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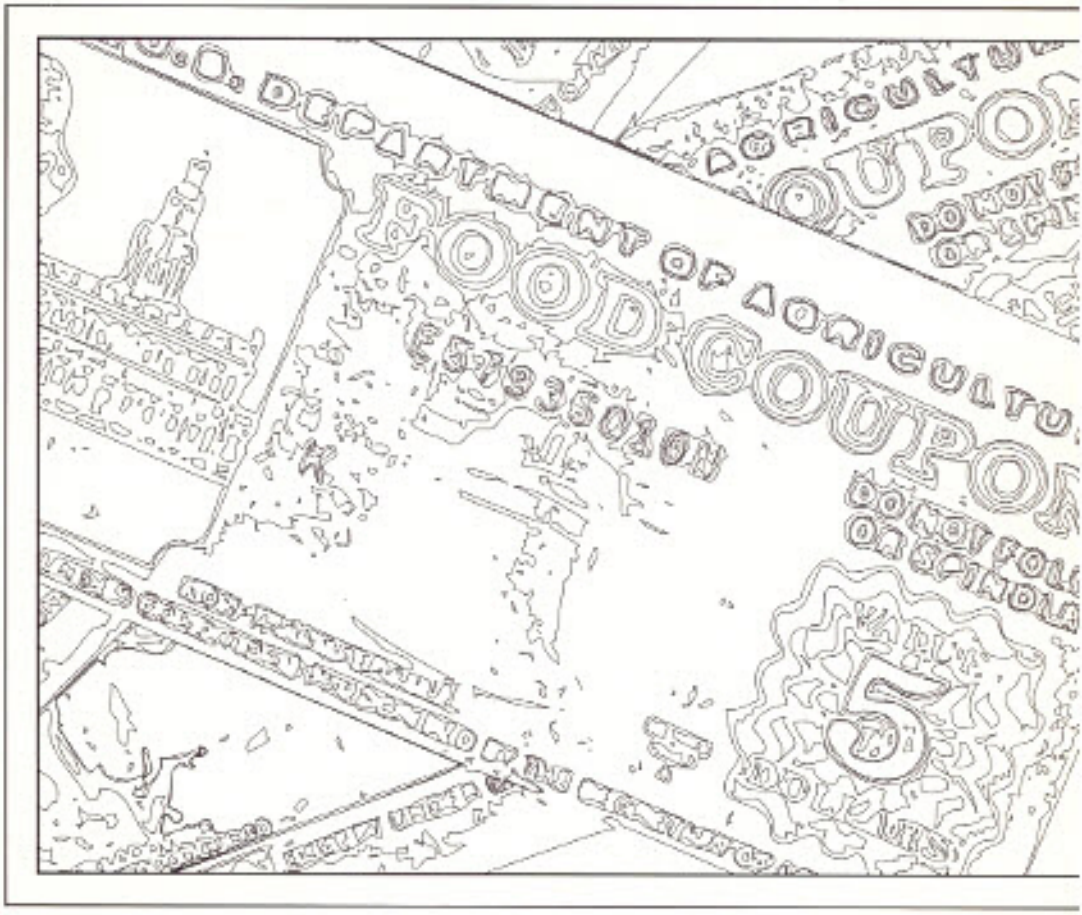

Recent Developments in Food Stamp Program Law

Medical-Legal Collaborations: A New Model for the Effective Delivery of Legal Services

By Joshua Greenberg

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I. Introduction

Legal services programs frequently have long-standing, informal relationships with sympathetic medical counterparts. They may have jointly addressed systemic issues of mutual concern. For example, in Massachusetts, members of the legal services and medical communities have served on an advisory group responsible for monitoring children's issues arising from the implementation of the state's managed care waiver. In addition, legal services advocates may have sought the assistance of medical personnel in individual cases. Advocates representing clients in supplemental security income (SSI) hearings know the value of an informed and committed treating physician.

However, more formal collaborations make possible exciting new initiatives. Access to new sources of medical information and assistance opens significant opportunities for increasing the advocacy capacity of legal services offices. The Family Advocacy Project at Boston City Hospital (BCH) is an innovative collaboration between the BCH pediatrics department and Greater Boston Legal Services. The project bases an attorney at the hospital to assist children and their families with a broad range of advocacy needs, including public benefits, housing, education, and family law matters. It offers an exciting new model for directing traditional legal services work in order to leverage additional resources on behalf of low-income clients.

This article discusses the siting of the legal advocate in a medical-legal collaborative project, the choice of substantive practice, opportunities for collaboration on policy initiatives, teaching and research functions, and a variety of programmatic concerns involved in designing the project. It is important to think through some of these issues in advance of implementation in order to maximize the success of the project. The purpose of this article is to help legal services staff design medical-legal collaborations by thinking about these issues in a structured way. Three themes emerge. First, medical-legal collaborations are significant opportunities to address new legal issues and to form cross-disciplinary constituencies on behalf of low-income people. Second, collaborations involve compromise, and legal services programs may need to revamp their case-acceptance priorities in

order to accommodate the needs of their newfound collaborators. Third, legal services programs should carefully consider key programmatic and administrative issues before beginning their collaborations.

II. Where to Hang Your Hat

The value of a medical-legal collaboration is in creating an interdisciplinary team. Simply outstationing a legal worker in a medical setting has its rewards, but it is unlikely that a weekly intake session at a neighborhood health center will reap significant benefits in terms of addressing structural barriers on behalf of clients. It will result in a steady stream of referrals, with some ability to net specific types of cases (e.g., childhood asthma SSI cases, Medicaid-eligible Medicare beneficiaries, or denials of specific Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits). However, with so many potential clients turned away for lack of resources, increasing intake numbers is probably the least compelling reason to begin a medical-legal collaboration.

Basing a legal worker full-time at the medical institution has obvious advantages. First and foremost, the advocate's interaction with medical staff is proportionately greater. This allows the advocate to overcome initial skepticism from health care providers and helps the advocate understand the peculiar pressures and opportunities presented in working in a medical setting. In addition, because medical systems tend to operate on a referral basis, a medical-legal collaboration works best if the legal advocate is immediately available. If the patient is in the treatment room, it is relatively easy to ascertain basic information about the patient's legal needs. This becomes significantly more difficult once the patient has gone home.

In terms of specific medical placements, programs should carefully consider whether to base a project in a primary care versus a subspecialty care setting. Primary care settings offer the advantage of bringing multiple issues into play. For example, BCH primary care physicians have referred housing, SSI, Aid to Families with Dependent Children (AFDC), Medicaid, education, family law, and homelessness cases to the Family Advocacy Project. Because primary care providers minister to the broad range of their patient's health needs on a longer-term basis, they may be more attuned to the general impact that poverty has on patient health. However, projects based in a primary care setting require legal generalists, or sufficient backup support, to operate effectively.

In contrast, the subspecialty clinic offers the possibility to focus on specific legal concerns. For example, prior to the implementation of the Family Advocacy Project, a Skadden fellow from the Disability Law Center spent significant time working with BCH patients who were Zebley class members. Similarly, the BCH Developmental Assessment Clinic, which evaluates young children with developmental delays, has proven an excellent setting in which to track problems with the early intervention and special education systems. Subspecialty clinics generally possess a wider range of targeted resources, including social work support, early childhood workers, and nutritionists. These clinics may be more susceptible to narrowing the substantive focus of the project.

The project should be located in a medical institution treating a large number of low-income patients. There, convincing medical providers of the relevance of the project and finding a substantial volume of clients will be less difficult. Disproportionate-share hospitals and neighborhood health centers are obvious candidates. In addition, institutions that serve as teaching sites for medical students or residents offer significant training and research opportunities.

III. What to Do All Day

Basing a legal project in a medical setting may require the legal services program to reorient some of its case-handling resources. As a general matter, the individual legal work undertaken will include a fair amount of brief service/client advising. In many situations, clients or medical staff seek information about patients' initial eligibility for benefits. This allows advocates to maximize benefits and to anticipate potential difficulties by, for example, presenting comprehensive, responsive medical information with a benefits application. Similarly, the medically based advocate can usually resolve problems before they reach the hearing stage because of the advocate's ready access to medical expertise. The downside is that, because of the volume of brief service work, medically based advocates cannot undertake sophisticated litigation.

Using a referral model, types of cases handled by the project may be either broadly or narrowly defined. In general, the project should allow priorities to develop over time. While the BCH project did not initially emphasize education issues, we have found a substantial interest on the part of both providers and parents and have begun to devise appropriate responses. Within this parameter, we believe there is a great deal of room to address issues of mutual concern.

It is particularly exciting to encounter issues that might not make it through the door of a legal services office. For example, denials of EPSDT services are more easily spotted in the medical setting than in the law office. Early on, the BCH project identified Medicaid's failure to pay for medically necessary nonprescription drugs as an EPSDT violation. Doctors were frustrated that their patients were not receiving Medicaid coverage for over-the-counter medications; lawyers understood this as a legal issue which could be addressed. Through negotiation, our state Medicaid agency has informed providers, pharmacists, and recipients about their right to such coverage and has revised the list of "automatically covered" medications. It is unlikely that this issue would have surfaced in the normal course of legal services work.

Some level of systemic focus is necessary. Funders are particularly interested in systemic and policy reforms. In addition, providers, like advocates, have particular substantive concerns. It is easier to involve them when the project design addresses some of their issues. To this end, advocates, and the network they help create, should develop the capacity to identify cases involving their chosen systemic issues. Advocates may wish to design appropriate screening and outreach materials and to conduct training on these issues.

It is important to recognize, however, that issues identified by medical providers may not fit into the current priorities established by the legal services program or may raise philosophical concerns within substantive units. For example, as a result of budget cuts, Greater Boston Legal Services does little education-related work. Yet, the pediatricians who work with the Family Advocacy

Project staff are deeply concerned about children's education and learning. We have thus represented children in special education and school expulsion matters. Similarly, in the housing context, health care providers often see apartment transfers as an acceptable solution where patients have medical conditions exacerbated by housing conditions. However, many legal services programs do not represent tenants in transfer-related matters because transfers have no long-term impact on overall housing conditions (indeed, another tenant may be moved into the unit that exacerbated the original tenant's health condition on the next day). Nevertheless, we have assisted a few individual patients seeking housing transfers, with good medical results. Ideally, advocates embarking on medical-legal collaborations consider how to resolve such issues before beginning their work.

IV. Integrating Policy Initiatives

The current debates raging in Washington over the continued existence of safety-net programs for our clients bespeak a need to spend more time organizing grassroots support for these programs. Clearly, organizing and empowering recipients is the best solution. Nevertheless, as a medium-term strategy, multidisciplinary constituencies will always be more effective than legal services advocates alone in arguing for the continued existence of these social supports. Health practitioners, in particular, have the ability and authority to reframe issues as public health concerns. For example, the pediatricians at BCH submitted extensive commentary to the Department of Health and Human Services on medical issues involved in Massachusetts' section 1115 waiver application. In the current political climate, it is strategically powerful and rhetorically useful to enlist such support.

At the same time, the legal side of the team brings an ability to target administrative, legislative, and litigation opportunities to effect systemic change. There is a concomitant need to reframe medical issues in policy terms. Several of the pediatricians at BCH have done extensive research work on the interrelationship between high housing costs and children's poor nutritional status. Recently, Family Advocacy Project staff were presented with the opportunity to draft an amicus brief to our state supreme court. The case, Massachusetts Coalition for the Homeless v. Whitburn, in part contests the state's right to terminate emergency assistance shelter benefits for families that do not accept expensive private-market housing. /1/ We "packaged" the medical information developed by BCH's pediatricians in our amicus brief, hopefully making it more accessible to the court.

V. Teaching and Research

Medical settings present extensive opportunities for teaching and research about legal issues. As a general matter, most hospitals have a well-developed regimen of grand rounds and case-of-the week presentations, which are ideal occasions for teaching about patient advocacy needs. In addition, individual practice groups (e.g., the pediatrics staff), functional divisions (e.g., social workers), or special projects (e.g., immunization outreach campaigns) usually have specific training opportunities. Finally, if the chosen medical setting is a teaching hospital, opportunities to interact with interns and residents abound. At BCH, we developed a four-part curriculum for residents in

their newborn nursery rotation during which we cover eligibility criteria for four key programs: AFDC, food stamps, SSI and Medicaid. The teaching sessions have been very well received and serve to introduce residents to benefits programs that their patients may need.

In institutions that conduct medical research, legal staff may find opportunities to become involved in research projects with policy-making implications. For example, at BCH, several pediatricians are interested in studying the effects of welfare reform on children's nutritional and growth status. The Family Advocacy Project has been deeply involved in designing the questionnaire for such studies seeking to discover the link between proposed sanctions and specific health outcomes.

VI. Programmatic Issues

A. Raising Money

Medical providers may be more able to raise money, or to tap different foundation resources, than legal services programs. As a general matter, foundations tend to offer large-scale money to medical providers for research projects as opposed to direct-service projects. While legal services programs do not normally "research" their clients, it may be possible to cast some of the advocate's work in research terms. For example, legal advocates may assist medical researchers studying the barriers posed by Medicaid-managed care to low-income clients' access to care. As the project becomes more established, it should be possible to write legal services into "medical" grants as a component of other funding requests. Of course, some amount of direct support from the institution may be available.

B. Confidentiality

Resolution of confidentiality issues depends on who employs the legal advocate. Advocates outstationed from a legal services program should have their clients sign explicit releases giving them access to clients' medical records and information available from providers. The situation becomes murkier for advocates employed by the health care provider. Such advocates may have significantly broader access to medical information but a more difficult time explaining attorney-client privilege issues to their medical counterparts. At a minimum, advocates should explain their relationship to the medical provider to all clients.

C. Malpractice Insurance

Malpractice insurance should be covered by the legal services program. The program should ensure that the policy covers advocates being paid by the medical provider and that it covers the proposed clients and substantive areas of law. For example, advocates in medical-legal projects are likely to see a high proportion of clients whose income exceeds legal services guidelines, and legal services programs' malpractice policies may exclude legal work performed for the benefit of individuals whose income exceeds the poverty guidelines.

D. Supervision

Supervision is a complicated issue. To the extent that the project employs a generalist, the legal services program needs to assure supervision across a variety of disciplines. The BCH project has established relationships with individual attorneys in different substantive units. This is by its nature an imperfect solution because no one unit feels completely invested in the project. Offices should probably assess how well unit-bridging works in their particular program. They also need to assure that legal advocates outstationed in the project can take advantage of training opportunities and skills-building workshops. If the project is limited to one specific substantive area, supervision is concomitantly simpler. It bears mentioning that no one in the medical setting is equipped to supervise legal issues; consequently, lack of supervision may be the primary frustration of the legal advocate.

E. Ability to Refer Cases

Even the best generalist would be unable to handle substantively complicated cases in an efficient manner. The legal services program should assess whether individual units would take referrals from the project and, if so, under which criteria. For example, would the program accept cases that lie outside normal acceptance protocols? In making such assessments, programs should keep in mind that broader referral options would only strengthen the project and the relationship between legal services program and medical provider.

F. Legal Services Funding and Restrictions

An in-depth discussion of how to revamp a program's funding streams to avoid the proposed restrictions on use of legal services and nonlegal services funds is beyond the scope of this article. However, advocates should note that projects funded through medical providers may be able to operate without relying on legal services funding. Consequently, some of the proposed funding restrictions may be avoidable.

VI. Conclusion

Medical-legal collaborations raise exciting possibilities for innovative legal work. While the legal services program embarking on a medical-legal collaboration may need to reconceptualize some of its priorities, it will realize increased benefits from the collaboration, including the opportunity to build grassroots support for low-income concerns. This organizing work is essential in the current political climate and should be nurtured accordingly. Legal services programs should develop projects that become integrated parts of the medical system, as opposed to short-term funding solutions, in order to bring about these results.

Footnotes

/1/ Massachusetts Coalition for the Homeless v. Whitburn, No. 80109 (Mass. Super. Ct. Suffolk County Dec. 24, 1993) (Clearinghouse No. 40,714).