

# Nurses forming Legal Partnerships to Meet the Needs of the Underserved in Rural America

Patricia M Vanhook<sup>1\*</sup>, Trish Aniol<sup>2</sup>, John Orzechowski<sup>3</sup> and Grace Titilayo Babalola<sup>4</sup>

<sup>1</sup>College of Nursing, East Tennessee State University, P.O. Box 70403, Johnson City, TN 37614, USA

<sup>2</sup>Patient Family Advocate, Certified Application Counselor, 2151 Century Lane, Johnson City, TN 37660, USA

<sup>3</sup>Tennessee Justice Center, 211 7th Ave N #100, Nashville, TN 37219, USA

<sup>4</sup>Department of Political Science, International Affairs and Public Administration, East Tennessee State University, Johnson City, TN 37604, USA

## Abstract

The impetus for the recognition of the need for legal partners in healthcare came from Boston City Hospital in 1993. The hospital provided care to the largest uninsured and underinsured population in the New England states. The pediatric patients were noted by Dr. Barry Zuckerman to have difficulty in recovering from medical illnesses. He linked their inability to improve their health to poor housing, food insecurity, and basic social determinants of health. His hiring of a part-time lawyer led to a national movement for the development of medical-legal partnerships. The American Bar Association, the National Center for Medical-Legal Partnerships at George Washington University in Washington, DC and the American Academy of Pediatrics formed the first national medical-legal partnership in 2007. Joint resolutions were passed for members to become partners with the other professional colleagues to “address the legal and social issues affecting patient health and well-being.” The American Bar Association resolution led to the creation of the Medical-Legal Partnership Pro Bono Project. In 2015, the East Tennessee State University College of Nursing nurse-led community health center was awarded a small grant from the National Nurse Centers Consortium to participate in the development of a medical-legal partnership. The health center is staffed by Nurse Practitioners who provide health care for the underserved in northeast Tennessee. The patients are diverse and include homeless, migrants, residents of public housing, uninsured, and underinsured. Partnering with the Tennessee Justice Center in Nashville, Tennessee, the nurse-led medical legal partnership improved lives of pediatric patients, adults, pregnant women across the state, and advocacy rights for those who cannot speak for themselves.

## Introduction

This paper focuses on how nurses and legal partners meet the medical and legal needs of patients, who by their social determinants of health cannot afford access to health services in rural America. The objective is to review the progress of a nurse-led legal partnership that is meeting the needs of the underserved populations of a federally funded community health center in rural Appalachian America.

The paper aims to highlight the roles nurses play in ensuring a transformed health care system, with the help of trained legal partners who guide the collaboration to enforce the laws and the regulations that are set up to protect the health of the citizens in the state of Tennessee.

## Medical-Legal Partnership History

The approach adopted by the medical-legal partnerships (MLP) is in line with the nurse-led model of care. The principles of the establishment are built around teamwork for the provision of comprehensive and robust clinical care to attend to the health of the patients and consequently improves their health. The motive is geared towards improving health care among the medically underserved and socially disadvantaged populations, which categorically distinguishes the nurse-led health care model from the more traditional health and public health models [1].

According to Cohen et al. [2], the MLP practically goes beyond just tending to the patients' sicknesses but also by addressing health disparities, addresses its social causes, including access to adequate food, housing, and income.

## Publication History:

Received: February 21, 2018

Accepted: April 03, 2018

Published: April 05, 2018

## Keywords:

Nurse-led, Legal, Medical-legal partner, Social determinants of health, Advocacy

The first medical-legal partnership began in 1993 in Boston City Hospital now known as Boston Medical Center. The needs of the HIV/AIDS community were the beginning of the program in conjunction with Harvard Law School. The true progression of medical-legal partnership began when the Chief of Pediatrics at Boston Medical Center hired an attorney to assist in addressing the pediatric social determinants of health such as poor housing conditions, limited access to food, and safety. It was the children's living conditions that was keeping them from recovering from childhood illnesses [3].

In 2006, the National Center for Medical-Legal Partnership was formed at the Milken Institute of Public Health at George Washington University in Washington, DC. The Center aids health centers to develop a formal medical-legal partnership through technical assistance, a toolkit, and ongoing support. The Center has assisted 294 agencies in 41 states to establish medical-legal partnerships [4].

## Nurses in Health Care Legal Partnerships: The Integration

The Johnson City Community Health Center (JCCHC) was the first nurse-managed health center developed by the College. The clinic was

**\*Corresponding Author:** Dr. Patricia M Vanhook, College of Nursing, East Tennessee State University, P.O. Box 70403, Johnson City, TN 37614, USA, Tel: +423-439-7184; E-mail: [vanhook@etsu.edu](mailto:vanhook@etsu.edu)

**Citation:** Vanhook PM, Aniol T, Orzechowski J, Babalola GTG (2018) Nurses forming Legal Partnerships to Meet the Needs of the Underserved in Rural America. Int J Nurs Clin Pract 5: 275. doi: <https://doi.org/10.15344/2394-4978/2018/275>

**Copyright:** © 2018 Vanhook et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

started in March, 1990 specifically to meet the primary care needs of the homeless population of Johnson City and its surrounding rural Appalachian region [5]. The clinic grew from one part-time APN in a donated room at the local Salvation Army post in 1990 to a thriving primary care practice that today provides more than 30,000 primary care visits annually by a staff of four full-time and two part-time nurse practitioners. In 2004, JCCHC and Hancock County School-Based Health Centers received funding as a Federally Qualified Community Health Center (FQHC) (H80CS00840). FQHCs are funded under section 330 of the Public Health Service Act with the CON serving as a co-applicant with the community Governing Board. The Governing Board is charged with the overall management of the clinics through establishment of services, hours of operation, and fiscal accountability. As a co-applicant, ETSU retains responsibility for financial and personnel management. These clinics provide health care to underserved populations. They are obligated to provide services on a sliding scale fee, provide comprehensive care, have an ongoing quality assurance program, and have a governing board of directors. This funding helps to support the mission of meeting the needs for homeless, uninsured, underinsured, and migrant workers. Since receiving this funding, the clinic now has five sites; JCCHC is the primary site for adult and pediatric primary care, women's health and prenatal care, Hispanic migrant and settled residents, uninsured, underinsured, and patients who are insured through TennCare (Tennessee's managed Medicaid system) and Medicare. Services for homeless individuals and families are conducted at the Johnson City Day Center. At this site, social services, placement, substance abuse counseling, and APN delivered primary care are available. In 2011, the third site opened. A satellite clinic in public housing was established as a partnership between ETSU CON and the Johnson City Housing Authority. This clinic is striving to meet the needs of those in public housing, especially the elders, by providing on-site and in-home primary care. In the poorest county of the state that is over two hours away from the CON, the two Hancock County School-Based Healthcare Centers provide access to the county residents for care across the lifespan. The operational hours of these sites provide over 200 hours of access per week through extended and weekend hours. This clinic network serves predominately uninsured individuals. In 2016, 22% of patients seeking care were Hispanic compared to 12% Hispanic patients in community health centers across the state. In addition, 37% of patients seeking care at the Johnson City sites are uninsured.

The Tennessee Justice Center (TJC) is a non-profit organization formed in 1995 to provide legal services to vulnerable populations. Because of its funding stream, TJC can serve clients and use legal tools (e.g., class actions) that federally funded legal services programs

cannot. In recent years, TJC has focused primarily on advocacy related to health care and the state's Medicaid program due to challenges clients face in that area (see below). TJC helps clients navigate public programs, provides education and tools to health professionals to assist them to be better advocates for their patients, and serves as a bridge between policy makers, public officials, and healthcare leaders and the individuals served by those programs. TJC uses insights gained by serving individual clients to work for improved policies. TJC is in Nashville, five hours from the JCCHC (Figure1).

The East Tennessee State University College of Nursing (CON) nurse-led clinics had the opportunity in the fall of 2014 to apply for a competitive grant funded by the Kresge Foundation [6] to form a medical-legal partnership (MLP). The application was awarded January 2015 as one of two in the country who received \$50,000 over a two-year period to establish the MLP grant to advance a medical-legal partnership that addresses patients' health and economic stability. This grant allowed the JCCHC to collaborate with the TJC to address high priority social determinants of health needs that could not be answered by healthcare providers alone.

## Needs of Population

JCCHC serves rural Appalachian and urban Johnson City, TN. Census.gov [7] reports the area population estimates for July 1, 2016 as 507,837. In the eight counties of service (Johnson, Carter, Unicoi, Sullivan, Washington, Hawkins, Greene, and Hancock), all counties but Washington have children living in poverty above the state average of 81%. Hancock County, the poorest county in the state, has 96% children living in poverty. Food insecurity, limited access to health and mental health providers, and commuting distance are high indicators of poor health [8]. Travel within the counties is primarily by two-lane mountainous roads.

There were two key barriers that had to be addressed: 1). professional barrier and 2). Cultural barrier. From the JCCHC and TJC partnership there were cultural and barriers between medical and legal language; unique challenges due to geographic distance; and resource limitations for both.

Investigation at JCCHC identified over 750 pediatric patients did not have health insurance. Yet the children were eligible for some sort of health insurance coverage. Many parents had issues with health literacy, trust, culture, and language barriers that are not unique to Appalachia but do represent many of the reasons identified for access to services for the children [9].

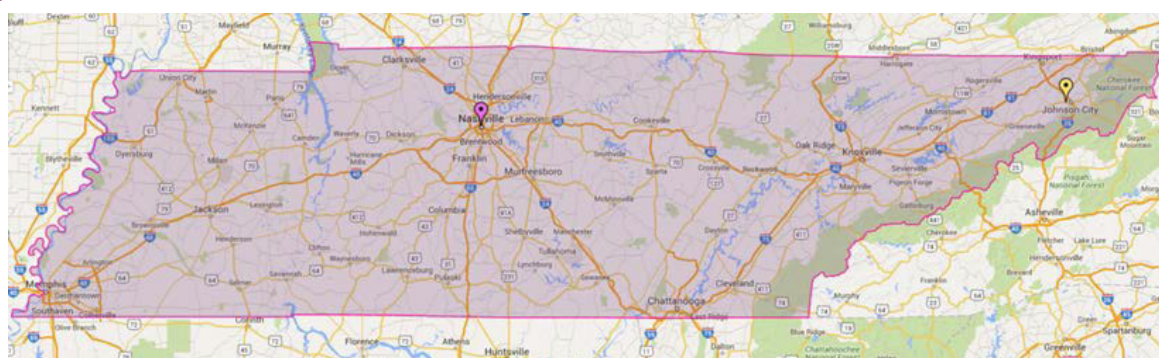


Figure 1: Distance from Johnson City to Nashville, TN (278 miles/447.4 kilometers).

Unique challenges related to the state of Tennessee's Medicaid program include the following: 1). Tennessee is the only state agency in the nation that did not accept Medicaid applications directly-meaning the applications had to be processed through the federal Marketplace, which was not designed to screen for state-specific eligibility rules; 2). no working computer system to screen for Medicaid eligibility; 3). no in-person Medicaid application assistance from the state; 4). months long delays in processing of applications, even though state and federal regulations require a 45-day processing period for nearly all Medicaid applicants; 5.) no Spanish translated advocacy appointment form available on the Department of Health webpage; 6). enrollment in health insurance (Medicaid or Children's Health Insurance Program) for pregnant women often happened after delivery instead of at the beginning of pregnancy; and 7). Significant issues with the process that allows a patient to appoint an advocate to follow their application through the process, discuss with agency, and assist with problems.

### Adapting a Successful MLP Model

The roles of the nurses have been essential in providing health care for the underserved populations in the United States and this has been in existence since the end of World War II.

Although it is known that the collaboration between social, legal, and health services have been in existence for some time, however, the apparent and formalized MLP was from Boston Medical Center's pediatric department in 1992. This in succession has led to the establishment of over 275 health institutions partnering clinical and legal professionals across the U.S. The Advanced Practice Registered Nurses (APRNs), specifically Nurse Practitioners (NPs) are poised to manage and ensure that over 1.5 million patients receive medical care annually. The location of the NMHCs is such that it serves the underserved, public housing developments, churches, schools, domestic violence shelters, and correctional facilities medical care [1,10].

While the integration has been key in addressing social and health care anomalies, the interdisciplinary team of lawyers and nurses in forming health care team also provide cost savings to the system and encourages better access for the patients thereby, improving the provider satisfaction [11]. The nursing code of ethics calls nurses to "practice with compassion and respect for the dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" [12].

### The Team

The organizational chart of the team described by the National Center for Medical Legal Partnership is depicted in Figure 2 [1, adapted].

The team for the nurse-led MLP was similar but had the overarching support of College of Nursing administration and the interprofessional collaboration of the CHC and the TJC with the patient. (Figure 3).

### Communication

The TJC is in Nashville, Tennessee, five hours from JCCHC. Most MLPs have their legal partner embedded at the practice site but the

limited expertise and resources in the Northeast Tennessee region did not allow JCCHC to have a local partner. During the initial implementation year of 2015, the legal and clinic staff met (in person and by phone/Skype) for discussion, training, and relationship building.

The team worked together to find an intersection of need with legal expertise. The TJC provided local and Webinar training workshop attended by the JCCHC team. These meetings provided the opportunity to have collaborative conversation with the TJC partners.

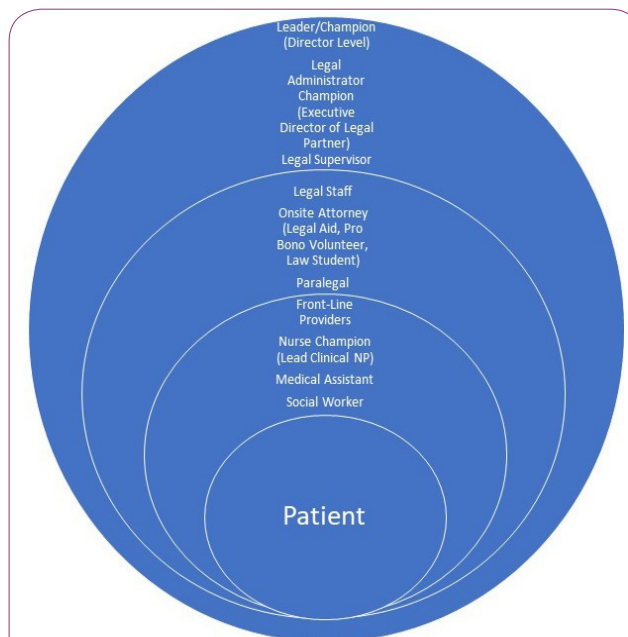


Figure 2: National Center for Medical Legal Partnerships MLP Team Organizational Chart [1, adapted].

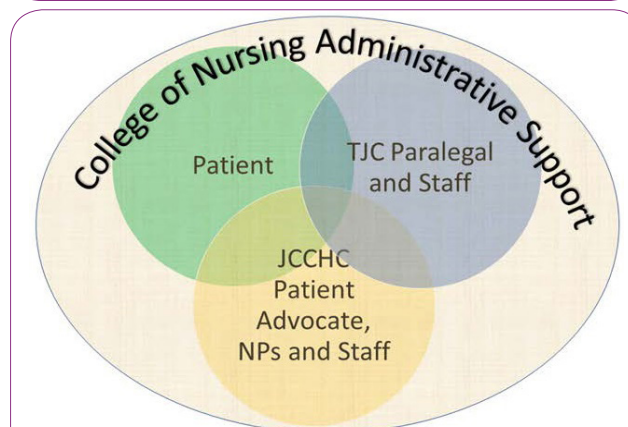


Figure 3: Nurse-Led Medical-Legal Partnership Organizational Chart.

The team used tele technology for "office hours." This is a standard form of communication used by the National Center for Medical Legal Partnership. The office hour provides the TJC advocate an opportunity to meet with patients "face-to-face" to discuss their needs and issues if they were not able to meet at the local level. This means of communication also allowed TJC advocates to address mediation of complaints or state non-compliance of regulations with the patient instead of the patient having to travel more than 10 hours' round trip to Nashville, Tennessee for the meeting. Because of TJC's existing relationships with state officials and the nature of the state's Medicaid



appeal process, many relevant legal issues were resolved through correspondence between TJC and opposing counsel or state agency staff, rather than requiring attendance at an administrative hearing. While some patients were seamlessly referred to TJC for representation as MLP clients, often the clinic staff maintained the relationship with the patient and shared needed factual and demographic information with TJC, who pursued appropriate legal action.

## Outreach

Outreach was both an internal and external process. For the internal process, informational tools for both providers, nurses, staff, and patients had to be developed. The information for patient was developed jointly and published in English and Spanish. The providers, nurses, and staff were provided formal education about the MLP that included the historical perspective of MLP and the mission and vision of the nurse-led MLP.

Best practice for medical-legal partnerships is an internal advocate to work directly with the patients [3]. The JCCHC and TJC team designed an innovative practice to mirror an internal legal consultant. This was accomplished by providing in-depth training for the Patient Advocate. The JCCHC Advocate was able to provide much of the support the patients needed without the TJC intervention unless mediation or litigation was indicated.

Outreach was both an internal and external process. For the internal process, informational tools for both providers, nurses, staff, and patients had to be developed. The information for patient was developed jointly and published in English and Spanish. The providers, nurses, and staff were provided formal education about the MLP that included the historical perspective of MLP and the mission and vision of the nurse-led MLP.

Best practice for medical-legal partnerships is an internal advocate to work directly with the patients [3]. The JCCHC and TJC team designed an innovative practice to mirror an internal legal consultant. This was accomplished by providing in-depth training for the Patient Advocate. The JCCHC Advocate was able to provide much of the support the patients needed without the TJC intervention unless mediation or litigation was indicated.

## Referral

Getting the patient to the Advocate for services required a process for internal referral. The initial internal process was developed in paper format using the I-HELP™ screener [Table 1]. The screener was originally published by Kenyon, Sandel, Silverstein, Shakir, and Zuckerman in 2007[13]. The mnemonic IHELLP addressed six domains, income, housing/utilities, education, legal status/immigration, literacy, and personal safety. The original questions were limited to 11 and were brief in context. As research into social determinants of health has grown, the needs to change the tool were identified. The National Center for Medical Legal Partnerships created a the I-HELP™ that is customizable to the patient population and setting. I-HELP™ is the mnemonic for income, education and employment, legal status, and personal and family stability. This tool was developed with the assistance of The Advisory Board Company without charge for their expertise. The tool is available for download on the public domain (<http://medical-legalpartnership.org/screening-tool/>)[14]. A guide to understand how the interconnectedness of the medical and legal professionals are in improving healthcare was developed by Marple [15]. The tool further expands on the I-HELP™

domains with an explanation of how legal services can be utilized and how these services can improve health. The CHC modified the tool to meet the needs of their population and translated the tool into Spanish. The tool can be self-administered, or the questions can be asked by the nurse or the healthcare provider (Figure 4 & Figure 5).

The process at the clinic was streamlined to quickly refer all children and pregnant women identified as uninsured by the clerical staff on registration to the patient advocate. The nurse and/or the nurse practitioner identified additional needs and made a referral via the electronic record. The Advocate sees the child with the parent or the pregnant mom at the time of the visit to introduce herself and to schedule a visit to enroll in the state plan. The process is embedded in the electronic medical record system as the has process become more defined.

## Case management

Successful case management of the uninsured is known to reduce emergency room visits and hospitalizations [16]. Case Management: patient advocate and legal aid worked together to provide case management of the patient through the insurance enrollment process or other health grievance issues. Due to the direct case management at the clinic, only one case out of 165 was sent to the TJC for review for mediation payment assistance. In the year 2017 this number rose to 21 due to the shortened timeframe for enrolling in the TENNCARE program.

The work of Condliffe and Link [17] demonstrated the effects of socio-economic status on children's health. Those children living in low SES families had illnesses that often became persistent and chronic. Access to the State Children's Health Insurance Program is critical for long-term improved health outcomes. The financial impact to the clinic with just one annual visit with the newly enrolled patients is nearly \$100,000 a year.

## Addressing Policy Issues through Advocacy

The MLP also identified policy issues that impact vulnerable Tennesseans beyond those who intersect directly with the MLP as patient/clients. The MLP partners worked together to identify such issues, catalog information about the impact on patients to demonstrate the need for policy improvement and share with appropriate agency stakeholders to address.

### Policy Issue 1:

*Children's Health Insurance Plan (CHIP) HIPAA Policy.* The state's CHIP contractor did not allow for a 3rd party to discuss an application with the agency and advocate for the child, even with appropriate authorization. However, the Health Care Finance Administration (HCFA) claimed forms used by the state would allow parents to authorize by signature a 3rd party to advocate for the child.

**ACTION:** The TJC engaged state HCFA counsel to address this issue. The state changed its policy and its contractor clarified its practice to recognize a 3rd party to advocate for a child when assigned by the parent.

**OUTCOME:** Certified Application Counselors (CAC) and other enrollment assisters and advocates now can track applications through the state system. If the coverage has not occurred in 45 days, as required by law, he/she can address the issue with program administrators directly.



**COMMUNITY HEALTH CENTERS**  
College of Nursing  
EAST TENNESSEE STATE UNIVERSITY

**Social/Medical/Legal Needs Questionnaire:**

**Income**

*Goal: Identify problems related to receiving income or benefits that effect your health  
Gather information from sliding scale.*

1	How much do you make at your job? _____ per (circle one) year / month / week / hour		
2	How many hours per week do you work? _____ How many days per week? _____		
3	If you are receiving any of the following benefits, and are having problems, please check the appropriate box.		
	a. Medicare / Medicaid / Health insurance	<input type="checkbox"/>	e. Unemployment benefits/compensation <input type="checkbox"/>
	b. Disability/Social Security	<input type="checkbox"/>	f. Child support <input type="checkbox"/>
	c. Family First	<input type="checkbox"/>	g. Pension <input type="checkbox"/>
	d. SNAP (Food Stamps) / Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/>	h. Other (please specify): <input type="checkbox"/>
	i. Not Applicable	<input type="checkbox"/>	

**Housing and Utilities**

*Goal: Identify issues related to housing that impact health*

1	Do you have any of these problems with your housing situation? You may choose none or more than one answer.		
	a. Bugs (e.g., roaches) or rodents	<input type="checkbox"/>	f. Medical condition that makes it difficult to live in current house <input type="checkbox"/>
	b. General cleanliness	<input type="checkbox"/>	g. Mold or dampness <input type="checkbox"/>
	c. Landlord disputes	<input type="checkbox"/>	h. Overcrowding <input type="checkbox"/>
	d. Lead paint	<input type="checkbox"/>	i. Threat of eviction <input type="checkbox"/>
	e. Unreliable utilities (e.g., electricity, gas, heat)	<input type="checkbox"/>	j. Other (please specify): <input type="checkbox"/>
	i. Not Applicable	<input type="checkbox"/>	
2	Are you living in section 8/public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Figure 4: Continue...



## COMMUNITY HEALTH CENTERS

### College of Nursing

EAST TENNESSEE STATE UNIVERSITY

#### Education and Employment

*Goal: Identify issues related to education or employment that impact health*

1	Do you have any of these problems with your child's education? You may choose none or more than one answer.	
	a. My child is receiving special education services and has an Individualized Education Plan (IEP), but it is not working well. For example, the IEP is not being followed, IEP doesn't address needs, or my child is being repeatedly suspended/expelled.	<input type="checkbox"/>
	b. My child is struggling in school (e.g., at risk of failing, repeatedly suspended/expelled or being held back). My child is not getting special education services.	<input type="checkbox"/>
	c. I asked for a special education evaluation ("multifactorial evaluation") to see if my child needs more help in school, but the school has not responded.	<input type="checkbox"/>
2	Do you have trouble working because of a disability or health problem?	
	a. I am unable to earn income as a result of a disability.	<input type="checkbox"/>

#### Legal Status

*Goal: Identify issues related to legal status that impact health*

1	Do you have any concerns about your family's immigration status? You may select none or more than one answer.	
	a. Do you have concerns about your family's immigration status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Are you interested in receiving resources about immigration concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### Personal and Family Stability

*Goal: Identify issues related to personal and family stability that impact health*

1	Do you have any of these problems with your family situation? You may select none or more than one answer.	
	a. Are you afraid of someone you love?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Do you have guardianship or custody issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Are you concerned about the welfare of one of your children or a child that you live with?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Other issues:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Please list the names, age, and relationship to you of people who you live with:	

#### Referral Area

*Goal: Identify issues that may not fall into the I-Help Screener and Area of Automatic referrals that impact health.*

1	Which of these areas do you need help with right away?
---	--

Figure 4: I-HELP™ Referral (Adapted ETSU English).



**COMMUNITY HEALTH CENTERS**  
**College of Nursing**  
 EAST TENNESSEE STATE UNIVERSITY

**Cuestionario de Necesarias Sociales/Médicas/Legales**

**Ingresos**

*Meta: Identificar problemas relacionados al recibir ingresos y beneficios que afectan su salud  
 Obtener información de la escala de descuento.*

1	¿Cuánto gana en su trabajo? _____ por (circule uno) año/mes/semana/hora.		
2	¿Cuántas horas trabaja por semana? _____ ¿Cuántos días por semana? _____		
3	¿Si usted esta recibiendo alguno de los siguientes beneficios, y esta teniendo problemas, por favor marque la caja apropiada.		
	a. Medicare / Medicaid / Seguro de Salud	<input type="checkbox"/>	e. Beneficio De Desempleo/Compensación <input type="checkbox"/>
	b. Incapacidad/Seguro de Salud	<input type="checkbox"/>	f. Manutención de hijos <input type="checkbox"/>
	c. Familias Primero	<input type="checkbox"/>	g. Pensión <input type="checkbox"/>
	d. SNAP (Cupones de comida)/Programa Especial de Nutrición Suplementaria Para Mujeres, Niños e Infantes( WIC)	<input type="checkbox"/>	h. Otro (por favor especifique) <input type="checkbox"/>
	i. No Aplica	<input type="checkbox"/>	

**Vivienda y Utilidades**

*Meta: Identificar asuntos relacionados a la vivienda que impactan la salud.*

1	¿Tiene usted alguno de estos problemas con su situación de su vivienda? Puede no escoger nada o puede escoger más de una respuesta.		
	a. Insectos(ejemplo: cucarachas) o roedores	<input type="checkbox"/>	f. Condición médica que le haga difícil vivir en la casa actual <input type="checkbox"/>
	b. Limpieza en general	<input type="checkbox"/>	g. Moho o humedad <input type="checkbox"/>
	c. Disputas con el arrendador	<input type="checkbox"/>	h. Sobrepoblado <input type="checkbox"/>
	d. Pintura con plomo	<input type="checkbox"/>	i. Amenaza de desalojo <input type="checkbox"/>
	e. Utilidades no confiables (ejemplo: electricidad, gas, calefacción)	<input type="checkbox"/>	j. Otro ( por favor especifique) <input type="checkbox"/>
	i. No Aplica	<input type="checkbox"/>	
2	¿Está viviendo en sección 8/vivienda pública? <input type="checkbox"/> Sí <input type="checkbox"/> No		

Figure 5: Continue...





## COMMUNITY HEALTH CENTERS

### College of Nursing

EAST TENNESSEE STATE UNIVERSITY

#### Educación y Empleo

*Meta: Identificar asuntos relacionados con la educación que impacta la salud*

- |   |   |                          |
|---|---|--------------------------|
| 1 | ¿Tiene usted alguno de estos problemas con la educación de su hijo? Puede no escoger nada o puede escoger más de una respuesta.   |                          |
|   | a. Mi hijo está recibiendo servicios de educación especial y tiene un Plan de Educación Individualizado (PEI), pero no está funcionando bien. Por ejemplo, el PEI no se está siguiendo, PEI no aborda las necesidades, o mi hijo está siendo repetidamente suspendido– expulsado. | <input type="checkbox"/> |
|   | b. Mi hijo está luchando en la escuela (ejemplo: en riesgo de fracasar, suspendido-expulsado repetidamente o retenido. Mi hijo no recibe servicios de educación especial.   | <input type="checkbox"/> |
|   | c. He pedido una evaluación especial de educación ("evaluación de multifactores") para ver si mi hijo necesita más ayuda en la escuela, pero la escuela no ha respondido.   | <input type="checkbox"/> |
| 2 | ¿Tiene usted problemas trabajando por causa de una incapacidad o problema de salud?   |                          |
|   | a. Yo soy incapaz de ganar ingresos como resultado de una incapacidad.  | <input type="checkbox"/> |

#### Estado Legal

*Meta: Identificar asuntos relacionados con el estado legal que puede impactar la salud*

- |   |   |   |
|---|---|---|
| 1 | ¿Tiene usted algunas preocupaciones acerca del estado migratorio de su familia? Puede no escoger nada o puede escoger más de una respuesta. |   |
|   | a. ¿Tiene usted preocupaciones acerca del estado migratorio de su familia?  | <input type="checkbox"/> Sí <input type="checkbox"/> No |
|   | b. ¿Está interesado en recibir recursos sobre preocupaciones migratorias?   | <input type="checkbox"/> Sí <input type="checkbox"/> No |

#### Estabilidad Personal y Familiar

*Meta: Identificar asuntos relacionados a la estabilidad personal y familiar que impactan la salud*

- |   |   |   |
|---|---|---|
| 1 | ¿Tiene alguno de estos problemas con su situación familiar? Puede no escoger nada o puede escoger más de una respuesta. |   |
|   | a. ¿Usted le tiene miedo a alguien que usted ama?   | <input type="checkbox"/> Sí <input type="checkbox"/> No |
|   | b. ¿Tiene usted problemas de guardianes o custodia?   | <input type="checkbox"/> Sí <input type="checkbox"/> No |
|   | c. ¿Le preocupa el bienestar de uno de sus hijos o el de un niño con el que usted vive?                                 | <input type="checkbox"/> Sí <input type="checkbox"/> No |
|   | d. Otros asuntos:   | <input type="checkbox"/> Sí <input type="checkbox"/> No |
| 2 | Por favor enumere los nombres, edades y relación de las personas con las que usted vive:                                |   |

#### Área de Referencia

*Meta: Identificar asuntos que no estén dentro de la prueba I-Help y el Área Automática de referidos que impactan la salud*

- |   |   |
|---|---|
| 1 | ¿ En cuál de estas áreas necesita ayuda inmediatamente? |
|---|---|

Figure 5: I-HELP™ (Adapted ETSU Spanish).



## Policy Issue 2:

**Prenatal Care.** Prenatal care for uninsured pregnant women was available at Community Health Centers across the state but the necessary care was not being delivered due to the laborious enrollment process.

**ACTION:** A data collection process was developed by the CAC, to clarify the issue. The data was collected from 26 community health centers across the state to verify if the enrollment process and time from enrollment to approval was preventing access to prenatal care. The data was collected from 99 CACs and authenticated the issue. The evidence was shared with the Tennessee Department of Health and the CHIP program administrators for review by the TJC.

**OUTCOME:** Presumptive eligibility is now established for uninsured pregnant women to receive CHIP coverage that provides immediate access to paid prenatal care ([Tennessee Presumptive Pregnancy](#)).

## Policy Issue 3:

**Access to appropriate language consent forms.** The state's Medicaid program, TennCare, only provided consent forms in the English language on-line. The process to receive the form in a separate language required the individual to write a letter to the state and request the form in their language to be sent to them. This process was inefficient and untimely.

**ACTION:** The CHC CAC, contacted TennCare to express the imperative need for multilingual downloadable forms to be available on the state's website.

**OUTCOME:** Forms were placed online which eradicated barriers that were created by the lack of multilingual consent forms.

## Discussion

Wagnerman, Chester, and Alker [18] research on the linkage between accesses to healthcare coverage for pregnant women results in better health outcomes in adulthood for their children. The results were dramatic for decrease in hospitalizations for health-related endocrine, metabolic, nutritional, and immunity disorders. Their observations when limited to just diabetes and obesity hospitalizations demonstrated greater than 9% reduction. Other areas impacted by access to health insurance by children included decreased healthcare utilization as an adult, decreased self-reported disability and early mortality. The other social determinant of health that having insurance as a child education; college education is a higher probability. The high costs of healthcare are spared by those with state supported health insurance for children. The families are more economically secure and less likely to be affected by financial issues. The myth that children on state supported insurance programs will go on to have children to continue these programs was dispelled by Wagnerman, Chester, and Alker. Their research suggests these children become self-sufficient as adults and the government recoups 56 cents of each dollar spent for health care insurance. Through the nurse-led MLP 450 children and 168 uninsured adults received health insurance.

The nurse-led MLP has impacted not only patient lives at JCCHC but changed policy across the state that has impacted thousands. Access to healthcare matters. Addressing this one social determinant of health assists healthcare providers and patient advocate to identify other social determinants of health impacting the lives patients and

their families. While the focus of TJC is on health insurance, JCCHC is now working to partner with other legal services to address issues such as immigration, housing, domestic abuse, economic disparities, and other social determinants that prevent the community from healthy living.

## Competing Interests

The authors declare that no competing interests exist.

## Author's Contributions

Patricia M Vanhook: Primary author, data gathering, paper organization, paper submission.

Trish Aniol: Data, forms, processes, and knowledge of MLP growth.

John Orzechowski: TJC facts, verification of information, data, and editing.

Grace Titilayo Babalola: Literature review and assistance with writing abstract and introduction.

## References

1. Family Practice & Counseling Network, FPCN, Legal Clinic for the Disabled, LCD & National Nursing Centers Consortium, NNCC (2016). Addressing Civil Legal Needs as Part of Nurse-Led Care.
2. Cohen E, Fullerton DF, Retkin R, Weintraub D, Tames P, et al. (2010) Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities. *J Gen Intern Med* 25: 136-139.
3. MLPB. <http://www.mlpboston.org/history>
4. Home -- National Center for Medical-Legal Partnership. (n.d.).
5. Edwards JB, Oppewal S, Logan CI (2003) Nurse-managed primary care: Outcomes of a faculty practice network. *Journal of American Academy of Nurse Practitioners* 12: 563-569.
6. Home--Kresge Foundation. <https://kresge.org/>
7. Census.gov QuickFacts. (n.d.). <https://www.census.gov>
8. Givens M, Gennuso K, Jovaag A, Van Dijk J (2017) University of Wisconsin Population Health Institute. County Health Ranking Key Findings Report 2017.
9. Singleton K, Krause EMS (2010) Understanding culture and linguistic barriers to health literacy, Kentucky Nurse.
10. Beeson T, McAllister BD, Regenstein M (2013). Making the Case for Medical-Legal Partnerships: A Review of The Evidence. The National Center for Medical-Legal Partnership: Department of Health Policy. George Washington University.
11. Pettignano R, Caley SB, McLaren S (2012) The Health Law Partnership: Adding a Lawyer to the Health Care Team Reduces System Costs and Improves Provider Satisfaction. *J Public Health Manag Pract* 18: E1-E3.
12. American Nurses Association (ANA) (2015) Code of ethics for nurses with interpretive statements. Silver Spring, MD: Author.
13. Kenyon C, Sandel M, Silverstein M, Shakir A, Zuckerman B (2007) Revisiting the social history for child health. *Pediatrics* 120: e734-738.
14. MLP legal needs screening tool available for download. <http://medical-legalpartnership.org/screening-tool/>
15. Marple K (2015) Framing Legal Care as Health Care. Washington, DC: The National Center for Medical-Legal Partnership.
16. Shah R, Chen C, O'Rourke S, Lee M, Mohanty SA, Abraham J (2011) Evaluation of Care Management for the uninsured. *Med Care* 49: 166-171.
17. Condliffe S, Link CR (2008) The Relationship between Economic Status and Child Health: Evidence. *The American Economic Review* 98: 1605-1618.
18. Wagerman K, Chester A, Alker J (2017) Medicaid is a smart investment in children. Georgetown University Health Policy Institute: Center for Children and Families.