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DOI: 10.1377/hlthaff.2010.0038  
HEALTH AFFAIRS 29,  
NO. 9 (2010): 1697–1705  
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The People-to-People Health  
Foundation, Inc.

# Medical-Legal Partnerships: Transforming Primary Care By Addressing The Legal Needs Of Vulnerable Populations

**ABSTRACT** Health care is undermined when patients don't receive the benefit of laws intended to address social determinants of health, such as housing and food. Medical-legal partnerships, which now exist in more than 200 clinical sites in the United States, integrate lawyers into health care to address legal problems that create and perpetuate poor health. This paper describes how such medical-legal partnerships can change clinical systems—for example, by adding legal form letters to electronic health records to help low-income patients rectify substandard housing conditions. We recommend the integration of medical-legal partnerships into federal health care programs.

**H**ealth reform efforts have focused on how to insure the millions of Americans who lack coverage and on improving efficiencies within the health care system. However, health is as dependent on social circumstance as it is on the health care received.

Over the past several decades, Congress, state governments, and federal agencies have enacted laws and regulations to address a host of social factors that influence health, such as adequate nutrition, safe and affordable housing, and disability income. However, primary care efforts to ensure health are undermined when patients do not receive the benefits or protections that these laws afford them.

Medical-legal partnerships are an innovation in health care delivery to improve access to these benefits and protections, which in turn will improve health.<sup>1</sup>

This paper describes how medical-legal partnerships use community legal resources by integrating them into the delivery of medical care. The partnerships can bring about clinical system changes such as adding form letters, standardized screening, and legal information to the elec-

tronic health record to address legal needs without a patient's needing to see a lawyer.

A patient's legal needs can include getting appropriate documentation to support disability applications or a referral to an enforcement agency for action on a housing code violation such as pest infestations.<sup>2</sup> In each instance, legal information can be conveyed without interactions between a lawyer and the patient.

This paper also describes how medical-legal partnerships can work with government agencies to change laws and policies affecting low-income populations. In so doing, they can prevent or address legal problems that pose a direct threat to health. Examples include expanding regulatory protections for medically vulnerable utility consumers and opening offices for food stamp applications in health care settings.

Lastly, we suggest possible implementation and funding strategies. One strategy is integrating medical-legal partnerships into Health Resources and Services Administration (HRSA) community health center grants or Healthy Start sites to address the legal issues at the root of many health disparities. Another strategy includes using innovation funds and medical home initiatives at the Centers for Medicare and

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Medicaid Services (CMS) to address legal issues that pose barriers to effective medical care. This can improve patients' satisfaction with their medical homes by adding on-site legal assistance.

### Addressing Legal Needs As Barriers To Good Health

Material hardships associated with poverty include hunger, safety, utility shutoffs, and substandard housing. These problems generally constitute legal needs and are themselves barriers to good health.<sup>2</sup>

**ADVERSE SOCIAL CONDITIONS WITH LEGAL REMEDIES** Legal needs are adverse social conditions with legal remedies that reside in laws, regulations, or policies.<sup>3</sup> For instance, a patient might not have enough food, which is frequently seen as a “social” need. But when a patient is wrongly denied Supplemental Nutrition Assistance Program (SNAP) benefits—formerly known as food stamps—what was a social need becomes a legal need, because access to the benefit is prescribed by law.

In the United States, civil legal aid is provided to low-income people by a range of agencies funded by federal and state governments. But these resources are chronically overwhelmed.<sup>4</sup>

Studies by the American Bar Association and others reveal that low-income households have an average of one to three unmet civil legal needs related to income, housing problems, employment, and family issues such as guardianship or domestic violence.

Fewer than one in five legal problems experienced by the poor are addressed with help from a private or legal aid lawyer, and most problems are left unresolved.<sup>5</sup> Despite federal- and state-funded legal aid agencies, law school programs, and substantial pro bono services from the private sector, low-income individuals and families often do not have a safety net because they lack access to legal assistance.

**ACUTE NEEDS FIRST** Like emergency physicians who focus on health emergencies and not prevention, legal aid professionals typically “treat” legal crises, such as evictions or domestic violence. Unless the legal need is acute—such as an eviction notice requiring a court appearance—most at-risk individuals might not know when their social problems actually have legal solutions. And even if at-risk individuals realize the legal nature of their problems, they then must struggle to find legal assistance.

**STRATEGIC THINKING** When legal aid agencies join with health care providers to form medical-legal partnerships, they can work together to reorient the delivery of health care and legal assistance to address legal needs before further complications arise for patients. For example, a job loss or extended unemployment could trigger a cascade of crises, from homelessness to domestic violence. Mold growth in the home, left unaddressed, could cause a hospitalization for asthma.<sup>6</sup>

Medical-legal partnership practices use the assessment tool I-HELP (Income, Housing, Education/Employment, Legal Status, and Personal and Family Stability and Safety) to identify patient problems that are responsive to legal intervention (Exhibit 1). For instance, a health care provider might screen for housing issues by asking: “Do you ever see mice or cockroaches in your home?” An affirmative answer signals a violation of a housing code. Alternatively, a health care provider might ask an employment question, such as: “Does your employer ever give you trouble because of your diabetes?” By law, employers must offer some reasonable accommodations for employees who have chronic diseases.

### The Model

The concept of medical-legal partnership was formally developed in the Department of Pediatrics at Boston Medical Center and the Boston University School of Medicine in 1993. Medi-

**EXHIBIT 1**

**Legal Needs That Affect Health**

Legal need	Examples of legal needs that affect health
Income/insurance	Insurance access and benefits Food stamps Disability benefits Social Security benefits
Housing	Shelter access Access to housing subsidies (such as Section 8 program) Sanitary housing conditions (such as mold or lead) Foreclosure prevention Americans with Disabilities Act compliance Utility access
Education/employment	Americans with Disabilities Act compliance Discrimination Individuals with Disabilities in Education Act compliance
Legal status	Immigration (asylum, Violence Against Women Act) Criminal record issues
Personal/family stability	Guardianship, custody, and divorce Domestic violence Child and elder abuse and neglect Capacity/competency Advance directives Powers of attorney Estate planning

**SOURCE** Adapted from Kenyon C, Sandel M, Silverstein M, Shakir A, Zuckerman B. Revisiting the social history for child health. *Pediatrics*. 2007;120:e734–38. These authors adapted the I-HELP assessment tool.

cal-legal partnerships are pioneering the practice of preventive law and have three core components designed to improve health (see the online Supplement).<sup>7</sup>

**LEGAL ADVICE AND ASSISTANCE** The first core component is providing legal advice and assistance to patients, with a focus on the early detection of legal problems and the prevention of legal crises and health consequences. Health care providers are trained to triage legal needs for their patients, to identify issues that patients cannot address themselves. Staff then can refer patients for on-site assistance, improving patients' access to community legal expertise.

**IMPROVING HEALTH CARE SYSTEMS** The second core activity of the medical-legal partnership team creates internal systems improvement within health care. This approach weaves early detection and responses to legal needs efficiently into clinical care so that needs can be addressed without an individual lawyer's intervention, if that is appropriate. This includes comprehensive training of health care teams on legal needs and remedies, improving clinical systems to trigger identification and triage of legal problems, and implementing tools to identify and "treat" legal needs that impact health.

There are many examples of effective tools that can be employed by medical-legal partnership teams. Electronic health record prompts can direct providers to screen for legal needs. Form letters from physicians in electronic health records can improve compliance with laws—for instance, by encouraging landlords to remedy code violations that harm asthmatic patients.

Health care providers also can offer improved clinic-based access to a range of government services for patients, including SNAP and Supplemental Security Income.<sup>8</sup> Special calculators can assist pediatricians in advising families of children with special education needs about timelines for compliance with the Individuals with Disabilities Education Act (IDEA).<sup>9</sup>

The opportunity for improving the health care system through medical-legal partnership is a core strength of this model. Health care teams have access to vulnerable populations and can identify their legal needs early and often address those needs. Given the prevalence of legal needs among low-income, vulnerable patients, the medical-legal partnership strategy is emerging as a critical component of care.

**CHANGE OUTSIDE THE SYSTEM** Medical-legal partnership teams also promote change outside the system, to protect and ensure health through compliance with existing laws. In addition, they can encourage the enactment or amendment of laws and regulations to benefit vulnerable populations. This includes working with coalitions,

developing specific policy initiatives, and creating health impact assessments in response to policy proposals.

Although the legal community has long pursued policy changes on behalf of vulnerable communities, medical-legal partnerships bring a uniquely powerful clinical voice to the advocacy process. Along with an ability to "diagnose" policy gaps, these partnerships can identify innovative policy remedies that can bridge the gaps that separate government and communities. One example is recommending changes in how public housing authorities get the medical documentation needed to make decisions on transferring disabled patients from one unit to another for medical reasons. These changes help authorities make more accurate decisions and cut down on the need for appeals.

Medical-legal partnerships follow the same ethical standards as all legal providers do. But their special role in the health care setting creates opportunities for change strategies outside of traditional litigation models. For example, the partnerships have had substantial impact in improving regulatory implementation of health-related policy when both medical and legal practitioners meet with agency administrators.

Medical-legal partnerships can stimulate change outside the health care system. For example, one partnership provided detailed comments to the Social Security Administration regarding revisions in the disability eligibility requirements.<sup>10</sup> Another documented the connection between a proposed housing voucher restriction and child health consequences by producing a health impact assessment.<sup>11</sup>

## Initial Growth

Although the first medical-legal partnership program started in 1993, national expansion began in earnest after the first national conference on the strategy in 2001.<sup>12</sup> All medical-legal partnerships make use of existing legal resources in the community and rely on joint funding for legal staff to work at the participating health care site. Health care partners provide matching funds from a range of sources, including the budget of an affiliated hospital or health center, community benefits, and philanthropy. Implementation varies depending on the community's legal resources and the health care partner's commitment. All medical-legal partnerships, by definition, consist of at least one health care partner and one legal partner.

In 2010, medical-legal partnerships served 100 hospitals and 116 community health centers in a range of specialties. Most of the programs were available in pediatric and family medicine set-

tings.<sup>12</sup> Increasingly, however, medical-legal partnerships are establishing comprehensive programs that serve entire community health centers or small community hospitals. More than 50 percent of community health centers with medical-legal partnerships received or were eligible for federally qualified health center funding, and at least half of the patient population served was eligible for Medicaid.<sup>11</sup>

Legal partners are predominantly federal- and state-funded legal aid agencies that provide core infrastructure and expertise. Law schools, private law firms, and bar associations are increasingly contributing to the partnerships. Legal aid fellowship programs such as Equal Justice Works and the Skadden Fellowship Foundation have been key catalysts in the expansion of medical-legal partnerships since 2001.<sup>13</sup>

Recent pilot studies have analyzed the cost of implementing medical-legal partnerships and focused on the revenue recovered for health care institutions through basic legal advocacy. These interventions include securing health insurance coverage for patients through a disability claim and appealing claims for health care previously denied by insurers. Studies at three medical-legal partnership sites have demonstrated that this sort of cost recovery more than covers the expense of program implementation, even when cases that have the potential to generate income constitute only a small fraction of all cases handled.<sup>14-16</sup>

Because medical-legal partnerships generally include lawyers employed by legal aid agencies, the desire of health care institutions to recover money does not take precedence over other pressing legal needs. The separation of legal aid agency and health care institution avoids potential conflict in the allocation of legal resources or prioritization of particular legal needs of patient-clients over others.

Medical-legal partnerships have benefited greatly from the visible support of leading organizations in law and medicine, including the American Bar Association<sup>17</sup> and the American Academy of Pediatrics,<sup>18</sup> which passed resolutions in support of medical-legal partnerships in 2007 and 2008, respectively.

In June 2010, the American Medical Association passed a resolution that encourages physicians to develop medical-legal partnerships and to help identify and resolve diverse legal issues that affect patients' health and well-being.<sup>19</sup> In addition, the Agency for Healthcare Research and Quality (AHRQ) has profiled the concept of medical-legal partnership as an innovation, in both 2008 and 2010.<sup>20</sup> Multiple research efforts studying how medical-legal partnerships impact legal needs and health are ongoing.<sup>21</sup>

## Success In The Field

Three examples from the medical-legal partnership network illustrate some of the best practices in deployment of the partnership model in primary care. The best practices include conducting a needs assessment to inform program implementation; using quality improvement practices to monitor, and offer feedback for, the achievement of implementation goals; and using a "patients to policy" strategy to improve internal and external systems and reduce the burden on patients and providers of addressing legal needs in a primary care setting.

**NEW BEGINNINGS** The Medical-Legal Partnership–Boston program was the first medical-legal partnership. It currently serves more than 1,000 patients annually at Boston Medical Center and six affiliated community health centers.<sup>22</sup> In the summer of 2008, the partnership decided to expand its reach to the geriatric patient population served by Boston Medical Center's Geriatrics Department.

The expansion had two goals: to engage front-line health care providers and to establish direct service and training targets for deploying resources efficiently. The partnership and the Geriatrics Department also developed a provider survey to assess providers' knowledge, attitudes, and behavior regarding patients' legal needs.

As an early step in the expansion, the partnership surveyed twenty-one providers, asking fifty-two questions covering ten domains related to legal needs. The domains included housing, utilities, immigration, and income support. Health insurance, estate planning, safety, education, and employment were also subjects of the survey. Each item allowed responses along a five-point Likert scale—strongly disagree, somewhat disagree, neutral, somewhat agree, and strongly agree.<sup>23</sup>

Of the twenty-one providers, almost all somewhat or strongly agreed that at least half of their patients were affected by issues related to capacity and competency to make medical decisions. Close to two-thirds of providers surveyed somewhat or strongly agreed that at least half of their patients were affected by issues of public benefits, health insurance, housing, utilities, and estate planning. Half of the providers surveyed somewhat or strongly agreed that at least half of their patients were affected by employment and immigration problems.

The survey also asked if providers were comfortable knowing when and how to contact legal resources to address these problems. Despite the general perception that legal issues frequently affect their patients, fewer than 20 percent of the respondents said that they knew how to refer to a legal resource, thus underscoring the need for

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## Health Care Sites In 2010

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medical-legal partnership services.

Health care providers overwhelmingly replied that they would like more training in legal advocacy. Eighty-six percent of respondents said that they would like more training on issues pertaining to the patient's capacity and competency to make medical decisions.

The majority of respondents (65–78 percent) requested legal advocacy training in estate planning, safety issues, family law, immigration, income supports and public benefits, and health insurance. These data guided the Medical-Legal Partnership–Boston in prioritizing the subject matter of its initial advocacy training curriculum for the geriatrics health care staff.

**CINCINNATI FOCUS ON QUALITY** The Cincinnati Child Health-Law Partnership, a partnership between the Legal Aid Society of Greater Cincinnati and Cincinnati Children's Hospital Medical Center, is in the early stages of framing its goals and practices. The Cincinnati partnership is focused on building a highly reliable system that can identify key social and legal factors that undermine family health and well-being. The partnership also coordinates care closely between the medical and legal teams.<sup>7</sup>

In trying to create a quality improvement framework, the Cincinnati Partnership has four main goals. These are having physicians screen for one or more social needs at 90 percent of well-child visits; having at least 90 percent of physicians trained and willing to make appropriate referrals; having at least 90 percent of referred families connect with legal staff and follow up;

and having at least 90 percent of referral outcomes recorded in the medical chart.<sup>7</sup>

To achieve the first goal, the Cincinnati program began a collaborative process to develop a social history template to be used in patient encounters. The template was also to be embedded in the electronic health record. Physicians, social workers, and lawyers contributed to the composition of the questions.<sup>7</sup>

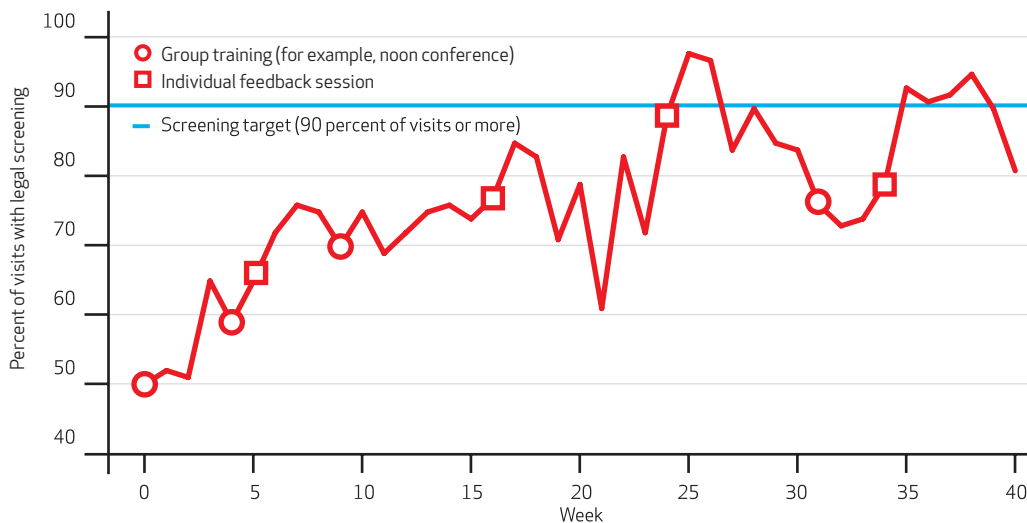
The program fed reports back to physicians. Those physicians with lower screening rates were given one-on-one training. Case-based conferences and preclinic conferences were also offered during this period. The goal of 90 percent screening at well-child visits was reached by week thirty-five after both group training and individual feedback sessions, although ongoing quality improvement is still needed (Exhibit 2).

Efforts to optimize the success of legal team referrals continue. For instance, the partnership is developing ways to communicate back to physicians the outcomes of the legal referrals (including failure to follow up) in ways that meet legal and ethical standards, particularly relating to confidentiality.<sup>24</sup>

**KEEPING THE UTILITIES ON IN BOSTON** Consistent access to utility service is a common legal issue confronting low-income patients, and losing service is frequently a precursor to eviction. Although federal and state governments provide small grants to low-income individuals and families through the Low Income Home Energy Assistance Program—also known as LIHEAP—to help them pay utility costs, the grants cover only

## EXHIBIT 2

Screening Of Children For Legal Needs In Well-Child Visits During A Forty-Week Period



**SOURCE** Cincinnati Child Health-Law Partnership. **NOTE** Percentage of 1,657 well-child visits that included legal screening over a forty-week period, with twenty-two participating physicians.

about 16 percent of eligible households nationwide.<sup>25</sup>

► **STATE PROTECTION:** As a partial solution for the dilemma that some low-income patients face in winter—whether to pay for food or for heat—forty-seven states also offer some form of utility shutoff protection: a guarantee of uninterrupted utility access.<sup>26</sup> This guarantee does not erase existing debt to utilities, nor does it stop the accumulation of additional debt. However, it does provide a measure of security to people who—because of their age, health status, or other vulnerability—are especially affected by interrupted utility service.

What's more, almost all states offer shutoff protection for people with chronic or serious illnesses if their medical conditions are verified by a letter from a medical care provider. Each state has its own rules regarding how frequently patients must recertify their eligibility for the protection.<sup>26</sup>

► **TARGETING THE VULNERABLE:** With fuel costs continuing to increase over the past several years, the Medical-Legal Partnership–Boston has developed a strategy to ensure more comprehensive access to consistent utility service for certain categories of individuals, including children with special health care needs. The first step was to make it easier to identify patients needing such protection. A training program, Utility Service Protection 101, gave nurses, social workers, and clinicians tools to identify patients in need of utility assistance. It also gave them the means to provide those patients with necessary documentation to protect utility service—for example, through form letters in the electronic health record.

This program increased the number of patients identified as needing their utility service protected. The 676 utility protection letters generated on behalf of patients in 2008 and 2009 represented a 350 percent increase from the 193 similar letters generated in 2005 and 2006.<sup>27</sup>

The Medical-Legal Partnership–Boston program also implemented an “energy clinic” in the Pediatrics Department of Boston Medical Center. With social worker and case management staff, the clinic coordinated a range of utility-related advocacy services for patients' families.<sup>28</sup> Finally, the legal team created a Utility First Aid Kit for front-line health care staff, including relevant forms and letters. The kit also contained a model utility access policy—the first in the country—for Boston Medical Center. The policy provided guidance for all health care staff regarding their role in ensuring consistent utility access for specified patient populations.<sup>29</sup>

► **EXTERNAL SYSTEMS CHANGES:** The Medical-Legal Partnership–Boston legal staff also

## Medical-legal partnerships can become an essential component of the patient-centered medical home.

implemented external systems change. Health care providers complained to the legal team that families—even those with children who were terminally ill with cancer or other diseases—were forced to recertify their chronic illness status every thirty to ninety days.<sup>26</sup> Consequently, many families had to return to their clinicians repeatedly to request new letters, burdening both the family and the clinical staff.

The partnership's legal staff assisted health care providers to submit formal testimony to the Massachusetts Department of Public Utilities regarding the onerous process of providing medical documentation every three months for lifetime genetic conditions and disabilities such as sickle cell disease.<sup>30</sup> The partnership then worked with local and national organizations, including the National Consumer Law Center and Action for Boston Community Development, to bring a medical voice more consistently and prominently into the Massachusetts utility regulatory reform process.

In 2008 the Massachusetts Department of Public Utilities made dramatic regulatory improvements in its shutoff protection regulations. The department specifically cited the testimony of the Medical-Legal Partnership–Boston as a basis for the regulatory reforms.<sup>31</sup> Now, fewer medical certification letters are required, and a broader cadre of licensed health care providers are authorized to certify patients' eligibility for this crucial service.<sup>32</sup>

### Implications For Primary Care

**PATIENT-CENTERED MEDICAL HOME** Medical-legal partnerships can become an essential component of the patient-centered medical home by making timely, on-site legal interventions available to patients and their families. For example, the Joint Principles of the Patient-Centered Medical Home, adopted in February 2007, incorporate important concepts of team-oriented,

# More health care institutions may choose to invest in medical-legal partnerships as a part of high-quality care.

personalized care, and of comprehensive services provided on site in ambulatory practices organized around the patient.<sup>33</sup> The NCQA also developed standards that emphasize and encourage the use of systematic, patient-centered, coordinated care management processes.<sup>34</sup>

The Joint Principles include addressing all of a patient's needs, sometimes referred to as "whole-person orientation." The patient's personal physician coordinates care across all elements of the complex health care system and within the patient's community.

Proposed reforms to the health care system include expanded coverage of vulnerable populations with a special focus on primary care screening and prevention, particularly in the context of chronic diseases such as diabetes and cardiovascular disease. Community health centers are expected to be a cornerstone of delivering better preventive care.<sup>35</sup>

As the health care delivery system is reorganized under the new national health reform laws, innovations that improve efficiency—such as medical-legal partnerships—will help ensure that high-quality medical homes are available to high-need groups. The partnerships can eliminate legal issues that exacerbate underlying disease, such as not getting the maximum amount of food subsidies for which one is legally eligible. In a diabetic patient, for example, the inability to afford sugar-free foods can have a negative impact on blood sugar levels.<sup>36</sup>

**PRIMARY CARE WORKFORCE** Perhaps one of the most daunting barriers to the universal adoption of primary care and patient-centered medical home principles is the limited number of primary care providers in the United States, and their distribution.<sup>37</sup> Improving the efficiency of primary care teams is therefore critical. Workforce development in primary care must include increasing the numbers of primary care physicians and mid-level providers, but it should also include developing interdisciplinary patient care

teams drawn from skilled professions such as the legal community.

As primary care reinvents itself to serve a larger aging population, the medical home will need to be more than the sum of its clinical parts. It will need to serve as a gateway not only to medical services, but also to nonmedical systems that affect health. Medical-legal partnerships are the right intervention to use in ensuring that primary care can be successful at the patient, provider, and institutional levels. With dedicated funding streams, and technical assistance to ensure that medical-legal partnership sites are successful at efficiently identifying and addressing legal needs, a national investment in these partnerships could demonstrate that they should be the standard of primary care for vulnerable populations.

**APPLYING PARTNERSHIPS TO PRIMARY CARE** There are many ways to apply medical-legal partnerships to the delivery of primary care.

► **FEDERAL EFFORTS:** The Health Resources and Services Administration offers a range of opportunities. Medical-legal partnerships could be included and funded as part of the standard mix of services offered at federally qualified health centers. Similarly, Healthy Start programs could be used to promote and fund medical-legal partnerships for underserved populations.

As CMS embarks on medical home demonstration projects, medical-legal partnerships can be an important tool for case managers or patient navigators working with patients who have complex primary care needs. Given the focus on quality and reimbursement based on outcomes, more health care institutions may choose to invest in medical-legal partnerships as a part of high-quality care to improve outcomes and reduce costs for vulnerable populations.<sup>38</sup> Additionally, CMS graduate medical education dollars could be used to support medical-legal partnership training, especially since fifty-five residency programs already include such training.<sup>39</sup>

► **EFFECTS ON THE ELDERLY:** Although the idea of medical-legal partnership started in pediatrics, it may have its deepest impact on the aging population. For older Americans, the convergence of legal needs with health status is a certainty, including advance directives and estate planning. Aging and Disability Resource Centers—funded through the Administration on Aging—could receive additional funding for medical-legal partnerships to more effectively serve geriatric patients.

**PERSISTENCE THROUGH UNDERFUNDING** Despite chronic underfunding, the legal aid community has made sizable contributions to the steady expansion of medical-legal partnerships

and has seized the opportunity to revitalize legal aid's profile, role, and impact.<sup>40</sup> It is critical that such resources be matched and increased to achieve the potential of the medical-legal partnership. The Department of Justice's new Access to Justice Initiative, dedicated to increasing access to legal services for poor people, is an excellent vehicle for modeling the matching of resources between the health care and legal communities. The program has the potential to replicate at the national level what is happening at the local level through medical-legal partnerships.<sup>2</sup>

## Conclusion

As the Robert Wood Johnson Foundation's Commission to Build a Healthier America report states: "Clinicians are in a unique position to identify vulnerable patients."<sup>41</sup> By offering preventive legal assistance within health care settings—and advocating for patients' legal and health care rights outside the clinical setting—medical-legal partnerships signal a positive transformation of primary care. A variety of implementation options and funding streams can help the partnerships realize their true potential. ■

Funding for this paper was provided by the W.K. Kellogg Foundation, the Kresge Foundation, and Atlantic Philanthropies.

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