The Medical-Legal Partnership Toolkit

Phase I: Laying the Groundwork

Updated March 2015

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Developed by the National Center for Medical-Legal Partnership
A project of the Milken Institute School of Public Health at the George Washington University

National Center for Medical Legal Partnership

Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP

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TOOLKIT ACKNOWLEDGMENTS

This toolkit was developed with generous support from The Kresge Foundation and the Robert Wood Johnson Foundation.

The National Center for Medical-Legal Partnership (NCMLP) is grateful to the medical-legal partnership practitioners who reviewed the toolkit and provided critical feedback, including:

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NCMLP recognizes that the engine for most of the early medical-legal partnerships has been the intrepid leadership and sweat equity of committed legal and health professionals who, against the odds, met and worked to build programs together. We salute those individuals, and express our gratitude to their pioneering efforts; their experiences are reflected in this toolkit.

About the Medical-Legal Partnership Toolkit

Since 2006, the National Center for Medical-Legal Partnership (NCMLP) has helped health care and legal institutions develop partnerships to better care for vulnerable populations. After nearly a decade of providing technical assistance, NCMLP designed this toolkit to guide health care and legal professionals through the process of building strong and sustainable MLPs that reflect the populations they serve and communities they live in.

All medical-legal partnerships (MLPs) address health-harming legal needs that disproportionately affect people living in poverty. These partnerships are defined by their adherence to two key principles. First, health care and legal professionals use training, screening and legal care to improve patient and population health. Second, this legal care is integrated into the delivery of health care and has deeply engaged health and legal partners at both the front-line and administrative levels.

At the same time, each MLP responds to the unique needs of the population and clinic it serves by deploying its specific resources. It is critical that each burgeoning partnership take the time to assess the need in their local community and how the existing health and legal landscapes meet that need before formalizing a partnership.

This toolkit is broken into three separate stages:

PHASE I: Laying the Groundwork helps potential partners assess their population's needs to best position their MLP and assess the local health and legal landscapes to better understand the professional world of their partners.

PHASE II: Building Infrastructure helps partners formalize their relationship in a Memorandum of Understanding and lay out MLP activities and each partner's responsibilities.

Phase III: Sustaining and Growing the Partnership helps partners strengthen the integration of services, incorporate more clinic and systemic level legal care, and begin to measure the work of their MLP (available in late 2015).

Phase I and II are available for download on the NCMLP website at **www.medical-legalpartnership.org**.

Partners may schedule an optional consultation with NCMLP at the completion of Phase I or Phase II of the Toolkit **using this online form.**

In January and July of each year, NCMLP holds open enrollment periods to add programs to **the Medical-Legal Partnership Map**. Programs must be actively training and delivering services to be eligible for inclusion on the map.

Understanding Your Partner's Framework

As you work on Phase I of the toolkit and investigate the heath and legal landscapes broadly and in your community, it is important to understand that medical-legal partnership asks very different things of the health care and legal professionals who incorporate it into their practice.

Civil legal needs are not currently part of the language of health care, nor is legal care a tool in the toolbox health care team members use to treat patients or address population health. The connection between legal needs and health is invisible in the provision of health care. Overcoming this invisibility will require considerable education, not just about the connection between legal needs and health, but also about how lawyers can help each member of the health care team provide the necessary care. Medical-legal partnership builds on an existing framework, asking health care team members to expand their understanding of social determinants of health to recognize that some of those problems require legal screening and intervention. It asks them to accept lawyers – as they have patient navigators, case managers and social workers – as unique but indispensable members of the health care team with a new expertise to help identify, treat and prevent these problems in patients, clinics and populations.

Civil legal aid organizations already provide assistance to individuals around many issues that impact health, but do so in a justice-driven framework, not a health-driven one. Medical-legal partnership requires civil legal aid organizations and professionals to dramatically re-orient the delivery of civil legal aid to prioritize health and to practice law in a public health framework, valuing population outcomes alongside individual case outcomes. Lawyers learn from their health care partners how to evaluate their work and adopt health-related priorities. It also asks legal professionals to move from crisis driven care (justice is about righting a wrong) to practicing prevention and upstream care. Civil legal aid services provided still include traditional case representation, but significantly shift time and resources to training health care team members, providing expert case consultation, and collaborating with health care team members on clinic and population health changes.

GLOSSARY OF TERMS

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

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

Medical-Legal Partnership: An approach to health that integrates the expertise of health care, public health and legal professionals and staff to address and prevent health-harming social and legal needs for patients, clinics and populations. By partnering together, health care, public health and legal institutions transform the health care system's response to social determinants of health.

RESOURCES FOR CONNECTING WITH THE MLP MOVEMENT

Newsletter

The MLP Update is NCMLP's bi-weekly e-newsletter for MLP practitioners that shares MLP news and resources. Sign up at: **www.medical-legal-partnership.org.**

MLP Summit

Each spring, NCMLP hosts the annual MLP Summit, which brings together hundreds of leaders in law, health, public health and government to discuss how best to integrate health and legal care for vulnerable people. Information about the next Summit available at: **www.medical-legal-partnership.org.**

Blog

"Bridging the Divide" is NCMLP's blog and shares trends, topics and tips related to MLP. Contributors include MLP practitioners and health and legal thought leaders. Read more at: **www.medical-legal-partnership.blogspot.com.**

Social Media

Join the conversation with other MLP practitioners.

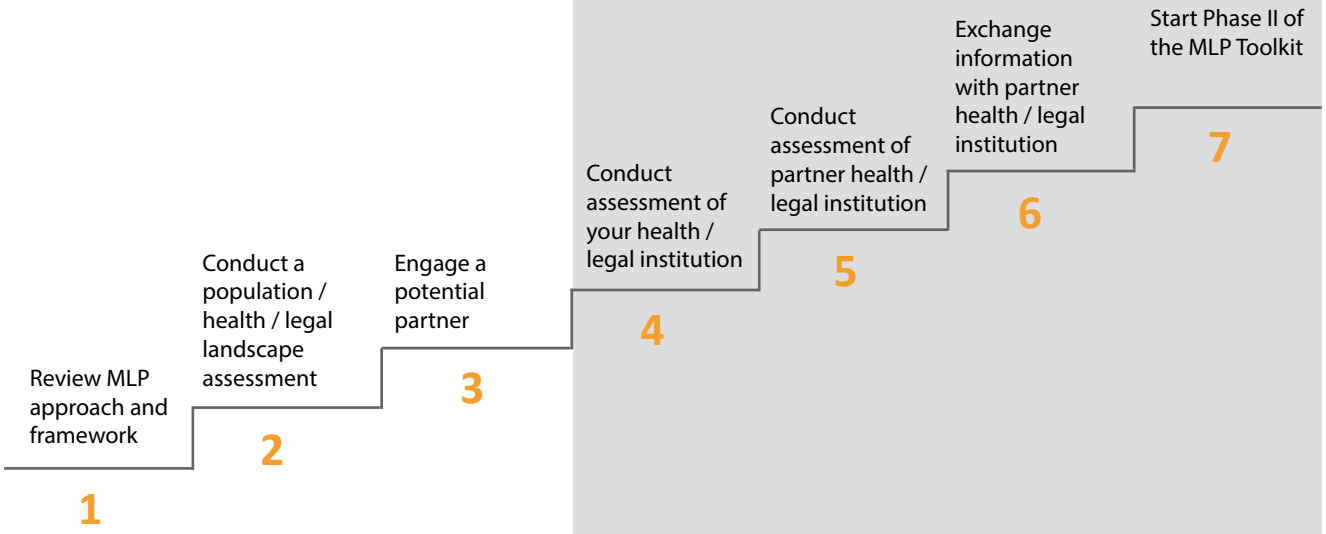
NCMLP

@National_MLP

INSIDE PHASE I: LAYING THE GROUNDWORK

What are the two most common mistakes that new medical-legal partnerships make? The first is failing to properly define the scope of need that the MLP will address. The second is setting up a partnership before thoroughly investigating the local community landscape and, most important, before fully understanding the health and legal frameworks in which their potential partners operate. Understanding the need, resources and landscape of your community is absolutely critical to the success and sustainability of your MLP. Phase I of the toolkit guides partners through this process and conversation. It should be completed *before* you attempt to formalize a partnership with a Memorandum of Understanding and *before* you begin delivering services.

Overview of Steps



Steps 1-3: Completed by the health / legal institution that downloaded the toolkit

Steps 4-7: Completed by the health and legal institutions together

Who should participate in completing the steps in the toolkit?

This toolkit recognizes that an individual "champions" will take the lead in developing the MLP, but Phase I demands community level reflection and research in the legal, social service, health and public health sectors. Intrepid and passionate leaders seeking to implement an MLP can only succeed when they engage front-line practitioners AND administration in this endeavor at the earliest phases. Phase I is also a road map for emerging programs to seek monetary support to ensure a properly funded planning process. A heavy emphasis on identifying the right partnering agency in both the health and legal sector means that Phase I participants must openly acknowledge their own limitations and strengths.

Where is there additional information on the MLP Approach?

As you complete Phase I, it will also be important to familiarize yourself with various aspects of the MLP approach and implementation. This toolkit offers a brief summary, but we strongly recommend that you purchase a copy of the MLP textbook ***Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership (ed. Elizabeth Tobin Tyler)*** **from Amazon.com** and watch some of the **free core MLP webinars.**

TOOLKIT PHASE I CHECKLIST

As you proceed through Phase I, use this checklist to ensure you are completing all the steps.

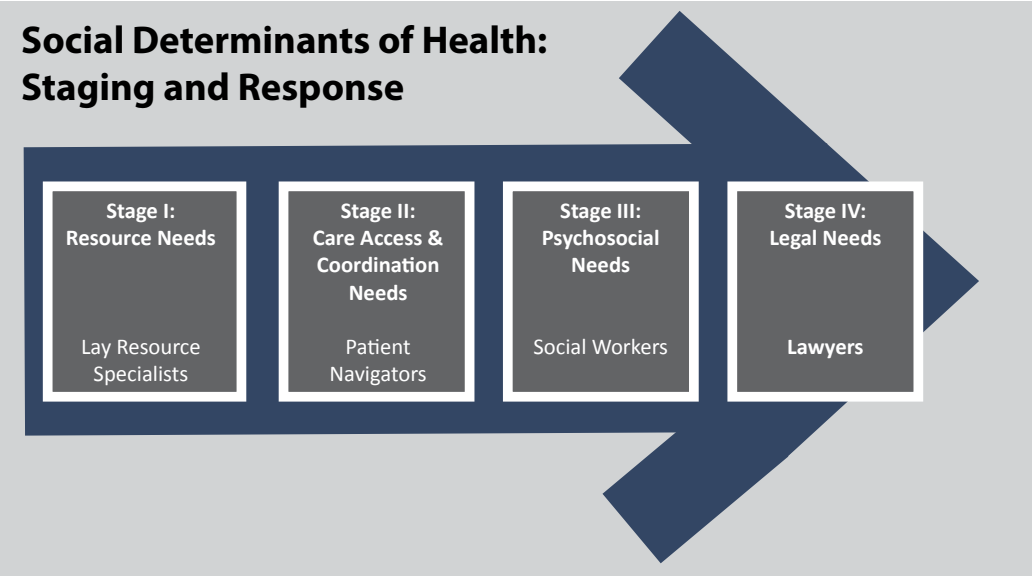
Step One: Review MLP Approach	
☐	Read suggested readings on social determinants of health
☐	Read the toolkit case study and reviewed the lessons learned
Step Two: Landscape Assessment	
☐	Read the two suggested readings about better understanding the health or legal landscape (depending on my profession)
☐	Completed the full landscape assessment worksheet, utilizing all available community resources and stakeholder interviews as necessary
☐	Reviewed the needs assessment with senior leadership at my institution
☐	**Passed CHECKPOINT 1: One or more needs in a specific population were identified that would be better addressed using the MLP approach**
Step Three: Engage an Informal Partner	
☐	Assessed which legal / health care institutions in my community serve the same populations as my institution
☐	Conferred with staff and leadership at my organization about potential contacts and relationships with legal / health care institutions in my community
☐	Identified front-line and senior leadership at the potential partner institution
☐	Developed, with sign-off from my institution's leadership, a one-page document that describes the scope of the problem I want to address. The one-pager describes the problem in a health or public health framework, and draws connections between legal needs and health.
☐	Set up meeting with potential partner
☐	Secured informal commitment from potential partner institution to complete rest of Phase I toolkit together
Step Four: Conduct an Assessment of Your Institution	
☐	Completed the "SWOT" assessment worksheet about my own institution using all available community resources and stakeholder interviews as relevant
☐	Reviewed the "SWOT" assessment and analysis with relevant staff and leadership at my institution
Step Five: Conduct an Assessment of Your Potential Partner Institution	
☐	Potential partner completed their "SWOT" assessment worksheet using all available community resources and stakeholder interviews as relevant
☐	Completed and reviewed the "SWOT" analysis with relevant staff and leadership at my institution
Step Six: Exchange Additional Information with Potential Partners	
☐	Reviewed both "SWOT" assessments with my potential partner
☐	Exchanged and reviewed organizational charts, financial statements, annual reports, community health needs assessments and access to justice reports with potential partner
☐	**Passed CHECKPOINT 2: Both partners agreed to proceed to Phase II. (Don't be afraid to walk away and start over if partner is not the right fit! Better now then later.)**
Step Six: Start Phase II of the MLP Toolkit	
☐	Download "MLP Toolkit Phase II: Building Infrastructure" and begin work on it with your partners.
☐	**Optional: Use this online form to request a consultation with NCMLP** (representatives from legal and health care institutions must be present on the call).

STEP ONE:
REVIEW MLP APPROACH AND FRAMEWORK

Setting the Stage: Legal Problems are Health Problems

One in six people live in poverty, and each of those individuals has a civil legal problem that negatively affects their health (**"Documenting the Justice Gap", The Legal Services Corporation, 2009)**. People are wrongfully denied nutritional supports and educational services, resources that are necessary to meet their daily needs. People who live in housing with mold or rodents, in clear violation of sanitary codes, are in a physical environment that is making them sick. Then there are seniors who are denied benefits, such as access to supportive services or long term care, whose lack of access to insurance prevents them from getting the health care they need. These all constitute health-harming legal needs.

While the impact that social problems have on health is well-documented, legal needs are not currently part of the language of health care, nor is legal care a tool in the toolbox health care team members use to treat patients or address population health. The connection between legal needs and health is invisible in the current provision of health care. Overcoming this invisibility requires transforming how health care team members understand and screen for these needs as well as how clinics and health care teams respond to the identified needs.



A variety of needs comprise what we understand as the social determinants of health. These needs require a 21st century integrated, interprofessional health team with each profession working together, each at the top of their licenses.

Suggested Readings on Social Determinants of Health:

1. RWJF Issue Brief "How Social Factors Shape Health: Income, Wealth and Health," The Robert Wood Johnson Foundation, 2011.
2. RWJF Survey results "Health Care's Blind Side: The Overlooked Connections between Social Needs and Health," The Robert Wood Johnson Foundation, 2011.

The Traditional Response of Civil Legal Aid

The backbone of the civil legal aid community is the 135 legal aid offices across the U.S. funded through the federal Legal Services Corporation. Staffed by 8,000 civil legal aid attorneys and paralegals, they handled cases for over 800,000 people in 2012 (**Legal Services Corporation Annual Report, 2012**). The Legal Services Corporation found that low-income people in the United States on average have two to three unmet legal needs, and that current resources only meet approximately 20 percent of the need (**"Documenting the Justice Gap."**) Civil legal aid is historically underresourced, poorly coordinated and frequently disconnected from other community resources.

Civil legal aid attorneys spend significant portions of their time helping low-income and underserved populations with legal issues that are inextricably linked to their health. In 2012, civil legal aid attorneys most frequently handled cases related to (1) safety and domestic violence; (2) safe housing including unlawful evictions, landlord tenant issues and disputes over federal subsidies; and (3) income maintenance including obtaining and maintaining disability benefits (**Legal Services Corporation Annual Report**). However, these services are framed by a mission of improving access to justice, not improving health, and their impact on health is not tracked or measured.

In general, the majority of legal aid staff time is focused on individual advocacy – in part driven by the requirements of the federal funding. State-funded programs and law school clinics are frequently more flexible and can pursue broader policy advocacy on behalf of poor communities, but their capacity is dramatically limited in both scope and reach. Since pressing need outstrips resources, legal aid faces challenges in moving resources upstream to prevent legal problems. This results in high level policy efforts being the singular prevention strategy.

The Traditional Response of Health Care

Recently, there has been a significant shift in health care toward incorporating strategies that target social determinants of health. Addressing psychosocial and care coordination needs have been increasingly accepted as critical to improving health, and both social workers and patient navigators have been integrated into the health care team at most health care institutions.

Yet, civil legal needs have not been recognized as part of this shift in health care. Many health care team members write certification letters for patients' public benefits or do ad hoc advocacy to try to help patients in poor housing conditions, but on a whole they do not see these legal needs as a health care problem. And while health care team members often have significant contributions to make to the development of health-related public policy, they are not trained to understand or navigate complicated systems like their legal counterparts. Health care in general has never viewed civil legal aid organizations as partners in delivering quality patient health care services or population health interventions.

The Medical-Legal Partnership Response

Despite the connection between health and legal needs and the fact that health care institutions and civil legal aid offices have long treated the same patients/clients, there has never been a coordinated effort to address these problems until now. Medical-legal partnership bridges the divide.

Medical-legal partnership (MLP) integrates the expertise of health and legal professionals and staff to address and prevent health-harming legal needs for patients, clinics and populations. By partnering together, health care and legal institutions transform the legal and health care systems' response to the social determinants of health. The medical-legal partnership approach:

- **TRAINS** health care, public health and legal teams to work collaboratively and identify needs upstream;
- **IDENTIFIES** patients' health-harming social and legal needs by implementing screening procedures;
- **TREATS** individual patients' health-harming social and legal needs with legal care ranging from triage and consultations to legal representation;
- **TRANSFORMS** clinic practice and institutional policies to better respond to patients' health-harming social and legal needs; and
- **PREVENTS** health-harming legal needs broadly by detecting patterns and improving policies and regulations that have an impact on population health.

What Happened When the Heat Went Off?

A Medical-Legal Partnership Patients-to-Policy Story

No heat or electricity meant asthma attacks, sickle cell pain and the inability to refrigerate medicine for thousands of low-income people in Boston. The story below illustrates the medical-legal partnership approach in action – how training for health care providers and legal care for patients led to clinic and population health innovations, and how the impact increases and becomes more preventive as the interventions progress. Note that each step of the way, the legal and health care team members communicated and worked together as part of the same team, not in silos.

TRAIN & IDENTIFY NEED → **TREAT PATIENTS** → **TRANSFORM CLINIC PRACTICE** → **IMPROVE POPULATION HEALTH (PREVENTION)**

Training & Screening

Legal team trained health care team members how to screen patients at-risk for utility shut off and write protection letters.

Physicians wrote letters protecting 193 people.

New Energy Clinic

Legal team opened new legal clinic at hospital to help people who health care team members identified as having already had their utilities shutoff.

Attorneys helped people get heat and electricity turned back on.

Utility Letter in the EMR

The volume of letters led health care team members to identify a need for a patient EMR form letter, which attorneys drafted. Health care team members no longer had to draft from scratch.

Physicians wrote 350% more letters helping 676 people. Saved clinic time.

Regulations Testimony

Legal and health care team members' testimony resulted in regulation changes that reduced need for chronic disease re-certification and allowed nurses to sign letters.

Fewer people faced utility shutoff, preventing problem.

Health Care Integration is Everything

The key to what makes medical-legal partnership successful is also what makes it unique: integration of legal care into the health care system. This diagram highlights how that integration is reflected in the health care institution's thinking and approach to services.

AUTONOMY → INTEGRATION	Referral Network	Partially Integrated MLP	Fully Integrated MLP
Health care institution's view of legal care	Legal needs loosely connected to patient well-being; legal professionals are valued allies, but separate from HC services.	Legal needs connected to patient health; Legal care is complementary/ancillary to HC services.	Legal needs are tightly connected to patient health; Legal care is integrated part of HC services.
Relationship between health care and legal institutions	Small legal team loosely connected to small number of HC providers who make case referrals for individual assistance.	Legal agency formally recognized by HC institution as a partner, but services often restricted to single unit/clinic. HC engagement at front-lines, but not within HC administration.	Legal institution formally recognized by HC institution as part of health care team and service system. HC engagement at all levels including administration.
Patients' access to legal care	Patients are inconsistently screened for health-harming legal needs and have inconsistent access to legal assistance from lawyers. No clinic, population health or preventive legal care offered by institution.	Screened clinic patients get regular access to legal assistance from lawyers, but not all patients and not across institution. Little clinic, population health or preventive legal care offered by institution.	All patients are screened for same health-harming legal needs and have some regular access to legal assistance from lawyers. Clinic, population health and preventive legal care regular part of institution's practice.

Every MLP is different because it responds to the unique needs and resources of its population, community and partners, and thus a variety of indicators can be used to assess integration. However, there is a strong and direct correlation between the level of health care integration and the success and sustainability of a partnership. Here are a few sample indicators.

Examples of Specific Indicators	Referral Network	Partially Integrated MLP	Fully Integrated MLP
Legal presence at health care institution	Legal professionals occasionally on-site at HC institution.	Legal professionals regularly on-site at HC institution to meet patients, occasionally meet HC providers.	Legal professionals see patients at HC institution, participate in meetings with HC providers and administration.
Case, clinical and systemic priorities	Set by legal team without HC input or health framework.	HC team has input, but priorities follow legal aid framework.	Set jointly by legal and HC teams using health frame and aligning with HC institutional priorities.
Communication between legal and health care teams	No feedback loop between legal and HC teams. Minimal/no regular training of HC providers. No shared data across partners/systems.	Minimal feedback loop between legal aid and HC teams. HC providers trained by legal professionals. Episodic, non-systemic data sharing.	Expectation of case feedback and clinical communication (often across Electronic Medical Record). Regular trainings between health and legal teams. Joint data collection and analysis.
Health care staffing	No dedicated staff time from HC providers.	Minimal dedicated, compensated staff time from HC providers.	Sufficient dedicated staff time from HC providers.

Note: Indicators in this chart are what NCMLP uses to help determine inclusion on the Medical-Legal Partnership Map during January and July open enrollment periods, so please keep these indicators in mind while planning your partnership.

Starting a Medical-Legal Partnership
A Case Study

**This case study reflects a common MLP start up tale. It is designed to help you apply your knowledge of the medical-legal partnership approach and recognize common pitfalls on the path to sustainability. Read it and review the lessons learned.*

Melanie attended law school in Virginia where she participated in a medical-legal partnership (MLP) clinic that served patients at a university hospital. When she graduated law school, she got a fellowship to work at legal aid agency in Portland, Oregon, to develop a new MLP for the elderly. Soon after starting at the civil legal aid agency, she reached out to Dr. Jones, a geriatrician at a local public hospital who agreed to help develop the MLP within the geriatrics department.

The MLP saw several successes in its first year. The civil legal aid agency secured $50,000 in start-up grant funding from the local bar association and a local health care foundation, alongside Melanie's fellowship funding, and secured an on-site office for Melanie to use while seeing patients at the hospital. Clinical staff began referring clients to Melanie, who was initially present once a week at the hospital to speak with clinical staff and conduct client intakes. Once the head of the geriatrics department saw the benefits of the program and the response from doctors and patients, she asked Melanie to be on-site at least three days a week.

Melanie and the health care team worked comfortably side-by-side. Melanie did several trainings for the clinical team on common civil legal needs of seniors and how to screen for them during a patient visit. The hospital staff answered ad-hoc queries from Melanie and vice versa. When a large volume of cases were referred, Melanie was able to refer some cases back to colleagues in the public benefit and housing departments at her civil legal aid agency.

After 10 months in operation, successful trainings had led to a steady increase in the number of cases referred to Melanie, but she did not have enough time to handle every case or enough resources to send them back to her legal aid office. On the health care side, Melanie's inconsistent capacity made comprehensive screening and streamlining referrals virtually impossible. At the same time, internal changes took place within the hospital and new administration did not prioritize or understand the MLP program or the value it was bringing to geriatrics patients and providers. Melanie and Dr. Jones were concerned about these changes, especially because there was no formal agreement between the hospital and legal aid agency. Melanie and Dr. Jones needed to introduce a new administrator to the program.

The legal aid agency received word that the grant which had helped fund the program's first year was not being renewed, and either had to find new funding or pull the attorney from the hospital, essentially dissolving the partnership.

Lessons Learned

More integration was needed.

In the case study, the hospital provided office space for the attorney on-site and the attorney had begun to train health care team members. Dr. Jones was also helping to navigate the health care administration. However, there should have been formal cross learning between attorneys and clinicians to share processes, systems, and terminology. The administration at the civil legal aid agency and hospital should have been a big part of the planning process, and resources (besides office space) should have been contributed by the health care institution.

Sustainability required deeper understanding of partners' priorities, needs and expectations.

NCMLP has provided technical assistance to MLPs in various life cycles of growth for many years and the most common barriers to long term sustainability stem from uneven partner engagement, failure to set expectations from the onset and specifically define the population and scope of need being addressed, funding, and overlooking the importance of clinical and systemic level interventions to expanding capacity. These problems are all best addressed by setting expectations during start up through a detailed Memorandum of Understanding.

Present success cannot be confused for sustainability or longevity.

Securing office space and referring cases are crucial steps in forming a successful MLP. However, as seen in the case study above, these are not measures or guarantees of long term success and sustainability. Capacity and impact could have been increased by focusing more effort upstream.

STEP TWO: CONDUCT POPULATION, HEALTH & LEGAL LANDSCAPE ASSESSMENTS

*The population, health and legal landscape assessments can be completed alone by the health care or legal institution that downloaded Phase I of the toolkit. It is meant to assist you in identifying the greatest need, defining the scope of your partnership, and beginning to think about partners. It should reflect your organization, not you as an individual, and you should reach out to colleagues to ensure the best answers. This step should be completed before reaching out to any possible health care or legal partner institutions.

Developing a Working Knowledge of your Partner's Professional Framework

To build a successful partnership, you must be literate in the priorities and challenges of your partner's field. Whether you are the health care or legal professional, you need to understand the basic framework your partner operates within. And when it comes to engaging a partner, you have to be able to speak their language and place MLP both in the context of your community and their professional needs and priorities.

IF YOU ARE A LEGAL PROFESSIONAL:

It is important to understand basic health care funding streams, critical changes health care institutions face under the Affordable Care Act and the differences between various types of hospitals and health centers.

Background reading:

1. **"Disparities in Health and Health Care: Key Facts," Kaiser Family Foundation, 2012.**
2. **"Health Care Costs: A Primer," Kaiser Family Foundation, 2012.**

IF YOU ARE A HEALTH CARE PROFESSIONAL:

It is important to understand the basic differences between civil and criminal legal aid, the scope of civil legal needs in the U.S. and the general lack of resources available to meet them.

Background reading:

1. **"Access Across America" report, American Bar Foundation, 2011 (Executive Summary only).**
2. **"Natural Allies: Philanthropy and Legal Aid" report, Public Welfare Foundation, 2012.**

EVERYONE:

It is important to understand how health care and legal professional frameworks align.

Background reading:

1. **Poverty, Health and Law & Health, Chapter 2: Who Cares for the Poor.**
2. **"Integrating health care and legal services to optimize health and justice for vulnerable populations: The global opportunity," 2012.**

Conduct a Needs Assessment

Each medical-legal partnership (MLP) responds specifically to the unique needs of the population it serves and deploys the specific resources of its community. Understanding the unique environment your medical-legal partnership will operate in is the first critical step to maximizing the potential benefits of your program, and it will provide you with critical information in making the case to the right partner institution.

The needs assessment on pages 12-13 helps you gather information about your proposed partnership's target population and the common legal needs impacting their health, and then assess the opportunity for an MLP.

NEEDS ASSESSMENT WORK PAGE 1

Directions: Fill out the chart below using reports and stakeholder interviews as necessary. Suggested resources are listed in each section. A completed sample is included on page 14 to help guide you.

Suggested Resources:

U.S. Census Data

Your local / state public health reports

Target Population within the Community

Define your target population below. Include any demographic information that is particularly relevant along with any information pertaining to the size and scope of the population.

Your target population should be framed in a health context and may be a (1) disease group (children with asthma in CITY); (2) socially defined group (homeless veterans in CITY); or (3) health care defined group (health care super-utilizers in CITY). *NOTE: Your MLP may have more than one target population, but being specific and intentional about the populations you serve will allow you to target screening, think strategically about how to address the problem at both a patient and clinic level, and open the door for evaluation and measurement.*

Suggested Resource:

Conduct interviews with local health care stakeholders

Health Care Institutions

Part of maximizing MLP impact is understanding where your target population gets their health care. Answer the questions below for each relevant health care institution in the area.

Health care institution name	**Health care institution type** *(e.g. Federally Qualified Health Center, Veterans Medical Center, Children's Hospital, etc.)*	**Percentage / number of health care institution patients who fit your target community** *(e.g. How many pediatric patients are treated for asthma? Or what percentage of the hospital's patients are considered super-utilizers?)*	**Payor mix for institution's patients: uninsured, Medicare, Medicaid, private** *(If you can find data for the target community that's great but it's okay to pull data for the overall institution here.)*

Suggested Resources:

VA Project CHALENG Report

The State of the Nation's Housing Report

County Health Rankings

U.S. Census Measures of Well-Being Report

Look for other reports that outline needs of population or prevalence of legal need

Population-Relevant Health-Harming Legal Needs

For each of the "I-HELP" categories below, note high rates of need for your target population.

The goal of this section is to identify which health-harming legal needs are most prevalent in your target population, and identify the 1-3 areas where an MLP can have the greatest impact on health. *NOTE: It is unlikely that you will find data that is specific to your city or state, but you can look broadly to national data to draw the connections. For example, data about the most prevalent legal needs of homeless veterans is available in the CHALENG survey. You can match those needs to the categories below.*

I Income supports / Insurance (food stamps, disability benefits, cash assistance, health insurance)	
H Housing and utilities (eviction, housing conditions, housing vouchers, utility shut off)	
E Education / Employment (accommodation for disease and disability in education and employment settings)	
L Legal status (criminal background issues, consumer law status, military discharge status, immigration status)	
P Personal and family stability (domestic violence, guardianship, child support, advanced directives, estate planning)	

NEEDS ASSESSMENT WORK PAGE 2

Suggested Resources:

Your local legal aid annual report

Your local / state access to justice report

Local Legal Institutions

Legal institution name	Legal institution type *(e.g. LSC-funded legal aid agency, law school, private law firm, etc.)*	Number of legal matters handled for target population last year for each identified health-harming legal need

Suggested Resource:

NCMLP Website

Medical-Legal Partnerships in the Area

Before starting a new medical-legal partnership, it is important determine if there are existing medical-legal partnerships in the area and what specific needs they are addressing. Describe below any other MLPs in the area and if there are opportunities to collaborate or strategically align with them.

Description of Purpose / Intended Scope:

Based on the information above, write a brief scope of the need that will be addressed by your MLP.

STOP! Checkpoint #1: Has an MLP need been identified?

☐ Yes: One or more needs in the target community were identified that would be better addressed using the MLP approach. Review with leadership at your institution and move on to step three of the toolkit.

☐ No: Needs were not identified, or needs are present but not suitable to be addressed with the MLP approach. Please go back and use the landscape assessment to identify a community whose needs are better served through MLP.

*It is important to be honest. If a specific need has not been articulated, it is not likely that your MLP will be successful.

SAMPLE COMPLETED NEEDS ASSESSMENT

NOTE: The health and legal institutions in this sample and the correlating numbers are fictional.

Target Community

Health care super-utilizers in Portland, Oregon.
Generally speaking, super-utilizers are the 5 percent of the population that utilize 50 percent of health care costs. They tend to be single, childless adults who are on Medicaid or uninsured. They have higher than average rates of mental health problems and complex physical and social needs.

Local Health Care Institutions

Health care institution name	Health care institution type	Percentage / number of health care institution patients who fit your target community	Insurance payor mix for institution's patients -- uninsured, Medicare, Medicaid, private
Central Portland Community Health Center	Federally Qualified Health Center (FQHC)	4 percent of patients are super-utilizers	Super-utilizers -- 60% Medicaid; 40% uninsured
Pacific NW University Hospital	Academic hospital	4.5 percent of patients are super-utilizers	Super-utilizers -- 85% Medicaid; 15% uninsured
St. Michael's Medical Center	Public Hospital	6 percent of patients are super-utilizers	Super-utilizers -- 78% Medicaid; 22% uninsured

Community-Relevant Health-Harming Legal Needs

I Income supports / Insurance (food stamps, cash assistance, disability applications and payments, health insurance)	Super-utilizers have high rates of disability and SSI Disability claims / denials
H Housing and utilities (eviction, housing conditions, housing vouchers, utility shut off)	Super-utilizers have unstable or chaotic living conditions -- high rates of eviction and homelessness
E Education / Employment (accommodation for disease and disability in education and employment settings)	Super-utilizers face joblessness from disability
L Legal status (criminal background issues, consumer law status, military discharge status, immigration status)	
P Personal and family stability (domestic violence, guardianship, child support, advanced directives, estate planning)	Super-utilizers have high rates of mental illness and often no one to care for them if they are released from hospital -- guardianship problems.

Local Legal Institutions

Legal institution name	Legal institution type	Number of legal matters handled last year in each identified health-harming legal need for the target community
Oregon Legal Aid (Portland office)	LSC-funded legal aid agency *13,000 clients annually*	Disability denials: 1690 (13% of total cases); Housing evictions: 1950 cases (15% of cases; housing cases = 30% of total cases); Adult guardianship: 52 cases (less than 1% of cases)
Legal Aid Center of Portland	Non-LSC legal aid agency *7,000 clients annually*	Disability denials 1400 (20% of total cases); Housing evictions: 770 cases (11% of cases); Adult guardianship: N/A
Pacific NW University School of Law	Law school	Housing evictions: 50 cases through its housing law clinic. Does not handle cases related to disabilities or guardianship.

Medical-Legal Partnerships in the Area

The only medical-legal partnership in the Pacific Northwest is in Seattle, Washington. There are not currently any partnerships in the city of Portland or the state of Oregon. *(*Note to self: inquire to National Center whether there are other superutilzer focused MLPs in the country.)*

Description of Purpose / Intended Scope:

Our MLP's goal is to add lawyers to the superutlizer teams at Portland hospitals and provide legal training, screening and care around disability and guardianship issues for high utilizing patients, both to help reduce health care costs and improve the health and well-being of this patient population.

STEP THREE:
ENGAGE A POTENTIAL PARTNER

*The information outlined in step three is intended to help you identify the right partner institution and individuals to approach, and offer guidance on what information to share with a potential partner.

Identify the Right Potential Partner Institution

Your landscape assessment should have shed light on potential partner institutions and highlighted which institutions are engaged in the same type of care for the population you are interested in serving. With leadership at your organization, you should also look for:

1. **Capacity to support MLP activities:** Health care partners occasionally inquire about the advisability of hiring civil legal aid attorneys directly, rather than partnering with a legal agency in the community. This is not recommended since much of the capacity, depth of expertise and mechanism to properly supervise legal work comes from the already existing structure within the civil legal aid agency. Capacity and infrastructure are critical factors to consider when identifying an appropriate legal partner. Civil legal aid agencies differ significantly in capacity and infrastructure from law school clinics and *pro bono* projects. Ensuring that stable, trained attorneys are at the center of your MLP is crucial to providing quality, consistent services. Be able to discuss and differentiate the capacity of each type of legal partner.

2. **Partner attitude and/or knowledge of MLP:** Organizations with leadership and staff who are receptive to MLP will be much easier to work alongside. Target organizations that have a history of being flexible, open to change, and are heavily involved in the community.

3. **Networks, relationships, and access:** Target organizations where there has already been some formal or informal contact, relationship, or positive experience. Look for existing access to leaders within that organization. Utilize internal resources including working across departments to gain access to leadership of the partner organization. If civil legal aid agencies collect data on where their clients receive health care services, it is an opportunity to highlight shared patient-clients and offer a starting place for discussion.

4. **Organizations with need based on the landscape assessment:** Target organizations that serve populations that identified in the landscape assessment. Try to find competitors of potential partners in the legal and health scan that are benefiting and leading the community with an MLP approach. If there were no MLPs found in the MLP Scan, highlight the "first in the community" advantage. Look for organizations that emphasize their role and take an active interest in the community and want to be innovators.

Determine the Right Contacts

It is important to identify an individual champion and to understand where that champion lives within the hierarchy of their home institution. Buy-in from an individual or team of champions does not replace the need for broader institutional support, but you will need someone who takes responsibility for helping to navigate his/her institution's internal environment and helps to complete the rest of the toolkit. This person should have the capacity and willingness to navigate their internal environment, organization and administration to bolster support which will lead to eventually formalizing the relationship later down the road.

It is critical that you have buy-in and support for your medical-legal partnership from the front-line AND administration at both the health and legal institutions, and it is important to set the stage for that engagement from day one. Potential partners should swap organizational charts and understand the power structures such as who can authorize funding and who can help you navigate training opportunities.

The chart below identifies individuals on both the health and legal side from whom you will eventually need support.

Partner	Person	Role
Health care	**Health care Institution Executives** • Board Members • General Counsel • Quality Officer • CEO • CFO • Medical Director	Senior leader engagement will frame MLP activities in the context of institutional goals, priorities and mission; they will identify resources, raise program profile, and promote sustainable integration. Without buy-in at this level, sustainability and growth are unlikely. **Members of this group should be play a role in the planning process and consulted before and during the MOU development (Phase II of the toolkit).**
	Front-line Health care Institution Practitioners • Clinic Leadership • Physicians • Nurses • Social Workers • Patient Navigators	Front-line teams provide the engine, ambassadorship and insights about institutional power centers and proclivities. Front-line practitioners benefit from being engaged in MLP planning and implementation to ensure buy-in from the entire team.
	Medical School & Residency Program Partners • Dean • Residency Directors	Educational leaders and practitioners can help integrate MLP into the academic mission of the institution, and embed MLP in educational activities. They can build resources to support MLP educational activities. **They should be part of the planning process around interprofessional education and training.**
Legal	**Civil Legal Aid Executives** • Board of Directors • Executive Director • Deputy Director • Managing Attorney	Civil legal aid executives hold the "value proposition" of MLP for their institution in front of them. Executive directors are not motivated to simply expand access to scarce legal services without accompanying financial resources. **Members of this group should be part of the planning process and consulted before and during the MOU development (Phase II of the toolkit).**
	Civil Legal Aid Front-line Staff • Staff Attorneys • Paralegals	Front-line civil legal aid staff benefit from being engaged in MLP planning and implementation to ensure buy-in from the entire team. They can also champion MLP when they realize the benefits of partnering with health care practitioners, including better access to medical records and expert medical opinion.
	Law School Partners • Dean • Legal Clinic Faculty	Law school leaders and practitioners bring academic experience and an educational mission that can match medical and residency programs. They can be an effective partner with other legal allies, but often have limited service capacity relative to patients. **They should be part of the planning process around interprofessional education and training.**

Reach Out to Potential Partner

Once you have identified an institution and a potential champion, you should reach out to set up a meeting. Remember, you are not making a formal commitment at this point; you are not asking for your partner to sign a Memorandum of Understanding or to begin delivering MLP services. You are asking this potential partner to explore what a partnership would look like and agree to do some homework together (steps 4-7 in the toolkit) to investigate whether the partnership is a good fit both for potential patients and for the partners.

You should plan to take two documents with you to your meeting:

1. **The MLP Overview handout** available on the NCMLP website
2. A one-pager you develop from the community needs assessment in step two.

Your one-pager should describe the population you want to serve, the extent of the need and the correlation between the identified health and legal needs of this population. **Personalize and localize your message. This one-pager should not reflect broad problems or national scope; they should reflect the need and opportunity in your community that was identified in your needs assessment.**

STEP FOUR:
CONDUCT AN ASSESSMENT OF YOUR HEALTH OR LEGAL INSTITUTION

*This step should be completed by the partner that downloaded the toolkit, and you should reach out to colleagues to ensure the best answers. The goal is to assess your resources and the best possible deployment of those resources to meet the need outlined in your landscape assessment.

All medical-legal partnerships (MLPs) address health-harming legal needs that disproportionately affect people living in poverty, but the specific legal needs they address depend on the populations they serve and the resources of the partners. This step helps you understand the resources of your organization and will help with MLP strategic planning when you and your partners get to that stage. This will also help you avoid two common errors new MLPs make: over promising services and not aligning priorities with existing resources.

Complete the "SWOT" assessment of your institution on page 18. When you finish it, review it with your institution's leadership (clinic director or legal aid executive director).

STEP FIVE:
CONDUCT AN ASSESSMENT OF YOUR INFORMAL PARTNER INSTITUTION

*This step should be completed by both potential partners, and you should reach out to colleagues to ensure the best answers. The goal is to assess their resources and the best possible deployment of those resources to meet the need outlined in your landscape assessment.

Finding the right partner can be a challenge. It is important to look for partners with which there is common ground especially related to mission, strategic goals, and expertise in a particular area. This step will utilize the knowledge you gained in the landscape assessment and your organization, and will assist in reviewing the informal partner relationship that has been developing.

Note that the components of an external assessment mirror those in the internal assessment. The purpose of this mirroring is to allow both assessments to be used side by side to screen the informal partner and assess if it is a good fit.

Have your potential partner complete the "SWOT" assessment on page 19 and ask that they review it with their institutional leadership (clinic director or legal aid executive director).

Once they have completed the assessment, you should complete the analysis on page 20.

YOUR "SWOT" ASSESSMENT WORK PAGE

General Institution Info:
If the health care partner is completing this section, you may answer these questions for the proposed clinics or departments the MLP will serve.

Budget	
Number of health care staff (doctors, nurses, patient navigators, etc.) or number of legal staff (lawyers and paralegals)	
Number of patients or clients served annually	

Strengths and Weaknesses (Internal Information)
List all of your organization's strengths and weaknesses that will impact a potential MLP. Think about these from both an insider perspective as well as the perception of outsiders such as clients and potential partner organizations. Please use the following factors to consider strength and weaknesses, but don't limit yourself to these factors.

- Human resources: staff, volunteers, leadership, capacity for training and recruiting
- Physical resources: space, equipment
- Funding resources: grants, agencies, private donors, other sources
- Activities and processes: available systems, current processes and activities, technical support
- Past experiences: areas that you can utilize to build upon or areas which in the past have needed building on
- Other: Areas, subject matter, or departments in which you are exceptional/non-exceptional

Be specific! An example of a good staff-related strength might be "My civil legal aid agency has a large public benefits staff that can handle # new public benefit cases a month from an MLP." A good funding-related weakness might be "My civil legal aid agency is facing a 20 percent decrease in federal funding this year."

Strengths:	**Weaknesses:**

Opportunities and Threats (External Information)
Consider the external factors that can potentially help or harm your potential partnership. Please use the following factors to consider strength and weaknesses, but don't limit yourself to these factors.

- Future trends: can be local or national
- Physical changes: changes in demographics, structural (buildings, transportation)
- Funding sources: public, private, grants, donors
- Legislation: changes in policies, new bills proposed in congress

Opportunities:	**Threats**

POTENTIAL PARTNER "SWOT" ASSESSMENT WORK PAGE

General Institution Info:
If the health care partner is completing this section, you may answer these questions for the proposed clinics or departments the MLP will serve.

Budget	
Number of health care staff (doctors, nurses, patient navigators, etc.) or number of legal staff (lawyers and paralegals)	
Number of patients or clients served annually	

Strengths and Weaknesses (Internal Information)
List all of your organization's strengths and weaknesses that will impact a potential MLP. Think about these from both an insider perspective as well as the perception of outsiders such as clients and potential partner organizations. Please use the following factors to consider strength and weaknesses, but don't limit yourself to these factors.

- Human resources: staff, volunteers, leadership, capacity for training and recruiting
- Physical resources: space, equipment
- Funding resources: grants, agencies, private donors, other sources
- Activities and processes: available systems, current processes and activities, technical support
- Past experiences: areas that you can utilize to build upon or areas which in the past have needed building on
- Other: Areas, subject matter, or departments in which you are exceptional/non-exceptional

Be specific! An example of a good staff-related strength might be "The hospital has robust social work and case management staff that can support the legal work of civil legal aid attorneys." An example of a good staff-related weakness might be "The health center is struggling to recruit physicians, and leadership to support new projects is thin."

Strengths:	**Weaknesses:**

Opportunities and Threats (External Information)
Consider the external factors that can potentially help or harm your potential partnership. Please use the following factors below to consider strength and weaknesses, but don't limit yourself to these factors.

- Future trends: can be local or national
- Physical changes: changes in demographics, structural (buildings, transportation)
- Funding sources: public, private, grants, donors
- Legislation: changes in policies, new bills proposed in congress

Opportunities:	**Threats**

"SWOT" ANALYSIS

Analysis: Answer the questions below and be able to articulate how each informal partner compliments the other and to what extent. This information is a key step in relationship development and will assist in the formalization process.	
Which gaps identified in the landscape assessment is my organization best suited to tackle given the organizational analysis?	
Keeping the informal partner's weaknesses and barriers in mind, what unique value does our organization bring to this partner in an MLP context?	
Will this partner utilize our organizations core assets?	
Keeping in mind our organization's weaknesses and threats, what value will my informal partner bring to us in an MLP context?	

STEP SIX: EXCHANGE INFORMATION WITH YOUR INFORMAL PARTNER INSTITUTION

*This step should be completed together by both potential partners.

Information Exchange

The purpose of this step is to review the "SWOT" assessments of both institutions with your informal partner and share additional pertinent information. This will allow a solid profile and understanding of each other and will allow you to fill in gaps and make clarifications as necessary. All of this is done in an effort to allow both parties to decide if the other is the right match and to confirm if they are ready to take active steps to formalize the relationship. This exercise assists in accurately highlighting areas that are compatible and areas which will require more development between the two partners.

In addition to the "SWOT" assessments, organizations should share their:

1. Organizational charts;
2. Financial statements;
3. Most recent annual reports;
4. Community health needs assessment (health care partner); and
5. Access to justice report or legal needs surveys (legal partner).

STOP! Checkpoint #2: The Goldilocks Test

MLP success is about finding partner institutions that are just right. Don't be afraid to walk away and approach another potential partner if you are not convinced after your assessments and information exchange that this is the right match. When the exchanging of information between the two partners is complete, both should deliberate independently and together to discuss whether or not to continue.

"The right match" in the MLP context means that the partners agree on the population and specific need and that they are both willing to invest in the success and ownership of the program. At this point, if both partners mutually agree to proceed forward toward formalizing the relationship then please proceed to NCMLP consultation.

If both parties do not agree to formalizing the relationship, please refer back to step three and begin work on engaging a new informal partner.

STEP SEVEN:
BEGIN PHASE II OF THE MLP TOOLKIT

*If both potential partners agree to move forward, then they should begin Phase II of the MLP Toolkit, which addresses creating a Memorandum of Understanding. Partners can also schedule an optional consultation with the National Center for Medical-Legal Partnership.

Begin Phase II of the Medical-Legal Partnership Toolkit

Phase II of the Medical-Legal Partnership Toolkit covers building infrastructure for your partnership. It helps partners formalize their relationship in a Memorandum of Understanding and lay out MLP activities and each partner's responsibilities.

Request an Optional Consultation with NCMLP

The optional free consultation with the National Center for Medical-Legal Partnership (NCMLP) builds upon and ties together all the themes addressed in Phase I. The consultation will ensure partners are ready to utilize Phase II of the toolkit to formalize their relationship with key documentation. The call is tailored to the specific program keeping unique partner profiles in mind, and it will address a plethora of issues, including:

1. Trouble shooting common MLP startup issues;
2. Guidelines for expectation setting and formalizing your relationship;
3. Technical assistance in areas that you and your partner are having the most difficulty developing; and
4. MLP best practices and the importance of "professional transcendence."

In order to request a consultation, **please complete this online form.** NOTE: A representative from both the health care and legal partner must be on the call.

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The Medical-Legal Partnership Toolkit

Phase II: Building Infrastructure

Updated March 2015

Team members from the MLP between Beaumont Health System and the Legal Aid and Defender Association in Detroit, Michigan. PHOTO CREDIT: John Meiu

Developed by the National Center for Medical-Legal Partnership

A project of the Milken Institute School of Public Health at the George Washington University

National Center for Medical Legal Partnership

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TOOLKIT ACKNOWLEDGMENTS

This toolkit was developed with generous support from The Kresge Foundation and the Robert Wood Johnson Foundation.

The National Center for Medical-Legal Partnership (NCMLP) is grateful to the medical-legal partnership practitioners who reviewed the toolkit and provided critical feedback, including:

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Jamie Ware, JD, MSW

NCMLP recognizes that the engine for most of the early medical-legal partnerships has been the intrepid leadership and sweat equity of committed legal and health professionals who, against the odds, met and worked to build programs together. We salute those individuals, and express our gratitude to their pioneering efforts; their experiences are reflected in this toolkit.

About the Medical-Legal Partnership Toolkit

Since 2006, the National Center for Medical-Legal Partnership (NCMLP) has helped health care and legal institutions develop partnerships to better care for vulnerable populations. After nearly a decade of providing technical assistance, NCMLP designed this toolkit to guide health care and legal professionals through the process of building strong and sustainable MLPs that reflect the populations they serve and communities they live in.

All medical-legal partnerships (MLPs) address health-harming civil legal needs that disproportionately affect people at or near the poverty level. These partnerships are defined by their adherence to two key principles. First, health care and legal professionals use training, screening and legal care to improve patient and population health. Second, this legal care is integrated into the delivery of health care and has deeply engaged health and legal partners at both the frontline and administrative levels.

At the same time, each MLP responds to the unique needs of the population and clinic or hospital it serves by deploying its specific resources. It is critical that each burgeoning partnership takes the time to assess the need in their local community and how the existing health and legal landscapes meet that need before formalizing a partnership.

This toolkit is broken into three separate stages:

PHASE I: Laying the Groundwork helps potential partners assess their population's needs to best position their MLP and assess the local health and legal landscapes to better understand the professional world of their partners.

PHASE II: Building Infrastructure helps partners formalize their relationship in a Memorandum of Understanding and lay out MLP activities and each partner's responsibilities.

Phase III: Sustaining and Growing the Partnership helps partners strengthen the health care integration of services, incorporate more legal interventions at the clinic and system levels to target population health, and begin to measure the work of their MLP (available in late 2015).

INSIDE PHASE II: BUILDING INFRASTRUCTURE

A NOTE FOR LAWYERS

The Memorandum of Understanding is NOT designed as a contract for services between a health care and legal entity.

Rather, think of an MOU as the raw material for grants and contracts. It forms the foundation of the MLP. It is also the operating document that explicitly sets the expectation for both health and legal partners that the MLP will provide legal care through training, screening, patient, clinic and population health interventions.

Successful MLPs will need to focus resources and impact in each domain to meet the needs of the populations being served at the local level.

Phase II of the medical-legal partnership toolkit helps health care and legal partner institutions formalize their relationship through a Memorandum of Understanding (MOU). The MOU is a renewable agreement that is entered into for a set period of time and formalizes and supports the MLP by outlining the key responsibilities and expectations of both partners, individually and collectively. Creating an MOU is an opportunity to prioritize health care integration and set joint priorities -- a critical step that should take place *before* beginning service delivery. Most important, the MOU will help catalyze the clinic or hospital and population health changes that will dramatically increase the impact MLP can have for vulnerable patient-clients and clinic or hospital quality improvement.

This toolkit offers a suggested structure for the MOU, provides background information and suggested content for each section, and offers advice on who should be involved in drafting the document.

The Essence of the MOU

The MOU supports maximizing health care integration by outlining the individual responsibilities and shared ownership for MLP activities. Individually, each health and legal partner institution will contribute leadership and staff, provide appropriate protection in terms of insurance, and always respect and abide by the privacy and confidentiality provisions that their partners' environment requires. Their collective duties will require considerable joint planning and shared responsibilities around: education, evaluation, resource sharing/access, and day-to-day administrative tasks. The MOU will also define legal interventions that the MLP will handle and outline any special notes and provisions. The MOU will curb misunderstanding and help build a solid foundation that fosters communication, collegiality, and trust among the parties.

Common Barriers to Successful MOU Completion

**These barriers reflect common stumbling blocks many MLPs have encountered over the last 20 years. Read through the barriers below and some of the strategies to overcoming them.*

Barrier #1: Risk-focused legal stakeholders (either civil legal aid staff or health care general counsel) overshadow health care perspective with legal analysis.

> **Remedies:** (1) Revisit conversations regarding mutual vision and alignment and revise language toward problem-solving. (2) Ensure participation or re-engage health care/clinical leaders to bring focus back to MLP goals and patients. (3) Connect questioning leaders with peers in other regions who have successfully overcome these concerns.

Barrier #2: Minimal or zero discussion about funding mechanisms and sustainability.

> **Remedies:** (1) Revisit the budget and staffing discussions with a clear emphasis on where the resources will come from to support the work. (2) Discuss realistic expectations for both program activities and funding sources. (3) Practice maximum flexibility in delineating project activities and goals, and prepare to disengage if you cannot agree on how to support the project financially.

Barrier #3: Ill-defined project activities and deliverables.

> **Remedies:** (1) Revisit discussion of health care institution priorities, along with existing resources and needs to address health-harming civil legal problems. (2) Refine/realign legal care options to align with and accelerate health care priorities.

Barrier #4: Promising too much impact or service level for too few resources.

> **Remedy:** Revisit health care priorities, and align resources and activities in a pilot that will test the level of legal care/resources deployed to manage the risk.

THE MOU DEVELOPMENT PROCESS

Staff and Leadership Involved in Drafting the MOU

Think of developing an MOU as an opportunity to build support and momentum for the shared goals of both organizations. It is likely that the main "champions" of the program at each institution will take the lead in drafting the MOU, but it is important to have strong input both from:

1. **A core team of front-line legal and health care team members including an attorney, paralegal, *pro bono* attorney, physician, nurse, social worker and mid-level health care administrator.** These are representatives from the groups that will be working with patient-clients and delivering MLP services. They can speak to the unique perspective of their professions and raise opportunities and concerns for program deployment. Gathering their feedback during the MOU drafting phase will help with buy-in once the program is operational, and these individuals can be ambassadors for the program within their own professions and departments.
2. **Administration at both the health care and legal institutions.** It is likely that someone in a senior leadership position (e.g. Executive Director, CEO, Board of Directors member) will be the MOU signatory for each agency. Ideally, you want more from this group than their seal of approval. The more input you have from administration while drafting the MOU, the more buy-in and support you are likely to have as the partnership becomes operational.

Suggested Steps for Drafting, Reviewing, Signing and Revisiting the MOU

1. The full group described above meets to discuss broadly the goals and expectations of the partnership.
2. The legal and health care champions draft an MOU based on the discussion and send to everyone for review.
3. The legal and health care champions meet with reviewers individually to discuss feedback and make revisions.
4. The legal and health care champions double check the MOU to ensure that timelines are set for deliverables and implementation as necessary in provisions throughout the agreement. (e.g. *Health partner will allocate $50,000 during year 1 towards the general operations of the MLP OR Legal partner will allocate one full-time attorney to the MLP for the first six months and by end of year 1 will have allocated one additional part-time attorney and one full-time support staff for MLP operations.)*
5. Appropriate administrative leadership at both institutions sign the MOU.
6. The MOU is shared widely and used as a team building tool. The MOU becomes a standing agenda for discussing program activities and impact. This will solidify the approach and help team members anticipate, confront and address challenges that may impede progress/implementation.

STOP! Checkpoint: Is everyone satisfied?

Ensure the MOU addresses as many expectations from both sides as possible. If either partner is not satisfied with the MOU or cannot come to an agreement, then you may contact NCMLP for further technical assistance or revert back to Phase I of the toolkit and work to find a partner that will be a better fit.

MOU CHECKLIST

Memorandums of Understanding can be organized in several ways. Outlined below are the basic sections all MLP MOUs should include. Depending on your MLP's unique circumstances more sections may be needed and can be added as necessary. The order of these three sections can vary and so can the content included in them.

I. Preamble	
	a. Statement of purpose
	b. Strategic goals
II. Common Provisions	
	a. Training and education
	b. Evaluation
	c. Funding
	d. Administration
	e. Term, renewal and termination of MOU
III. Legal Aid Partner Responsibilities	
	a. Leadership and staff
	b. Resource allocation
	c. Insurance
	d. Privacy / confidentiality
IV. Health Partner Responsibilities	
	a. Leadership and staff
	b. Resource allocation and access
	c. Confidentiality
V. Appendix	
	a. Issues addressed by MLP and legal care services provided
	b. Issues NOT addressed by MLP and legal care services NOT provided
	c. Conflicts of interest

Each section is explained in detail on pages 6 - 10. It's a good idea to keep this checklist close by while writing the MOU to make sure you include all the necessary sections.

Suggested Resource:

Three full sample MOUs are included in Appendix E of this Phase of the MLP Toolkit (pages 15-26). They come from real MLPs situated in a children's hospital, a Veterans Medical Center and a community health center. The institution names and identifying information have been redacted.

EXPLAINING THE SECTIONS AND CONTENT OF AN MOU

Part I: Preamble

The preamble states the objectives the MOU was created to support, and therefore, both partners must jointly plan and flesh out the purpose and strategic goals of the medical-legal partnership.

a. Statement of Purpose

The statement of purpose should clearly define the problem you are seeking to address. It should aim to answer two simple questions: (1) Why does your MLP exist? and (2) What does your MLP do? Some version of this statement of purpose was already articulated in the needs assessment of Phase I of this toolkit.

When you have drafted your statement of purpose, use these questions to check its validity.

1. Is our statement realistic and plausible?
2. Is our statement specific and relevant to the work we want to do?
3. Will our statement motivate our internal (employees, lawyers, doctors) audiences?

Keep editing until you have the most condensed version without compromising your message. It is always a good idea to test your statement of purpose on your internal audiences. Making sure that your team agrees with and is involved in the development of your core values and purpose is empowering and will ensure a clear and consistent message throughout the organization from the start. Also, revisit your statement of purpose over time and ensure that it always remains relevant as your MLP evolves.

Sample statements of purpose

1. The purpose of our MLP is to add legal professionals to the super-utlizer team at Pacific Northwest University Hospital and provide legal training, screening and care around disability and guardianship issues for high utilizing patients, both to help reduce health care costs and improve the health and well-being of this patient population.

2. The purpose of the medical-legal partnership between ABC Legal Assistance and St. Michael's Hospital is to improve the health of children in Cleveland with asthma by providing legal training, screening and legal care around poor housing conditions for children seen at the hospital.

Note that both of these sample statements defined the population served, the type of legal needs being addressed and the intended outcome.

a. Strategic Goals

Include 3-5 strategic goals for the medical-legal partnership. They should be specific and directly assist you in achieving the statement of purpose.

Sample strategic goals

1. Develop a standardized procedure for screening all super-utilizer identified patients for disability denials.

2. Develop a standardized procedure for screening all asthmatic patients for housing problems.

Part II: Common Provisions

This section of your MOU requires both joint planning and sharing of resources, knowledge, and expertise to execute. It includes five categories: (1) education; (2) evaluation; (3) funding; (4) administration; and (5) term, renewal, and termination of the MOU.

Suggested Resource:

Cincinnati developed best-in-class MLP training on social determinants of health available on AAMC MedEd Portal

a. Training & Education

Outlines the bi-directional educational activities and trainings of the MLP.

Understanding each other's environment, terminology, and systems is crucial to sustaining your MLP. MLP relies on bi-directional, not one-directional, learning. Cross training sessions, especially during the first few months, are crucial to get health care and legal staff on both sides up-to-date on how to identify and effectively resolve health-harming legal issues in the population. For example, sessions on how to identify health-harming civil legal needs for doctors, nurses, and other hospital staff will be needed along with sessions on understanding the health landscape for lawyers. Both partners should work together to create at least 3-5 training sessions a year to increase knowledge and exposure for both health and legal sides.

Suggested Resources:

MLP Literature Review

Opportunities to Collect Data (Appendix A)

MLP Metrics Introduction (Appendix B)

b. Evaluation

Outlines the data that will be tracked by the MLP and how.

Evaluating MLP activities is key in ensuring the service provided to patients and the community is effective and utilizing resources in its best capacity. This is an area where health care providers, many of whom are trained in data collection, have much to teach the legal community. Joint planning is critical here so that data being collected aligns with health care priorities.

Quarterly or bi-yearly meetings should be conducted to evaluate the MLP program, get feedback from all staff and volunteers, and implement changes and formulate solutions based on this feedback. This forum can be used to collate best practices and disseminate them to the NCMLP to share with the MLP field.

Suggested Resources:

MLP Cost-Sharing Menu (Appendix C)

MLP Sample Budget (Appendix D)

c. Funding

Outlines how current partnership expenses will be covered alongside future fundraising expectation.

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

A note of caution for legal partners: Legal programs that offer MLP services without a concomitant investment from their health partners not only risk program success and sustainability, but they jeopardize

future investment in other programs both locally and nationally by undercutting the necessity of shared funding. Some health care leaders have pushed back on shared cost structures for MLP programs after observing a handful of early MLP programs that did not seek shared funding.

d. Administration

Outlines administrative and support requirements related to human resources, financial management and case management.

Human Resources includes information on administering salaries, benefits and training, support and supervision for employees and volunteers. Financial Management includes information on allocating budget and tracking expenditures and sources of funding. Case Management includes information on referral systems, case logging, tracking, review, and follow up and any other administrative functions necessary for day to day operations of the MLP. Depending on resources, all or part of the ownership of human resources, financial management, and case management functions are split up between partners. If this is the case be sure to write them appropriately and specifically into either the Health Partner Responsibilities or Legal Aid Partner Responsibilities sections as applicable.

e. Term, Renewal and Termination of MOU

Outlines the number of years the MOU will be in effect and any guidelines and provisions surrounding its renewal, additions and termination.

Part III: Legal Aid Partner Responsibilities

This section of the MOU outlines the specific responsibilities of the Legal Services provider, including (1) leadership and staff; (2) resource allocation and access; (3) insurance; and (4) privacy and confidentiality.

a. Leadership and Staff

Outlines the members of the legal staff (i.e. attorneys, civil legal aid executive director, paralegal, etc.) and their specific job responsibilities.

Example 1: The MLP Attorney strictly handles MLP cases and is available on-site at the health providers' facility. [Due to lack of resources, many MLP's write in provisions for case work to be shared until resources are secured to place an attorney on-site solely to focus on MLP case work.]

Example 2: The civil legal aid Executive Director will provide leadership, expertise, raise visibility, and assist in budgeting, raising funds, and strategic planning in collaboration with leadership at the health care institution.

In addition to the above positions, legal institutions may specifically allocate volunteers and staff for administrative and support purposes, add more attorneys, or appoint social workers and other expert staff to assist in MLP cases depending on case load and available resources.

b. Resource Allocation

Outlines access to other experts and departments (i.e. public benefit attorneys) and any other resources including software or case tracking systems to assist in case work and to conduct and improve MLP operations.

Evaluating MLP activities is key in ensuring the service provided to patients and the community is effective and utilizing resources in its best capacity. This is an area where health care providers, many of whom are trained in data collection, have much to teach the legal community. Joint planning is critical here so that data being collected aligns with health care priorities.

Quarterly or bi-yearly meetings should be conducted to evaluate the MLP program, get feedback from all staff and volunteers, and implement changes and formulate solutions based on this feedback. This forum can be used to collate best practices and disseminate them to the NCMLP to share with the MLP field.

c. Insurance

Outlines provision of adequate insurance for attorneys and students that will represent the MLP.

Suggested Resources:

Chapter 6 of the MLP textbook

d. Privacy / Confidentiality

Outlines attorneys' responsibilities toward patient privacy.

Attorneys and staff must respect and honor the patient information and medical records of which they become aware while working at an MLP. Additionally, attorneys and staff are required to respect and honor the medical and legal confidentiality requirements applicable to client/patient medical records and other Protected Health Information pursuant to state and federal law and applicable professional codes (e.g., HIPAA, medical confidentiality, and attorney-client privilege.)

Part IV: Health Partner Responsibilities

This section of your MOU outlines the specific responsibilities of the health partner institution and providers, including (1) leadership and staff; (2) resource allocation and access; and (3) confidentiality.

a. Leadership and Staff

Outlines the members of the health care staff (i.e. physicians, nurses, social workers and administrators, etc.) and their specific job responsibilities.

Example 1: The MLP Project Coordinator is a single primary contact within the health facility for access to assist in coordination of the day-to-day operations of the MLP project.

Example 2: The Medical Director provides leadership and expertise, raises visibility, and assists in budgeting and strategic planning in collaboration with Legal Services Executive Director. The Medical director will also advocate for funds and support for the MLP within the health facility.

In addition to the above positions, health institutions may specifically allocate volunteers and staff for administrative and support purposes, appoint social work and nursing champions with protected time to perform similar functions as medical directors.

b. Resource Allocation and Access

Outlines access to office space, parking, computer, Internet, voicemail, software, social workers, language access and other departments and expertise to conduct and improve day-to-day MLP operations on-site.

c. Confidentiality

Outlines health care providers' responsibilities toward client privacy.

Health care providers must respect and honor the attorney-client privilege and the ethical confidentiality requirements that MLP representatives must maintain with their clients pursuant to state and federal law and applicable professional codes.

Part V: Appendix

This section of your MOU should include special provisions and guidelines regarding:

a. Types of legal care and issue areas which will be addressed by the MLP team

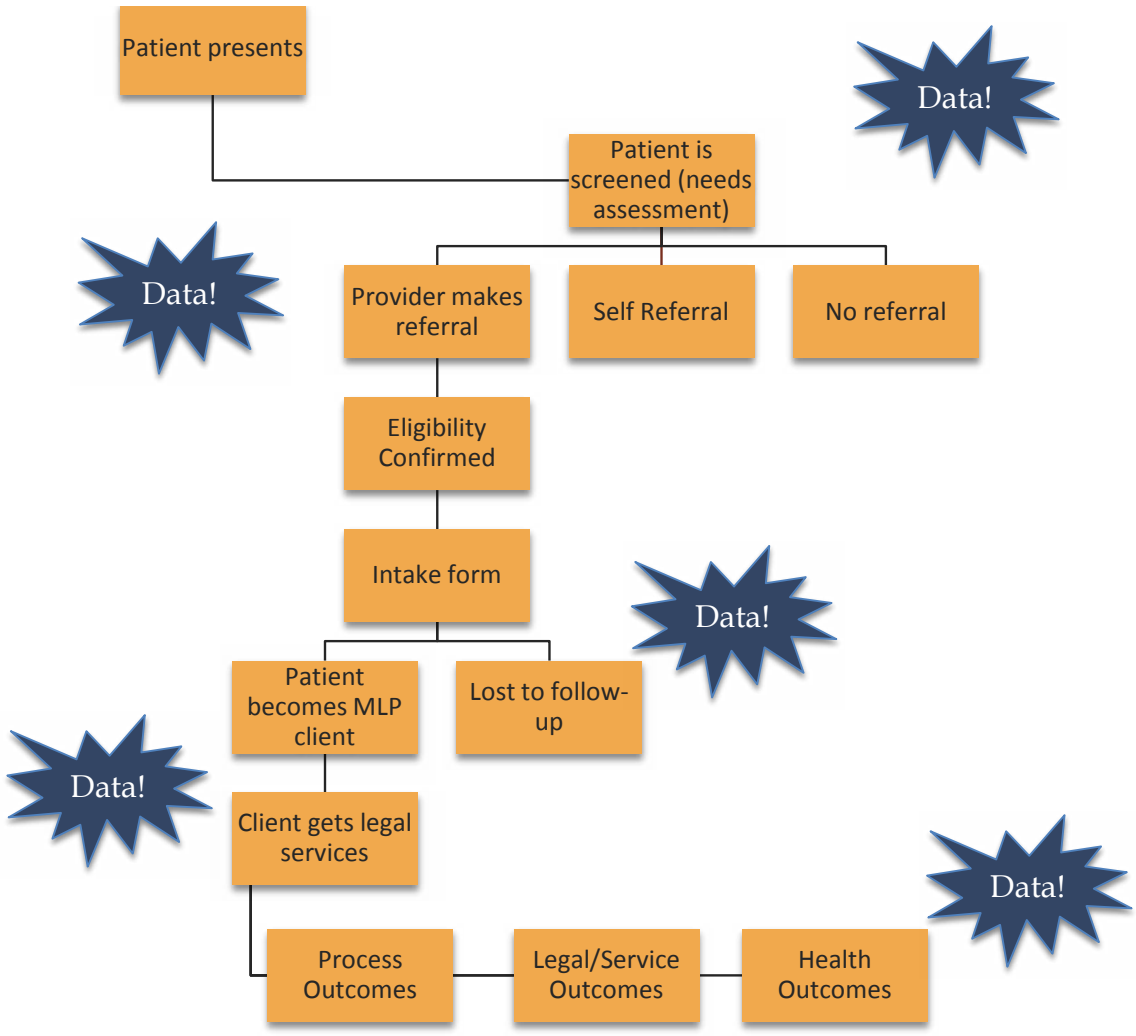
This section should offer both the scope of areas addressed by the MLP (e.g. housing evictions, social security disability benefits, etc.) and the scope of services provided (e.g. Seven health care provider trainings, 75 case consultations by attorneys with health care providers, 50 patient legal case intakes and representations, two systemic advocacy projects, etc.)

b. Types of legal care and issue areas which will not be addressed by the MLP team

c. Any conflicts of interest that exist or persons that are not eligible for representation by the MLP

Appendix A: Opportunities to Collect Data

The chart below outlines how most patient-clients find their way to MLP services, and the various points at which interventions can be measured. You should think broadly about what data you want to collect and where you can collect it.



Appendix B: Introduction to Medical-Legal Partnership Metrics

While no set of universal metrics exists yet for medical-legal partnership, the following outcomes have been measured by partnerships to demonstrate impact.

Outcomes and Evaluation Tools		
Process Measures	**Civil Legal Aid Measures**	**Intermediate Health Measures**
Client was appropriately screened for legal needs	Client's legal issue resolved/unresolved	Client increased access to health services
Legal needs were appropriately identified	Client obtained or maintained household income	Client reduced Emergency Room use
Appropriate referral was provided	Client received retroactive benefits	Increase in number of clients with regular provider
Client obtained legal help	Client completed/received legal documentation	Client reduced overnight hospital stay
Client increased understanding of legal rights	Client increased access to services	Client perceived stress reduced
Client was connected with another resource		Client self-report health status
Client was satisfied with services		Client self-efficacy
Residents or Providers received legal training		
Residents or Providers increased their legal knowledge/understanding		
Residents or Providers increased confidence in working with legal services		

There are three potential areas within the MLP framework that are amenable to evaluation: 1) outputs, which tend to be quantifiable (countable) activities reflecting the number, type and scope of MLP activities; 2) outcomes, organized at the patient, provider and organization level, that describe or weigh the amount of tangible benefits accrued; and 3) impacts, which assess the relationship between the MLP intervention or particular MLP activities on patient health, health system costs, and health care improvement.

The National Center for Medical-Legal Partnership's review of the MLP landscape reveals that systematic data collection and measurement activities currently do not capture outputs, outcomes or impacts of MLP. However, there is an ongoing effort to develop a set of performance measures, which are process-oriented, that capture data on potential areas for quality improvement. In order to sustain and grow both individual MLPs and the MLP landscape, as a whole, it is necessary to identify and implement quality improvement efforts.

Appendix C: Sample Cost-Sharing Menu for MLP Services*

*Based on a cost-sharing framework generated by Medical-Legal Partnership | Boston.

To be successful, both the legal partner and health care institution must commit financially to the partnership. This cost-sharing menu is not intended to be an exact guide but rather to (1) get both partners thinking about attaching cost to the AMOUNT and TYPE of services provided; and (2) ensure both partners are thinking about the financial resources they are committing to the MLP.

	Planning Grant	$50k / year	$100 k / year	$150 k / year
Training	Joint planning across legal, health and social service communities over 6-12 months.	• 4-part advocacy series for HC team	• 5-part advocacy series for HC team	• 6-part advocacy series for HC team
Patient Legal Care		• 100 HC provider consults w/ legal team • On-site legal clinic bi-weekly • Intake interviews w/ 30 patients • Legal advice and assistance on 75 legal matters	• 150 HC provider consults w/ legal team • On-site legal clinic weekly • Intake interviews w/ 50 patients • Legal advice and assistance on 120 legal matters	• 150 HC provider consults w/ legal team • On-site legal clinic weekly • Intake interviews w/ 65 patients • Legal advice and assistance on 150 legal matters
Clinic Legal Care		• 1 new advocacy toolkit for HC team	• 2 new advocacy toolkits for HC team	• 3 new advocacy toolkits for HC team
Systemic Legal Care			• 1 policy change collaboration	• 2 policy change collaborations

In addition to cash resources, it is suggested that health care institutions make the following resources/infrastructure available to the MLP team: (1) Designation of health care team directors (e.g., physician, nurse, social worker) with protected time; (2) Access to interpreter, translation, social work, domestic violence, and IT support services, (3) Private space for on-site MLP activities (e.g., client interviews) with necessary IT features, and (4) Periodic integration of other key health care leadership (QI, Communications, Development) .

Appendix D: Sample MLP Budget

Below is a sample MLP budget. On average, this staffing commitment could provide: (1) 5-10 trainings for the health care team; (2) 50-200 lawyer-to-health care provider case consultations; (3) 50-100 legal intakes / representation with patients; and (4) two toolkits or clinic quality improvement initiatives to address legal needs more efficiently and serve thousands of patients (e.g. incorporating a utility shut off protection form letter into the Electronic Health Record.) As a general rule, case consultations with health care providers require considerably less attorney time than legal intakes. The budget below does not reflect all of the team members who will help deliver MLP services. One of MLP's strength is as a leveraging mechanism for existing community resources -- broad internal legal aid expertise and case handling capacity and internal health care expertise and capacity that is only unleashed by the legal team. The staffing outlined in the sample budget is what is necessary to optimize/ trigger those resources.

The most important thing to consider when devising your budget is the scope of services your partnership plans to offer. The staffing commitment below will not meet the legal needs of an entire hospital's patient population. You need to match the staffing to the project scope you outlined in Phase I of the toolkit. Depending on the number and type of legal issues being addressed and how upstream you are addressing those needs, you should adjust the staff size and expectations accordingly. This may mean budgeting for additional attorney, social worker or community health worker time. Alternatively, it may mean dedicating a significantly larger portion of an attorney's time to training, case consultations and clinic quality improvement initiatives or toolkits, while greatly reducing the number of patient intakes / case representations. You should be realistic about how many patients your partnership will actually serve.

SALARY TIPS

1. Include benefits or "fringe" in salary estimates.

2. Budget for health care staff time; they require salary coverage.

3. In-kind coverage should be noted on budget.

STAFF SALARY AND BENEFITS

Staff	Organization	Base Salary	MLP Effort	MLP Effort Salary	MLP Effort Fringe (25% fringe rate)	TOTAL
Lead attorney	Legal aid agency	$ 65,000	100%	$ 65,000	$ 16,250	$ 81,250
Paralegal	Legal aid agency	$ 40,000	50%	$ 20,000	$ 5,000	$ 25,000
Legal supervisor	Legal aid agency	$ 80,000	10%	$ 8,000	$ 2,000	$ 10,000
Physician Champion	Health center	$130,000	10%	$ 13,000	$ 3,250	$ 16,250
Case Manager / Social Worker	Health center	$ 60,000	10%	$ 6,000	$ 1,500	$ 7,500
Administrative / Data Coordinator	Health center	$ 50,000	10%	$ 5,000	$ 1,250	$ 6,250
TOTAL SALARY COSTS				$117,000	$ 29,250	**$146,250**

OTHER COSTS

OTHER COSTS

1. Consider all non-salary costs.

2. Include any in-kind costs on budget.

3. We recommend budgeting for travel to MLP Summit.

Item	Description			Legal Aid In-Kind	Health Ctr In-Kind	CASH
Rent, phones, office supplies	At legal aid agency			$ 15,000		
Rent, phones, office supplies	At health center 2 days / week				$ 20,000	
Printing and communications expenses	Reports, brochures					$ 1,500
Medical-Legal Partnership Summit	Travel for 3 staff members					$ 4,500
TOTAL OTHER COSTS				$ 15,000	$ 20,000	$ 6,000
					TOTAL MLP CASH BUDGET	**$152,250**

Appendix E: Sample MOUs

The following MOUs were shared by real medical-legal partnerships across different health care settings. Only names and identifying information has been redacted.

MOU #1: A children's hospital / legal aid MOU

KIDS HOSPITAL MEDICAL-LEGAL PARTNERSHIP
MEMORANDUM OF AGREEMENT

This Memorandum of Agreement ("Agreement") is effective [DATE] ("Effective Date") by and between A Non-Profit ("ANP") [LEGAL ORGANIZATION NAME] with an address at [ADDRESS] and Kids Hospital ("KH"), a State non-profit corporation with an address at [ADDRESS].

KH and ANP desire to work together to develop and implement the Kid's Medical-Legal Partnership ("KMLP"). The mission of the KMLP is to improve child health outcomes through interdisciplinary collaboration that employs targeted outreach, holistic assessment, legal services, and strategic advocacy to eliminate health care barriers and address the social and environmental factors that negatively impact child well-being.

1. KMLP Program.

A. **Services.** ANP will provide free legal services in various matters to KH's and its affiliates' patients and their families, as appropriate. KH and its affiliates will refer patients and their families to the KMLP, as appropriate. ANP retains the right to accept or decline representation of patients referred by KH to the KMLP in accordance with ANP's established criteria.

B. **Facilities, Equipment, and Space.** The KMLP will be housed at one or more KH locations, as designated by KH. KH will provide office space for the KMLP to perform activities hereunder, which will include private locking office space, access to a shared conference room, telephone service and voice mail, Internet access, and access to a printer, photocopier, scanner and fax machine.

C. **Expenses.** Subject to section D below, Program Funding, each party will be responsible for their own expenses and costs associated with forming the KMLP.

D. **Program Funding.** The KMLP will be funded by KH operating funds and donations from third parties as set forth below. Each party agrees to actively seek funding for the KMLP, and to coordinate their efforts to maximize fundraising efficiency and impact.

i. **Initial Term.** The parties will mutually agree on a budget and staffing plan for the initial term, which will be attached as an amendment to this Agreement. KH has committed to provide funding for the on-site attorney (salary plus benefits) for the initial term.

ii. **Subsequent Terms.** After the initial term, the parties agree to collaboratively seek out and support fundraising efforts to sustain the partnership. At all times, both parties will communicate openly and promptly with each other regarding proposed and actual funding sources for the KMLP.

2. ANP Responsibilities.

A. Legal Director. ANP will designate a legal director who has authority to make decisions on behalf of ANP with respect to KMLP program operations and initiatives.

B. Staff. ANP will assign attorneys, including the on-site attorney, and other necessary legal and sup-

port staff, as agreed upon by KH and ANP, to provide services hereunder to patients at KH's locations. ANP will supervise ANP staff and administrate the salary and benefits of ANP personnel, including health insurance and malpractice insurance. All such appointments will be consistent with a mutually agreed upon budget.

C. **Supervision and Training.** ANP will supervise ANP personnel during the provision of services. ANP will participate in Medical-Legal Partnership ("MLP") training, as appropriate and in conjunction with KH. KMLP personnel will attend relevant orientation and training activities and abide by applicable KH policies and procedures while on-site at KH facilities.

D. **Client Intake.** ANP will oversee the intake of clients, which shall include, but is not limited to, ensuring that the clients meet income and other eligibility requirements.

E. **Coordination of Cases.** ANP will assign cases to the appropriate attorney, which may be the on-site ANP KMLP attorney, another ANP staff attorney, another organization that provides pro bono services, or a pro bono lawyer or law firm. ANP and KH will coordinate the use of pro bono lawyers and law firms.

F. **Reporting.** ANP shall provide a report, at a frequency and with content as agreed upon by both parties, to KH. The report shall include the number of cases handled by the KMLP, the types of cases, and explanation of how the matter was resolved in a manner that is compliant with all laws and regulations. The parties may agree to include or exclude other items or information from the report.

3. KH Responsibilities.

A. **Administrative Director.** KH will designate an administrator who has authority to make decisions on behalf of KH with respect to KMLP program operations and initiatives.

B. **KH Staff.** KH staff will be designated by KH, to provide support hereunder to the KMLP. KH will supervise KH staff and administrate the KH salary and benefits of KH staff, including health insurance and malpractice insurance.

C. **Supervision and Training.** KH will supervise KH staff during the provision of services. KH will provide orientation to KMLP staff. KMLP personnel will attend relevant orientation and training activities and abide by applicable KH policies and procedures while on-site at KH facilities.

D. **KH Access.** KH shall determine the locations/departments at which KMLP services will be available. KH will consult with ANP prior to making such determinations.

4. Program Features.

A. KMLP Committee. The parties agree to form a KMLP committee that will provide legal and operational oversight to the KMLP. Members shall include the Kids Hospital's administrative Director, The Director of the Kids Hospital's Legal Department, and the ANP legal director, or their designees. Other members may be added as determined by the parties. The Committee will discuss staffing, budget, fundraising, marketing, partnerships and related KMLP matters.

B. Protocols. The parties agree to jointly establish operational protocols, including, but not limited to, those covering the following topics:

i. KMLP Patient-Client/Family eligibility for KMLP legal services;
ii. Screening of patients for issues requiring KMLP involvement;
iii. Case consultation;

iii. Case consultation;
iv. Referral process;
v. Patient-Client information shared between KH and ANP.
vi. Forms specific to the KMLP;
vii. Hiring process and final approval for ANP staff assigned to KMLP;
viii. Training process;
ix. Content and format of information reported back to KH; and
x. Metrics and evaluation of the KMLP.

C. **Utilization Review and Program Improvement.** ANP and KH agree to meet on a regular basis to review utilization of the program and opportunities for improvement. Such meetings will include, at a minimum, the ANP legal director and the designated KH administrator referenced in 3(A) above. ANP and KH will develop and agree on program metrics to track and review program utilization and effectiveness.

D. **Partners.** The parties agree to consult and jointly decide on any new collaborative partners after the Effective Date.

5. Records.

A. **Legal Files.** ANP retains the right to the exclusive possession of the legal files developed for the KMLP clients. KH shall not have access to the legal files absent written authorization by the client.

B. **Medical Records.** Medical Records will belong solely to KH. ANP staff will not have access to the medical records of any KH patient absent a HIPAA-compliant written authorization by the patient or the patient's guardian, in accordance with applicable laws and regulations, and KH policies and procedures.

6. Term and Termination.

A. **Term.** The initial term of this Agreement is two (2) years beginning on the Effective Date and will automatically renew for additional one-year terms unless terminated earlier as set forth in Section 6(C).

B. **Program Timeline.** The parties intend to have the program operational no later than six months after the Effective Date. In the event the program is not operational by that time, the parties will meet to review progress and determine a revised timeline to achieve an operational program. ANP's Executive Director and KH's administrator will attend this meeting.

C. **Termination.** This Agreement may otherwise be terminated by either party, with or without cause, by providing the other party with sixty (60) days written notice, unless such termination would violate existing grant or funding obligations or any law or regulation.

7. Indemnification, Limitation of Liability, Exclusion of Warranty

A. If there is any injury (including death), loss or damage to the person or property of any third party, then, subject to any limitations set forth in this Agreement, each party agrees to indemnify and defend the other party to the extent of the indemnifying party's negligence.

B. Each Party represents and warrants that it has the full right and power to make this Agreement.

C. EACH PARTY HEREBY DISCLAIMS ANY WARRANTY, EXPRESS OR IMPLIED, AS TO THE SERVICES IT PROVIDES UNDER THIS AGREEMENT INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY OR FITNESS FOR ANY PARTICULAR USE OR PURPOSE.

D. IN NO EVENT SHALL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY INCIDENTAL, CONSEQUENTIAL, OR PUNITIVE DAMAGES ARISING OUT OF THIS AGREEMENT OR ANY BREACH HEREOF, WHETHER ARISING IN TORT, CONTRACT, OR OTHERWISE.

8. Miscellaneous.

A. **Confidential Information.** For purposes of this agreement, confidential information is considered to include any information that is not readily available in the public domain which belongs to either party or regarding a patient, and which is provided by one party to the other. Information need not be identified or marked as "confidential" or "proprietary" in order to be considered confidential information. The parties, including their respective affiliates, subsidiaries, employees and agents, to whom the confidential information is disclosed, agree to only use the confidential information of the other party solely for the purpose of meeting obligations under this Agreement.

B. **Intellectual Property.** The parties agree that no intellectual property is licensed under this Agreement. In addition, each party agrees not to use each other's name or trademarks without the other party's prior written consent, and the parties will consult and agree prior to printing or distributing any KMLP promotional materials, advertising or press communications, in any medium.

C. **Compliance with Laws.** The parties will perform services in accordance with applicable laws, standards, and rules that govern the practice of medicine and the practice of law.

D. **Assignment.** Neither party may assign or subcontract any rights or obligations under this Agreement to another party without the prior written consent of the other party to this Agreement, and any such attempted assignment shall be void and of no effect.

E. **Independent Parties.** Neither party may legally or contractually bind the other party nor shall either party may act as agent, employee, partner or joint venturer of the other party. Neither party's personnel will for any purpose be deemed to be an employee of the other party for tax withholding, liability coverage, or for compensation or benefit plan participation.

F. **Ethical Behavior.** Both parties are committed to conducting business ethically and lawfully and in accordance with rules of professional ethics and KH's Code of Ethical Behavior, attached as Exhibit B. If either party knows or becomes aware of a conflict of interest, the party shall divulge this information promptly to the other party.

G. **Licensure.** Both parties' personnel hereunder will be properly trained and licensed to meet their respective duties hereunder, and will maintain any applicable licenses, registrations, or certifications in good standing.

H. **Lawful Employment.** Both parties' personnel must be eligible for employment in the United States and will be screened for criminal background activity for the seven (7) years preceding the Effective Date of this Agreement. Both parties will agree to notify the other party immediately upon becoming aware of any individual who provides services or is scheduled to provide services hereunder, who has been convicted, found guilty, or has accepted deferred adjudication or a similar agreement with the court for (1) any felony or (2) a misdemeanor involving minor children, violent activity, weapons, theft, burglary, fraud, dishonesty, drugs or sexual activity.

I. **Tuberculosis Testing.** Both parties' personnel who provide services on-site at KH facilities must have a negative TB skin test (PPD) in the current calendar year, or if positive, must submit a report of a negative chest x-ray in the previous six (6) months.

J. **Marketing of the KMLP.** The parties will coordinate marketing efforts relating to the KMLP. Neither party shall refer to the other party in press, website, social media, or marketing materials without

express written permission.

K. **Entire Agreement.** This Agreement sets forth the entire agreement and understanding of the parties relating to the subject matter herein, and supersedes all prior or contemporaneous communications or agreements, whether oral or written, between the parties regarding the subject matter hereof.

APPROVED AND ACCEPTED:

[SIGNATURES AND DATES]

MOU #2: A Veterans Medical Center / legal aid MOU

VETERANS MEDICAL-LEGAL PARTNERSHIP
MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) is between [Legal organization came] (LO) and [Veterans Medical Center name] (VMC) for the purpose of increasing veterans' access to legal representation. The President and the Secretary of Veterans Affairs have established a goal of ending homelessness among Veterans by 2015. VA issuances have acknowledged that veterans' lack of access to legal representation contributes significantly to their risk of becoming homeless. Under this MOU, LO will provide legal services for homeless and low-income veterans through a pro bono law clinic located on the campus of VMC. This MOU sets forth the roles and responsibilities of the parties as follows:

I. Purpose and Scope

a. There is an enormous unmet need for legal services for veterans. Legal services are often essential for removing barriers to obtaining or retaining permanent housing, receiving needed health care, increasing income and opening doors to employment. LO's Homeless Veterans Project specializes in benefits claims related to psychological disabilities. LO runs several legal services intake clinics related to benefits claims and appeals, focused on homeless and low-income veterans who need legal assistance with their service- connected benefits claims.

b. In connection with the Fellowship of LO' s Equal Justice Works Legal Fellow, [Fellow Name], LO is interested in providing a pro bono legal services clinic for the veterans seen at the VMC.

II. Responsibilities of LO. LO shall undertake the following:

a. **Legal Clinics.** ICLC will provide a legal services intake clinic n a private office setting at least once a week, on dates mutually agreed upon by ICLC and LAHPC. The dates of the clinics may fluctuate based on the availability and capacity of ICLC staff. The determination of the attorney and resource capabilities of ICLC shall be made solely by ICLC.

b. **Legal Assistance Limited to Certain Issues.** ICLC staff and pro bono attorneys shall provide intake for legal services primarily related to assistance with claims for service-connected disability benefits for homeless and low-income veterans. Legal assistance will include on- site intakes, brief counsel and advice, as well as hill representation in connection with certain matters through ICLC staff or pro bono attorneys. All intake and referrals are subject to ICLC's policies and limited resources. Referrals will be provided to veterans where appropriate. The legal assistance provided by ICLC will be limited to these substantive issues:

i. Initial claims, notices of disagreement, and appeals for service- connected VA benefits associated with mental health conditions such as PTSD and TBI

ii. Other public benefits claims, appeals and issues, particularly related to the Social Security Administration

iii. Traffic citations, outstanding warrants and expungements

iv. Discharge upgrade assistance

v. Other types of matters may be referred to other legal service organizations or, in some instances, placed with pro bono attorneys specializing in the area of law at issue on a case-by- case basis.

vi. LO shall have sole possession and access to its legal files. Employees of VMC may not access the LO files of a client without the client's written consent, obtained after consultation LO.

vii. LO will comply with the Privacy Act, HIPAA and all other applicable laws regarding any disclosure of protected information or records about a Veteran.

c. **Training VMC Staff Members.** LO will provide initial training to VMC staff members about LO's services and the clinics, and the role of VMC staff members. Subsequent trainings may be held as needed and as mutually agreed.

d. **Malpractice Insurance.** LO shall provide malpractice insurance for its staff and pro bono attorneys.

e. **Laptop with Technical Support.** LO shall supply its own laptop with remote access capability to VMC's computer system along with relevant technical support for LO staff.

f. **Compliance with disclaimer provision in VHA DIRECTIVE 2011-034.** LO will post a disclaimer in its designated office space that reads "DISCLAIMER: VA assumes no responsibility for the professional ability or integrity of the organizations whose names appear on this list. This referral does hot constitute an endorsement or recommendation by VA. "

III. Responsibilities of VMC. VMC shall undertake the following:

a. **Private Office Space.** VMC shall provide private office space at its facility in which LO staff can meet with clients in a private setting, including an electrical ;outlet, desk, and several chairs. If possible, VMC will provide LO staff with access to the Internet through LO provided laptops so LO staff may access LO servers remotely.

b. **Inform LO of VMC's HIPAA**. Compliance Measures. VMC staff will inform LO staff of VA procedures for ensuring compliance with protection of information and records about a veteran under the Privacy Act, HIPAA and other applicable Jaws.

d. **Assist in Publicizing Legal Services.** VMC shall assist LO in publicizing the legal services intake clinic among VMC patients who meet the criteria for LO client eligibility.

IV. **Attorney-Client Privilege Between LO and Patients.** Communication between LO staff and any patients referred by VMC or other LO clients are privileged and confidential, and the attorney-client privilege applies. LO retains the right to exclusive possession of the legal files of patients referred by VMC.

V. **No Attorney-Client Relationship Between LO and VMC.** This agreement does not create an attorney-client relationship between LO and VMC.

VI. **Compensation.** LO offers its services to homeless and low-income veterans without charge. At no point will LO request remuneration from VMC its staff, or patients referred to LO by VMC. VMC is providing use of its facilities for LO's legal clinic without charge.

VII. **Term & Termination.** The parties of this MOU do not currently propose an end date for the legal clinics. This MOU is non-binding and may be terminated by either party upon written notice. Any such termination will not terminate any ongoing representation of clients by LO.

Signatures:

Executed: [SIGNATURES AND DATES]

MOU #3: A community health center / legal aid MOU

MEDICAL-LEGAL PARTNERSHIP FOR THE ELDERLY
MEMORANDUM OF UNDERSTANDING

This Memorandum of Agreement (the "Agreement") is entered into by and between [Community health center name] ("CHC") and [Legal aid agency name] ("LAA") (individually, the "Party" and collectively, the "Parties") to set forth the objectives, understandings and agreements between the Parties.

WHEREAS, CHC is a nonprofit corporation operating as a community health center that provides, or arranges for the provision of, high quality, cost-effective, community-based comprehensive primary and preventive health care and related services to the residents of [CITY] and its surrounding communities, regardless of the individual's or family's ability to pay for such services; and

WHEREAS, LAA is the primary legal services provider to low and moderate income residents of [CITY] who are 60 years and older, providing quality, free legal services in the areas of consumer, landlord/tenant, foreclosure, real property tax sales, estate planning (including Wills, Powers of Attorney and Guardianships), and public benefits and other income maintenance.

WHEREAS, Medical-Legal Partnerships have been officially recognized by the American Bar Association (ABA) and American Medical Association (AMA) and recognized as an innovation by the Agency for Healthcare Research and Quality (AHRQ);

WHEREAS, CHC and LAA wish to collaborate to form a Medical-Legal Partnership ("MLP") in which CHC will refer elderly patients in need of legal services to LAA;

NOW THEREFORE, in consideration of the mutual covenants contained in this Agreement, the Parties hereby agree as follows:

I. Obligations of LAA

During the term of this Agreement, LAA shall:

a. Provide legal advice and/or representation to low-income patients of CHC who are in need of legal assistance in one or more of the following areas: housing, consumer matters, income maintenance (e.g., food stamps, Social Security Disability benefits, Social Security Income benefits), elder abuse, guardianship matters, and estate planning (e.g., wills and Powers of Attorney) in accordance with the following restrictions:

   i. Clients must:

      1. Be residents of the [CITY];

      2. Be 60 years of age or older, except for disability cases, in which clients can be 55 years of age or older; and

      3. Have an income of 200% or less of the federal poverty level.

   ii. Eligibility for advocacy services will depend on existing LAA staff expertise and capacity.

   iii. LAA retains the right to accept or decline representation of patients referred by CHC providers and staff.

b. Consult with CHC providers who have identified CHC patients with unmet legal needs who may be

be eligible for LAA services. Consultations may result in one of four outcomes:

i. resolution of the question in the course of the conversation with the CHC provider;

ii. identification of the issue as a social work matter and not a legal matter;

iii. identification of the issue as a legal matter that cannot be handled by LAA or its referral resources; or

iv. recommendation that the CHC patient be referred to LAA for an intake interview.

c. Provide CHC providers and staff with periodic on-site advocacy trainings concerning legal issues faced by low-income elderly patients.

d. Leverage advocacy support for CHC's low-income elderly patients from its panel of pro bono partner law firms.

e. Upon obtaining funding, hire an additional attorney to solely represent MLP clients. Until this attorney is hired, the LAA in-house attorneys will represent the MLP clients.

f. Administer the salaries and benefits of the LAA employees representing clients of the MLP.

g. Supervise and otherwise support the professional development of LAA employees representing clients of the MLP.

h. Track the salaries, benefits, time commitment, and non-personnel expenses of the LAA employees representing clients of the MLP. LAA shall also track the income and expenditures of the MLP and will provide to CHC a bi-annual accounting of all services rendered by and costs associated with the MLP. LAA shall provide any additional financial information or documentation requested by CHCfor funding purposes or otherwise.

i. Undergo Unity's HIPAA training and certify compliance with Unity's policies and procedures.

II. Obligations of CHC

During the term of this Agreement, CHC shall:

a. Support partnership-related research and evaluation initiatives, as reasonable.

b. Provide the necessary infrastructure for on-site advocacy trainings of CHC providers and staff by LAA, when possible.

c. When appropriate, refer low-income, elderly patients Unity staff to the LAA hotline.

d. Provide private office space where an LAA attorney can hold weekly or bi-weekly office hours to meet confidentially with MLP clients. The office space should contain a computer with Internet access, a telephone, and should lock. While on site, the LAA attorney shall be allowed access to office supplies and equipment.

e. Provide interpreter and social work services to LAA as needed.

III. Mutual Obligations

During the term of this Agreement, CHC and LAA alike shall:

a. Disseminate best practices developed through the MLP to other MLP Network sites and the National Center for Medical-Legal Partnership.

b. Seek grant opportunities to fund the MLP during its first year as mutually agreed upon by the parties.

c. Seek opportunities to raise visibility for the MLP as mutually desired and agreed upon.

IV. Professional Assurances

LAA represents that, during the term of this Agreement, LAA's legal professionals providing services hereunder shall be duly licensed, certified and/or otherwise qualified to provide the legal services contemplated hereunder in accordance with all relevant Federal, city laws and regulations.

V. Insurance, Liability, Identification

a. LAA shall secure and maintain, or cause lo be secured and maintained , professional liability insurance for itself and its officers, directors, employees, contractors, and agents, consistent with prevailing standards. If LAA's professional liability insurance is written in a "claims made"; as opposed to an "occurrence" form, LAA agrees to purchase or otherwise make arrangements for a "tall" or extended disclosure period policy for all activities so insured during the course. of this Agreement. If LAA provides services through an affiliate, LAA shall assure that such affiliate satisfies the requirements of this Section V .

b. LAA shall be solely liable for all services provided by LAA and its professionals pursuant to this Agreement, and CHC shall not be liable, whether by way of contribution or otherwise, for any damages incurred by such patient s or arising from any acts or omissions in connection with the provision of such services. LAA agrees to defend and hold harmless CHC, its directors, officers, agents, employees and contractors from any and all claims or losses resulting to CHC and/or any third parties, including attorneys' fees, costs and expenses, arising out of LAA's (i) performance, failure to perform or negligent performance of any of its obligations under this Agreement; or (ii) violation of any term or condition of this Agreement.

c. CHC shall not be responsible for any harm an LAA employee suffers as a result of this agreement, including, but not limited to, harm arising from or during an LAA employee's visit to CHC's sites.

VL Term and Termination

The term of this Agreement shall commence on [DATE] and continue through [DATE] unless sooner terminated as follows: (a) Either Party may terminate this Agreement without cause upon sixty (60) days' prior written notice to the other Party or (b) this Agreement may be terminated, in whole or in part, at any time upon the mutual agreement of the Parties.

VII. Privacy and Confidentiality of Patient Information

a. LAA and CHC agree to exchange individually identifiable health information on referred patients, including patient names and other medical information, maintained in electronic, oral or written form ("Protected Health Information"), for the purposes of treatment, payment and health care operations, as such terms are defined in and in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its i1nple1m.mting regulations set fort h at 45 CFR Part 160 and Pan 164.

(b) The Parties (and their directors, officers, employees, agents and contractors) shall maintain the privacy and confidentiality of all information regarding the personal facts and circumstances of the

patients receiving care provided by CHC, in accordance with all applicable city and federal laws and regulations regarding the confidentiality of such information including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Both Parties agree to abide by all HIPAA requirements including each and every obligation imposed by the Health Information Technology for Economic and Clinical Health Act, Division A of Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 1 1 1-005 (the HITECH Act) and each of those obligations is incorporated by reference into this. Agreement, including, but not limited to: (i) not using or disclosing Protected Health Information other than as permitted or required by this Agreement for the proper performance of its duties and responsibilities hereunder; (ii) using appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for under this Agreement; and (iii) notifying the other immediately in the event the Party becomes aware of any use or disclosure of Protected Health Information which violates the terms and conditions of this Agreement or applicable federal and city laws.

c. LAA will maintain possession of all legal files developed through the MLP. CHC staff shall not have access to any legal files without appropriate client consent.

d. The Parties shall develop appropriate documentation protocols to enable CHC's providers to follow up on referrals and allow for appropriate documentation in Unity's medical records.

e. The provisions of this Section VII shall survive expiration or termination of this Agreement.

VIII. Notices

Any and all notices, designations, consents, offers, acceptances or other communication required to be given under this Agreement shall be in writing, and delivered in person or sent by registered or certified mail, return receipt requested, postage prepaid, to the following addresses:

[ADDRESSES FOR LAA AND CHC]

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other Party hereto in writing and in the manner hereinafter set forth. All notices shall be effective upon receipt.

IX. Relationship of the Parties

a. The term "medical-legal partnership " means an entity -

i. that is a partnership between -

1. a community health center, public hospital, children's hospital, or other provider of health care services to a significant number of low-income beneficiaries; and

2. one or more legal professionals; and

ii. whose primary mission is to assist patients and their families navigate health related programs activities, and services through the provision of relevant civil legal assistance onsite in the health care setting involved, in conjunction with regular training for health care staff and providers regarding the connections between legal interventions, social determinants, and health of low-income individuals.

b. CHC and LAA shall remain separate and independent entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between or among the Parties other than that of independent contractors. Except as otherwise provided, neither of the Parties shall be construed to be the agent, partner, co-venturer, employee or repre-

sentative of the other Party.

X. Entire Agreement; Modification

This Agreement represents the complete understanding of the Parties with respect to the subject matter herein and, as such, supersedes any and all prior agreements or understandings between the Parties, whether oral or written, relating to such subject matter. This Agreement may be amended only with express written consent of both Parties.

IN WITNESS THEREOF, CHC and LAA, through their duly authorized employees or agents, have caused this Agreement to be executed and delivered effective as of:

[SIGNATURES AND DATES]

The National Center for Medical-Legal Partnership
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