

ALIGNING IN ACTION: MLPB

- Lead organization: MLPB (formerly Medical-Legal Partnership | Boston)
- Lead sector: Independent (operates as a fiscally sponsored program of TSNE MissionWorks)
- Headquarters: Boston, Mass.
- Year founded: 1993
- Interviews with: Samantha Morton, MLPB's CEO, and Jeannine Casselman, MLPB's law and policy director

Health is impacted by factors outside of the health care delivery system, including housing, education, poverty, employment, food availability, transportation, and safety. Recognizing that addressing these socioeconomic determinants of health is needed to meaningfully impact health inequities, a national policy shift is taking place.

Government agencies, payers, and providers are all adopting a social determinants perspective. To effectively address these nonclinical needs, partners must work across sectors. Now, the question is how — what are the best practices for effectively aligning systems?

[Aligning Systems for Health: Health Care + Public Health + Social Services](#), sponsored by the Robert Wood Johnson Foundation (RWJF) and managed by the Georgia

Health Policy Center (GHPC), is focused on learning from stakeholders across the nation about effective ways to align these three sectors to better meet people's goals and needs.

Given variance in the local context, there is no single model or formula to align systems. However, Aligning Systems for Health seeks to understand commonalities that drive successful efforts to align sectors. This series examines how communities that describe their work as aligning systems are doing it around four core components of a [Framework for Aligning Sector](#) that RWJF and GHPC are testing: purpose, governance, data, and sustainable financing mechanisms.

MLPB (formerly Medical-Legal Partnership | Boston) equips communities of care with legal education and problem-solving insights to foster prevention, health equity, and human-centered system change. It partners with teams and organizations that understand that comprehensive care should systematically account for people's legal rights, risks, and remedies.

LOCAL CONTEXT

MLPB originated in 1993 within Boston Medical Center's (BMC's) Department of Pediatrics with a team of attorneys who carried pagers and responded with urgency to patients' often-acute, time-sensitive legal questions and crises, an approach used by medical-legal partnerships (MLPs) nationally. At that time, the program operated under different names (initially the Family Advocacy Program and then Medical-Legal Partnership for Children), and its lawyers often represented patient-families in housing or immigration court, which MLPB describes as "legal emergency rooms."

404.413.0314

ghpc.gsu.edu

aligning@gsu.edu



Support
provided by

Robert Wood Johnson
Foundation



“Historically, this type of case handling typically is only available at no cost to some people in limited, acute situations,” says Samantha Morton, MLPB’s CEO. “The demand-supply gap is sobering. It’s hard to imagine being able to parachute in enough free or affordable lawyers with specialized expertise to meet the huge need.”

In 2012, after concluding participation in the Developmental Understanding and Legal Collaboration for Everyone (DULCE) randomized controlled trial, MLPB spun out of BMC and became independent of any health or legal organization as it shifted its focus to “preventive law as preventive medicine.” DULCE was a pilot geared toward families with infants 0-6 months treated at BMC’s pediatric primary care clinic. MLPB offered continuous, proactive legal education and problem-solving insights to the DULCE family specialist and broader multidisciplinary team. The study’s promising results were published in 2015 and showed reduced emergency department utilization, greater engagement with preventive care, and accelerated access to concrete supports like food resources and utility service. Significantly, only a small percentage of DULCE intervention families required resource- and time-intensive legal representation to address their legal concerns. DULCE now operates in several communities in California, Florida, and Vermont and is expanding to six additional states in 2021 under the leadership of the Center for the Study of Social Policy.

This data-driven learning prompted MLPB to fully embrace and refine a new operating model that is geared toward prevention and capacity building and is referred to as *team-facing legal partnering*. Unlike most MLPs nationally, MLPB no longer provides direct patient-facing legal services. Instead, to optimize for more midstream and upstream impact, MLPB is expanding care teams’ “toolboxes” to include familiarity with people’s basic legal rights, risks, and remedies. Through training, consultation, telementoring, and technical assistance, MLPB supports communities of care to more effectively tackle social care partnering with the people they serve.

“By allocating our scarce team resources differently, we are promoting prevention. After all, many social, economic, and environmental challenges are ‘pre-legal’ matters that will become legal problems if they escalate,” says Morton. “In making this shift to more midstream and upstream strategies, the goal is that fewer people will land in high-stakes and high-stress legal proceedings — situations that are not ideal for health and well-being. And that people confronting legal crises will have quicker pathways to legal resources with deep and specialized case-handling expertise.”

TEAM-FACING LEGAL PARTNERING IN ACTION

Jeannine Casselman, MLPB’s law and policy director, partners with a range of care teams (comprised of complex care specialists, community health workers, physicians, care managers, social workers, pharmacists, and peer recovery specialists) to build team capacity.

As the law and policy generalist integrated within a care team, Casselman is a new kind of educator who promotes role-aligned problem-solving among an interdisciplinary team not seeking — or authorized — to act as attorneys.

“For a brand-new team, a case presentation involving a family worried about eviction prompts a lot of questions from me,” Casselman explains. “Are we discussing a scenario that involves a written notice? Or just a heated argument with a landlord? Several months in, the conversations sound a lot different. The team has heard the information that I share, and now they are getting that information proactively. Having absorbed all that learning, now they start with, ‘This person received a written notice for tenancy termination. This person may actually have a fair housing violation based on discrimination.’ Also, they can better direct the family to an available fair housing expert. Ultimately, this builds care team capacity around people’s law and policy contexts, not just in housing but across other areas of life.”

“MLPs can be very focused on how the courts impact individuals, and there is massive impact on individuals,” says Morton. “But drivers of health impact populations, and our strategies have to better mirror the scale of the problem.”

MLPB reinforces its knowledge-sharing work with care teams through ongoing trainings and web-based tools for its partners. MLPB also has leaned into translating trends identified through consultation with partners into policy change contributions, including filing an amicus brief with the Massachusetts Supreme Judicial Court in June 2020 in connection with litigation that threatened the continuation of a state eviction moratorium.

Morton says MLPB’s partners typically include communities of care that take a comprehensive view of human-centered care, explicitly embrace an anti-racism lens, and adopt commitments to social care data collection and data-driven decision-making. Building on learning from the DULCE pilot, MLPB has expanded its partnerships to include early childhood programs and public health programs, which are natural allies of this approach.

“We spend time around a lot of the tables where system transformation and policy change imperatives are being discussed, and we are very clear that we want to be a bridge,” says Morton. “Stakeholders in public health, housing, the criminal legal system, and the health care community are coming together to collaborate more intentionally these days, it’s true. But health equity progress will not accelerate until all of these systems center people and the law and policy contexts that shape their lives.”

DATA

“A capacity-building strategy is a tough nut to crack from a measurement perspective because measuring prevention — a need that didn’t emerge — is a conundrum,” explains Morton. Given this, MLPB not only prioritizes partnerships that are invested in data-driven decision-making, but often will pilot new kinds of measures and include a formal evaluation component.

“When we plan together with partners, the goal is to set into place a kind of mutual data sharing,” says Morton. “We start to build a data set — really a storytelling device to connect the dots between inputs and outputs and outcomes and impacts. Partner readiness varies — culturally, operationally, and from a resource perspective — and some are more or less well-positioned to sign up for that. But increasingly, there is momentum toward that and a real growing consensus that that’s where the partnership work should be.”

FINANCING

MLPB attributes its growth and sustainability to three primary decisions:

- Becoming independent of any health care, legal, or academic entity helped MLPB to grow its partnerships and boost sustainability. Among other things, this structural change enabled a more regional approach to the work.
- Embracing a capacity-building lens keeps the work responsive to partners and the communities they serve, as opposed to being focused on sustaining a target number of staff positions or special projects or revenue.
- Recognizing that conflicts of interest do develop between communities of care and the people they serve (conflicts that Morton predicts, increasingly will develop as social care adoption gains traction) and restructuring its work accordingly.

“Systems of Care do a lot of good. They also can make mistakes and commit bad acts that cause harm to people,” says Morton. “For many years, MLP work across the country has focused on areas where institutional interests and consumer interests align. But those interests do not always align, and we cannot look away from that. MLPB has developed team-facing legal partnering as a distinct strategy that complements the more familiar patient-facing legal representation. This role differentiation is essential to assure maximum transparency with the individuals, families, and communities who are the intended beneficiaries of the work. If we’re not clear about boundary lines and fiduciary obligations, this will diminish trust, hinder sustainability, and stall progress on equity.”

Morton also noted that its origins in Massachusetts and work in New England align with transformation and innovation efforts underway in states that have Medicaid 1115 waivers. MLPB is a certified MassHealth Delivery System Reform Incentive Payment technical assistance provider in Massachusetts and a Health System Transformation Project partner in Rhode Island.

“I see a future where social health integration will happen, will be robustly financed, and will incorporate sound levels of law- and policy-related capacity building in care-delivery teams and systems,” predicts Morton. “But funding is not flowing to social care yet. So, we continue to pay close attention to cross-sector delivery and financing transformation trends and how they may create space for legal rights education infrastructure going forward.”

GOVERNANCE

For the first 20 years of MLPB, it sat within what Morton described as a “visionary department” inside a large safety net hospital, so decision-making and governance flowed through BMC.

Now, MLPB operates under the 501(c)(3) umbrella of TSNE MissionWorks (formerly Third Sector New England), which is one of the largest fiscal sponsor programs in the country. This structure enables MLPB to have strategic independence and affordable back-office infrastructure.

While fiscally sponsored programs are subject to formal governance by TSNE’s board of directors, MLPB has its own nine-person advisory board, which it treats as a governance body, with active subcommittees for strategy and impact, human resources and governance, and finance. As part of a national planning initiative at the intersection of early childhood and access to justice, MLPB currently is assembling several new advisory bodies that will include community members and representatives of partner organizations.

ALIGNING IN ACTION

Additional interviews conducted with Kim Prendergast, director of social determinants of health at Community Care Cooperative (C3), and Becky Cruz Crosson, director of Healthy Start Systems at the Boston Public Health Commission (BPHC).

The Upstreaming Housing for Health pilot involved MLPB, BPHC, the Boston Housing Authority, and C3, a MassHealth Accountable Care Organization (ACO) composed of 17 Federally Qualified Health Centers across Massachusetts. These partners had worked together in a range of different contexts over the years, and in 2018, MLPB reached out to explore whether a new grant opportunity from the Massachusetts Attorney General’s Office could take their collaboration to the next level.

The pilot built on a long-standing collaboration between BPHC and the Boston Housing Authority called Healthy Start in Housing. Healthy Start in Housing leverages a variety of strategies to reduce housing instability and related stress among low-income, pregnant women living in Boston; to date, the program has largely served women of color and their families.

MLPB had been “admiring the work from afar,” but when the grant opportunity came about, Morton says they wondered if adding an accountable care organization, with its patient- and population-level lenses, and some legal problem-solving tools, might enable the program to grow even more impactful.

Program enhancements were implemented over an 18-month period and included:

- Comprehensive case management using a multidisciplinary team of family advocates from BPHC’s Healthy Baby/Healthy Child program, BPHC supervisors and leadership, C3 ambassadors, and an MLPB team member
- Legal education and problem-solving insight from MLPB for the multidisciplinary team
- A flexible fund to pay for some housing-related expenses that were financially out of reach for families (e.g., first month’s rent, a crib, etc.)
- A cross-sector steering committee that included representatives from all four organizations

While expanding an existing program like Healthy Start in Housing eases the need to develop certain infrastructure, it can also create some confusion, as was the case with the pilot’s multiple eligibility criteria. But given MassHealth’s requirement that ACOs begin regular health-related social needs screening, it seemed like an opportune time to bring cross-sector partners together to expand health and housing efforts for mothers and families. A formal, external qualitative evaluation was conducted but has not yet been published. Cruz Crosson and Prendergast identified the following alignment strategies as successful:

The benefit of time. Time benefited personal and professional relationship building. The group credits being intentional about meeting with creating the collaborative space to discuss and overcome many challenges. These meetings were both formal (twice-monthly multidisciplinary team meetings and monthly steering committee meetings) and informal (ad hoc operational meetings).

Trust + commitment + structure = adaptability during leadership change. Early on in the work, both C3 and BPHC experienced staff transitions. Because the organizations had a track record of working together and leadership remained committed to the project, new staff were able to ramp up very quickly and got to know each other while pitching the program to different health centers.

“Even though it wasn’t necessarily the very same people, it seemed to me that there was a culture of working together for a long time organizationally, so there was a feeling that we’re all in this together and therefore, this is going to work because we just trust that it’s going to,” said Prendergast.

Directing dollars to families made a difference. The flexible fund was crucial to meeting families’ housing goals. This type of fund, however, is complicated to sustain given public policy norms around direct cash transfers to individuals and families.

Key challenges included:

Operational design should err in favor of simplicity. The group quickly hit a “sink or swim” moment, Cruz Crosson recalls, with the realization that referrals were not occurring as quickly as anticipated because eligibility criteria were admittedly “a little bit convoluted.” The mindset quickly turned to centering on the shared purpose of meeting the needs of the consumer, while ensuring each partners’ organizational goals were met. To be eligible, women had to be members of C3, in addition to meeting the Healthy Start in Housing or Healthy Baby/Healthy Child requirements regarding health and level of housing insecurity. Ultimately, to simplify the process and ease demands on health center staff, the health centers sent all possible referrals directly to BPHC, which took up the slack in determining eligibility specifics.

Data sharing. Having multiple public agencies with protected patient data can complicate data-sharing efforts. C3 was the primary grant recipient, and there were subcontracts and business associate agreements in place with MLPB and BPHC, but not the Boston Housing Authority.

“A huge lesson for C3, both through this project and another one that we’re working on, is really thinking about the idea that as a health care entity, we can’t just say, ‘This is our business associate agreement, this is our contract, you have to sign it,’” says Prendergast. “We had to recognize everyone comes with their own needs and their own documents. I have now learned to go back and say, ‘this needs to be shorter because I know that the MassHealth addendums can’t be changed, and this needs to be a readable document that we can actually use.’”

Centering parent voice. While there was a shared purpose to empower women and families who are impacted by race and health inequities, the only channel for communication with women enrolled in the pilot was through their one-to-one relationship with BPHC family advocates (community health workers or public health nurses).

“The cross-sector collaboration team owns with enthusiasm that when we have the opportunity to continue this work together in a formal way, we can do more and better to integrate perspectives, feedback, and design thinking from the intended beneficiaries,” Morton says.

Several unintended consequences surfaced in the pilot’s evaluation.

“Healthy Baby/Healthy Child is our overall program but is now known as a housing program, and we’re not a housing program — it is a home-visiting program with a housing component,” says Cruz Crosson. “It is good that there is more awareness, but we are getting tons of referrals, and if you don’t meet our eligibility criteria then it can be very disappointing. We are in the process of just trying to make sure that we’re communicating with different sites what the difference is between Healthy Baby/Healthy Child and Healthy Start in Housing and Upstreaming.”

While not a stated goal at the beginning, the partners were able to strengthen connections among each other to enable future equity-focused work together. While this pilot is not currently funded, the referrals are continuing.

INSIGHTS FOR ALIGNING

- Early on in MLPB’s development, there was a shift from a wholly legal perspective to a more holistic, person-centered perspective that ultimately better meets the needs of patients.
- The partnership faces a common evaluation challenge for entities that are aligning and attempting to change policies and systems — how to measure something that didn’t happen.
- The partnership has an eye on sustainability by keeping up with the trends in social health integration. While change comes slowly, the group is better prepared by envisioning what such a transformed system could be so that they are ready to act when opportunities arise.
- Like many partnerships reflecting on how they relate to communities and community voices, MLPB is re-examining how partner organizations and community members might be directly involved in governance as the work moves forward.

ALIGNING SYSTEMS FOR HEALTH

Health Care + Public Health + Social Services

55 Park Place NE, 8th Floor
Atlanta, GA 30303
ghpc.gsu.edu/project/aligning