to address the structural determinants that pose barriers to health for too many people, while the other points in a direction that will likely lead to a widening gap between those who are afforded the opportunity to achieve full health and well-being, and those who are not.

Three final things bear mentioning. First, regardless of the direction taken by the federal government, states and localities have the ability to—and some have already begun to—explore ways to tackle health equity through either a health quality or civil rights lens. For example, the states of New York and Georgia have passed laws that aim to promote collaborations between health care service providers and legal aid, legal services, pro bono and law school clinical programs to

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144. See, e.g., Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504 (2013).

145. Betancourt, *supra* note 137.

146. According to the Organization for Economic Cooperation and Development (OECD), an international organization consisting of nearly three dozen democracies with market economies who work together to promote economic growth, prosperity, and sustainable development, the United States had, as of 2013, the second-worst poverty rate (the ratio of the number of people whose income falls below the poverty line) among its OECD counterparts. *Poverty Rate*, OECD (2017), <https://data.oecd.org/inequality/poverty-rate.htm> [<https://perma.cc/7CN9-LQLM>]. Put another way, in 2015 the official poverty rate in the U.S. was 13.5 percent, a number representing 43.1 million people. BERNADETTE D. PROCTOR, JESSICA L. SEMEGA & MELISSA A. KOLLAR, *INCOME AND POVERTY IN THE UNITED STATES: 2015*, U.S. CENSUS BUREAU, REP. NO. P60-256 (2016), <http://www.census.gov/library/publications/2016/demo/p60-256.html> [<https://perma.cc/HC8J-MH5J>].

promote individual and community health.<sup>147</sup> Minnesota's Department of Health leads an effort called "Advancing Health Equity in Minnesota",<sup>148</sup> which focuses on eliminating health disparities and evaluating how policies and practices impact these inequities. And the city of Seattle launched a Race and Social Justice Initiative<sup>149</sup> aimed at eliminating racial disparities (including health disparities) and achieving racial equity.

Second, tying back to the discussion at the outset about the structural competency education movement, colleges and universities must reevaluate their approaches to training the next generation of medical, legal, public health, social work, public policy and other professionals to provide students with a more detailed appreciation of the multiple dimensions of poverty, inequality, and poor health. While many medical schools have in recent years begun to incorporate population health and social determinants of health into their curricula, much more work is required to make multidisciplinary training a common feature of both undergraduate and graduate education.<sup>150</sup>

The third and final aspect of this closing discussion that cannot be ignored is the current and future state of civil legal aid funding.<sup>151</sup> Because civil legal aid programs are the legal partners in the majority of MLPs,<sup>152</sup> the health of the civil legal aid community is of enormous importance to the sustainability of MLPs—and to reducing and remedying health-harming legal needs generally in the name

147. See Dep't of Health, *Standards for Health-Related Legal Services Programs that Serve Income Eligible Individuals and Families Pursuant to PHL Section 22*, N.Y. STATE (Jan. 2013), [https://www.health.ny.gov/diseases/aids/providers/regulations/standards\\_for\\_health\\_related\\_legal\\_services\\_prog.htm](https://www.health.ny.gov/diseases/aids/providers/regulations/standards_for_health_related_legal_services_prog.htm) [<https://perma.cc/MK8X-AWX5>]; Ctr. for Law, Healthy & Soc'y, *HeLP Provides MLP Model for Other Schools, Including Ones in Macon, S.C.*, GA. ST. UNIV., <http://clhs.law.gsu.edu/2016/12/08/help-provides-mlp-model-schools-including-one-macon> [<https://perma.cc/A6F5-DJRT>].

148. See *Advancing Health Equity in Minnesota: Report to the Legislature*, MINN. DEP'T HEALTH (Feb. 2014), [http://www.health.state.mn.us/divs/chs/healthequity/ahe\\_leg\\_report\\_020414.pdf](http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf) [<https://perma.cc/DZ8R-YAD3>].

149. See *Race and Social Justice Initiative*, SEATTLE.GOV (2017), <http://www.seattle.gov/rsji> [<https://perma.cc/6W4U-747B>].

150. See, e.g., *Poverty-Related Courses Taught by IRP Affiliates*, INST. RES. ON POVERTY (2016), <http://www.irlp.wisc.edu/initiatives/trainedu/povcourses.htm> [<https://perma.cc/68BB-LBYE>].

151. While civil legal aid funding is not the only type of funding that sustains medical-legal partnerships, it is essential enough that it deserves its own brief discussion. For a discussion of MLP financing generally, see the excellent report written by law professor Dayna Bowen Matthew. Dayna Bowen Matthew, *The Law as Healer: How Paying for Medical-Legal Partnerships Saves Lives and Money*, BROOKINGS INST. (Jan. 2017), [https://www.brookings.edu/wp-content/uploads/2017/01/es\\_20170130\\_medicallegal.pdf](https://www.brookings.edu/wp-content/uploads/2017/01/es_20170130_medicallegal.pdf) [<https://perma.cc/38F9-SUJQ>].

152. In the minority of instances, law school clinics and private lawyers providing *pro bono* support serve as the legal partners in an MLP. It is our hope, particularly in light of the overwhelming demand facing civil legal aid programs, that both legal clinics and the private Bar will continue to grow their involvement in medical-legal partnership. The American Bar Association, for example, was the recipient of the National Center for Medical-Legal Partnership Leadership Award for 2016 for its efforts to promote the MLP approach to health through its Veterans Legal Services Initiative, its Standing Committee on *Pro Bono* and Public Service, and its Health Law Section.

of health equity—going forward.

As noted above, the primary mechanism by which civil legal aid programs are funded in the U.S. is through the Legal Services Corporation (LSC), an independent, not-for-profit entity established by Congress in 1974 to provide financial support for civil legal aid to low-income Americans.<sup>153</sup> Also noted was that only a fraction of the approximately 60 million people eligible for LSC-funded services are able to receive services due to funding/personnel shortages. The chasm between demand and supply need not be so vast, of course: Congress controls LSC's purse strings and, like most social policy issues these days, congressional appropriations for LSC has become something of a political matter.<sup>154</sup> The heyday of LSC funding was in 1980, when in inflation-adjusted dollars pegged to 2015 Congress appropriated nearly \$840 million dollars to the organization.<sup>155</sup> That number took a massive (25%) hit just two years later<sup>156</sup>—not long after Ronald Reagan took office (and tried to abolish the Corporation altogether)—and it has never come close in inflation-adjusted numbers to returning to its prior funding level. Despite the increase in the number of people living in poverty between 1980 and 2015,<sup>157</sup> in both real and inflation-adjusted numbers LSC's budget in 2015 was just \$375 million.

Needless to say, we cannot predict with any accuracy what a Trump Administration and a Republican-controlled Congress will do with LSC's budget in the

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153. Notably, LSC also has its roots in President Johnson's Economic Opportunity Act of 1964. *History: The Founding of LSC*, LEGAL SERVS. CORP. (2017), <http://www.lsc.gov/about-lsc/who-we-are/history> [<https://perma.cc/QP7E-JWJH>]. While LSC itself was not established until 1974, the Economic Opportunity Act's focus on eliminating poverty through access to educational and vocational programs, loans, and other services uncovered a rash of non-criminal legal matters (e.g., family disputes, housing problems, food insecurity, wrongful job termination, lack of educational supports, etc.) that were holding low-income individuals and families from establishing a financial foothold. *Id.* Ten years after President Johnson signed the Economic Opportunity Act into law, President Richard Nixon did the same with the Legal Services Corporation Act after a couple years of political wrangling. *Id.*

154. For views from both sides of the political spectrum, see *Why the Legal Services Corporation Must Be Abolished*, HERITAGE FOUND.: BACKGROUNDER (Oct. 18, 1995), <http://www.heritage.org/crime-and-justice/report/why-the-legal-services-corporation-must-be-abolished> [<https://perma.cc/8RZ9-8T3W>]; Kat Aaron, *The GOP Plot to Destroy Legal Aid*, MOTHER JONES (Feb. 14, 2011, 7:00 AM), <http://www.motherjones.com/politics/2011/02/gop-slashes-legal-aid-fund> [<https://perma.cc/ZM7L-GB42>].

155. *LSC by the Numbers: The Data Underlying Legal Aid Programs*, LEGAL SERVS. CORP. (2015), <http://www.lsc.gov/media-center/publications/lsc-numbers-2015> [<https://perma.cc/NAT5-739V>].

156. *Id.*

157. *Historical Poverty Tables: People and Families - 1959 to 2015: Table 1 Weighted Average Poverty Thresholds for Families of Specified Size*, U.S. CENSUS BUREAU (Sept. 1, 2016), <https://www2.census.gov/programs-surveys/cps/tables/time-series/historical-poverty-people/hstpv1.xls> [[perma](https://perma.cc/)].



coming years.<sup>158</sup> Because civil legal aid (to which there is no legal right) is a powerful tool in the war against poverty and its effects, we argue that it must be expanded, rather than diminished, if the nation is at all serious about helping low-income and otherwise vulnerable Americans improve and sustain the conditions necessary for health and well-being across the range of environments in which they are born, live, learn, play, work, and age. To achieve a society in which everyone has the opportunity to attain his or her full health potential,<sup>159</sup> we must much more thoroughly address the upstream drivers of health and wellness that touch us all, but that are disproportionately burdensome for individuals, families, and communities that reside at the lower end of the income distribution scale. The most powerful lever at our disposal to fix and redesign these determinants of health is the law, and medical-legal partnership is one example of an intervention that can squarely address both upstream factors and downstream, in-the-moment patient needs. It is our hope and our goal to see medical-legal partnership shed its status as a mere “innovation” in the years to come, and become an integral and normative part of a truly equitable 21<sup>st</sup> century health system.

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158. It is telling, however, that the Trump Administration’s first budget blueprint, released March 16, 2017, zeroes out funding for the Legal Services Corporation. See Sara Randazzo, *Proposed Trump Budget Would End Legal Services Corp.*, LAW BLOG: WALL. ST. J. (Mar. 16, 2017), <http://blogs.wsj.com/law/2017/03/16/proposed-trump-budget-would-end-legal-services-corp> [https://perma.cc/94UZ-AQUA]. The response from several legal constituencies—including the American Bar Association, law firms, corporate general counsel, and the legal aid community itself—was swift and angry. See, e.g., Press Release, Statement of ABA President re: Eliminated Funding for the Legal Services Corporation, American Bar Ass’n (Mar. 16, 2017), [https://www.americanbar.org/news/abanews/aba-news-archives/2017/03/statement\\_of\\_abapre3.html](https://www.americanbar.org/news/abanews/aba-news-archives/2017/03/statement_of_abapre3.html) [https://perma.cc/TDD4-NM5V]; Victor Li, *Heads of Over 150 Law Firms Warn Trump Administration Against Defunding Legal Services Corp.*, ABA J. (Mar. 10, 2017), [http://www.abajournal.com/news/article/heads\\_of\\_over\\_150\\_law\\_firms\\_warn\\_trump\\_administration\\_against\\_defunding\\_leg](http://www.abajournal.com/news/article/heads_of_over_150_law_firms_warn_trump_administration_against_defunding_leg) [https://perma.cc/58VL-FNVT]; Marcia Coyle, *185 Corporate Counsel Urge Congress to Fund LSC*, NAT’L L. J. (Mar. 28, 2017), <http://www.nationallawjournal.com/id=1202782257144/185-Corporate-Counsel-Urge-Congress-to-Fund-LSC?slreturn=20170812155211> [https://perma.cc/Z7T6-S62S]; Bryan J. Reilly, *Trump Budget Would Gut Legal Aid for Veterans, Domestic Abuse Victims and Disaster Survivors*, HUFFINGTON POST (Mar. 16, 2017), [http://www.huffingtonpost.com/entry/legal-services-corporation-trump-budget\\_us\\_58cabca5e4b00705db4cef22](http://www.huffingtonpost.com/entry/legal-services-corporation-trump-budget_us_58cabca5e4b00705db4cef22) [https://perma.cc/J88K-9J5H]. As of the time of this writing, Congress has not acted on the budget blueprint. Based on the Trump Administration’s view of LSC, it is also worth pondering the fate of the Legal Aid Interagency Roundtable (LAIR), formally established by President Obama in 2015 to spur federal departments and agencies to consider how the impact of civil legal aid could enhance the success of their respective programs. Lisa Foster, *Establishing the Whitehouse Legal Aid Interagency Roundtable*, BLOG: WHITEHOUSE.GOV (Sept. 28, 2015, 3:43 PM), <https://obamawhitehouse.archives.gov/blog/2015/09/28/establishing-white-house-legal-aid-interagency-roundtable-0> [https://perma.cc/4BRG-8A9Y].

159. We have a long way to go: Research indicates that life expectancy can differ by as much as 20 years in neighborhoods approximately five miles apart from one another. See Ctr. on Soc’y & Health, *Mapping Life Expectancy*, VA. COMMONWEALTH U., <http://www.societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html> [https://perma.cc/WP9S-EXEP].

