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What Are Epidemiological Foundations for Integrating Legal Services Into Health Care Settings?

Adrienne W. Henize, JD and Andrew F. Beck, MD, MPH

Abstract

Medical-legal partnerships vary widely in how they are structured and use data to inform service delivery. Epidemiological data on certain chronic conditions' prevalence, the incidence of potentially preventable morbidity, and health-harming legal factors also influence approaches to care. This article draws on a pediatric example of how data-driven medical care complements data-driven legal care. This article also considers medical and public health ethical frameworks to guide protected information sharing, promote optimal service delivery, and achieve the best possible medical-legal outcomes.

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Drawing on Data

Medical-legal partnerships (MLPs) address a range of social, economic, and environmental challenges by mitigating affronts to legal rights of patients and populations (eg, poor housing conditions, denial of appropriate public benefits, inadequate special education services). The effectiveness of such collaborations among medical, legal, public health, and other sectors is bolstered by the accrual and sharing of epidemiological data on health outcomes and on health-harming legal risks (eg, living in a community dense with housing code violations).¹ Here, we highlight the importance of providing data-driven medical care alongside legal care.

Cincinnati Child Health-Law Partnership

Our MLP, the Cincinnati Child Health-Law Partnership (Child HeLP), links Cincinnati Children's pediatric primary care centers and the Legal Aid Society of Greater Cincinnati.² The founding of Child HeLP in 2008 was formalized through a memorandum of understanding. Child HeLP currently encompasses 3 pediatric primary care centers serving roughly 30 000 children, the majority of whom are low income and insured by Medicaid. Attorneys and paralegals are on-site at the largest of these clinics.

At these centers, pediatric patients and their families are universally screened for social and legal risks (eg, housing instability, food insecurity) during clinic visits. Clinicians refer

patients for legal advocacy when risks are identified. At the same time, parents or guardians sign waivers enabling bidirectional sharing of patient- or family-level data by medical and legal partners. This agreement allows medical and legal partners to discuss pertinent information with one another. For example, the medical partner could relay to the legal partner that a child has a diagnosis like asthma, a condition known to be **influenced by housing conditions**.³ Following placement of the referral order by the medical team, legal aid attorneys or paralegals meet with the family (in person or via phone follow-up) to determine the optimal course of action. If there are questions or updates pertaining to the case, and upon case resolution, the legal partner shares information with the medical partner. The Child HeLP management team, comprising both medical and legal partners, closely tracks referral numbers, case types, and outcomes.^{1,4} This team also identifies opportunities for system-level advocacy (eg, influencing city- or state-level policy) that emerge from patterns recognizable in patient-level data.^{5,6}

Child HeLP relies on collaborative approaches to measurement and data sharing between organizations. Yet as protected patient- and population-level medical and legal information changes hands, very real ethical considerations emerge about how and when to share what data and with whom. In what follows, we ground our argument about the importance of data-driven medical and legal care in a recent case of multiple patients, all living in the same apartment complex with various housing concerns. We examine this case—and the cross-sector collaboration and data sharing that enabled its resolution—using both medical and public health ethical frameworks that show how care and data sharing can be extended from patient to population and then refocused on the patient.

A Case of Health-Harming Housing

In 2018, a Delaware limited-liability company acquired a 976-unit apartment complex in Cincinnati, and, after 4 years of disinvestment, widespread disrepair posed a serious threat to tenants' health. Tenants were living with water damage, mold, blocked sewer lines, hazardous wiring, and pest infestations. A fire in November 2022, followed by failure to routinely winterize plumbing, resulted in the flooding of dozens of units. Water was shut off multiple times during the winter. The City of Cincinnati issued orders to the owner to correct pervasive building, health, and fire code violations or risk legal action, but to no avail. Concurrently, tenants organized and voted to have the Legal Aid Society of Greater Cincinnati represent their interests. The City of Cincinnati Manager's Office and the Greater Cincinnati Homeless Coalition supported the development of a tenant association. A tenant leader created a Facebook Group for tenants to connect, share experiences, and get updates on meetings and legal proceedings.

Upon learning of the poor conditions, widely described in local media in late 2022, the Child HeLP management team sought to join the effort. At a patient level, the management team sought to proactively identify patients and their families living within the complex and offer Child HeLP referrals. Accordingly, Cincinnati Children's team members queried the electronic health record for pediatric primary care patients with an address within the apartment complex. Members of the clinical team then pursued outreach at clinic visits, by phone, or in person. When clinical team members made contact, they asked tenants if their children were sick, if they were experiencing poor unit conditions or knew of others who were, and offered to help them connect with the Legal Aid Society or the tenant association. If families requested a connection, then waivers were signed and referrals placed. Cincinnati Children's community health

workers and community engagement specialists also attended tenant association meetings to offer support and resources.

The city filed a public nuisance lawsuit against the owner in January 2023.⁷ The tenant association was allowed to join the city's suit as an interested party. In addition to supporting tenant-patients through existing referral pathways, the Child HeLP team supported the city's litigation with population-level epidemiological data. At a population level, the city and tenant association believed that being able to describe the health impact of housing conditions on children living in the complex would enhance the case for urgent remediation and legal action. After conferring with the Cincinnati Children's compliance and privacy officer, the MLP team deemed that the benefits of sharing deidentified data in the aggregate for population-level management outweighed the risks. The primary risk was that deidentification would be incomplete, enabling families (tenants) to see themselves in shared data and potentially provoking their discomfort and compromising their trust in the care team. Because this risk was deemed sufficiently small, the Cincinnati Children's team, in response to city requests and with tenant association guidance, tabulated how many children cared for at Cincinnati Children's lived in the complex, the number of pediatric hospitalizations and emergency department visits in the preceding 2 years, and the estimated prevalence of select chronic conditions sensitive to poor housing conditions (eg, asthma).

The analysis identified approximately 200 children who had more than 450 clinical encounters between May 2021 and April 2023. These encounters included more than 40 hospitalizations and 300 emergency department visits. The most common diagnosis codes attached to encounters were diseases of the respiratory system and injuries. Using comparative citywide data available from the Cincinnati Children's electronic health record system, we were able to quantitatively demonstrate that patients living in the complex had higher incidences of hospital admissions and emergency department visits and a higher prevalence of asthma than Cincinnati youth not living in the complex. These epidemiological data were paired with data emergent from housing inspections completed by city health and building department officials prior to a scheduled June 2023 trial in order to inform ongoing litigation.

A court hearing in June 2023, before the trial was set to begin, was requested by the mortgage lender that had filed a foreclosure case against the owner in May 2023 for defaulting on the lease. This hearing resulted in the establishment of new management via appointment of a receiver as temporary property manager to collect rents and oversee repairs. The trial was continued to allow the receiver to follow through on these responsibilities, and the case is currently ongoing. As such, it is too soon to measure the effect of the cross-sector data sharing partnership and litigation on patient- or population-level outcomes. That said, the initiation of tangible unit- and complex-level improvements holds promise for healthier living conditions and, in turn, healthier tenants.

Ethics and Medical-Legal Collaboration

Medical-legal data sharing allowed members of both the medical and the legal team to achieve more impact than they would have had alone. Nevertheless, the case of this unhealthy apartment complex—and those who call it home—provokes questions related to how we collaborate across sectors to optimize service delivery. Overlaying clinical with contextual data can promote more informed care for patients and more efficient recognition of risk patterns across, and actions for, populations.^{8,9} Yet privileged,

protected information should be shared with caution and in alignment with legal and ethical standards,^{10,11} especially as we move our focus from patient to population, apartment unit to complex, and back again.

The American Medical Association defines **core ethical principles** related to patient care, two of which are relevant here: (1) “a physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient”; and (2) “a physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.”¹² Pursuant to these principles, patient-level data are shared with consent when in the “best interests of the patient”—and deidentified population-level data are shared when consent is difficult to obtain but sharing is anticipated to benefit patients in the aggregate (eg, when hundreds of children live in a deteriorating, health-harming apartment complex).¹²

In our pediatric primary care centers, legal care is now delivered alongside medical care. Clinicians routinely ask patients about health-harming legal factors, such as adverse housing conditions. Many also identify the patient’s home community, glean insights that may prompt referral to Child HeLP.^{1,2} Should a family consent to a referral to Child HeLP, they sign the 2 aforementioned consents: one authorizes the sharing of protected health information with the Legal Aid Society of Greater Cincinnati, and the second allows the sharing of legal information with Cincinnati Children’s. These releases, developed under a memorandum of understanding between Cincinnati Children’s and the Legal Aid Society, are compliant with medical and legal requirements.¹⁰ They allow the medical team to communicate with the legal team about health challenges that may be influenced by the environment (eg, asthma) and the legal team to communicate with the medical team about the family’s legal rights and legal remedies that could affect medical outcomes. Legal advocates communicate with families about those rights as well. This approach is not unlike information sharing between primary care and subspecialty practitioners insofar as it remains patient centered and problem focused, but it expands the notion of what constitutes a subspecialty practitioner. Patient-level data sharing, with consent, facilitates effective mitigation of both medical and legal risk.^{2,4}

Public health ethics are similarly instructive for mitigating medical and legal risk, especially as population-level data is bidirectionally shared—clusters of respiratory disease are shared with legal (and public health) partners and clusters of substandard housing conditions with medical partners. Kass explicitly argues that “an appropriate, if not obligatory,” function of public health is to reduce social ills.¹³ As such, we believe it is an ethical requirement to act to mitigate harmful effects of certain situations (eg, a health-harming apartment complex). We also believe it is a duty to share data, to work across sectors to improve health and overcome injustice,¹⁴ and to ensure that those whose data are shared are guiding data uses in meaningful ways. Community “power,” epitomized by the tenant association’s data requests and advocacy, ensures that data and interventions are community centered, community shaped, and **community driven**.^{15,16} As clinicians and public health professionals consider their duty to act and the benefits of acting, they must acknowledge potential risks. True deidentification may not be possible when data emerge from small, insular populations.

Relatedly, the concept of a public health emergency, defined as “an occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property

resulting from a natural phenomenon or human act,”¹⁷ can be instructive when confronted by an epidemic of substandard housing driven by the “human act” of property neglect. There are formal requirements for governmental agencies to pursue public health emergency declarations. Such declarations can lead to funding for public health action. They also can spur cross-sector data sharing. And evidence suggests that population-level, cross-sector data sharing can guide collaborative action during public health emergencies, no matter the pathogen.¹⁸

Conclusion

There is a strong epidemiological and ethical basis for cross-sector collaboration and data sharing. We suggest that patient-level data sharing, with appropriate guardrails, enables patient-level action that is more proactive and tailored to a specific harm (eg, legal advocacy to address a patient’s health-harming housing). We also suggest that population-level data sharing that minimizes the potential for identification of an individual and that is guided by the population in question enables population-level action that can more effectively target risk patterns that are otherwise invisible or easily ignored (eg, a cluster of public health-harming housing conditions). All of us clinicians collectively seek optimal service delivery and medical outcomes. We are most likely to achieve such optimization through collaboration—with consistent connections among clinical teams, legal advocates, municipal stakeholders, and, most importantly, affected community members.

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Adrienne W. Henize, JD is an associate professor of pediatrics. She is the program manager for the Cincinnati Child Health-Law Partnership and oversees several additional clinical-community partnerships central to Cincinnati Children’s Hospital’s commitment to the pursuit of health equity.

Andrew F. Beck, MD, MPH is a professor of pediatrics and a director of population health and health equity research and innovation. He serves on the management team for the Cincinnati Child Health-Law Partnership. He practices clinically as a primary care and hospitalist pediatrician.

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Conflict of Interest Disclosure

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