

# WHOLE HEALTH: A COMMUNITY APPROACH TO HEALTHCARE

## KEYNOTE SPEAKERS:

PROFESSOR LARRY VAN HORN, *VANDERBILT UNIVERSITY*  
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PROFESSOR LEAH R. FOWLER, *HEALTH LAW AND POLICY*  
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[edited for reading]

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**Professor Farringer:** Hi, I'm Debbie Farringer, I'm a professor here at Belmont, and I'm the director of Health Law Studies, and I wanted to say first thank you so much for coming to our 3<sup>rd</sup> annual Belmont Health Law Journal Symposium. We are really excited to have everyone here. I wanted to say a quick thank you, first off to the Belmont Health Law Journal staff who have worked tirelessly to put this together today. Our Editor and Chief Bill FitzGerald, our Symposium Director Tanner Yancy our Managing Editor Nikki Caruso and our Symposium Team have worked countless hours to put all of this together, and I am very, very grateful for all of their work. I also want to thank our sponsors today. We have our segment sponsors Gideon, Cooper, & Essary, Bass, Berry & Sims, and Baker Donelson. Our lunch today is going to be hosted by Waller, Lansden, Dortch, & Davis. And then our platinum sponsor here is Sherrard, Roe, Voigt, & Harbison. We are very excited that they have decided to partner with us on the Symposium today. And to that end, I'm going to introduce Mark Ison, who is going to introduce our first speaker. Mark is from Sherrard, Roe.

**Mark Ison:** Thank you. Thank you also to the Belmont Health Law Journal for all of your work in putting this together. Mr. FitzGerald, you're in charge of this illustrious gathering?

**Bill Fitzgerald:** I am. [Laughter]

**Mark Ison:** Thank you very much, and we really look forward to all that we have to learn today. It falls to me to introduce our first speaker, and I apologize for using notes but when you have a speaker as illustrious as Professor Van Horn here you should probably say a few nice things about him.

He is a renowned expert in research on health care management and economics, currently an Associate Professor of Management and the Executive Director of Health Affairs at Vanderbilt University's Owen Graduate School of Management. He is the Founder and Co-Director of the Center for Health Care Market Innovation at Vanderbilt and is also the Co-Director of the Nashville Health Care Council. He holds an MPH and MBA from the University of Rochester and a Ph.D. from The Wharton School at the University of Pennsylvania. He has been honored by the U.S.

Department of Health and Human Services as a Ruth L. Kirschstein National Research Service Award Fellow. Professor Van Horn's research on health care organizations, managerial incentives in nonprofit hospitals and the conduct of managed care firms has appeared in leading publications such as the *Journal of Health Economics*, *Journal of Law and Economics*, *International Journal of Industrial Organizations*, and the *Harvard Business Review*.

Professor Van Horn's current research interests include nonprofit conduct, governance and objectives in healthcare markets, and the measurement of healthcare outcomes and productivity. And so, without further ado, I give you professor Larry Van Horn. [Applause].

**Professor Van Horn:** So, the key to happiness in life is low expectations, alright. And I'll be, I'll try to be upbeat. I am, I occupy this narrow vision to be a motivational speaker. And I own that space, but I'm an economist, so I see the world through a very particular lens. I do a little work with the law school, I'm currently employed there, and I actually have a paper<sup>1</sup>, for those of you that are so inclined, that came out this month in the Stanford Law Review on the impact of apology laws on malpractice liability in the United States. So, if that's your space, I have a great paper that just came out this month. So, I wasn't told what my homework assignment was I guess I can talk about anything and everything that keeps me awake at night or makes me look badass. Getting the topic of the day on the social determinants of health and wellness, I thought it is worthwhile to add a few comments there.

Before I get to that though, everything I say from this point forward in no way shape or form reflects the official views of anybody or organizations of which I'm affiliated, including the dear Vanderbilt University or I sit on a number of public company boards. They aren't responsible for what comes out of my mouth either. This is just Larry unchained, giving you his perspectives on things.

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<sup>1</sup> Benjamin J. McMichael, R. Lawrence Van Horn, W. Kip Viscusi, "Sorry" Is Never Enough: How State Apology Laws Fail to Reduce Medical Malpractice Liability Risk, 71 *Stan. L. Rev.* 341 (2019).

The topic of social determinants is so massively important. Unfortunately, ninety percent of what determines healthcare has nothing to do with medical care. We spend 3.6 trillion dollars a year, and we are impoverishing America. Ninety percent of it is the environment. The decisions we make day in and day out. Behavior, genetics. It's all those things which are so fundamentally important. And yet we spend all of our time talking about medical care in this country. On top of it, if you look at the United States health care spending and put it in context with other countries. You know we always say, the U.S. health care spending is so anomalous compared to other OECD wealthy countries, and we are overrent. That is one characterization. If you add public health spending and medical care spending, and then you look at how we compare, we are right in the middle of everyone else. What we don't do is we don't invest in public health infrastructure, and public health spending. We have slighted that and shoved all of our money into restorative medical care. And that is probably a very suboptimal resource allocation. Because what we do day in and day out in terms of our social and active environment in our communities has a massive impact.

And so, a homework assignment for all of you, to take away from today, is I want you to go and look at the ted talks on YouTube by Dan Buettner<sup>2</sup> and blue zones. Dan has been here in town and done talks with me in the past. But he traveled the country, the world, supported by National Geographic, trying to find the fountain of youth. The place where people lived a really long time and what did they do. And he identified five regions, and he labeled them blue zones. And there is one in the United States; it's located in California. Where he characterized what was it about the way that people lived their lives that made them live to be over one hundred years old and be in a high functioning capacity and had great mental acuity and what was it about those communities. And it had nothing to do with access to medical care. In fact, most of these communities had very limited access to medical care. They didn't have much access to wealth either. As a byproduct of that, some of the key things that they did was they moved around a lot, they walked. They were a highly mobile group.

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<sup>2</sup> Dan Buettner, *How to live to be 100+*, TED TALKS (Sept. 2009), [https://www.ted.com/talks/dan\\_buettner\\_how\\_to\\_live\\_to\\_be\\_100](https://www.ted.com/talks/dan_buettner_how_to_live_to_be_100)

I don't do any of the things I'm talking about right now. I move too rapidly here, and I start getting moisture on my brow, it's an allergic reaction, which tells me I have to stop. They ate a largely plant-based diet. They drank red wine. In terms of community, the elderly were an essential part of the lifeline of the community, and they maintained a high degree of vitality and community connectedness throughout their lives.

So, Dan profiles this. If you look at his blue zone work they actually went and the problem that research created, this blue zone project, where they've gone around the country trying to rewire the faulty environments of communities to make them more healthy. So, it's short, it's interesting, and you should take a look at that.

You know, notwithstanding the fact that I know all of those things, I make seriously bad life decisions. I have a deep love affair with mayonnaise and Hardees. I love the Frisco Melt. And I have a very difficult time making good life decisions day in and day out. Every morning I take six prescription drugs. I take my ACE Inhibitor, my beta blocker, all those calcium channel blockers to control my hypertension because of all my seething rage. [Laughter].

I take Lipitor to inoculate myself against the consequences of my love affair with Hardees. I take my Synthroid in ways that my endocrinologist would never suggest, as a weight regulating device, speed up my metabolism, and burn it off. That way, I don't have to move too fast. Maybe even a little Celexa, an SSRI to take the edge off. [Laughter].

Here's the point. All of these things that I do day in and day out, don't really solve the underlying problem. I need to change the way I live my life. And that's a much harder proposition. And instead I take a bunch of prescription drugs that aren't going to solve my problem, and in part, it's the only way I can get my money back from my employer who involuntarily, and against my will, converted it to prepaid medical consumption. So, this is about value reclamation if you will.

At the end of the day, the real path is for all of us is to make better life decisions and allow ourselves a path in doing so. And over

the last forty years, we have absolved Americans of that responsibility. That's stress. I mean, all of the stress that we find ourselves under has a massive impact on the loneliness is as costly to your health as having high blood pressure. That stress which is entirely self-imposed by living beyond your means is just as costly as being obese in terms of your life expectancy. And if you look in 43.2% of U.S. counties between 1987 and 2007 the median life expectancy of women has declined. It has nothing to do with medical technology; it has to do with the way our society has devolved if you will.

If you look at the work of Angus Deaton, that he got a Nobel prize for. Men, white men of my demographic, are living shorter. Why? Because they are committing suicide, they have cirrhosis of the liver and a bunch of other diseases which are the result of our bad life decisions. So, this is a huge issue in our society that what we do in U.S. healthcare is we try to point to our providers and say oh population help you have to figure out a way to do something about it. I don't know that there is a business model for it. I don't know that the healthcare delivery system is the right setup to actually address any of these social ills. To me, these issues are about poverty. It's about safety in communities. It's about community attachment and engagement. These are things outside the purview of our medical industry. Yet instead of directing and investing in our community we've thrown the money over here to the healthcare and said you guys fix it. And I personally believe they are ill-equipped to do so.

Which leads us to some key facts I'm going to put out there; this is my public service announcement any time I talk. Do you guys understand how broke we are as a country? I mean it's scary broke. And that's really troublesome because in healthcare, today we have about 50% of medical care is financed by Medicare and Medicaid in the public exchanges. And yet that's predicated on governments, both state and federal, having money and having a balance sheet that can support the service delivery.

You probably are familiar with the fact that we are twenty-two trillion dollars in debt, right? We are running an 800-billion-dollar deficit this year at the federal level. Twenty-two trillion dollars is a big number, but you lose context when you're twenty-

two trillion dollars in because a trillion, a billion, a million, you change the consonant in the front and stuff comes diluted really quick. So, let me help you. A million seconds is just twelve days' worth of seconds. A billion seconds is thirty-two years' worth of seconds. A trillion seconds is thirty-two thousand years' worth of seconds. Everything we are talking about is in trillions here. And we are twenty-two trillion dollars in debt. Now, it's better to create an analogy if I take you back to a household. We are twenty-two trillion dollars in debt, and we bring in about 3.6 trillion dollars in the federal conference per year. So, this is like a household that makes \$36,000 a year, has \$220,000 on their credit card, seven times. And it's only getting worse.

If you find yourself in the uncomfortable position of being a hospital operator or sitting on the board of one, or if you have hospitals in Illinois, do you know how Illinois Medicaid pays you? IOUs. They don't pay you cash, because they are broke. And you have to wait until they float more bonds and take on more debt for you to actually get paid to pay payroll. So, we have this structural problem where so much of what we are looking towards to support our citizenry is part of the flawed balance sheet that we can't support sustainably. That keeps me awake at night. That keeps me angry. That's why I have no hair. [Laughter].

And you know, with the backdrop that healthcare is not the answer to any of these problems to start with. So, the way I like to frame it these days is we've got this conversation going in Washington is, and I don't care which side of the aisle you are on, I think everyone in this room will admit, to a degree, that Washington is a colossal hot mess, a train wreck. In all ways, shape, and form. But you've got the government through health policy pushing all kinds of initiatives, accountable care organization, population health reform. All of these are MIPS, MACRA, APM, trying to engineer changes in health care delivery. In ways that, in really speaking to Medicare and Medicaid and public exchange, which is about 140 million Americans. But all of the things they're doing, I don't think any of us would want to buy it or take it. And everybody in this room, not including the students, probably has employer-sponsored health insurance, which has about 170 million Americans with employer-sponsored health insurance.

So, on one side, we have health policy, Washington, trying to drive the debt over here but the 175 million of us who have employer-sponsored health insurance. What's driving change there? It's the changing cost to your employers. So, in 2006, in the United States, only four percent of Americans were on a high deductible healthcare savings account. There was no price sensitivity. No one was paying for anything out-of-pocket. No one cared what the price of anything was. Today in 2019, thirteen years later, thirty-three percent of Americans face a high deductible. And those deductibles are going to go up year over year as we go forward. It's not uncommon. I have friends that work at Amazon, and they have a \$9,000 deductible. I see lots of families with \$7,000 deductibles. That's the norm. That's the future. And the path of what is happening on the employer side is for everybody having more and more financial responsibility, having more out of pocket spend and whether you think that's good or not, as an economist, to me it's exactly the path we are on and exactly the path we will continue down. Because at its core, insurance is for high consequence, low probability events. What we got is a bunch of prepaid medical care. And back when I was a kid, my parents had employer-sponsored health insurance called major medical. And forty percent of the Nation's healthcare expenditures in 1970 were paid out of an individual's wallet. Today it's eleven percent. That is not an equilibrium. That being unwound. We are going to go back in the other direction.

**Professor Van Horn:** That actually, to me, gives me tremendous hope for the future of healthcare because if you ask me what the single biggest problem in U.S. healthcare is today--it's that every single price is wrong. Every price. Whether you're talking drugs, whether you're talking...every single price is completely off the rails. And that has devolved over the last 40 years. If you deliver a baby in the United States, the average cost of delivering a baby is \$10,000. The median household income in the United States is \$55,000. We're saying that to produce a human being in America cost 20% of the median household's income. Something that we have been doing since the beginning of time. That's criminal and that's an indictment of the U.S. healthcare industry. If I go see my primary care doctor at Vanderbilt, I'm gonna get an EOB explanation of benefits which is going to say they charge \$257, and \$190 is paid to the provider for what was effectively a seven-minute



visit... in the United States is about a \$20,000 a year guy. That means it's 100 bucks an hour. That means I should get 15 minutes of his time for 25 bucks. That simple. That's the way transaction is used to take....

We've created this incredibly complex, byzantine apparatus that surrounds the delivery of medical care that does nothing for value creating for any of us in this room. And that's because up until 2006, the customer of all healthcare providers were third party payers and insurers, it wasn't us. It's only as we've come back into the mix because of the increasing financial responsibility we all have, to having these doctors to having greater cost sharing, that we actually have people who care about price. That is awesome to me because it creates innovation. If I were to show you a chart, when I'm on the road on the Larry going to hell tour, on healthcare, talking about the world of healthcare, and I showed you a chart looking at how healthcare spending is changing in the United States between 1970 and 2010 there's basically no change.

Hospitals roughly the same, doctors roughly the same, pharma roughly the same, DME roughly the same. The industry has had no value added it has basically been captured by \$3.6 trillion dollars of interests who want to keep it just the way it is. In over forty years we had tremendous technological innovation, tremendous evolution of what we can do, how we can do it, and to whom. But none of that is reflected and changed in how we spend our dollar in healthcare. Because, we have had control. One of the things that excites me, is that as more and more Americans have high deductible health plans, and that money is sitting in an account, and today, let me give you some context, there's about 400 billion dollars in health savings accounts for most Americans. That's twice the size of the U.S. hotel industry. That's enormous money. And that's creating an incentive for everybody to come to the table and solve the problem of: how do I create value for someone who wants to buy something in healthcare? I don't need to go to see my doc at Vanderbilt Medical Group and wait the 17 to 25 minutes in the waiting room and go through the whole rigamaroll. I can just call Vanderbilt on Call and the nurse will come to my office.<sup>3</sup> If I'm in

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<sup>3</sup> See <https://www.vanderbilthealth.com/vhoc/>.

California, um where they've got heal.com, where you can go online and you can have a board certified physician show up at your home or office within two hours for a flat rate of \$99.<sup>4</sup> Average time is 27 minutes.

They employ logistics engineers as they do physicians. And they can do this profitably and sustainably. As you have more and more market entry trying to get a share of that 400 billion-dollar proposition, they're going to be solving our problems in ways that, our, the legacy healthcare delivery system never focused on, because they were focused on third party payers as a customer. And so that creates tremendous dynamism and tremendous opportunities in the market. It also is going to be very challenging for the existing person/board review healthcare. A lot of which is headquartered here in Nashville. Because the way they've operated and done business for the last 40 years is not going to be as impactful going forward. We don't need to be in hospitals. It's just an unfortunate reality. We've got—So much that needs to be done at hospitals can be done at AFCs or at home, or at alternative sites of care. What is the U.S. hospital industry doing in response? They're suing CMS around their site service differential, their intent to change the site service differential. They want to keep it exactly the way it is. So, these special interests want this market to stay exactly the way it is, but with this money flowing out, it creates tremendous opportunities for the money flow to go in a different direction to different providers. And I think that's a very exciting thing, something that gives me a lot of hope. The things that you should be watching that's being pressed right now, in the legal realm, one is the issue of price transparency.

Um, you heard President Trump allude to it in the State of the Union on January 1<sup>st</sup>, all healthcare providers, hospitals had to put out their prices.<sup>5</sup> They put out charge amounts which were completely useless for anybody buying medical care. But that's a step down the path of making that, that public increase the price dimension in the market. Uh more scrutiny around working with

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<sup>4</sup> See <https://heal.com/>.

<sup>5</sup> See <https://www.youtube.com/watch?v=bYj4cDmilxc> (President Trump's State of the Union address 2019).

horizontal integration, a lot of which has been expanded and pushed by the ADCA, increasing concerns about that on the anti-trust side as well. So, I think that the future is bright. I think for all of us as Americans, we have great hopes here and great opportunities. It's just that we're gonna need our industry in Nashville to pivot and reorient itself to the new evolving customer, which is us as individuals. Uh, and help us solve problems and help communicate with us in ways that we understand and allow us to buy products and services where we want to buy it at a price what we can afford. And that hasn't been the case in U.S. healthcare for forty years. Uh, so being mindful of time, I want to have-I mean I can go a lot of different directions. Are there questions, kind of things you want to chat about, or uh put on the table that you would like me to respond to uh and tell some pithy stories around? Anybody? Yes.

**Question from Audience:** I'm concerned about the impact on rural communities, so the loss of hospitals and healthcare facilities, the business model might not be working but yet that community is dramatically affected if they lose the hospital then they can't improve the industry, they can't get jobs. Other than everybody moving to the urban areas, what's a solution to healthcare in the rural areas?

**Professor Van Horn:** Yeah, so David, that, I mean to that, I worry about it. I'm going to be flying to Tooele, Utah next week to look at a hospital in the middle of nowhere. The problem we have is that no one wants to look at rural America anymore. The population ... two is that we can't get providers to go to rural America. We can't get nurses, and we can't get the volume of clinical service delivery in those communities to support enough quality care. Um, you know Life Point is one provider.<sup>6</sup> I'm hoping that Life Point can reinvent themselves with RCCH and come up with a new model of delivery. But I think unfortunately, many of these rural communities, those hospitals can't be sustained. There's no economic sustainability and quite frankly from a quality perspective, we don't want to be doing stuff there anyways. I think what we got to figure out is what is a minimal footprint that we need to have in a distributive way across rural America such that we can deliver as much care as is clinically

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<sup>6</sup> See <http://lifepointhealth.net/>.

safe and appropriate in that venue and at the same time have those feeders back in. So, Telehealth, Telecoms also can help support some of that. And then we have new delivery models here as well, uh, I don't think any of you are familiar with Contessa Health uh founded by Charlie Martin, Martin Ventures.<sup>7</sup> Um what is it? It's a hospital at home. 40 % of what's done in a hospital, they have clinical care pathways and technology to enable solutions to allow for the delivery of that in your home. Okay now take that to rural America. If you have sufficient home health, resources at play, do you need the bricks and mortar, or could you be doing a lot of these things CHF, COPD, these medical... Technological and psycho-care delivery changes that, all are mitigating against retaining those community hospitals. So what if, they're the hub of the community? So, it's not, to me it's a pretty challenging picture. Yes sir?

**Question from Audience:** So what's the role of government in helping to pivot profit mode?

**Professor Van Horn:** Um, so to me uh, and I'll reveal my bias. Yeah, everybody has bias. Everybody has, it's okay, it's part of what makes us human, let's just put it on the table. So I'm a wackjob libertarian, you know? Uh, and to me, what I want is for the government to provide a platform of information to allow markets to operate and then let that innovation come forth in the markets. I think unfortunately, one of the biggest challenges we've had in healthcare is too little innovation. And, because it's been so hard to do it. One of the things that CMS has done under Cimagis is they've been deregulating, pulling back on regulation, and allowing more flexibility and more innovation both across states and across business lines and I think that's a good thing. So what I would want the government to do is help facilitate transactions where there's gains from trade. Right now, I don't know the prices for anything, period. I would like there, I would like price transparency. Not around charge masters and inputs at the hospital, I want to know how much does it cost to see a doctor? How much to go and have an x-ray? Just getting that information out in the market, and standardizing that, I think would be helpful.

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<sup>7</sup> See <https://contessahealth.com/>

Um so, listen if you ask me, I would like to pull back on Stark Clause, which I think are really constraining in terms of our ability to affect a ration of healthcare organization and delivery. Um, people talk frequently about, hey, all the money we spent, \$500 billion on meaningful use and all the electronic health records and what not and they haven't done anything in terms of actual...in healthcare. Why? Because we, there isn't a business model to create information healthcare transmits with somebody. If all of, take your ATM, you can go anywhere in the world and use your ATM card and you can get money out. Why? Because everybody is getting paid. Your banks getting paid, outer network transaction, the other one is getting paid. In healthcare, data and information can't flow for a lot of regulatory and legal reasons. Um, that's the big friction here. It's not technological one, it's a business model flaw, and a regulatory one. So, I want to see more flexibility, pull back on some of this stuff. Let us move, let us try to figure out new ways of creating value. Uh, that's where I'm at. Okay, we got one or two more minutes. Yes sir?

**Question from Audience:** So, obviously, consumers having more information and having them buy directly from hospitals, you know with market force and pushing down prices, but isn't there something to be said for healthcare being kind of a unique product that there aren't any alternatives? Like I break my leg, I can't just like go shop around and see who can fix my leg.

**Professor Van Horn:** Well actually you can.

**Question from Audience:** Well it would be, the takeaway would be painful and take a lot of time, if it's an emergency.

**Professor Van Horn:** So, a couple things. One, is that we shouldn't talk about all healthcare being the same. Okay? Right now we talk about all healthcare as being treated through the same financing and delivery of purchase vehicle. Um, routine blocking and tacking medical care is different than chronic care is different than acute care, uh, if you have traumatic incident. All right? So, we should break those down as you get treated very differently. The majority of what we do day in and day out falls into a bucket very minimal to us making trails. Reality is, is that Americans purchase medical care, this block here, in just the way they purchase any other good and

service. And we've got companies, MDSave here in town founded by Paul Ketchel uh that is an online, think about it as Travelocity for medical care.<sup>8</sup> And they've got a bunch of individuals in California who work, who are internet purchase people. And the way people purchase medical care at MDSave is exactly the way it's purchased... The visit-revisit rates, the click-through rates, all the information and time is very similar. Um, so yes, there are certain places where healthcare is special. But there's a lot of other health we do where it is a commodity, it is something that we can increasingly commodify and all of that is a mantle to a new model of purchase, that way we purchase is not new, it's what we used to do in 1970.

Um, a final point, and I want to make sure that I don't take your time. People talk about innovation in healthcare. What I want you to think about is innovation is not gonna solve the entire problem. Innovation starts by solving a targeted problem for a subset and then we learn and diffuse, learn and diffuse. You know, I like to use the example of smartphones. We didn't end up here by having the government say, "How are we going to untether all Americans from corded landline phones with 25-foot chords in their kitchen, so you can go to the bathroom and talk to your girlfriend?" That's not how it started. It was, you saw the problem, uh, corporate executives, who had a high opportunity of cost and time, you gave them a really bad product, the 15 lbs. bag phone that had 45 minutes of life. Okay? It was only during the early targeting. And from that point, over 35 years, we've gotten to the point where everyone in this room lives on this. So, as we think about the future of healthcare and the possibilities, don't think about everything is going to be one size fits all, can be applied to all communities, all groups across all demographics and clinical medical stages and needs. We are going to solve it by solving a particular problem and then having it diffuse as we learn, and that to me is our real hope in healthcare and how we're going to solve the more official problems. So, with that, keeping it back on time, I think we're good. Alright, let's go.

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<sup>8</sup> See <https://www.mdsave.com/>.

**Nikki Caruso:** Thank you Professor Van Horn. My name is Nikki Caruso and I am a managing editor of the Belmont Health Journal, and I will be introducing you to our first academic speaker of the morning. Professor Leah R. Fowler is a research assistant professor and a research director for the Health Law and Policy Institute focusing on public health law, bioethics, and health legislation and policy. Her current research includes a grant-funded project tracking Texas municipal smoking ordinances and a project exploring barriers to the exchange of patient client information among the professionals participating in medical-legal partnership. In addition to her research, studious Professor Fowler is involved in several Health Law and Policy Institute initiatives including oversight of the Health Law Legislative Fellowship Program and development of a medical legal partnership. She is also a faculty advisor for the Health Law Organization and the Houston Journal of Health Law. Professor Folwer has coauthored papers appearing or forthcoming in *Health Matrix*, *The Journal of Law Medicine*, *Jamma Internal Medicine*, and *Theology and Science*. She has also written for the Center for Medical Ethics and Health Law Policy's blog, *Policy Wise*, where she was an editor from 2016 to 2018. She now serves as a faculty editor for the *Houston Journal of Health Law and Policy* and the Health Law Policy Institute's *Health Law Perspective*.

Prior to joining the University of Houston, Professor Fowler worked as the Health Policy program manager in the Center of Medical Ethics and Health Policy at Baylor College of Medicine, where she maintains a designation as Health Policy Scholar. Immediately after law school, she practiced law as a personal injury attorney. Professor Fowler earned her Bachelor of Science with Honors in International Health from Georgetown University and her Juris Doctor from the University of Houston Law Center. So please join me in welcoming Professor Fowler.

**Professor Fowler:** Could I have a PowerPoint? No, I'll totally click it as long as you pull it up. I hate following people who are super funny and dynamic and walk around a lot because that's just not how I would present, because I would trip and fall. Um, but I appreciate you tolerating me after that very dynamic performance. So, all of you I'm sure have used clickers before. This is my first time with this one, so depending on how it goes, we'll see. Um, thank you for the introduction, I'm Leah Fowler and like she said, I

am here from the University of Houston Law Center where I am Research Director and Research Assistant Professor of the Health Law Policy Institute.

It's 2019 so as a quick matter of housekeeping if you are on Twitter, and I imagine most if you if not all of you are, you are welcome to tweet this presentation and you can even tweet @ me or my institution and I promise I won't be distracted by you being on your phones, as long as you don't use flash or something. But that's sort of the extent of the housekeeping issues. I am here today to talk to you about law as healthcare. So why me, why am I in front of you today talking about medical-legal partnerships? First, the University of Houston is experiencing a period of tremendous growth. We are about to open a college of medicine, which is going to be very exciting and it will be focused entirely on educating primary care physicians, and that will be opening its first class in 2020. And in addition to that we will have a federally qualified health center on campus that will be a training ground for these primary care physicians and will also serve as a health resource to the Houston Community that we call home. And as part of that broader educational initiative, we're working on creating a medical-legal partnership to help serve that, so, obviously this takes up a lot of my time during the day. And on top of that I do legal research on medical-legal partnerships, and I also do social science research, which is largely what I'll be speaking about today. And that means I do qualitative empirical work, semi-structured interviews with actual attorneys, clinicians and social workers who work in medical-legal partnerships to explore some of the barriers they encounter in their everyday life. And I think this is a really fun way for academics to do research because so often we're on the inside looking out and this is a way to find out what's happening on the ground, and better understand what's happening for them so when we talk about these challenges we're talking about things that actually impact them.

So I'm going to talk to you a little more about that research today, again if you're hoping to get into the really sticky legal and regulatory issues, that's probably not where I'm going to be going with this presentation and luckily this is a real room of experts so that is, I'm sure there is somebody in here who can answer your questions. Um, I do have one part of my presentation that is sort of participatory, but in a very benign way. Who in here is a practicing



attorney? Yeah, hand raising, great. Does anyone work in a healthcare setting? Keep your hand up. Does anybody work in a medical-legal partnership? I was hoping to get more people to interview. That's okay, but what's awesome about this is this means that some of the ideas that I will present to you will be entirely new and I hope this is a fun and interesting way for you to think about the provision of medical care and also maybe law as healthcare. Oh, good it works.

Alright, so to roadmap my presentation for you, today I'll be talking briefly about the social determinants of health, and you'll be getting a lot more of that later on, health legal needs, which is a different way of looking at the social determinants of health, medical-legal partnerships and the idea of an attorney as a care team member and then we'll move on from that to talk about different challenges integrating legal and medical care together because as you're all probably very familiar with, these are both very siloed services. We develop laws and regulations around this idea that they're separate, so bringing them together can create some unexpected hurdles. And I know in this roadmap I saw I'm going to be talking about challenges last but I'm also gonna present a challenge first, and this one is a little more conceptual than it is practical. This has to do with the way we think about health and the way we think about health law. And I can't take full credit for this idea because it came up in a conversation about multidisciplinary education at a conference I was at last week. And a clinical professor who teaches in a medical-legal partnership and teaches law students how to provide medical-legal partnership services said she likes to begin her classes talking about definitions and we're all lawyers, we love definitions. So, I'll pose this one rhetorically here: What is health? And inevitably when this clinical professor poses this idea of what is health to her students, she's screened with very lofty, ambitious answers, often touching on the WHO's definition of health, which is, "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity."<sup>9</sup> And I find this definition hilarious.

Because to me, and certainly for attorneys and law students, I am not sure by this definition that any of us have ever actually been

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<sup>9</sup> See <https://www.who.int/about/who-we-are/constitution>.

healthy. But what is really nice about this definition is that it's broad and holistic and it encompasses lots of different factors. But when the same clinical professor I was talking to asks her students 'what is health law?' she gets a very different type of answer. According to her students health law is stark<sup>10</sup> and anti-kickback<sup>11</sup> and fraud and abuse. And the students aren't alone the Texas Board of Legal Specialization says its largely operational, regulatory, and transactional legal issues. And they're not wrong. This is absolutely health law. But I want to propose to you today that where health and law intersect can actually be much more broad than this. And maybe the provision of legal services can actually be a form of health care. Now you don't have to buy this, and you can totally leave here being completely skeptical of this idea. But I want you to keep it in the back of your mind as I'm talking. And maybe, like the CDC says, "Law is a tool for protecting and promoting the health of the public."<sup>12</sup> And this is a great way of thinking of using law to protect public health on a population level. But I can even venture to say that we can even take it a step further and say that in the context of medical-legal partnership, you can use your legal services to in fact improve the health of the individual patient. But to get there, we have to go through the social determinants of health first, so like I promised in my road map, this presentation more appropriately begins here.

So we got a little bit of social determinants health in Larry's not very uplifting talk before. And we will touch on the social determinants of health again, but put very simply, the social determinants of health are where we live, work, and play. And all of these things have different aspects that influence our lives both positively and negatively, and thus can influence health outcomes. And this is all good to say, but it is also nice to spell out on a slide, so here we go. Where we live, like having a stable house can help people follow medical treatment plans, especially when those medications have to be refrigerated or their treatment plan requires electricity. Where we work, having a safe job site is important to promoting health and physical safety. In addition, it can improve our income. And where we play is important because we require safe

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<sup>10</sup> 42 U.S.C. § 1395nn.

<sup>11</sup> 42 U.S.C. § 1320a-7b(b).

<sup>12</sup> Center for Disease Control and Prevention, About Us, <https://www.cdc.gov/phlp/about/index.html> (last visited July 30, 2019).

spaces to promote healthy recreation. We're going to be less inclined to go outside and exercise, even more so than we already are, if our neighborhoods are unsafe, they are poorly lit, or our parks and sidewalks are not maintained. And all of these things are not perfectly siloed, they are completely interrelated. So maybe where you work is unsafe, but also your income is bad so you can't afford to live somewhere good so you live in a food desert so your nutrition is poor so you're stressed, you can't feed your family, you have unhealthy coping mechanisms, and everything is a downward spiral to poor health. And there are lots of ways to visualize the social determinants of health and I think as you are going to pick up during the course of the day is that there is no one right way to talk about social determinants of health. And there is no one right way to visualize them. But I like this one, and you will see very soon why I like this one.

But this is how Healthy People 2020<sup>13</sup> likes to visualize social determinants of health in the context of neighborhood built environment, education, economic stability, access to healthcare, and social and community context. And I like this visual for a number of reasons, but I like it because it relates very closely to the idea of health harming legal needs. And that's why I like it because you didn't even have to remember what it looked like to know that it looks very familiar here. So the National Center for Medical Legal Partnership<sup>14</sup> came up with the mnemonic 'IHELP' to describe health harming legal needs or social determinants that have at their core a legal problem that can be remedied to improve health. And 'I' stands for income, and this relates to legal issues that impact access to resources that can help patients reach basic needs, like appeals of denial of benefits like food stamps or disability. 'H' stands for housing and utilities. And this impacts the physical environment, including housing subsidies, or preventing infection, or utilities shut off, or insuring that a home is actually inhabitable. 'E' stands for education and employment. And these are legal needs that help patients or clients, however you like to talk about them in literature, we often just call them patient-clients which is a whole mouthful, maximize education and job opportunities, such as deal

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<sup>13</sup> See generally HealthyPeople.gov, <https://www.healthypeople.gov> (last visited July 30, 2019).

<sup>14</sup> See generally National Center for Medical-Legal Partnership, <https://medical-legalpartnership.org> (last visited July 30, 2019).

with employment discrimination claims or workers' rights or access to specialized education services. 'L' stands for legal status. It is very easy to make assumptions about what that means, and the first thing that probably comes to mind for you is asylum. But this is actually a pretty diverse category, and can include things like resolution of veteran discharge status disputes and also expungement. 'P' stands for personal and family stability. This ensures a safe home and adequate social support. And the types of legal needs that come up a lot with this are restraining orders for victims of domestic violence or issues impacting custody and guardianship. But identifying something as a legal need doesn't necessarily help us understand how its successful resolution helps to improve health outcome. So to that end, I broke it down a little bit like the previous one. This is all adapted from a great chart that you can find I cited in the end, so I certainly take no credit for this, it's also at the bottom.

And to look at it granularly, looking at things that help improve income in the household will help patients make fewer tradeoffs with things like affording medication because if you've perhaps read the news lately then you might remember that medication is very expensive. But this is also easy to explain in the context of an antidote that comes up a lot when talking about medical legal partnerships. The one that comes up often is the idea of the child presented to the emergency room with acute respiratory distress and perhaps the physician can treat maybe what is a recurring asthma attack, but until you can address what might properly be a mold or a pest infestation problem in the home you're going to keep having this child coming back you're not going to be able to fully resolve the medical issue. This is where having an attorney actually can help provide a better medical outcome. And this is important because there are lots of really interesting statistics about low income populations and their unmet legal needs. Some say that 80% of legal needs experienced by low income Americans go unmet, and other statistics still say that every low income American has 2-3 unmet legal needs. And I'm not really sure how one can accurately identify the exact number, but the point I'm making is this is a huge population that has legal needs that by being unmet are adversely impacting their health outcomes.

So if legal services can help improve these outcomes, how do we get them directly to the patient? And this is happening in what are called medical-legal partnerships. And these are healthcare delivery models that integrate legal assistance as a vital component of healthcare and its built on the understanding of three key factors. I've got another animation. One, the social economic and political context in which people live has a fundamental impact on health. This is just like the social determinants of health that we talked about at the beginning of this presentation. Two, these social determinants often manifest in the form of legal needs, i.e. the health harming legal needs we just mentioned. And three, that attorneys have the special tools and skills necessary to address these needs, i.e. all of the attorneys here in this room have the ability to impact the health of their clients on an individual level. And this idea may be new to some people, but it's not entirely new generally. These are actually growing in popularity across the country and are present in 46 different states and I think the last number they identified was about 333 different medical-legal partnerships. They're also not particularly new, and often literature cites the first medical-legal partnership as being in Boston in 1993. Though even before the term medical-legal partnership was formed, attorneys were helping to improve the health outcomes patients in HIV and AID clinics in the 80s. So this is not a totally new idea, but its growing in popularity as we start thinking more about how do we tie physician reinforcement and value to outcomes.

So let's talk a little bit about the ways MLPs can happen and the basic forms that they can take. Yup this is the one that I wanted to be on right now. So there least integrated form, medical-legal partnerships don't look radically different than the way medical and legal services are provided in the real world as it is. And this is technically referred to as like a referral funnel. And in this circumstance, a patient may be seen in the clinic and may be screened for health harming legal needs by a physician or perhaps a social worker. And if they screen positive for a health harming legal need, either the patient will be given referral information to the attorney or the attorney will be contacted with the contact information for the patient. And these are kind of interesting models, and they are serving really important purposes, but from an academic perspective and from a research perspective, these pose fewer challenges than some of the more integrated models. On the

other end of the spectrum of integration, we see the attorney truly as a care team member. In some of these circumstances they are rounding with physicians, they are attending care team meetings, they may be housed physically on the same site as the medical provider, and in some even rarer circumstances, they may have read and write access to the medical record, which obviously raises a ton of red flags for anyone who thinks of things like privacy or confidentiality. And these are super interesting because they challenge our ideas of what law and what health are, and what it means when we bring them together. So between those two poles we have a lot of options about what these can look like and the configuration of the medical legal partnership can vary on a number of factors. On one level its institutional comfort. If the general counselor of risk management of a hospital is uncomfortable with the idea of having an attorney on site, they may be reluctant to be able to house them there. On the other hand, we also have the different type of legal service providers driving what these medical-legal partnerships look like. In some cases they are affiliated with law schools, so they are a part of a larger clinic program where students are introduced to health harming legal needs to address them by direct patient contact and handling the cases themselves. And also with a law school component so they are learning about it in the classroom. Other ones are linked to legal service organizations, so legal aid may partner with a clinic to be able to provide these services. And in other more integrated services, the attorney may be a direct employee of the medical provider. So, they may be housed on site, they may be paid by the medical provider, and in that way they have much more access.

Another thing that will drive the function and the structure of medical-legal partnerships is the type of patient population seen. So that will dictated, largely, the types of legal services provided. For example, if you are in a pediatric clinic, you are more likely to work on issues related to guardianship or individualized education plans. As opposed to a medical-legal partnership that is focused on elders, and then you might have more issues with trusts, wills, and estates. And this is all well and good, but what we are talking about now is a big push towards integrated models for lots of reasons. On one hand we are talking about vulnerable populations, these are people who very easily fall through the cracks. So the more integrated we can have an attorney and the care team, the less likely

we are to lose patients when they leave the clinic. And this can be caused by a number of reasons. Some of them don't have consistent contact with cell phones, some of them don't have consistent addresses, and on top of all of that, you also have people who have a number of pressing things happening in their lives and addressing a legal need may not take priority at that time.

And also, there is more push towards integrated care because limited coordination means more limited solutions. Attorneys and doctors and social workers all approach problems differently. And by having these people working together in the same setting you have more creative solutions that may more completely treat the problem that is impacting the patient. And also, this has come up several times in our interviews though its counter to how I think things often work in a medical setting, patients appreciate that there is broad information sharing between all of these different providers because they like that it alleviates the burden of telling their story over and over again to multiple providers when they think it should just be able to be shared freely. So all of this is well and good, but we are now talking about combining two things in these highly integrated partnerships that are previously very distinct. And as attorneys, and as some care providers, you may be aware that the way we practice these services and the rules, regulations, and laws around our respective practices keep them separate and anticipate them staying separate. But they don't always stay separate now. And because of that, different barriers are encountered.

And that's where we get back to the research I've been conducting at the University of Houston where we talk to attorneys, clinicians, and social workers about the types of barriers that come up. And were going to talk about a few of those now. First, were going to talk about ethical and legal barriers. So obviously the first thing that comes up when we're talking about sharing different types of health information is concerns about HIPAA.<sup>15</sup> And one of the things we found that's really surprising is in speaking to, and we've mostly talked to attorneys at this point, this doesn't seem to be an

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<sup>15</sup> See Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in sections 18, 26, 29, and 42 U.S.C. (2012)); The HIPAA Privacy Rule, 45 C.F.R. §§ 160, 164(A), (E) (2014).

area of huge concern. And that's not because HIPAA's<sup>16</sup> not important, that's because they felt that they found very good work arounds. On one hand, they usually have patients sign authorization and intake. And on the other hand, they also are looking at exceptions to the privacy rule, and including the idea of legal services in treatment, payment, and healthcare operations. And so largely these things aren't coming up in our discussions. What they have found to be more concerning in these preliminary results is issues about confidentiality. And obviously when we are talking about bringing an attorney into a care team meeting or you are having all these very collaborated discussions about the patient and their legal and their medical case, we have issues about whether or not we are waiving attorney-client privilege or if we are in anyway compromising work product protections. And this is important because there are lots of types of legal cases that can't be handled by medical-legal partnership. And as a former personal injury attorney, one of the ones that logically comes to mind is fee generating cases. And so we have to worry about whether or not the issues that come up in the context of a medical-legal partnership will maybe ultimately be used against that patient client in a subsequent legal proceeding for which they are not using medical-legal partnership services.

We also have the issue of professional obligations. And this one is sort of interesting because we owe different duties to our clients and patients respectively. So this comes up a lot in the context of mandatory reporting requirements. So where a doctor may have to do no harm and seek to promote the best interest of their patient, attorneys must be zealous advocates for their clients rights and interests, and these two things sometime conflict. So if an attorney learns about something where there might be a case of suspected child abuse, they may not be able to bring it up in a care team meeting even though it might promote the best health outcome because it might prompt mandatory reporting requirements on the clinician side, it would go against their client's interest. So in these ways, the flow of information in this truly holistic and integrated care is being stifled. And there aren't clear answers to how we

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<sup>16</sup> See Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in sections 18, 26, 29, and 42 U.S.C. (2012)); The HIPAA Privacy Rule, 45 C.F.R. §§ 160, 164(A), (E) (2014).



should address this, and that's one of the common things were running into, 'oh you know if you figure out the answer you're going to let us know, right?' 'Ya, definitely will let you know.' But beyond ethical and legal barriers, we also have issues with cultural barriers. And anybody who has had to deal with a physician who might be weary of medical malpractice claims, is already very aware of what these types of barriers can look like. But fear does not just exist on the physician-attorney side, it can also exist on the institution side. So if you have a general counsel or risk management office that is weary of having this third-party attorney wandering around, who might be more attuned to liability, you may not be able to get that same level of integrated care.

But even beyond the attorney, physician, and administrative side, you also have fear on the patient side. We are talking about vulnerable populations, who are already disenfranchised and marginalized and may have had bad experiences with the legal profession already, so they may be less inclined to take up these services. And lastly, I'll talk briefly about logistical barriers. And these can take a lot of different forms, but on its most basic level, hospitals weren't designed to have an entire law firm on site. And so on a very basic level, it's hard to have room for the attorneys to meet and to even have attorney staff on site. And this also extends to the electronic health record. So, the electronic health record would be very expensive to modify, to incorporate any sort of legal information, should that be a direction the medical-legal partnership wants to go. And beyond that, logistical barriers have populated unexpected. So, in one of the interviews, we were talking about limited financial resources, which is a common theme that you will hear in talking about these programs because they are largely grant funded and grant funding is hard to maintain and it's hard to grow with that. And one of the attorneys I was talking to was saying 'an unexpected place I have run into financial constraints is in requesting medical records.' Which is fascinating when you think about attorneys working with a medical provider to represent a patient, but they still have to go the same route of requesting medical records as the rest of us. And she said she had to pay upwards of \$2,000 to get medical records in a very specific case. And in some of these circumstances we followed up with these attorneys to figure out if they figured out work arounds to be able to get access to these medical records, and in some small towns and settings they have

been able to develop a sort of back door way to get medical records, but in large cities, they are subject to the same limitations as the rest of us. And anybody who have had to request medical records to support a case knows that its extremely time consuming and extremely expensive. So limited resources are and continue to be a huge hinderance to this sort of integrated care and sharing of information. So what, right?

One of the larger questions that looms in the periphery of all of this type of research is, yes, the literature can identify problems, and yes, we can talk to people about how those problems manifest and we can talk to them about whether they need to address it, but what are the normative implications of this research? And are there certain things we should be trying to do on a policy level to facilitate these types of integrated care? But on the flip side, are there certain things we should be doing to preserve or protect barriers that exists because maybe they exist for legitimate reasons? Unfortunately, none of these have super easy answers, and I certainly can't answer any of them today. But they're ones I want you to think about as you think about whether or not medical-legal partnerships are programs that we absolutely want to promote in the community, and if they are, what types of changes would we need to make. And I also hope that at some point in your life you come back to this idea about what is health and what is health law, and ask yourself if maybe right now, with all the tools you have as an attorney, you have everything it takes to improve the health of not only your community but also your clients. And I would offer that maybe you do, but maybe you don't.

Thank you so much. You can find me at any of these places on the internet. And also, if you are interested in the results of my research, which is still on going, it will be published forthcoming in Northeastern University Law Review. So if you want a copy of that, I look forward to sharing it with you when it is done. And here is a look at some of the sources I cited today. I hope I stayed on time, are we on time? Oh, anyone have questions? I need some water, but does anyone have questions? I am actually going to get that while you all think of all the important questions you have.

**Question from Audience:** "So have you come across any medical-legal partnerships that have worked outside of hospital settings?"

**Professor Van Horn:** “Yes.”

**Question from Audience:** “And what kind of settings have those been?”

**Professor Van Horn:** “So, some of them will work with clinics that stand alone in the community, so they aren’t necessarily in a hospital setting. So we’ve interviewed one or two attorneys that were the legal aid office has partnerships with independent physicians in the community, and those are usually with specialized patient populations.”

**Question from Audience:** “Are those referral models?”

**Professor Van Horn:** “Those are referral models, yes. Actually, it was partially a referral model, and partially a, one of them was a referral model and one of them was a law clinic base model. They’re all referrals that are not imbedded, so they end up getting the patient’s information and contact them directly. Which has proven to be like a really hard thing with contacting patients when you have a referral model, and I’m going to go off on a tangent here. This also goes back to the idea of logistical barriers. So even something as simple as having a similar email address or phone number as the medical provider will increase the amount that these patients are willing to even pick up the phone or respond when you are referring to an attorney. So that was an interesting thing that came up in the context of these referral models that have a high level of attrition after someone has been screened positive for health harming legal needs. So there are different creative solutions that you can come up with if you can’t physically be on the site. I hope that answered.”

Anyone else? Anyone want to know anything else about qualitative research?

**Question from Audience:** “I’ll ask. How much participation do you have and do you see in these legal partnerships? Are attorneys turning up for those as much as other legal aid or volunteer organizations?”

**Professor Van Horn:** “So, the problem with medical-legal partnerships is the onus of funding often falls on the legal provider. And so you see a lot of legal services providers partnering with it because they have some of the funding necessary and the resources available to do these types of services. Same with law schools, so they may be able to as part of their educational initiative may be able to fund parts of this. So yes, they are getting a lot of attorneys that are interested in this. On the pro bono side, there are certain benefits to getting private attorneys involved, and this also speaks to the funding issues. There’s a direct link between promoting pro bono work and becoming future donors, so there’s a big push towards getting private attorneys involved in these types of programs too.”