

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.

* Joel Teitelbaum, J.D. LL.M is Associate Professor of Health Policy and of Law; Co-Principal Investigator, National Center for Medical-Legal Partnership; Director, Hirsh Health Law and Policy Program, The George Washington University. Ellen Lawton, J.D. is Lead Research Scientist and Co-Principal Investigator, National Center for Medical-Legal Partnership, The George Washington University. The authors are indebted to AnnaLise Bender-Brown, a candidate in the Juris Doctor degree program at The George Washington University School of Law, for her excellent research assistance in the preparation of this article.

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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;¹ however, discussions of these "social determinants of health"² often tend to exclude law as a factor.³

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;⁴ the way in which facially neutral laws (such as those prohibiting the use of illicit drugs) are enforced inequitably across populations can result in

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 [<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; 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 [<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." *NCHHSTP 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;⁵ the lack of enforcement of many types of laws (think, for example, of local housing codes) can be health-harming;⁶ 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);⁷ 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,⁸ the Health Center Program,⁹ Title VI of the 1964 Civil Rights Act,¹⁰ Medicare,¹¹ Medicaid,¹² and the Children's Health Insurance Program.¹³

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-

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: Reinventing 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,¹⁴ an emerging medical and public health educational movement¹⁵ 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*, CTMS. 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.aHRQ.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*, CTMS. 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.¹⁶ 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.¹⁷ 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.¹⁸

As co-directors of the National Center for Medical-Legal Partnership (NCMLP),¹⁹ 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.”²⁰ Indeed, as described more fully below in Part II, the various clinicians, civil legal aid lawyers, and social workers who practice

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,²¹ 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,²² 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.²³

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

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.”²⁴ Between 1820 and 1850, attorneys and physicians worked side by side to develop the

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.²⁵ 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.²⁶ 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.²⁷

However, the emergence and growth of medical malpractice litigation fueled antagonism between the professions.²⁸ 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.²⁹ Furthermore, physicians did not unilaterally blame attorneys for the earliest malpractice claims, believing that attorneys "usually discouraged rather than caused suits[.]"³⁰

Once the 1840s arrived, however, the relationship between the two professions began to fray under the weight of increased medical malpractice litigation.³¹ Indeed, the sharp rise in the number of suits near the mid-nineteenth century—a period deemed the nation's first "medical malpractice crisis"—soured relations between the professions.³² 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,³³ 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."³⁴ 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,³⁵ 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.³⁶ 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,"³⁷ 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-[19th] century."³⁸

B. Early- to Mid-Twentieth Century Relations

Generally speaking, anti-professional attitudes among the lay public showed signs of weakening by the late 19th century.³⁹ By 1900, physicians' status had improved, and by 1940, it had "skyrocketed[.]"⁴⁰ 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.⁴¹

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[.]"⁴² Institutionally, the legal system supported physicians' independence, giving them control over the medical care decision-making and costs, and generally deferring to physicians' judgment.⁴³ Whereas attorneys had enjoyed greater overall social recognition for their profession's status in the nineteenth century, by the mid-20th century physicians had actually surpassed attorneys in terms of both economic and social stature, coming to dominate both health care delivery and policy.⁴⁴

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.⁴⁵ Many physicians served as

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,⁴⁶ 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.⁴⁷ 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.⁴⁸

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 20th 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.⁴⁹ 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 1973.⁵⁰

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. Evelyne 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.⁵¹ 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.⁵²

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.⁵³ 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.⁵⁴ The latter organization, an interracial coalition of law students, provided legal research and support to activists.⁵⁵ 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.⁵⁶

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.⁵⁷ 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.⁵⁸ By 1980,

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 [<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://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.⁵⁹

3. Federal Health Center Program

Neighborhood health centers were federally authorized for the first time under the Economic Opportunity Act of 1964,⁶⁰ 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.⁶¹ The founders of these two centers were doctors H. Jack Geiger and Count Gibson,⁶² both pioneers in community health practice and advocates for civil and human rights.⁶³ 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.⁶⁴

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.⁶⁵ Technically speaking, the Delta Health Center of the 1960s could fairly be viewed as the first medical-legal partnership, well ahead of its time.⁶⁶

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.⁶⁷ The organization's founding president, Dr. Elliot Sagall, co-instructed a law and medicine course alongside an attorney at Boston College Law School.⁶⁸

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*.⁶⁹ From 1980 to 1982, the organization also published a *Nursing Law and Ethics* journal, which eventually merged with JLME.⁷⁰ 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.⁷¹

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,⁷² 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.⁷³

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 [<https://perma.cc/4JDA-3HUJ>].

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,⁷⁴ formed the American Committee for Human Rights.⁷⁵ 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.⁷⁶ 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.⁷⁷

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.⁷⁸ 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

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.⁷⁹ 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.⁸⁰

In 2001, an article in *The New York Times* about the BMC partnership⁸¹ 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.⁸²

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-RUJV>].

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-off⁸³—NCMLP moved its activities to Washington, D.C.⁸⁴ 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.⁸⁵ 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,⁸⁶ the authorizing statute for the health center program overseen by HRSA.⁸⁷

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.⁸⁸ 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.⁸⁹

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.⁹⁰

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.⁹¹ 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.⁹² 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.⁹³

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.⁹⁴ 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.⁹⁵

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

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 [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/JusticeGainAmerica2009.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.⁹⁶

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,⁹⁷ (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.⁹⁸

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.⁹⁹ 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.¹⁰⁰ 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

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.¹⁰¹ 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 Health¹⁰²

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	<ol style="list-style-type: none"> 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.	<ol style="list-style-type: none"> 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 [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]

<p>Education and Employment</p>	<p>Access to opportunity to learn and work</p>	<p>Secure specialized education services; prevent and remedy employment discrimination and enforce workplace rights</p>	<ol style="list-style-type: none"> 1. A quality education is the single greatest predictor of a person's adult health. 2. Consistent employment helps provide money for food and safe housing, which also helps avoid costly emergency health services. 3. Access to health insurance is often linked to employment.
<p>Legal Status</p>	<p>Access to opportunity to work</p>	<p>Resolve veteran discharge status; clear criminal/credit histories; assist with asylum applications</p>	<ol style="list-style-type: none"> 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. 2. Consistent employment provides money for food and safe housing, which helps people avoid costly emergency health care services
<p>Personal and Family Stability</p>	<p>Exposure to violence</p>	<p>Secure restraining orders for domestic violence; secure adoption, custody, and guardianship for children</p>	<ol style="list-style-type: none"> 1. Less violence at home means less need for costly emergency health services. 2. Stable Family relationships significantly reduce stress and allow for better decision-making, including decisions related to health care

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.¹⁰³ 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.¹⁰⁴

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."¹⁰⁵

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.¹⁰⁶

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

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.¹⁰⁷

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 be 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.¹⁰⁸ 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.¹⁰⁹

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.

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.¹¹⁰ He was admitted to Lancaster General Hospital three times in seven months due to problems with his lungs and kidneys.¹¹¹ Each time he went to the hospital, bills piled up from procedures and medications for which he had no insurance coverage.¹¹² Depressed from the mounting debt, Mr. Jackson stopped taking some of his pills, and his health worsened.¹¹³ 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.¹¹⁴ 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.¹¹⁵ 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.¹¹⁶ He started taking his medications regularly, lost over 150 pounds, and experienced enormously improved health.¹¹⁷

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-

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.”¹¹⁸ 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.¹¹⁹ 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.¹²⁰

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.¹²¹

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

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.¹²² 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.¹²³ 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.¹²⁴

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,¹²⁵ 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.¹²⁶ 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).¹²⁷ 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.¹²⁸ Her recommendations include identifying social, legal, and health needs as well as tracking unmet need for the purposes of achieving social policy change.¹²⁹ 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.¹³⁰

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 21ST 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 generally¹³¹ and the Affordable Care Act (ACA)¹³² 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

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 issue¹³³ 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.¹³⁴

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,¹³⁵ 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.”¹³⁶

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.¹³⁷ While using

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*, CTRS. 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*¹³⁸ and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,¹³⁹ 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.¹⁴⁰

Passage of the Affordable Care Act in 2010 signaled the next phase in the effort to address the issue of health inequity.¹⁴¹ 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.”¹⁴² 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,¹⁴³ and the idea of disparities was ex-

[<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 [<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,¹⁴⁴ and many hospitals began to orient their practices around notions of equity.¹⁴⁵ 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,¹⁴⁶ 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

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.¹⁴⁷ Minnesota's Department of Health leads an effort called "Advancing Health Equity in Minnesota",¹⁴⁸ 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 Initiative¹⁴⁹ 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.¹⁵⁰

The third and final aspect of this closing discussion that cannot be ignored is the current and future state of civil legal aid funding.¹⁵¹ Because civil legal aid programs are the legal partners in the majority of MLPs,¹⁵² 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 In-come 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://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 [<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.irp.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://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.¹⁵³ 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.¹⁵⁴ 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.¹⁵⁵ That number took a massive (25%) hit just two years later¹⁵⁶—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 2015,¹⁵⁷ 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

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/hstpov1.xls> [[perma](#)].

coming years.¹⁵⁸ 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,¹⁵⁹ 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 21st century health system.

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://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 [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 [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].

