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# Patient Referral Failures

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ABSTRACT

Coordinated, interdisciplinary care shows immense promise to address seemingly intractable health disparities caused by social inequities.However, these efforts to integrate the health and social care systems face significant challenges in successfully connecting patients to the providers of non-clinical services. These missed opportunities to link patients with non-clinical services result in worse health outcomes, as they leave unaddressed the social determinants that adversely impact patients' health. Referral failures are so commonplace as to be expected—especially for medically and socially vulnerable populations—but they are not inevitable.This Essay explores the causes of and solutions to referral failures by presenting novel empirical research on referral failures in medical-legal partnerships and situating those findings within the broader context of programs that integrate health and other social services. Emerging from this work are strategies for reducing the number of patients who fall through the cracks when referred for legal and social services so that thesebeneficial programs can provide help to those most in need.

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## INTRODUCTION

Payment models that reward improved health outcomes have led many health care providers to embrace care delivery models that integrate services across the health care spectrum. In recent years, these efforts haveexpanded beyond coordinating clinical care to address the social determinants of health, or the social, economic, and environmental factors that significantly impact health by shaping how patients live, work, play, and learn.[1]

Despite their immense promise, programs that coordinate health and social services face persistent challenges that researchers have not adequately studied. One such challenge is high levels of referral failures resulting from patients not receiving the social, legal, and behavioral healthcare services recommended by their health care provider.[2] These missed opportunities to connect patients with non-clinical services result in worse health outcomes, as they leave unaddressed the social determinants that adversely impact patients' health.

With a growing number of health care providers referring their patients for social, legal, and behavioral health services (which we refer to collectively as "social services"[3]), understanding how to optimize this

1. *See* Laura Gottlieb, Megan Sandel, & Nancy E. Adler, *Collecting and Applying Data on Social Determinants of Health in Health Care Settings*, 173 JAMA INTERNAL MED. 1017 (2013).

2. *See infra* notes 23-25 (summarizing studies showing high rates of referral failures).

3. The literature occasionally will refer to this grouping of services as "human services."

referral process takes on increasing importance. Unfortunately, existing research gives scant attention to the causes of referral failures and strategies for overcoming the problem. Using medical legal partnerships as a case study, this Essay fills this void by providing insights on referral failures thathealth care providers and their social services partners can use to increase the number of patients accessing needed resources.

This Essay proceeds in four parts. Part I discusses the growth in health care providers screening for social risk factors and referring patientsto organizations in the social services sector. It explains that despite the immense promise of integrating medical and social care, health care providers who do so report that patients referred for social services often donot utilize the services. Part II presents the results of novel empirical research based on qualitative interviews with 31 medical-legal partnership (MLP) professionals about common challenges in providing MLP services, including referral failures.[4] Specifically, this Part identifies the common causes of referral failures and solutions for reducing referral failure rates in the MLP context that emerged during these interviews. Part III considers the implications of these findings beyond the MLP context, including strategies for generally increasing the number of patients who benefit from recommended social services. Finally, Part IV explains the need for additional research on referral failures that explores the patient perspectiveand applies theories of behavioral change. Combined, these insights will make care coordination programs that serve socioeconomically disadvantaged individuals more effective at improving patients' health andreducing health disparities.

## I. INTEGRATED CARE AND REFERRAL FAILURES

Although access to medical care and an individual's genetic predisposition are key factors impacting individuals' lifetime health and functioning,[5] of bigger consequence are the conditions in which individualslive, work, and play.[6] These social determinants of health

4. The University of Houston Institutional Review Board approved this research.

5. *See* Sandra Braunstein & Risa Lavizzo-Mourey, *How the Health and Community Development Sectors are Combining Forces to Improve Health and Well-being*, 30 HEALTH AFF. 2042, 2043 (2011); MAIA CRAWFORD ET AL., POPULATION HEALTH IN MEDICAID DELIVERY SYSTEM REFORMS 2 (2015). Experts estimate that medical care and genetics account for less than half of premature deaths with 10% of preventable deaths is attributable to shortfalls in medical care and 30% attributable to genetic predispositions. *See id.* at 2.

6. *See* Sanne Magnan, *Social Determinants of Health 101 for Health Care: Five Plus Five*, NAT'L ACAD. MED. (Oct. 9, 2017), https://nam.edu/social-determinants-of-health-101-for-health-care-five-

include income and wealth, education, social support and isolation, discrimination, community settings, and the built environment.[7] These factors directlyimpact an individual's physical or mental health as well as affect an individual's ability to access traditional medical care and follow healthy behaviors.[8] Those facing greater social disadvantage are particularly at riskof poor health.[9] Therefore, improving lifetime health and reducing health disparities cannot be achieved without improving individuals' mental healthand social and environmental conditions.[10]

Growing recognition of the strong link between health and social determinants has led to health care providers giving greater attention to thenonclinical factors that adversely impact patients' health.[11] Many health care providers now incorporate into their patient clinical encounters screening for social risk factors, such as food and income

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plus-five/ [https://perma.cc/A6BB-5P4W] (citing C.M. Hood et al, *County Health Rankings: Relationships Between Determinant Factors and Health Outcomes*, 50 AM. J. PREVENTIVE MED. 129 (2016)).

7. *Social Determinants of Health*, U.S. DEP'T OF HEALTH AND HUM. SERV., https://health.gov/healthypeople/objectives-and-data/social-determinants-health [https://perma.cc/C5S7-F99X] (last visited Jan. 4, 2022); Laura McGovern et al., *The Relative Contribution of Multiple Determinants to Health Outcomes*, HEALTH AFF.: HEALTH POL'Y BRIEF 1 (2014).

8. *See* Geoffrey R. Swain et al., *Health Care Professionals: Opportunities to Address Social Determinants of Health*, 113 WIS. MED. J. 218, 218 (2014) (describing the different types of social determinants affecting health).

9. *See* Paula Braveman, Susan Egerter & David R. Williams, *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 384 (2011) ("Evidence from decades of research examining associations between key social factors—primarily educational attainment and income in the United States and occupational grade (ranking) in Europe—and health outcomes throughout the life course overwhelmingly links greater social disadvantage with poorer health.").

10. *See* NAT'L ACAD. OF SCI., ENG'G, & MED., INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE: MOVING UPSTREAM TO IMPROVE THE NATION'S HEALTH 20 (2019) ("Improving social conditions is likely to reduce health disparities and improve the health of the overall U.S. population.").

11. *See id.* at 27 ("The consistent and compelling evidence on how social determinants shape health has led to a growing recognition throughout the health care sector that improving health and reducing health disparities is likely to depend—at least in part—on improving social conditions and decreasing social vulnerability"). This movement beyond the traditional biomedical model of care is reinforced by the shift to value-based payments that reward health care providers for improved health outcomes and lower costs further encourages. *See* Jessica Mantel, *Tackling the Social Determinants of Health: A Central Role for Providers*, 33 GA. ST. U. L. REV. 217, 239-242 (2017) (discussing various payment reforms that incentivize health care providers to address the social determinants of health).

insecurity,depression, and social isolation.[12] Health care providers may then adjust patients' clinical care based on an individual's social circumstances.[13] Increasingly, some health care providers also help their patients connect with government and community resources that can address their social riskfactors.[14] For example, health care providers may give patients information on local food banks or public assistance programs or refer patients to counselors who can assist with housing or financial issues.[15] In addition to providing information about available resources, some health care providers provide direct assistance that facilitates patients making these connections.[16] This support could include scheduling appointments with or arranging transportation to and from social services providers or helping patients enroll in Medicaid or theSupplemental Nutrition Assistance Program (SNAP).[17] These health care providers typically employ professionals trained in social care to help patients and their families bridge the health and social

12. *See* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 10, at 38 ("On the clinical side, patients visiting health care organizations are increasingly being asked to answer social risk screening questions in the context of their care and care planning."); Kare LaForge et al., *How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care*, 41 J. AMBULATORY CARE MGMT. 2, 6-7 (2018) (reporting the social risk characteristics included in screening tools develop by health organizations interviewed by the authors).

13. *See* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 10, at 41-42 (describing ways in which health care providers alter clinical care to accommodate identified social conditions, such as offering evening and weekend hours, using telehealth services, and changing drug regimens). *See also* Jessica Mantel, *Refusing to Treat Noncompliance Patients is Bad Medicine*, 39 CARDOZO L. REV. 127, 149 (2017) (explaining how health care providers can improve patient adherence by conveying information in a manner consistent with a patient's health literacy, intensive patient education interventions, and simplified medication regimens).

14. *See* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 10, at 44.

15. *See id.*

16. *See id.*

17. *See id.* Increasingly, health care providers are targeting the social determinants of health through what the National Academies of Sciences, Engineering, and Medicine refers to as alignment and advocacy activities. Alignment activities "include those undertaken by health care systems to understand existing social care assets in the community, organize them in such a way as to encourage synergy among the various activities, and invest in and deploy them to prevent emerging social needs and improve health outcomes." *Id.* at 47. Advocacy activities involve health care organizations working with social care organizations "to promote policies that facilitate the creation and redeployment of assets or resources in order to improve health outcomes and prevent emergence of unmet social needs." *Id.*

services systems, such as social workers, community health workers, and patient navigators.[18]

Emerging evidence suggests that efforts to integrate health and social services can increase patient satisfaction and well-being, improve health outcomes, and lower health care spending, particularly among disadvantaged populations.[19] Nevertheless, studies of integrated care delivery models have found mixed results.[20] These conflicting findings suggest that more successful integrated care models include

18. *See id.* at 46. The literature has not yet settled on consistent definitions of the terms "community health worker" and "patient navigators," but we use the terms as defined by the American Public Health Association:

> A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

*Community Health Workers,* AM. PUB. HEALTH ASS'N, https://www.apha.org/apha-communities/member-sections/community-health-workers [https://perma.cc/QYE8-JKCQ]. "The [patient] navigator helps guide the patient through the healthcare system and works to overcome obstacles that are in the way of the patient receiving the care and treatment they require." *Patient Navigator*, CAREERS IN PUB. HEALTH, https://www.careersinpublichealth.net/careers/patient-navigator/ [https://perma.cc/MMN8-5PYY].

19. *See, e.g.*, C. Annette DuBard, *Savings Impact of Community Care of North Carolina: A Review of the Evidence*, CMTY. CARE OF N.C. DATA BRIEF 11 (2017) https://nciom.org/wp-content/uploads/2018/04/CCNC-Primer-FINAL-4-26-18.pdf [https://perma.cc/E7UR-VVKE] (among patients participating in Community Care of North Carolina, finding substantial reductions in inpatient utilization and annualized per-beneficiary net savings for Medicare and Medicaid of approximately $3 for every $1 invested); Craig Jones et al., *Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care,* 19 POP. HEALTH MGMT. 196 (2019) (reporting a reduction in health care expenditures and utilization and improved outcomes for participants in Vermont's patient-centered medical home program); NADEREH POURAT, ET AL., INTERIM EVALUATION OF CALIFORNIA'S WHOLE PERSON CARE (WPC) PROGRAM 27-34 (2019) (finding that California's Whole Person Care program improved care coordination, care processes, and some health outcomes); Dahai Yue et al., *Enabling Services Improve Access to Care, Preventive Services, and Satisfaction Among Health Center Patients,* 38 HEALTH AFF. 1471 (2019) (finding that services that address barriers to access and the social determinants of health led to improvements in patients' use of primary and preventive care and higher levels of patient satisfaction).

20. Caroline Fichtenberg et al., *Health and Human Services Integration: Generating Sustained Health and Equity Improvements*, 39 HEALTH AFF. 567, 569 (2020) (summarizing the evidence on impacts of integrating health and social services and stating that "[s]ome studies have

programmatic features and processes that lead to greater advances in patients' health and well-being. Researchers, however, have not fully explored the challenges facing health care providers who integrate health and social care and how they can overcome these challenges.[21]

One implementation challenge facing all integrated care programs is ensuring that patients referred for social services successfully connect with the social services provider. Some patients referred to social service providers do not receive the recommended service—an outcome we refer to as a "referral failure." Specifically, a referral failure occurs when the patient declines the recommended service, never connects with the social service provider, or connects with the social service provider but either does not receive the recommended service or fails to follow-through with the service to completion.[22]

Significant referral failure rates undermine health care providers' efforts to link their patients to social services that promote better health and well-being. Unfortunately, few published evaluations of integrated health and social services delivery models assess the extent to which patients access or utilize recommended services.[23] Studies that do report referral outcomes, however, suggest that high referral failure rates are common. For example, a 2017 systemic review of studies evaluating social prescribing by general practitioners in the United Kingdom identified three studies that examined referral outcomes, with all three studies reporting that fewer than half of referred patients "attended a prescribed activity/service."[24] Similarly, a systemic review of U.S. studies on social and medical care integration in the primary care setting found reported success rates for "community resource

documented improved health outcomes and cost reductions, but other studies did not find anticipated health or health care benefits").

21. *See id.* at 568 (noting that there is little published evidence on whether, when, and how integration of health and social services works, and that "key challenges faced by implementation efforts . . . have not yet been fully explored").

22. Health professionals also consider a physician's failure to refer a patient to needed services or referring patient for inappropriate services a form of referral failure. *See, e.g.*, David T. Nash & J. Thomas Arno, *Physician Referral Failure,* N.Y. ST. J. MED. 76(1) (1976) (highlighting the failure of physicians to refer patients to appropriate home care services). For purposes of this article, however, we do not include these referral problems in our definition of "referral failures."

23. *See* Kevin P. Fiori et al., *Integrating Social Needs Screening and Community Health Workers in Primary Care: The Community Linkage to Care Program*, 59 CLINICAL PEDIATRICS 547, 551 (2020) (reporting that two systemic reviews of programs in the United States and United Kingdom "observed a dearth of studies reporting referral outcomes").

24. *See id.* at 551 (stating that a systemic review of United Kingdom practices found 3 studies that reported whether a patient attended a prescribed service/activity, and that these results ranged from 42% to 48%).

enrollment or contact" ranging from 32% to 64%.[25] Other studies also report high rates of referral failures.[26]

Referral failures result in missed opportunities to connect patients tosocial services that can improve their health. If efforts to integrate health and social services are to succeed, we must better understand why patientsfall through the cracks and how to mitigate the causes of referral failures. To help advance stakeholders' understanding of this issue, in Part II we present the results of empirical research on referral failures in the medical-legal partnership context.

## II. AN EMPIRICAL STUDY OF MEDICAL-LEGAL PARTNERSHIPS

Some of the social determinants that adversely impact health have legal underpinnings.[27] Landlords who provide substandard housing may bein violation of local housing standards, domestic abuse victims may need protective court orders, or individuals denied coverage for needed medical care may need assistance with their appeals.[28] Yet members of vulnerable populations may be unaware of their legal rights or unable to secure legal assistance to address their health-harming legal needs (HHLNs).[29]

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25. *See id.*

26. *See, e.g.*, Annie L. Nguyen, *A Clinic-Based Pilot Intervention to Enhance Diabetes Management for Elderly Hispanic Patients*, 8 J. HEALTH ENV'T EDUC. 1 (2016) (reporting that half of the patients requesting referrals to community resources contacted their given referrals); Omolara T. Uwemedimo & Hanna May, *Disparities in Utilization of Social Determinants Among Children in Immigrant Families*, 6 FRONTIERS IN PEDIATRICS 1, 4 (2018) (reporting that among immigrant patient-families who accepted patient navigator assistance for referrals, less than one-third utilized referral resources); Fiori, *supra* note 23, at 547 (reporting that 43 percent of the patient-families in an urban pediatric referred for social services had a successful social service uptake); Paul J. Rowan et al., *Why Don't Depressed Pregnant Women Follow Through With Mental Health Referral?*, 2 J. WOMEN'S HEALTH, ISSUES & CARE 1 (2013) (summarizing studies finding very modest rates of pregnant women referred for behavioral health care making contact with a mental health care provider).

27. *See* Johnna S. Murphy, Ellen Lawton & Megan Sandel, *Legal Care as Part of Health Care: The Benefits of Medical-Legal Partnership,* 62 PEDIATRIC CLINICS N. AM. 1263 (2015).

28. *See* M. Regenstein et al., *Addressing Social Determinants of Health Through Medical-Legal Partnerships*, 37 HEALTH AFF. 378 (2018).

29. DAYNA BOWEN MATTHEW, THE LAW AS HEALER: HOW PAYING FOR MEDICAL-LEGAL PARTNERSHIPS SAVES LIVES AND MONEY 3 (2017) ("It is precisely these people and groups with the greatest social needs who are least likely to be able to access the legal services required to address them.").

> The need for MLP representation is particularly acute among the poor. Studies consistently show that low income people have

In response, over 450 health care organizations across 49 states and the District of Columbia have partnered with attorneys who support patients through legal advocacy.[30] Through these medical-legal partnerships (MLPs), attorneys counsel those who have been denied public benefits such as Social Security Disability Income (SSDI); help individuals enforce their legal rights under anti-discrimination, housing, employment, and education laws; and obtain court orders that establish guardianship or protect against abusive partners.[31] MLP attorneys also train clinicians, social workers, and other members of the medical care team to use available legal processes to address their patients' HHLNs, such as how to navigate the SSDI application and appeals process more effectively.[32]

As MLPs increase in number and popularity, the scholarly literature describing their possible structures and benefits has also grown.[33] Yet, despite a developing body of empirical literature on the health and

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> significantly more unresolved civil legal problems than higher income people, and that low income people are less likely to obtain legal assistance for their problems. As a result, 70 to 90 percent of the legal needs related to housing, family, and consumer issues that low-income families face go unaddressed."

*Id.* at 9.

30. *Home*, NAT'L CTR. MED. LEGAL P'SHIP, https://medical-legalpartnership.org/ [https://perma.cc/5T2J-74ZV] (last visited Jan. 26, 2022). These programs are also growing in popularity globally. *See* C. Andrew Eynon et al., *Medical-Legal Partnerships: 11 Years' Experience of Providing Acute Legal Advice for Critically Ill Patients and Their Families,* 21 J. INTENSIVE CARE SOC'Y 40 (2020).

31. *See Civil Legal Aid 101*, U.S. DEP'T OF JUST., https://www.justice.gov/olp/civil-legal-aid-101 [https://perma.cc/TQJ5-3H7V] (last visited Jan. 3, 2022). MLP attorneys may assist with family law and estate planning matters such as divorce, guardianship, and powers of attorney, or provide legal aid to individuals with immigration and creditor/debtor issues. *See id. See also Directory of Medical-Legal Partnership Programs,* AM. BAR ASS'N, https://www.americanbar.org/groups/probono_public_service/projects_awards/medical_legal_partnerships_pro_bono_project/directory_of_programs/ [https://perma.cc/YC65-6BGN] (last visited Jan. 3, 2022).

32. *See* Krishnamurthy B. Hagins et al., *What We Know and Need To Know About Medical- Legal Partnership*, 67 S.C. L. REV. 377, 381 (2015).

33. *See, e.g.*, Jessica Mantel and Leah Fowler, *A Qualitative Study of the Promises and Perils of Medical-Legal Partnerships,* 12 NE. L. REV 1 (2020); Jane Hyatt Thorpe et al., *Information Sharing in Medical-Legal Partnerships: Foundational Concepts and Resources,* 1 MED.-LEGAL P'SHIP FUNDAMENTALS 7 (2017). The National Center for Medical Legal Partnership has also published numerous case studies of different MLP models. *See Impact,* NAT'L CTR. MED. LEGAL P'SHIP, https://medical-legalpartnership.org/impact/ [https://perma.cc/5PMV-TNUP] (last visited Jan. 3, 2022).

financial benefits of MLPs,[34] published research has given little attention to referral failures. To fill this gap, below we present the findings of original research on the experiences of MLP professionals and their insights on referral failures.[35]

### *A. Causes of MLP Referral Failures*

Our research suggests that MLPs incur high rates of referral failures. Many of the professionals we interviewed commented that a high number of patients referred to MLPs ultimately do not receive any legal assistance or fail to follow through with legal representation. A pair of attorneys noted that their MLP experiences a "50% drop off rate between referral and actually getting a case open."[36] Other interviewees reported similar rates of referral failures.[37] In specific vulnerable

34. *See generally* Mantel & Fowler, *supra* note 33, at 52-54 (summarizing existing empirical research on MLPs).

35. We conducted 25 semi-structured qualitative interviews with 31 interviewees between November of 2018 and March of 2019. Most interviews were conducted with one interviewee, though some interviews included two or three members of the same legal or clinical teams. The research team identified several candidates for interviews using an advertisement in the National Center for Medical Legal Partnership bi-monthly newsletter. The remaining were identified using snowball sampling of contacts from interviews or through professional networks. The Institutional Review Board approved recruitment methods and scripts. The interviewers obtained written informed consent from all interviewees, who were assured responses would remain anonymous.

    Interviewees included MLP-affiliated professionals currently working as attorneys, social workers, care coordinators, program administrators, and clinicians for their partnerships. Some interviewees self-identified as performing multiple functions (e.g., an MLP program administrator and clinician). In those instances, interviewees were categorized by type of professional license (or primary practice area, in the case of multiple professional licenses). Interviewees represented diverse geographic areas, targeted patient populations, and partnership structures.

    Interviews lasted approximately one hour and were conducted by either one or both authors. Questions probed operational processes, governance, and barriers to integration of and communication among medical and legal services providers, focusing on the challenges experienced by MLP professionals and solutions for overcoming them. Interviews were audio-recorded, transcribed verbatim, and analyzed using MAXQDA software. A code book was developed collaboratively by the co-investigators, both of whom completed two rounds of coding of a subset of interview transcripts before reaching consensus about the "fit" of codes to the data. Transcripts were analyzed using thematic content analysis by a single investigator (LRF).

36. Qualitative interview on file with authors.

37. Additional examples of interviewees describing their rates of referral failure include the following:

    > We probably received around 140, 150 referrals . . . Those have translated probably to around 60 or 70 cases. So, a little bit over

populations, such as those with mental and behavioral health concerns, rates of referral failures often are higher. For example, an attorney serving patients being treated by behavioral medicine and addiction services observed that "60% of [patients] had a huge number of [legal] problems . . . but then [they were not] following-up, or being too paranoid to follow-up."[38]

Thematic content analysis of our interviews[39] reveals multiple causes of the high rates of referral failures in the MLP context, which we summarize in Table 1. Perhaps unsurprisingly, these causes frequently occur at the patient level due to the many challenges confronting the vulnerable populations served by MLPs. In addition, limitations imposed on the legal services provider may restrict who they can serve and the volume of cases they can accept.

Patients who screen positive for HHLNs may decline the referral to legal services because they mistrust the legal system or are intimidated by the legal process.[40] In addition, patients may fear that initiating legal action will lead to unwanted consequences. For example, patients may be reluctant to pursue a fair housing claim because they fear their landlord will terminate their lease or raise their rent, potentially leaving them homeless.[41]

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> half. Out of 357 declined referrals, 148 of those, when the MLP staff reached back out to the patient, the patient did not respond to the attempt to contact them. It may be 40-50%, depending on the quarter or the year. But what we've experienced is that number has been increasing over the last couple of years.

Qualitative interviews on file with authors.

38. Qualitative interview on file with authors.

39. *See* ELIZABETH E. TOLLY ET AL., QUALITATIVE METHODS IN PUBLIC HEALTH: A FIELD GUIDE FOR APPLIED RESEARCH 173-217 (2d ed. 2016) (describing how to conduct qualitative analysis).

40. As described by one case manager, "[o]ne barrier to representation is patient trust. Many clients are scared of lawyers and do not understand legal representation." Qualitative interview on file with authors. Another interviewee similarly commented that "[o]ne barrier [is that] families don't have [trust in] legal support. Some people can really get intimidated and scared." Qualitative interview on file with authors.

41. *See* patient navigator interview on file with the authors (discussing reasons why a patient may decline a referral for legal services). *See also* Dana Weintraub et al., *Pilot Study of Medical-Legal Partnership to Address Social and Legal Needs of Patients*, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 157, 163 (2010) (noting that "taking up legal action was perceived as too risky given potential unfavorable ramifications, particularly in of the area of housing violations and landlord issues."). An MLP patient coordinator reflected on this specific challenge by recalling a time in which a patient-client declined assistance on a housing issue:

> Right now, the housing crisis that we have here in [our geographic area] is horrible. So a lot of people sometimes don't really want to move from where they are. You have to move very far away to find

Interviewees also noted that undocumented immigrants frequently fear deportation should they pursue legal action against others.[42]

After accepting a referral for legal services, some patients subsequently do not respond to the MLP attorney's initial outreach or follow-up contacts. This often stems from patients feeling overwhelmed by other challenges in their lives, as the populations served by MLPs often struggle financially, have serious medical conditions, or face other hardships.[43] As explained by one MLP attorney:

> I have clients not show up all the time, and I think it's mainly because of the population that we serve. They're indigent, a lot of them are transient, they have much larger issues in their life, a lot of times, than a legal issue, because of financial matters. You add to that the fact that they may have a medical condition like cancer, and that makes their legal issue seem that much smaller.[44]

Patients struggling with depression or other behavioral health issues also may not follow-up with the MLP attorney. As one MLP attorney noted, "I could tell you anecdotally if someone's referred and doesn't follow-up, often it's because they're overwhelmed, they're really depressed and are struggling with following through with anything."[45]

Several interviewees cited logistical impediments to patients meeting in-person with the MLP attorney. Transportation challenges and geographic distance underlie many referral failures. One MLP attorney underscored that these challenges are significant in rural settings:

> A reason there is such a huge drop off is that so many individuals are low income They lack transportation, or they may rely on

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> affordable housing. . . . I had a few [patient-clients], I have actually one, she said, "No, it's alright [I don't want to pursue my housing issue].I mean, I don't pay too much rent. I'm already used to putting cartons in the windows.But because if they kick me out, I don't know where am I [to] go."

Interview on file with the authors.

42. *See* qualitative interview of patient navigator on file with authors (commenting that when she discusses with patients legal assistance for their immigration or housing issues, "they think, oh what happens if they kick me out?").

43. *See* qualitative interview with MLP attorney on file with authors ("If there's a higher need, they are not connecting.").

44. Qualitative interview of MLP attorney on file with authors. Another interviewee similarly commented on the difficulty connecting with patients who are suffering from depression and have stopped answering the phone. *See* qualitative interview on file with authors.

45. Qualitative interview on file with authors.

> someone to bring them. They may not have money to pay for theircab to get to our office. And then we are so rural in our MLP setting that there is a huge lack in public transportation resources out there.[46]

Similarly, patients unable to take time off from work may forego legal services for their HHLNs. As one attorney observed, "[If patients] don't have time off from [their] job to come to the doctor's [they're] not going totake the time to go to one more service . . . Even when we say, 'We'll call you. We can do this by phone,' those tend to be the folks who no-show."[47] Interviewees also reported that sometimes MLP attorneys fail to connect with a patient because the patient's contact information is no longer valid. This occurs more frequently with vulnerable populations, as they often are transient and do not have a consistent address, or their financial woes result in cell phones being turned off.[48]

Finally, some causes of referral failure stem from limitations that constrain the legal services provider. Many interviewees reported that understaffing prevents their MLP's legal team from serving all patients with HHLNs, and that they therefore must limit the number of cases they accept.[49] Moreover, understaffing can cause delays in the legal team contacting patients referredfor legal services, increasing the chance that these individuals will not follow through with legal representation. As explained by one attorney, patients should be contacted quickly while they "are still mindful, and the legal need is probably still relevant and current."[50] MLP attorneys also report that they cannot accept certain cases when they either lack the relevant legal expertise[51] or their funding

46. Qualitative interview on file with authors.

47. Qualitative interview on file with authors.

48. Qualitative interviews on file with authors ("Well, given who our clients are, once they leave, sometimes their cellphone is shut off or they didn't have, they weren't at home, so they didn't get our messages;" "[a]ll we had was the phone number. If the phone number was no good anymore, we couldn't reach them.").

49. Illustrative comments from interviewees include the following:

> Resource limitations can impact the number of cases a legal partner can take on. Lack of resources is a barrier to expanding services . . . .
>
> I don't go to sleep. This last year, I slowed down and didn't take as many cases and just provided technical assistance, because my paralegal and I literally get two to five calls and referrals a day.

Qualitative interviews on file with authors.

50. Qualitative interview on file with authors.

51. *See* qualitative interview on file with authors ("Sometimes attorneys cannot take a case because they do not have the relevant legal expertise.").

source prohibits them from serving certain individuals, such as undocumented immigrants or individuals with incomes above eligibility thresholds.[52]

*Table 1: Causes of MLP Referral Failures*

| *Point of Breakdown* | *Cause* |
|---|---|
| Patient Declines Referral to MLP Services | Patient Does Not Trust or is Fearful of the Legal System or Does Not Understand the Process of Legal Representation |
| Patient Fails to Follow-Through with the Referral | Patient Unable to Prioritize HHLN Over Competing Demands or Struggling with Mental Health Issues |
| | Patient Faces Logistical Impediments to Meeting with Attorney |
| | Attorney Unable to Contact Patient |
| | Attorney Unable to Timely Follow-Up with Referred Patient |
| Attorney Unable to Accept Referral | Attorney Cannot Meet Demand for Legal Services |
| | Attorney Lacks Relevant Legal Expertise |

52. *See* qualitative interview on file with authors ("Attorneys may not be able to represent certain kinds of cases as a result of their funding structures."). In particular, certain statutory and regulatory restrictions apply to legal services providers who receive federal funding from the Legal Services Corporation, limiting the type of cases and clients eligible for representation. *See generally* 45 C.F.R. § 1609.2(a) (prohibition on fee generating cases); 45 C.F.R. § 1626 (2021) (Restrictions on Legal Assistance to Aliens); 45 C.F.R. § 1613 (2021) (Restrictions on Legal Assistance with Respect to Criminal Proceedings); 45 C.F.R. § 1611 (2021) (Financial Eligibility).

| | |
|---|---|
| | Funding Source Constrains Cases Attorney Can Accept and Patient is Ineligible |

### *B. Reducing MLP Referral Failures*

Although no MLP can completely eliminate all referral failures, interviewees identified concrete steps that health care organizations and their legal partners can take to reduce referral failures. We summarize these steps in Table 2.

Interviewees repeatedly highlighted how active engagement from the health care organization can improve the rate of successful referrals to the MLP attorney. In particular, trusted care team members such as social workers, community health workers, and patient navigators can address patients' suspicions or fears about attorneys and the legal process. For example, a patient navigator we interviewed explained that she helps patients understand who the MLP attorney is, that at the initial meeting the attorney and patient are "only talking" so that the attorney can give legal advice, and that the attorney will not take any action without the patient's approval.[53] Health care organizations also can improve referral success rates by following-up with referred patients by phone or at subsequent medical appointments to confirm that the patient connected with the attorney and, if not, encourage them to do so.[54] Interviews further reported that when a patient is overwhelmed with other concerns or too depressed to deal with any legal issues at the moment, care team members can alert MLP attorneys of the need to step back until the client is ready for legal assistance.[55]

53. MLP interview on file with the authors ("[L]egal is not going to do nothing if you don't approve [it] to them. You [are] only talking and you [are] only getting advice.").

54. As explained by an MLP attorney,

> And one of the things we currently do is tell the referral source, "We can't reach this person, we can't contact this person." Occasionally we get a referral again because the person has come back to their primary care doctor or their specialist. Because that referral source will talk to them again about the legal issue.

MLP attorney interviews on file with the authors.

55. As explained by the patient navigator,

> [S]ometimes when you have the mentality as a [lawyer], you only thinking about what is the need, what is supposed to happen. But sometimes we kind of slow down and meet with the family. I think it's good to let the legal know that now they kind of have to step out away from the family. Sometimes I have to let them know, you know, Mom is having this emotional crisis right now. She's not ready to talk. Can you give us a little bit of time? And like

Interviewees also described ways in which a health care organization can help the MLP attorney connect with a patient. MLP attorneys have greater success connecting with referred patients when their health care partner shares multiple points of contact, such as the patient's alternative phone numbers or addresses where letters of introduction can be sent.[56] In addition, some health care organizations proactively help the MLP attorney locate patients whose addresses or phone numbers have changed.[57] Health care providers can also give patients written materials that include the MLP attorney's contact information so that the patient can directly reach out to the attorney.[58] These supportive steps make it less likely that the MLP attorney will simply close the case if unable to find the patient or the patient does not respond to the attorney's outreach.[59]

MLPs can lessen patients' mistrust of lawyers and the legal process by purposively creating the appearance that the legal services are part of the continuum of care offered by the health care organization. For example, the MLP attorney can use a phone number with the same area code and first three digits as the health care partner or the same email address, as patients are more likely to answer the phone or respond to email when they recognize the caller's phone number or

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> they understand now. Before it was like, we [were] calling [the patient], no answer.

Interview with patient navigator on file with the authors.

56. As explained by one interviewee,

> They developed different ways to try and make the contact quicker and more direct, like getting alternative phone numbers. At first we didn't get the actual written address. We just got the phone numbers. We couldn't send a letter saying, "Hey we've been trying to get in touch with you." We've ironed that out and that's increased the number of cases.

MLP attorney interview on file with the authors.

57. *See* MLP attorney interview on file with the authors ("We go back to the medical team and try to come-up with other ways to find the client and to connect with them.").

58. *See* qualitative interview on file with the authors ("We created a postcard as well. So when a patient receives a referral, or consents to a referral, they also get the phone number and the email so that they can reach out to the lawyers directly if they aren't able to connect with a call that's coming from Legal Aid lawyers.").

59. When a patient is unresponsive to the attorney's follow-up, many MLP attorneys simply close the file and move on to other matters. An attorney described this by saying, "I would love to say that every single referral that I get I make contact with, but that's absolutely not the case. How do we deal with that? I call them twice, and I leave two voice mails. If they don't call me back, I move on." Qualitative interview on file with authors.

email address.[60] Similarly, having the health care partner's schedulers call patients and schedule appointments with the MLP attorney builds on patients' familiarity with and trust in their health care provider.[61] Arranging for patients to meet with the MLP attorney at the health care partner's clinical site also increases the likelihood of patient engagement.[62] Because the clinical site is a familiar and safe space for manypatients, patients who meet with the MLP attorney on-site may be less mistrustful of or intimidated by the attorney.[63] In addition, meeting with theattorney at the clinical site may be more convenient for patients who cannoteasily travel to the attorney's office.[64] Co-locating the legal and medical services also may reduce the lag time between the referral and initial patient-attorney contact. As explained by an MLP attorney we interviewed

> [T]he attorney for the MLP needs to be onsite and to be accessible at the time a client's being interviewed [by the medical partner], so there would be less loss of clients . . . . [I]f the attorney's embedded they are there when the client, the patient, is

60. *See* MLP social worker interview on file with the authors (noting that patients are more likely to "answer the phone and be a lot more responsive" when the MLP attorney uses a phone number affiliated with the health care provider); MLP attorney interview on file withthe authors (describing how a hospital assigned the MLP attorney an email address).

61. An MLP attorney whose MLP uses the medical partner's schedulers explained the benefits of doing so as follows:

> [I]t's the same schedulers that they're used to talking to that call and schedule a legal appointment just like they would schedule a medical appointment. That has actually been one thing that's really helped with making that connection.

MLP attorney interview on file with the authors.

62. As one interviewee put it, when the MLP attorney is physically present, "the moreconnections you make, the stronger the likelihood of patient engagement and actual retention or connection to that service." MLP attorney interview on file with the authors.

63. As explained by one interviewee:

> So, because they're medical homes and they're trusted places, the attorney is able to bridge that distrust issue [ . . . ] They can drop in and they're dropping into a place thatI think feels safer to them than a legal office, [ . . . ] that was really one of the ways we're innovating and saying, "We've got a community that really distrusts legal systems. They have legal problems. What can we do to use the good feelings you've created to help them with those problems which are going to help them to be healthier people?"

Interview on file with the authors.

64. *See* qualitative interview on file with the authors ("We really believed that the [attorney's] office needed to be an elevator ride away, not a bus and a train ride away. It'd break down a lot of barriers for patients to be able to be seen.").

> interested in talking about the problem . . . . Sometimes if you don't catch them at the moment that they're ready to deal with a particular issue, then you're not going to catch them at a later point in time.[65]

Scheduling a legal consultation during a patient's next medical appointment also decreases referral failures by simplifying the process for meeting with the MLP attorney.[66] Alternatively, if the MLP attorney cannot physically be on site to meet with a patient, an interviewee suggested that the MLP attorney could consult with a patient during their medical visit via video conferencing.[67]

Finally, MLPs can take various steps to mitigate the resource limitations on the legal side that contribute to referral failures. In some MLPs, paralegals, rather than attorneys, conduct the initial outreach to referred patients, reducing the lag time between the referral and initial patient contact.[68] This also gives MLP attorneys more time to focus on substantive legal issues.[69] For MLPs that offer legal services on-site in the clinical setting, MLPs can use paralegals or law students to expand their on-site presence, making it more likely that patients will connect with the MLP the day they request a legal referral or during their next visit for clinical care.[70] MLP attorneys can also lessen the

65. Another MLP attorney similarly emphasized the importance of quickly connecting patients to legal services: "I think our experience has been trying to connect people same day in the moment, like I'm going to walk you to the lawyer's office . . . to make sure that you connect on that issue." MLP attorney interview on file with the authors.

66. One MLP attorney we interviewed emphasized this point:

> [W]e just really leaned into the processes and, as much as we can, the workflow that exists rather than making this some kind of special thing that requires and feels like, for the patient, that it's going to require a whole lot of effort.

MLP attorney interview on file with the authors.

67. *See* MLP attorney interview on file with the authors ("No, we [the MLP attorneys] did not video conference. I think that's a tactic to be considered if the lawyer is not embedded [at the clinical partner].").

68. MLP interview on file with the authors.

69. One interviewee noted that when the initial demand for legal services resulted in an unmanageable volume of referrals, her MLP hired a paralegal to contact patients. The attorney explained that "[At the beginning] everybody was a first-time client. Our attorney was overwhelmed with referrals. It was very hard for us to get out from underneath all the initial referrals, to make all those client contacts at once." MLP interview on file with the authors.

70. For example, the clinical professor for a law-school-based MLP explained that she schedules law students to be present whenever the clinic is seeing patients, as this allows for a legal services consult "as a part of the outpatient visit." MLP attorney interview on file with the authors.

time spent on inappropriate referrals by training the health care team on the types of patient issues for which the attorney can and cannot provide legal assistance.[71] In addition, MLPs can maintain a network of pro bono attorneys to whom the MLP attorney can refer cases that they are unable to accept due to competing demands, lack of relevant legal expertise, or eligibility restrictions.[72] When the funding source restricts who the MLP attorney can accept as a client, the health and legal partners can find alternative funding sources that do not impose eligibility criteria.[73] Alternatively, the health care organization can partner with additional legal services organizations that can assist those patients the legal aid partner must turn away.[74]

71. *See* MLP attorney interview on file with authors (commenting that when the MLP attorney is "getting referrals for things that aren't actually legal issues or are for areas of law that we're not able to assist on," they go back to the health care partner and do "more targeted trainings").

72. One attorney noted that "[A local law firm] also provides the hospital with some funding for my program, because the hospital gives them tons of business around health law issues. That's been a really nice partnership, and they've taken a few cases of guardianship, which I don't really do, and they do guardianship." However, she also cautioned that pro bono attorneys can also take considerable training and oversight to ensure quality. "If you're going to give a case to someone pro bono, you want to make sure the quality is good. So you supervise, and you read stuff, [ . . . ], because they don't know the content law the same way we do, because it's very nuanced. [ . . . ]" MLP attorney interview on file with authors.

73. For example, one legal aid attorney we interviewed explained that her MLP avoids eligibility restrictions by obtaining funding from third parties: "[A]ll of our funders have said, 'Do not screen for income eligibility or resources or whatever else, we want you to help our patients. We're serving them all so can you all do the same.'" MLP attorney interview on file with authors.

74. In response to a question about restrictions to representation, one physician explained that by partnering with multiple legal partners, it reduces the number of patient-clients that must be turned away based on funding restrictions. This MLP physician elaborated, stating, "That's why we have four legal partners. I think the main thing we don't take is really criminal cases because none of the civil agencies do criminal cases. We pretty much do everything else. We haven't encountered a situation yet that I know of that between the four they can't handle it." Physician interview on file with the authors.

*Table 2: Solutions that Reduce Referral Failures*

| ***Method**** | ***Causes Addressed*** |
|---|---|
| Help Patients Understand Legal Representation | Patient Does Not Trust or is Fearful of the Legal System or Does Not Understand the Process of Legal Representation |
| Communicate with Legal Team When Patient is Not in a Position to Participate in Representation | Patient Unable to Prioritize HHLN Over Competing Demands or Struggling with Mental Health Issues |
| Obtain Multiple Contact Numbers and Addresses from Patient as Part of Referral Process | Attorney Unable to Contact Patient |
| Provide Patients with Written Materials about the Referral Process and Next Steps | Attorney Unable to Contact Patient |
| Ask Patient if Connected with Attorney During Follow-Up Phone Calls or Medical Appointments | Attorney Unable to Contact Patient |

| *Method** | *Causes Addressed* |
|---|---|
| Create the Appearance of Cohesion | Patient Does Not Trust or is Fearful of the Legal System; Attorney Unable to Contact Patient |
| Attorney Meets with Patients at Clinical Site | Attorney Unable to Contact Patient; Patient Faces Logistical Impediments to Meeting with Attorney; Attorney Unable to Timely Follow-Up with Referred Patient; Patient Does Not Trust or is Fearful of the Legal System |
| Use Paralegal/Law Students to Manage Initial Outreach and/or Intake Consultation | Attorney Cannot Meet Demand for Legal Services; Attorney Unable to Timely Follow-Up with Referred Patient |
| Refer Patients to Pro Bono Attorneys | Attorney Cannot Meet Demand for Legal Services; Attorney Lacks Relevant Legal Expertise; Funding Source Constrains Cases Attorney Can Accept and Patient is Ineligible |
| Find Alternative Sources of Funding or Partner with Additional Legal Services Organizations | Funding Source Constrains Cases Attorney Can Accept and Patient is Ineligible |

## III. LESSONS FOR PROVIDER REFERRALS FOR SOCIAL SERVICES

Like other studies that have evaluated whether referred patients successfully accessed or utilized recommended services,[75] our research suggests that referral failures are an all-too-common occurrence. However, our research also found that health care organizations and their legal partners can achieve more successful referrals through targeted actions directed at the underlying causes of referral failures. These findings offer broader lessons for how care coordination programs that integrate health and other social services can improve their referral process, which we discuss below.

75. *See* Fiori et al., *supra* note 23 at 553 (citing studies finding high rates of referral failure among health care providers referring patients for social services).

### *A. Causes of Referral Failures*

During our interviews with MLP professionals on the causes of referral failures, four recurring themes emerged. First, our research suggeststhat patients' perceptions of and attitudes toward lawyers and the legal system are a primary cause of patients declining or failing to follow throughon a referral for legal services. Specifically, health and legal services providers believe that patients often are intimidated by or fearful of lawyersand the legal system, mistrust the legal process, or doubt that the MLP attorney can help them.[76] Second, interviewees identified low patient motivation due to competing life demands, depression, or other mental health issues as a key reason for referral failures.[77] Third, patients and MLPattorneys frequently fail to connect due to logistical issues such as transportation challenges, inability to take time off from work, or the patient's contact information is no longer valid.[78] Finally, referral failures may be caused by limitations that constrain who or how many patients canbe served by the MLP attorney.[79]

We believe these four themes also underlie referral failures in other contexts, and the limited research on the causes of referral failures supportsthis. Consistent with our first theme, prior research in the United Kingdomon referrals for social services identified mistrust, fear, and skepticism as primary causes of patients not accessing or utilizing recommended social services.[80] Echoing our second theme, research in

76. *See supra* note 42 and accompanying text. *See also* Weintraub, *supra* note 41.

77. *See supra* notes 37-39 and accompanying text.

78. *See supra* notes 43-44 and accompanying text. *See also* Melissa D. Klein et al., *Doctors and Lawyers Collaborating to HeLP Children – Outcomes from a Successful Partnerships Between Professions*, 24 J. HEALTH CARE POOR UNDERSERVED 1063, 1067 (commenting that logistical impediments and challenges in getting in touch with patients quickly or at all results in referral failures).

79. *See supra* notes 46-49 and accompanying text.

80. *See* Keeryn Husk et al., *What Approaches to Social Prescribing Work, for Whom, and in What Circumstances? A Realist Review*, 28 HEALTH SOC. CARE CMTY. 309, 314 (2020) (reviewing United Kingdom studies on referring patients to non-medical, community or social activities to identify programmatic themes, including "participants' perception of the reliability of the provider of the activity."); Molly Knowles et al., *Successes, Challenges, and Considerations for Integrating Referral into Food Insecurity Screening in Pediatric Settings*, 29 J. HEALTH CARE POOR & UNDERSERVED 181, 186 (2018) (identifying fears of stigmatization by government agencies as a barrier to patients accepting referral for food insecurity issues); Julia Vera Pescheny et al., *Facilitators and Barriers of Implementing and Delivering Social Prescribing Services: A Systemic Review*, 18 BMC HEALTH SERVS. RES., 2018, at 1, 10 (reviewing studies of social prescribing for general practitioners in the United Kingdom and identifying skepticism of services' potential benefit and fears of

both the United Kingdomand the United States has identified competing life demands and low patient motivation as reasons for referral failures.[81] Studies also have highlighted logistical issues similar to those reflected in our third theme as causes of referral failures.[82] Finally, one researcher flagged social services providers' limited capacity, including long waitlists and inadequate funding, as causes of referral failures.[83]

### *B. Strategies for Reducing Referral Failures*

The commonalities across our research and other studies identifying the causes of referral failures suggest that many of the solutions raised by our interviewees are generalizable to different contexts. In this subpart, weexplain how health care organizations can reduce referral failures through facilitators that support individual patients and their families, co-locating social services in the clinical setting, minimizing the time-lag between the referral and initial patient outreach, and

stigmatization or losing welfare benefits as reasons for low patient engagement).

81. Pescheny et al., *supra* note 80 (identifying "low [patient] motivation to move from contemplation to action" and "lack of confidence" as barriers to social prescribing); Arvin Garg et al., *Linking Urban Families to Community Resources in the Context of Pediatric Primary Care*, 79 PATIENT EDUC. & COUNSELING 251, 253 (2010) (finding a discrepancy between families contacting a clinic's family help desk and receipt of recommended services or enrollment in recommended community resources, and stating that the discrepancy may result from low-income families' "competing demands at home"); Fiori, *supra* note 23, at 552 (suggesting that factors associated with low patient uptake of recommended social services includes "perceived acuity of issue relative to other life events").

82. *See* Husk, *supra* note 80, at 316 ("Where public transport was necessary and there were high levels of neighborhood crime, traffic, or poorly maintained streets or lighting, individuals were less likely to engage."); Knowles et al., *supra* note 80, at 186, 188 (barriers to referrals include "frequently changing phone numbers, lapses in phone access because of inability to pay, time constraints, and avoiding answering phone calls from unfamiliar numbers"); Garg et al., *supra* note 81 ("Low income families likely face multiple barriers to accessing resources, such as . . . time constraints, childcare, and transportation issues."); Pescheny et al., *supra* note 80 (stating that a cause of low patient engagement includes "transport issues to the prescribed services"); Rowan et al., *supra* note 26, at 4 (citing distance to an acceptable mental health provider, time off from work, difficulty setting appointment time, and childcare availability as barriers to depressed pregnant women linking to mental health services).

83. Pescheny et al., *supra* note 80 ("There is a risk that available services and activities in the [social services] sector may be cut below the level of service users' needs, which could hinder the delivery of [special prescribing] services. Navigators have reported difficulties to refer service users to appropriate services and activities because of reductions in scope and long waiting lists.").

addressing constraints that limit thesocial service provider's capacity to meet all patients in need.

Our research shows that patients are more likely to connect with an MLP attorney when the referring health care organization offers patients follow-up support and navigation services. As described in Part II, professionals such as social workers, community health workers, and patient navigators can mitigate some of the obstacles to patients connecting with MLP attorneys. These facilitators typically receive training on how to convey information in a culturally sensitive manner. Furthermore, many facilitators are members of the communities they serve.[84] Many patients are therefore comfortable asking facilitators questions about social services or discussing their concerns.[85] Consequently, in the MLP context, facilitators can be very effective in addressing patient mistrust in or fear of attorneys and the legal system, as well as helping patients better understand the process of legal representation.[86] In addition, when attorneys are unable to connect with a patient, facilitators can help locate the patient or assist patients with logistical barriers such as transportation.[87] Also, given the facilitator's familiarity with a patient's personal situation, they can alert MLP attorneys of circumstances that may delay the patients' uptake of the

84. Denise O. Smith & Ashley Wennerstrom, *To Strengthen the Public Health Response to COVID-19, We Need Community Health Workers*, HEALTH AFFAIRS BLOG (May 6, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200504.336184/full/ [https://perma.cc/D8P4-23WR] ("Given their experiences and understanding of communication needs and preferences in their communities, [community health workers] can play an important role in efforts to develop and disseminate culturally sensitive health education materials."); Richard C. Boldt & Eleanor T. Chung, *Community Health Workers and Behavioral Health Care,* 23 J. HEALTH CARE L. & POL'Y 1 (2020) ("Community health workers are community members trained to facilitate interactions between the health care system, individual patients, and the communities in which they are situated."); Sarah R. Arvey & Maria E. Fernandez, *Identifying the Core Elements of Effective Community Health Worker Programs: A Research Agenda*, 102 AM. J. PUB. HEALTH 1633, 1633 (2012) ("[B]ecause most [community health workers] are members of the communities within which they work, they are assumed to delivery health messages in a culturally relevant manner."); Jayshree S. Jani et al., *Cultural Competence and Social Work Education: Moving Toward Assessment of Practice Behaviors*, 52 J. SOCIAL WORK EDUC. 311, 311 (2016) (noting that social work education teaches students to be culturally competent).

85. Avery League et al., *A Systematic Review of Medical-Legal Partnerships Serving Immigrant Communities in the United States,* 22 J. IMMIGRANT & MINORITY HEALTH 163, 172 (2020). *See also* Shannon M. Fuller et al., *Medical-Legal Partnerships to Support Continuity of Care for Immigrants Impacted by HIV: Lessons Learned from California,* 22 J. IMMIGRANT & MINORITY HEALTH 212, 213 (2020).

86. *See supra* note 50 and accompanying text.

87. *See supra* note 54 and accompanying text.

MLP referral, such as the patient dealing with competing demands or mental health issues.[88]

We believe facilitators can similarly support patients accessing other social services recommended by the health care organization, and the limited research on referral failures in other contexts supports this. This research similarly highlights the importance of health care organizations providing patients "a supportive structure" that includes one-on-one contact with facilitators.[89] As explained by one author,

> [S]takeholders believe in the importance of networks to facilitate and increase the likelihood of a successful social prescription, with the assumption that the converse would be true: patients who are simply given information about an opportunity will not necessarily take it up without some handholding. Thus, having someone to encourage or support [the patient] was considered central to successful referrals.[90]

Some researchers also emphasize that personal support from care team members can allay patients' fears or mistrust of the social care system.[91] In addition, facilitators can help patients better understand

88. *See supra* note 52 and accompanying text.

89. Pescheny et al., *supra* note 80, at 2. *See also* Uwemedimo, *supra* note 26, at 5 (finding that culturally diverse patient families "are more likely to utilize resources provided in [social determinants of health] screening programs offering navigation and follow-up support."); *supra* note 52 (author interview stating that "structured contact and regular communication between [the patient] and navigators and practice staff served as a reminder for [social prescribing], [and] encouraged a higher number of referrals."); Vivian N. Emengo et al., *Qualitative Program Evaluation of Social Determinants of Health Screening and Referral Program*, 15 PUB. LIB. SCI. ONE 1, 7 (2020) ("[P]atient navigators appeared to be instrumental to the successful implementation of the [Social Determinants of Health screening and referral] program," and they "enabled timely coordination of referrals to community-based organizations and follow ups," and "providers seeking to create successful [Social Determinants of Health] programs would do well to well [sic] employ trained navigators and integrate them into screening, referral, and follow-up phases.").

90. Husk et al., *supra* note 80 (internal citations omitted). *See also* Janet Brandling & William House, *Social Prescribing in General Practices: Adding Meaning to Medicine*, 59 BRIT. J. GEN. PRAC., 454, 454 (2009) ("[P]atients who are simply given information about an opportunity will not necessarily take it up without some hand-holding . . . . [T]he most favoured among existing schemes involves the use of a 'facilitator' . . . coupled with personal support . . . for the patient in actually taking up social opportunities.").

91. *See* Husk et al., *supra* note 80 at 314 ("Referrers had a role to play in allaying fear . . . " by, during their consultations with the patient, reassuring patients that they "would not be expected to do anything that they were not confident about doing or which made them uncomfortable."); Knowles et al., *supra* note 80, at 185–86 (explaining

the results of their social determinants screening and why they are being referred to a social services provider.[92] Other researchers also emphasize that facilitators can serve as "a bridge" between the health care organization and social services provider[93] and that regular communication between them supports more effective delivery of social services by allowing them to address challengesas they emerge.[94]

Our research on MLPs further indicates that patients referred to social services are more likely to utilize the services when they are easily accessible. As discussed in Part II(B), many of our interviewees commentedthat co-locating the MLP services in the clinical setting lowers logistical barriers to patient engagement.[95] This finding is consistent with other literature encouraging "one-stop-shopping" for patients.[96] For example, a recent study of partnerships between health care providers and financial services organizations emphasized that having the financial services professionals on-site "significantly reduced barriers to patient/client engagement and retention," as it "addressed the challenge of off-clinic-siteschedulingand access for some clients."[97] Another study similarly emphasized the importance of the social services provider's physical proximity to the patient, finding that

how patient navigation services supported patients applying for public assistance by addressing their concerns that government assistance offices would be unhelpful, disrespectful, and dehumanizing); Rowan et al., *supra* note 26, at 5 (suggesting that obstetrics practices employ someone on staff who can provide reassurances to pregnant women referred for mental health treatment).

92. Rowan et al., *supra* note 26, at 4 (suggesting that depressed pregnant women referred for mental health treatment would be more likely to seek treatment if they receive additional education about depression and depression treatment, including review of the depression screening tool).

93. Brandling & House, *supra* note 90, at 454. *See also* Rowan et al., *supra* note 26, at 5 (suggesting that obstetrics practices include on staff someone who could guide depressed pregnant patients and provide a bridge to a psychiatrist or psychologist).

94. *See* Pescheny et al., *supra* note 80, at 8 ("Regular feedback and effective communication between the navigator and service providers in the [social services] sector facilitates the implementation and delivery of SP [social prescribing] services, as it allows to react to emerging challenges and promotes shared delivery and partnership working.").

95. *See supra* note 61 (discussing co-location).

96. Dennis Hsieh, *Remodeling the Medical Home: Integrating Safety Net Services with Healthcare Delivery*, 2 L.A. PUB. INT. L.J. 16, 32–34 (2009).

97. Orly N. Bell et al., *Medical-Financial Partnerships: Cross-Sector Collaborations Between Medical and Financial Services to Improve Health*, 20 ACAD. PEDIATRICS 166, 172-73 (2020). Bell et al. found that co-locating the financial services and health care services also supported program efficiency, including ease of data sharing and providing opportunities to tailor services to the patient and health care organization's needs. *Id.* at 172.

"if the activity is accessible to the patient then they are more likely to attend."[98]

The MLP professionals we interviewed also stressed the importance of programmatic features that help minimize the time between the initial referral and subsequent outreach to the patient.[99] As described in Part II(B), co-locating the legal services at the clinical site not only makes these services more readily accessible for patients but can shorten the timebetween the referral and the MLP's initial patient contact—especially if the attorney has a regular presence on-site.[100] MLP attorneys facing significant demands on their time also commented that delegating initial patient outreach to paralegals or law students reduces the lag time between the MLP referral and initial patient contact.[101] These findings suggest that for other social services, co-locating the social service in the clinical setting or using non-professional staff to conduct initial patient outreach similarly would minimize the lag time between the referral and follow-up contact, thereby increasing the likelihood that a patient will utilize the service.

Follow-up by a patient facilitator soon after the initial referral also promotes patients connecting with the social services provider. Although none of our interviewees mentioned this factor, one interviewee emphasized the importance of contacting referred patients when they are "still mindful"of their legal issue.[102] This observation finds support in a study of social service referrals in the pediatric setting, which found higher rates of referral success when community health workers followed-up with patients within 30 days of their initial referral.[103]

Finally, our research highlights the importance of increasing social services providers' capacity to serve more patients in need. Some social service providers can augment their staff with volunteers. For example, similar to the support provided to MLPs by pro bono attorneys,[104] medical financial partnerships frequently rely on financial professionals who volunteer their time.[105] Importantly, training the health care team about which patient issues can and cannot be addressed by the social services provider lessens the time the latter spends on inappropriate

98. Husk et al., *supra* note 80, at 315–16.

99. *See supra* note 65 and accompanying text. *Cf.* Emengo et al., *supra* note 89, at 8 (reporting that participants in an SDH program "were less satisfied with the legal services referral process," citing "lack of timely contact from the legal resource team").

100. *See supra* notes 65 and 69 and accompanying text.

101. *See supra* note 70 and accompanying text.

102. *See supra* note 50 and accompanying text.

103. *See* Fiori et al., *supra* note 23, at 551.

104. *See supra* note 72 and accompanying text.

105. *See* Bell et al., *supra* note 97, at 169 (table lists examples of medical-legal partnerships that use volunteer financial advisors).

referrals.[106] More generally, however, health care providers can help the social services sector reach more individuals by supporting increased funding for social services. Some health care providers have taken steps in this direction by calling on payors to cover social services prescribed by health care providers and lobbying state and federal officials for greater public fundingof social services programs, such as SNAP and welfare benefits.[107]

## IV. REFERRAL FAILURES AND THE PATIENT PERSPECTIVE

Our research, like most research on referral failures, is based on the experiences and perceptions of the health care and social services professionals who work with vulnerable populations.[108] While the views ofprofessionals provide important insights on the issue, they paint an incomplete picture.[109] Patients themselves are a key resource for understanding and addressing referral failures because they alone can tell their own stories. They can also provide feedback on educational materials, revised workflows, and other programmatic changes designed

106. *See supra* note 50 and accompanying text.

107. *See* Press Release, Am. Med. Ass'n, AMA Urges Multifaceted Approach to Address Social Determinants of Health (Nov. 17, 2020), https://www.ama-assn.org/press-center/press-releases/ama-urges-multifaceted-approach-address-social-determinants-health [https://perma.cc/WE4A-4AEF] (reporting that the American Medical Association's House of Delegates adopted policies that address the social determinants of health as part of health insurance coverage, including that "The AMA support continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs"); Hilary Daniel et al., *Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper*, 160 ANNALS INTERNAL MED. 577 (2018), https://www.acpjournals.org/doi/full/10.7326/M17-2441?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org [https://perma.cc/J2F9-BFRL] ("The American College of Physicians supports the adequate and efficient funding of federal, state, tribal, and local agencies in their efforts to address social determinants of health, including investments in programs and social services shown to reduce health disparities."). *Cf.* Mantel, *supra* note 11, at 255 (predicting that health care providers' increased appreciation for the link between the social determinants of health and providers' success under value-based payment models will result in health care providers' calling on elected officials to increase funding for social services programs).

108. *But see* Rowan et al., *supra* note 26 (presenting the views of antepartum patients referred for mental health services that emerged during semi-structured interviews).

109. *See* David J. Knesper, *A Study of Referral Failures for Potentially Suicidal Patients: A Method of Medical Care Evaluation*, 33 HOSP. & CMTY. PSYCHIATRY 1, 52 (1982) (stating that merely quantifying the issue may highlight an area of substandard performance to the degree that it captures organizational attention and resources).

to improve the referral process.[110] This knowledge would help health care organizations and their social services partners implement more effective interventions that reduce referral failures.

Research that engages patients, such as qualitative interviews with patients referred for social services, could benefit from applying theories of behavioral change such as the Health Belief Model (HBM) or the Transtheoretical Model (TTM). HBM uses constructs that help predict why individuals facing remediable problems do or do not take action, taking into account the interplay between modifying factors (e.g., age, socioeconomics), individuals' beliefs, and cues to action.[111] For example, the construct for perceived barriers explores the factors that hamper individuals' undertaking recommended actions[112] and strategies program developers can use to overcome these barriers, including reassurance, correction of misinformation, incentives, and assistance.[113]

TTM recognizes that behavior changes, such as choosing to follow through with a referral to social services, typically do not happen all at once but instead are a process. Specifically, TTM posits that behavioral change occurs over six stages—precontemplation, contemplation, preparation, action, maintenance, and termination.[114] Each stage is associated with processes of change and principles that support meeting individuals' unique needs and helping them move to the next stage.[115] Studies have demonstrated TTM's usefulness in improving outcomes for a broad range of health and mental health behaviors.[116] Importantly, TTM's stages paradigm may be particularly useful for programs targeting vulnerable populations, as these individuals often are not action ready and may not be well-served by traditional programs that rely on patient motivation and self-initiative.[117]

In sum, given the dearth of existing studies examining referral failures, expanding the evidence-based literature on the causes of referral failures and strategies for overcoming these challenges is of crucial importance. While our study partially fills this knowledge gap,

110. *See* NAT'L ACAD. SCI., ENG'G, & MED., *supra* note 10, at 14.

111. VICTORIA L. CHAMPION & CELETTE SUGG SKINNER, HEALTH BEHAVIOR AND HEALTH EDUCATION: THEORY, RESEARCH, AND PRACTICE, CHAPTER 3: THE HEALTH BELIEF MODEL, 49 (Karen Glanz et al. eds., 4th ed. 2008).

112. *Id.* at 46–47.

113. *Id.* at 48.

114. James O. Prochaska & Wayne F. Velicer, *The Transtheoretical Model of Health Behavior Change*, 12 AM. J. HEALTH PROMOTION 38, 38 (1997).

115. *Id.*

116. *Id.*

117. *Id.* at 45 ("We simply cannot treat people with a precontemplation profile as if they were ready for action interventions and expect them to stay in treatment . . . [t]hose in precontemplation are more likely to need dropout prevention strategies.").

research that includes the patient perspective and applies theories on behavior changes would promote a deeper understanding of the problem and additional solutions.

## CONCLUSION

Health care delivery models that integrate health and social services will not live-up to their promise if patients do not utilize recommended social services. Unfortunately, vulnerable patients often fall through the cracks and fail to connect with social services providers, resulting in missed opportunities to address the social, legal, and behavioral challenges that adversely impact their health and well-being. These referral failures are so commonplace that many health care providers and their social services partners consider them a normal part of any program that integrates health and social services. This Essay, however, shows that while referral failures are common, they are not inevitable.

The insights of MLP professionals presented in this Essay promote a better understanding of breakdowns in the patient referral process not only for legal services but for other social services as well. Greater appreciation of the causes of and solutions to referral failures benefits patients, health care providers, and payors alike. Most importantly, ensuring that referred patients gain access to recommended social services helps ameliorate the social conditions contributing to poorer health and well-being. In addition, because members of vulnerable populations are most likely to benefit from these referrals, reducing referral failures reduces health disparities. Fewer referral failures also ensure that the staff time and other resources health care providers devote to integrating health and social services are being put to efficient use. Finally, connecting patients with resources that improve their social conditions improves the overall health of the U.S. population, which in turn lowers health care spending and improves productivity. In sum, reducing referral failures will translate into significant benefits for everyone.