TOWN and GOWN
Legal Strategies for Effective Collaboration

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Interdisciplinary Health Partnership between Graduate Schools and Host Communities

Emily A. Benfer

Introduction

Today, universities are challenged with preparing students to work in a new, complex, and rapidly evolving environment. Students will face challenges in the workforce that are multifaceted and, as such, require the type of creative and effective problem solving that is only achievable in an interdisciplinary response. Modern decision making cannot be made apart from the legal, economic, social, historical, and political implications of these decisions. As such, success in the workplace requires understanding of other disciplines' knowledge bases and knowing when to seek assistance from each.¹ For example, policy work requires an understanding of economics and social sciences; a lawyer advising a client about industry matters must be able to engage with the field of business; litigators often need to learn about subjects to communicate with experts; doctors must engage with social scientists and public health experts to understand the social and root causes of a patient’s illness; and educators must be tech savvy to engage the Millennial generation.

Without this interdisciplinary foundation, students will be unprepared to interact with other professionals, and confusion, delays and poor outcomes will result.² Interdisciplinary education in professional schools can circumvent crisis in interprofessional relations.³ This is especially true in the field of law, medicine, and social work. As one scholar stated, “The traditional curriculum, with its emphasis on cases and principles, trains law students to view problems only from a legal perspective... Little is done to make... students aware of alternate methods of problem solving.”⁴ As a result, they do not become sensitized to the other aspects of the condition.

No matter what the field of study, students require an understanding of the circumstances and conditions to which the principles of the field are to be applied. They must be exposed to

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context, and focus on "societal conditions that created the conditions, which, in turn cause the problems."6

**Interdisciplinary Approaches to Education**

Interdisciplinary education is defined as education "of or pertaining to two or more disciplines or branches of learning; contributing to or benefiting from two or more disciplines."6 Interdisciplinary education has been a common approach in universities for many years.7 As early as 1907, scholars espoused the importance of interdisciplinary teaching. For example, Roscoe Pound stated, "The modern teacher of law should be a student of sociology, economics and politics as well. He should know not only what the courts decide and the principles by which they decide, but quite as much the circumstances and conditions, social and economic, to which these principles are to be applied... It is, therefore, the duty of American teachers of law to... give to their teaching the color which will fit new generations of lawyers."8 In the medical field, "the primary goal of interdisciplinary education is for students to develop an understanding [of] and appreciation for the expertise and perspective that each discipline brings to patient care."9 As early as the 1970s, the Center for Legal Services for the Aging brought law students to work with graduate students in public administration, social work,10 nursing, architecture, and other nonlegal professions.11 "Interdisciplinary programs that join legal studies with other departments at the university offer opportunities to transcend not simply course boundaries but disciplinary boundaries as well."12

There are multiple approaches to interdisciplinary education that vary according to the classroom setting and available opportunities. In the doctrinal course, one discipline might study another;13 a representative from another discipline may share their expertise, education, and knowledge base; teams of faculty from diverse disciplines might plan and teach a course enrolled by students from multiple disciplines and professions.14 In the clinical, experiential setting, in which students work directly with clients or patients, the students could adopt principles and techniques of other fields to meet the client's needs;15 professionals from other disciplines could be used as consultants or collaborators on an as-needed basis; or faculty in each discipline could co-teach an integrated partnership model.16 In the research setting, teams consisting of multiple disciplines could be convened to study a community and devise strategies to address any issues presented.17

Interdisciplinary cultivation engages students in the continuous examination of the relationship between themselves, the field, the people it affects, and the broader societal implications. The benefits of interdisciplinary education are wide reaching and will serve students long into the future.18 Students may be expected to gain:

(a) Greater diversity of thought
(b) Broader perspective
(c) Heightened awareness
(d) Multi-dimensional analytical ability
(e) Involvement with and respect for the role of other professions
(f) Collaboration and team work
(g) Creative problem solving skills
(h) Leadership experience

Interdisciplinary education is not without its challenges. It requires diligence and resolve to overcome silos between schools and marginalization between professions. Examples of common challenges include:

(a) Ethical differences between professions
(b) Logistics related to class schedules, availability, distance between schools and community partners
(c) Assumptions about institutions and practices among other professionals
(d) Different teaching objectives
(e) Design flaws
(f) Community partners reluctant to work with students

Many of these challenges, such as ethical differences and teaching objectives, allow for rich discussion and learning among the faculty and students. Others, including logistics and design flaws, can be addressed with rigid organization or flexibility on the part of participants. Cross-cultural tools are highly effective in avoiding harmful assumptions, as well as bringing community partners into the fold. Student work product and success rate is often the best antidote to any reluctance among potential community partners. Best practices are discussed throughout this chapter.

Interdisciplinary Collaboration between Schools of Medicine, Nursing, Law, Social Work, Public Health, and the Community

Addressing Barriers to Health

In addition to the educational benefits of interdisciplinary education, the timing of partnerships that involve medicine, law, social work, and public health is ideal. Both the Accountable Care Organization (ACO) and Patient Centered Medical Home (PCMH) models described in healthcare reform laws shift the delivery method from an episodic model to a quality and cost-based model, in which the overall health of the patient and preventative health are emphasized. Effective implementation and real change requires widening the scope by engaging a different
set of experts that include those who can address the root causes and triggers of health issues. For example, a focus on nutrition and food deserts must also address a patient’s battle over “I Eat,” in which food is sacrificed in order to pay utility bills. Similarly, a focus on preventative health must include the removal of hazards, such as poor housing conditions and homelessness, from a patient’s environment. Both ACO Proposed Rules and the PCMH provisions of the Patient Protection and Affordable Care Act (ACA) call for collaboration within the healthcare industry. Community-based interdisciplinary collaboration that is inclusive of all fields could address the litany of neighborhood and health access barriers. This is not only consistent with ACA, it is also critical to population health.

The U.S. Department of Health and Human Services (HHS) created a new factor in the Healthy People 2020 report entitled “Social Determinants of Health.” In the report, HHS supports “[i]mproving the conditions in which people live, learn, work and play and addressing the interrelationship between these conditions [in order to] create a healthier population and a healthier workforce.” Several federal and state laws, including ACA, were enacted to address social issues that affect health, including poverty, housing, health insurance, nutrition, education, disability, and other benefits. Yet, oftentimes, patients do not receive the benefits or protections the law affords them. Patients confronting unlawful actions on the part of governmental agencies, schools, or a landlord are often unable, or unaware of their right, to challenge them. These unmet needs and such problems as lack of access to healthcare, domestic violence issues, unsafe housing conditions, and food access can have serious consequences for a patient’s health. Interdisciplinary partnerships between the medical, legal, and social work fields, among others, have a profound impact on the patient’s health and help to reduce costs to the healthcare system.

The interdisciplinary health partnership, or medical-legal partnership, model originated at the bedside. After sending sick children home to dangerous housing conditions where they were unable to respond to medical treatment, doctors involved lawyers to assist the patients in navigating complex legal systems that held solutions to the social issues that created the poor health outcomes. The National Center for Medical-Legal Partnership designed the model that proved that, through collaboration, the medical and legal fields are able to protect patients from the legal and social crises that lead to adverse health effects. Sites across the country adopted the model with the support of the national center. Health care providers (doctors, residents, nurses, social workers, public health experts) and lawyers (legal aid offices, law schools, and pro bono attorneys) are partnered at more than 275 sites nationwide, in a variety of specialties that include pediatrics, family medicine, internal medicine, geriatrics, oncology, adolescent medicine, and others. As the Robert Wood Johnson Foundation stated, “Clinicians are in a unique position to identify vulnerable patients. In partnership with programs and agencies that offer legal or social services counseling and advocacy, health care providers can help patients
address homelessness, help paying for groceries and meals, utility bills, and landlord remediation of safety and health problems in the home. Examples of programs that connect patients with services and resources in the greater community are the Medical-Legal Partnership.\textsuperscript{30}

The result is the effective and optimal use of resources. By engaging members of disciplines that address the different and complex aspects of an individual's health (social, environmental, mental, physical), the model allows for the transition from an acute-care model to the whole-patient model. It replaces episodic treatment with treatment of the root problem, even if the "treatment" is not necessarily medical in nature.\textsuperscript{31} As a result, the factors that contribute to repeat hospital visits are removed, reducing the utilization rate and allowing the physician time for the remaining patient panel.

\textit{Components of an Interdisciplinary Health Partnership}

Applying this model to the interdisciplinary and collaborative learning environment for students of medicine, nursing, law, social work, and public health helps to shape their concept of society, enhances their creative problem solving, and results in improved health outcomes and social conditions for the community served. In order to create an atmosphere that is conducive to attaining educational objectives, multiple components must be carefully assessed. The key components of a successful interdisciplinary health partnership include: (1) identifying the community\textsuperscript{22} need and community stakeholders; (2) engaging "champions," or committed partners and faculty,\textsuperscript{33} who understand the relevance of social determinants of health and the role of other disciplines in addressing them; and (3) agreeing to the logistics of partnership, including individual roles and responsibilities, methods of communication, and preservation of ethical, confidentiality, and other professional rules.

Identifying the Community Need

Most, if not all, medicine, nursing, law, social work, and public health students will encounter the health field at some point in their careers through the representation or treatment of a patient/client or assessment of systems. One of the most meaningful and effective interdisciplinary interventions occurs in the medical and public health context. Across the United States, low-income individuals, children, and families experience adverse health outcomes that are directly linked to their socioeconomic status and environment. As a result, they access the health care system at higher rates, reducing efficiency and effectiveness, and accruing higher costs to the system.

It is well documented that emergency room visits—the substitute for primary care for many low-income people—break down prevention and comprehensive treatment, and are one source of exponentially growing costs in the health care system. In fact, the highest rate of emergency room usage is among patients with low socioeconomic status.\textsuperscript{34} Research suggests
that lower socioeconomic status is linked to poor health outcomes, which in turn affect an individual’s capacity to work or succeed in school, further reducing socioeconomic status and health outcomes. In a study of Camden, New Jersey, the highest hospital costs originated in two buildings, a nursing home and a low-income housing tower. These residents are the “hotspoters.” Between January 2001 and June 2008, the 900 people in the two buildings accrued $200 million in health care bills. It is an understandable phenomenon in light of the challenges facing low-income communities: food deserts that contribute to malnutrition and food insecurity; substandard housing that results in respiratory distress, lead poisoning, and developmental delays among children; and the frequency of trauma, such as domestic violence, that leads to chronic illness and disability in adulthood.

Ultimately, the amount the patient/client costs the system is directly related to the patient’s ability to effectively implement a treatment plan and safeguard against environmental and social factors contributing to poor health. The social determinants of health in the United States are multifaceted and caused by multiple categories of vulnerability, including but not limited to minority and economic status. In light of the prevalence of the environmental and social factors that contribute to health disparities and amount to repeat hospital visits across the country, it stands to reason that every university nationwide could identify a need in the surrounding community.

Interdisciplinary health partnerships are an innovative way to address unmet needs related to housing, education, food, income, chronic illness, and disability, among other issues that exacerbate or create health problems. This model has proven effective in pediatrics and adult patient populations, and in the management of chronic disease.

**Engaging Diverse “Champions” to Respond to the Need**

The most successful interdisciplinary health partnerships are integrated in such a way that key leaders from each discipline are actively engaged, committed, and collaborating. Not only does this ensure viability, but it also provides an example of model collaboration for students, as well. Identifying “champions” of interdisciplinary health partnerships presents unique challenges, which provide further incentive to shift to the interdisciplinary model.

Our current legal, medical (medicine, nursing, public health), and social work systems are not designed for collaboration, though each could benefit dramatically from the involvement of the other. In the attainment of their degrees, students of each profession spend all of their time learning an overwhelming amount of material that will assist them in caring for their patients/clients. Only in rare instances do they learn about the societal context in which their patients/clients are presenting, or how to identify partners who could assist them in addressing all of the patients/clients needs in a holistic and expeditious way.
Many physicians and nurses who care for underserved populations struggle with the relationship between their patients' health and social determinants. The medical profession recognizes the importance of the patient's environment, but the time with a patient is limited and social history inquiries focus on limited factors of health, such as smoking, alcohol consumption, drug use, family history, and sexual activity. Yet, social and environmental factors, which are rarely investigated during patient social history, have a direct bearing on the cause and management of disease and often underlie the health problems among people living in poverty.43 For the health care providers involved in an interdisciplinary health partnership, underlying adverse social conditions that were once difficult to identify are surfaced and addressed.44 The legal and social work remedy becomes part of the treatment plan. Champions hailing from the medical field recognize and appreciate the effect of social determinants of health on patient health outcomes.

Legal champions must be supportive of transforming the traditional legal assistance model. The current system places the responsibility on the client to obtain legal services, which requires recognizing the need for legal intervention. As a result, clients rarely seek assistance until the matter has evolved into a crisis. For example, legal services attorneys and law students often meet a client after the eviction was upheld, or public benefits were reduced or denied. In a few fortunate cases, the court date or hearing that will decide the fate of the individual or family is postponed to a few days out. The interdisciplinary health partnership moves the timeline back and allows a lawyer to intervene earlier and to engage in "preventative lawyering" in response to the social issues identified by the healthcare team.45 Meeting the patient early on and at the first sign of a health problem allows attorneys to confront the root causes of the health problem and address the legal issues before they proliferate.46

It also enables the attorney to involve partners in order to more effectively meet the patient's/client's needs. For example, in a landlord-tenant dispute, successfully defending against an eviction will not improve the patient's/client's health if they are returning to an infested, dilapidated apartment.47 A social work partner could guide the patient/client as they maneuver through a complex system of public benefits, housing assistance and other public programs in an effort to assist the patient/client in moving to a healthier home and to curb the effects of the underlying barriers to health. This should be a natural adjustment for lawyers and law students, as "[l]aw, by its very nature, is almost always interdisciplinary: the job of most lawyers is to assist others with the portion of the legal system that address a particular issue in that person's life. In fact most law classes are theoretically interdisciplinary, given that they provide instruction in the law 'of' something."48

Similarly, ensuring access to healthcare is not exclusively the responsibility of the medical profession. Lawyers and social workers can play a major role in obtaining health insurance and autonomy over one's person through living wills and medical powers of attorney.
The identification of champions in each partner field is critical to the success of the partnership and the student's educational attainment. Champions recognize the shortcomings of the current system and appreciate the utility of other disciplines to better meet the patient/client need. They are eager to collaborate to accomplish a more effective use of resources and they are committed to developing and redesigning the partnership until students are engaged and learning, and patients/clients are improving. As the partnership develops, the knowledge and understanding of each discipline will increase and, as partners will develop familiarity with other disciplines' rules, beliefs, ethical principals, and objectives, the outcomes will only improve.

Partnership Coordination, Organization and Management
Interdisciplinary health partnerships vary in size, scope, and structure and can often be modified to accommodate the needs of partners. Effective management of the partnership requires clear delineation of each partner's roles and responsibilities. The key logistical components of a successful partnership include:

Effective and frequent communication among partners. Frequent and scheduled communication is necessary to identify any expectations or concerns partners or their host schools or administrators may have. Transparency is critical and will allow for the resolution of conflicts and shifting of priorities or procedures to meet the needs of each partner. Immediate communication may also be required to meet the needs of patients/clients. For example, the lawyer or law student may require the assistance of the medical provider or medical resident to interpret medical records, or to write a medical source statement in support of a patient's/client's appeal of a social security denial. Ongoing strategic planning to ensure the partnership continues to fulfill the mission, goals and shared learning objectives of the partnership is highly recommended.

Agreement on timing and method of training in social determinants of health. There are multiple and varied ways to train medical providers in the social determinants of health. Possibilities include presentations during didactics or grand rounds, doctor or resident shadowing with immediate feedback, cross-discipline student partners, and required or elective courses, among others. If the partners elect to enter into a memorandum of understanding or an affiliation agreement, they may decide to include time during grand rounds meetings as part of the law and social work students' responsibilities. This will ensure that time is always set aside and will provide faculty with unchanging deadlines. The opportunities for training will depend on the structure and format of the healthcare delivery system. Partners committed to the time and preparation of training will identify the ideal setting.
Structure of referral system. Once a partner identifies an issue that is better served by another discipline, he or she will need to introduce the patient/client to the partner who can best assist him or her. Some medical-legal partnerships rely on facsimile or email to transmit patient referrals. Another approach, used by the Health Justice Project, is to consider the partners part of the “internal referral” system in order to integrate the partnership into the electronic medical record (EMR) system. The benefit of EMR is multifold. It increases the likelihood of referral, because the doctor or resident must use it every time he or she examines a patient, and the referral is a “click” away. It also creates a tracking system that, feasibly, could be used to track repeat patient usage of the partnership, track health outcomes once the partnership matures, and track referral by medical provider. Whatever the structure of the referral system, it should be one that allows for immediate follow-up by the receiving partner and, ideally, data collection to identify partner champions who frequently refer patients/clients, “hotspotter” neighborhoods, and health outcomes after intervention.

Frequency and method of feedback. To ensure investment in the partnership, maintain lines of communication, and increase partner engagement, partners must create a “feedback loop.” The feedback loop prevents the medical provider from assessing the asthmatic patient as “non-compliant” with treatment when the provider knows the legal and social work partners are working to restore the patient’s electricity so that she can plug in the prescribed nebulizer that will reduce symptoms. Feedback can be in the form of an email, a phone call, a hallway conversation, or a highlight during grand rounds. In the Health Justice Project, students are required to send a “legal consultation report” or a “social work consultation report” to the referring provider as a “note” in the EMR system. Uploading the report as a note requires the provider to read it before he or she can open the patient’s file. This ensures delivery, reminds the provider to check the patient’s social determinants of health, and creates a record of health outcomes in the EMR. It is important to caution students and other partners against providing advice or disclosing information that is protected by professional confidentiality and ethical rules in the report without the client’s express and written permission. (See appendix A for sample report.)

Space and equipment. Partners should consider where the students would encounter one another and the patients/clients. Factors to consider are modes of transportation and distance of travel, reimbursement policies, and the importance of exposure to other discipline’s environments. In addition, it is often preferable and easier for the client to meet with all providers in one location. If the legal and social work students meet with patients/clients at the medical center, partners should discuss the supplies students will need to successfully serve patients/clients. For example, they may require a private meeting space and access to business equipment such as a copier, fax, printer, Internet, or wireless connection, among other
things. In many partnerships, the medical partner provides these items in exchange for the patient health benefit.

**Deliberate and constant protection against liability, and ethical and confidentiality breaches.** Partners must attempt to limit or eliminate any potential professional violations or liability for themselves, their students, and each other. Steps to avoid liability may include ensuring that student involvement in the partnership is covered by each partner’s respective liability insurance; training in partners’ policies, rules, standards and practices; an agreement on emergency care in the event of injury to a participant; agreement to an information-sharing policy; up-to-date accreditation and approvals required by state regulatory agencies; an indemnification policy and an agreement not to represent parties in actions directly adverse to any partner, among other items. In addition, partners should engage in frequent discussion about their discipline’s rules of confidentiality and ethics. At times, they will conflict and partners will need to determine how to approach these situations. Ethical and confidentiality issues are excellent opportunities for student discussion and education that should be embraced. Partners should also be trained in privacy and confidentiality laws and regulations that could affect the standing of any partner, particularly the medical partner, and take steps to ensure compliance. These steps could include:

(a) Asking patients to sign releases prior to a referral, the release of medical records, detailed “feedback loop” consultation reports, and other information
(b) Providing the patient with the referral information
(c) Assigning a coordinator to contact all referred patients after the referral but before transmission to a partner to confirm understanding of and agreement with the referral
(d) Providing partners with internal email accounts or using encrypted email systems to discuss or transmit confidential patient information
(e) Adding confidentiality disclaimers to correspondence
(f) Requiring participants and personnel involved in the partnership to sign a confidentiality agreement
(g) Including details about the partnership and student involvement in any client retainer form
(h) Redacting protected health information from all transmitted documents.

These components can be enumerated and agreed to through informal or formal agreements, including memorandum of understanding or an affiliation agreement. (See appendix B for a sample affiliation agreement, and appendix C for a sample retainer.)
Interdisciplinary Health Partnership in Practice: Loyola University Chicago's Health Justice Project

The Health Justice Project at Loyola University Chicago provides an example of how this learning environment can be created to bring students of law, social work, medicine, and public health together in order to address the poor health outcomes among low-income individuals and to prepare students for the complex problems they will be called on to solve throughout their careers.

The Need for Interdisciplinary Approach to Health Disparities in Chicago

Chicago is no exception to the health crisis among low-income populations. In designing the Health Justice Project, faculty sought to identify an urgent and unaddressed need in the community. The first step, researching the common barriers to health, revealed an overwhelming need:

(a) *Asthma:* Twenty percent of inner city children become sensitized to rodent allergens and develop asthma.\(^5^3\) In fact, Illinois has a higher rate of mortality from asthma than that of the U.S. population.\(^5^4\) In 2007, asthma accounted for approximately 111,618 hospitalizations, either as a primary or secondary diagnosis.\(^5^5\)

(b) *Lead Poisoning:* There are about 44,445 known cases of children in Illinois with elevated lead levels, and estimates of more than 81,000 children being harmed.\(^5^6\)

(c) *Diabetes:* More than 827,000 adults in Illinois have diabetes, with the largest concentration in the Humboldt Park area of Chicago (the primary site of the Health Justice Project).\(^5^7\)

(d) *Food Insecurity:* According to the USDA, 13.3 percent of Illinois households face food insecurity.\(^5^8\) Some 1,793,886 individuals in Illinois participate in the Supplemental Nutrition Assistance Program,\(^5^9\) and 609,034 Chicagoans live in a food desert and are part of the forty-four square miles lacking fresh produce or meat.\(^6^0\)

(e) *Electricity Shut Off:* Heat and electricity are keys to maintaining health.\(^6^1\) Even for low-income individuals who manage to pay their utility bills, high energy costs force families to dig into their food budgets.\(^6^2\) An overwhelming number of Chicagoans are part of the 24 million low-income households in the United States having to choose between a balanced diet or energy access.\(^6^3\)

Compounding the health risk among low-income individuals is immigration status. The state of Illinois has one of the largest immigrant populations in the United States and, out of that population, 21.7 percent live below the federal poverty level, compared to 16.3 percent of native born. These households are more likely to have legal problems than the average low-income household in Illinois (54% compared to 49% of all low-income households). Many immigrants
express concern taking public benefits, because they mistakenly believe that doing so will make them ineligible for permanent residency and citizenship. Over half (52%) of recent immigrants were uninsured in 2008, compared to 15 percent of native citizens, making it difficult if not impossible to obtain medical treatment.

The totality of the statistics made it clear to the faculty that members of the Chicago immigrant community suffered poor health outcomes associated with low socioeconomic status, such as malnutrition, asthma, diabetes, and lead poisoning, that could be addressed by members of an interdisciplinary team. The fact that the immigrant populations in the city was less likely to obtain legal, social, and medical care also revealed an urgent need to which the Health Justice Project could respond.

**Health Justice Champions**

Among the most important elements of an interdisciplinary partnership are the partners, or champions. Ideally, though not mandatory, partners will be close in proximity in order to ensure student involvement, and value the role of other disciplines in meeting the needs of low-income individuals. The Health Justice Project considered multiple healthcare systems, federally qualified health centers, clinics, and teaching hospitals before inviting Erie Family Health Center (Erie) to partner.

Erie has been serving Chicago's medically underserved communities for more than fifty years. The federally qualified health center is made up of thirteen clinics that serve 40,000 patients annually through 148,000 visits. Erie's patient population is 68 percent female, 79 percent Hispanic, 34 percent uninsured, and 83 percent living below the Federal Poverty Level. One of Erie's largest sites, which includes the administrative offices, is less than two miles from Loyola's law and social work schools, making it accessible to students. Erie staff and healthcare providers are committed to serving low-income individuals, and providing culturally competent care with compassion and respect. In addition, most of the providers are faculty at the Northwestern University Feinberg School of Medicine and understand the importance of investing in students. As if these characteristics were not enough, David Buchanan, MD, MS, the Chief Medical Officer and Health Justice Champion, focuses his work on the health and economic impact of housing homeless individuals, and on quality improvement in primary care settings. He is an ideal champion, who sets an example for other partners in his profession.

Erie Family Health Center also partners with the Northwestern University McGaw Medical Center to host the Northwestern Family Medicine Residency Program. This presents a unique opportunity to engage law, social work, and public health students with another group of professionals in training, in addition to the frontline medical providers.

Within Loyola University Chicago, partners include the School of Law's Beazley Institute for Health Law and Policy legal clinic (named, Health Justice Project) and the School of Social
Works’ Institute on Aging, Intergenerational Study and Practice. In addition, the Health Justice Project hosts Masters of Public Health students who study the effect of the partnership on patient health, and Schweitzer Fellows who select a discrete public health project in the community and collaborate with partners to address it. For example, one fellow is addressing food insecurity and food deserts in the low-income community of Englewood in Chicago and another is enrolling Erie patients in CountyCare and Medicaid expansion under ACA.

In order to better meet the needs of patients, the Health Justice Project also partners with Equip for Equality, Lawyers Committee for Better Housing, and AIDS Legal Council of Chicago, among other allies.

**The Health Justice Project Mission and Learning Objectives**

In collaboration with partners, faculty members involved in the Health Justice Project engaged in strategic planning to formulate the mission and learning objectives of the partnership. The mission of the Health Justice Project is to “resolve the social, legal and systemic barriers that prevent long-term health and stability for low-income individuals and families.” To achieve our mission, and resolve the legal and social issues that underlie, exacerbate or could result in health disparity, students and professionals:

(a) Provide highly effective quality representation to low-income clients

(b) Train and mentor students of law, medicine, social work and public health in an intensive, challenging education in the fundamentals of legal practice, systemic advocacy, and interdisciplinary collaboration necessary to becoming effective problem solvers and socially responsible, service-oriented professionals

(c) Collaborate with other discipliners, community members, advocates, and stakeholders to employ a multifaceted approach

(d) Create public policy to address barriers to health and invigorate our communities.

For the law students involved in the law school clinic component of the Health Justice Project, the experience provides an opportunity to learn lawyering skills by connecting theory and practice through direct client interaction and participation in the clinic. The course emphasizes the development of skills in interdisciplinary practice, client interviewing and counseling, fact-finding and analysis, legal research and document drafting, pursuit of administrative and other legal remedies, policy reform where appropriate, and creative problem solving for the benefit of clients. These skills are learned in the context of team and group work, with an emphasis on collaboration and interdisciplinary problem solving. Using this collaborative model, all clinic members are exposed to the range of cases handled in the clinic, terminology and culture of healthcare, and delivery of services to low-income people. Students are encouraged to reflect
on these experiences in developing lawyering skills, interacting with the social, justice, and healthcare systems in which the cases originate, and realizing their own personal philosophy of lawyering. Students have the opportunity to:

(a) *Practice Traditional and "Preventative" Lawyering Skills in Context.* The clinic gives students the opportunity to engage in experiential learning through direct client representation and to develop practical lawyering skills through the use of legal and nonlegal remedies.

(b) *Gain Experience in Exercising Responsibility.* Students assume and accept ultimate responsibility for matters of critical importance to individual clients.

(c) *Work in Collaboration and Partnership.* By partnering with each other and participating in the medical-legal community partnership, students learn the importance of interdisciplinary approaches and collaboration with individuals engaged in the practice of law, public policy, medicine, social work, public health, organizing, media, and epidemiology, among others.

(d) *Enhance Creative Problem Solving.* Students practice innovative techniques by engaging in strategies that complement litigation, including interdisciplinary problem solving, targeted policy development, working with the media, and client empowerment.

(e) *Lay the Foundation for Lifelong Learning.* Students enhance self-awareness and cross cultural competences, learn to think independently and to examine their own learning processes while experimenting with multiple techniques and approaches in order to find the ones that work best for them.

(f) *Embrace Social Justice, Service and Values.* Students gain firsthand knowledge of social and legal disparities in low-income and minority communities, and the impact lawyers and other partners can have on access to health and justice in these areas. In the process, students discover the importance of public interest service and collaboration in all areas of their profession.

The learning objectives for the law students complement those of the medical residents involved in the Health Justice Project through the Northwestern Family Medicine Residency Program. Residency Program faculty designed a curriculum that is aimed at overcoming social determinants of health through an interdisciplinary health partnership. The learning objectives include: (1) work within an interdisciplinary team and demonstration of professional behavior throughout the medical-legal partnership curriculum; (2) ability to successfully assess patients' needs by screening for unmet social needs, and referring patients to an appropriate resource; and (3) ability to describe the ways in which social determinants of health present in patients. Through the achievement of these objectives, residents meet multiple Accreditation Council for Graduate Medical Education Milestones and Core Competencies, including patient care,
medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, advocacy, and systems-based practice. Residents encounter law and social work students during "precepting" (similar to shadowing), didactics and grand rounds, through direct requests for consultation and advice, and through assigned interdisciplinary teams.

Similarly, the social work students, who are onsite as members of the law school clinic and are supervised by School of Social Work faculty, Dr. Marcia Spira, PhD, LCSW, BCD, are bound by confidentiality agreements that allow them to collaborate with the law students. They also engage in activities that meet the School of Social Work's learning objectives, including direct service, psychosocial assessment of patients/clients, patient/client consultation, linking patients/clients to community resources, evaluating the social services available in the community, and developing resources. They work hand in hand with the law students and perfect intervention strategies for Health Justice Project patients/clients.

The public health students complete their practicum requirement through placement in the law school clinic of the Health Justice Project. The most recent public health student, supervised by a faculty member at Loyola University Chicago Stritch School of Medicine, is investigating whether interdisciplinary health partnerships improve health outcomes and have a positive affect on social determinants of health. Through adherence to partnership confidentiality and privacy rules, the public health student is able to access data collected through the partnership and interview clients served by teams of doctors, residents, law students, and social work students.

Since taking its first patient/client in 2010, the Health Justice Project has addressed more than 1,400 legal issues for more than 1,100 patient/clients of Erie Family Health Center, contributed pro bono hours that are the equivalent of more than $4 million in attorneys fees, obtained reimbursement of medical expenses to Erie Family Health Center after winning Medicaid denial appeals, trained more than two hundred health care providers and more than one hundred students in interdisciplinary health advocacy, jointly commented on government rule making related to public health, visited Capitol Hill to educate legislators on the model, represented national organizations in addressing health disparities, and engaged in creative problem solving.

The Health Justice Project demonstrates how interdisciplinary collaboration can improve patient health among low-income and minority patients and provides a replicable model for law, medical, and social work school implementation. Interdisciplinary health partnerships provide an unparalleled opportunity to foster collaboration between a university's graduate schools and the surrounding community, improve community health outcomes, and invest in students—the next stewards of public health and society.
Notes

1. Practice of law “often requires some degree of convervance with other disciplines—at the very least, an ability to know when to seek the assistance of other types of professionals or experts,” Joan S. Meier, Notes from the Underground: Integrating Psychological and Legal Perspectives on Domestic Violence in Theory and Practice, 21 Hofstra L. Rev. 1295, 1296–97 (1993).


5. Id.


13. Weinberg & Harding, supra note 2, at 34.

14. See id.; Emily A. Benfer et al., Advancing Health Law & Social Justice in the Clinic, the Classroom and the Community, 21 Loyola U. Annals Health L. 241 (2012).


17. For example, see Loyola University Chicago’s Center for Urban Research and Learning, at http://www.luc.edu/curl.

18. In fact, this is one of the reasons students are drawn to interdisciplinary education. Steven J. Hoffman, Daniel Rosenfield & Louise Nasmith, What Attracts Students to Interprofessional Education and Other Health Care Reform Initiatives?, 38 J. ALLIED HEALTH e-75, e-76 (2009).


22. See. e.g., Alexis Anderson, Lynn Barber & Paul R. Tremlay, Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism and Mandated Reporting, 13 CLINICAL L. REV. 169 (2007) (discussing the differences in reporting obligations between attorneys and social workers); Heather A. Wydra, Keeping Secrets Within the Team: Maintaining Client Confidentiality While Offering Interdisciplinary Services to the Elderly Client, 62 FORDHAM L. REV. 1517, 1541–43 (1994) (discussing the effects of an interdisciplinary team on attorney-client privilege). For a discussion of how to come to terms with ethical divides between disciplines, see Brustein, supra note 7; Galowitz, supra note 10.

23. For a detailed discussion of barriers related to cost and class size, see Connolly, supra note 3.

24. Id; see also Weinberg & Harding, supra note 2, at 37; Randye Retkin et al., Lawyers and Doctors Working Together—A Formidable Team, 20 HEALTH LAW, 33, 33 (2007).


32. Tokarz, supra note 16.

33. "Provokeurs share their passion so that students can see the value of such a choice." Jane H. Aiken, Provocateurs of Justice, 7 CLINICAL L. REV. 287, 296 (2001).


36. Hot spots are areas defined by disproportionate health costs per resident.


38. Food deserts are areas that lack access to fresh produce, whole grains, milk, meat, and other foods that make up the full range of a healthy diet. See http://www.cdc.gov/features/fooddeserts.


42. Linda Morton et al., Teaching Interdisciplinary Collaboration: Theory, Practice, and Assessment, 13 Quinnipiac Health L.J. 175, 177 (2010).

43. Retkin, supra note 24, at 34.

44. "Doctors and other members of the health care team often use the assessment tool I-HELP (Income Supports, Housing and Utilities, Education and Employment, Legal Status/Immigration, and Personal and Family Stability and Safety) to identify unmet basic needs that have an impact on health and that may be responsive to legal remedies." Pamela C. Tames et al., Medical-Legal Partnership: Evolution or Revolution? 45 CLEARINGHOUSE REV. 124, 131 (2011).


46. See Megan Sandel et al., Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations, 29 HEALTH AFF. 1697, 1698 (2010).
47. See, e.g., Sylvia Caley et al., The Private Bar: Partner for Healthy Communities, 35 J.L. MED. & ETHICS 112, 113 (2007).

48. See Connolly, supra note 3; Galowitz, supra note 10, at 2143 ("Law students need opportunities to learn how to collaborate with other lawyers and to work in an interdisciplinary team. The law school curriculum should incorporate methods and methodology for interprofessional collaboration.").

49. See, e.g., Retkin, supra note 24, at 35.

50. Weinberg & Harding, supra note 2; Connolly, supra note 3, at 44.

51. The National Center for Medical Legal Partnership offers multiple resources for the design, implementation, and evaluation of partnerships, including medical and residency program curricula. See http://www.medical-legalpartnership.org.


55. Id.


60. Jennifer Wehunt, The Food Desert, CHICAGO MAGAZINE (July 2009). Chicago neighborhoods with out easy access to a grocery store shrank 40 percent from 2006 to 2011, according to Chicago-based Mari Gallagher Research & Consulting Group, the firm that conducted the first study of Chicago food access. About 384,000 residents, most of them African Americans on the West and South sides, live in food deserts, down from about 650,000 five years earlier—and Mari Gallagher, principal of her namesake firm, says that number likely has dropped by at least 20,000 in the last year. Brigid Sweeney, Can Whole Foods Help Turn Food Deserts into Oases?, Chi. Business, Feb. 18, 2013, http://www.chicagobusiness.com/article/20130216/ISSUE01/302169979/can-whole-foods-help-turn-food-deserts-into-oases#ixzz3SYA3gVRD.

61. Adam Sege, UTILITY ACCESS AND HEALTH, NATIONAL CENTER FOR MEDICAL LEGAL PARTNERSHIP 4 (June 2010).

62. Id. at 3.

63. Id. at 2.
64. CHICAGO DEPARTMENT OF HEALTH, OPENING DOORS TO HEALTH CARE FOR IMMIGRANTS AND REFUGEES, available at http://www.cityofchicago.org/.../PP_Open%20Doors%20to%20Health%20Care%20Appendix.pdf


72. For summaries of recent cases handled by interdisciplinary teams, resources and additional materials, see the Health Justice Project at http://www.luc.edu/healthjustice or contact ebenfer@luc.edu. For an example of creative advocacy on the part of law, social work and public health students, see Meribah Knight, Homeless Families Walking a Hard Road, N.Y. TIMES, Dec. 10, 2011, available at http://luc.edu/healthlaw/hjp/hjp_pdfs/Homeless_Families_Walking_a_Hard_Road_-_NYTimes.com.pdf.
Appendix A
Loyola University Chicago School of Law Health Justice Project
Legal Assistance Consultation Report

CONFIDENTIAL

Date of Report: ______________________
Sender's Initials: ____________________
Client Name: ________________________
MRN: _______________________________
Referring Provider: ____________________
Action Taken: _________________________
Client contacted ______________________
Case referred to outside organization(s) listed below (at next patient visit, please encourage patient to contact organization) ________________________________
  Issue resolved ______________________
  Legal representation in progress ________________
  Provided resource(s) listed below (at next patient visit, please encourage patient to review resources) ______________________________
  Unable to reach patient ____________
Notes: ________________________________
Thank you for your referral.
Appendix B
Loyola University Chicago School of Law Affiliation Agreement

This agreement ("Agreement") is entered into by and between Loyola University Chicago ("University"), an Illinois not-for-profit corporation and Erie Family Health Center ("Center") and is effective and commences on January 19, 2011, and terminates on January 18, 2014. It is the intent of the parties to continue the partnership after the initial term if the parties mutually agree it continues to serve a valuable purpose for University students and Center patients/clients.

WHEREAS, vulnerable populations, including racial and ethnic minorities and low-income populations, disproportionately suffer from health disparities;

WHEREAS, health and healthcare are a function of not only access to healthcare, but also social determinants of health that may be resolved by legal intervention;

WHEREAS, the parties to this Agreement recognize that Interdisciplinary collaboration is crucial to promoting the health and wellbeing of their patients/clients and ideal setting for education students,

WHEREAS, the Center and the Health Justice Project ("Clinic"), a legal clinic at the School of Law, desire to form a medical-legal community partnership in order to provide legal services to Center patients and remedy social determinants of health;

WHEREAS, the University desires to establish at Center an education program to provide learning opportunities and experiences to students enrolled in the Clinic; and

WHEREAS, the Center supports the provision of such opportunities and experiences to students and desires to have the Clinic students on its premises;

NOW THEREFORE, in consideration of the promises set forth in this Agreement, the parties agree as follows:

1. Erie Family Health Center Coordinator. Dr. David Buchanan of the Center is the partnership coordinator who will identify and appoint a "Physician Champion" at each site. The Physician Champion will coordinate qualified patient access to the Clinic. In this capacity, the Physician
Champion is responsible for ensuring that Center providers know about the medical-legal community partnership and the Clinic's services and how to refer patients to the Clinic appropriately. David Buchanan and/or the appointed Physician Champion will also conduct necessary communications with Center's administrators about the partnership and Clinic operations. In the event Dr. Buchanan and/or the appointed Physician Champion resigns or is terminated from the Center, the President and CEO of the Center will consult with the Clinic and appoint a mutually agreed upon Physician Champion and Partnership Coordinator.

2. Curriculum. The Clinic shall be responsible for establishing the content of the curriculum of the Clinic and the method of instruction.

3. Legal Representation and Supervision. Emily Benfer and authorized University staff will train and supervise University law students in the delivery of legal services to Center patients in one or more basic needs areas, such as Social Security Disability Income, Temporary Assistance to Needy Families, Medicaid, and Food Stamps. Cases will be screened for conflicts, educational utility and eligibility. Legal representation will include on-site intake, referrals to local service providers and attorneys, provision of legal advice and brief legal services. The Clinic retains the right to accept or decline representation of clients seen at the Center or referred by Center staff members.

4. Onsite Intake. The Clinic will host weekly or bi-weekly office hours for intake in at least one Center site. The Clinic will make a reasonable effort to refer any cases it declines.

5. Authorized Project Staff and Students. The Clinic reserves the right to provide additional staffing in order to provide appropriate educational opportunities to students and representation to the clients retained by the Clinic. The Clinic will accept new student enrollment, of approximately 6 to 10 students, every semester. Loyola will notify the Center with the names of staff persons and students.

6. Student Records. The Center shall comply with the applicable provisions of the Family Educational Rights and Privacy Act of 1974 and shall take all measures necessary to ensure the confidentiality of any and all information in its possession regarding the students participating in the Clinic.

7. Removal of Students. The University has the right to remove a student from the Clinic. The University shall notify the Center of such removal in writing. The Center may immediately remove any student participating in the Clinic from the Center's premises for behavior that the Center deems to be an immediate threat to the health or welfare of the Center's clients, staff members or visitors or to the Center's operations. In such event, the Center shall notify the Clinic in writing of its actions and the reasons for its actions as soon as practicable. If the Center desires to remove a student for any other reason, the Center shall notify the University in writing of the reasons for the removal and shall consult with the University before removing the student.
8. *Erie Family Health Center Policies.* The Center and the Clinic shall provide an orientation to the students participating in the Clinic to familiarize them with the Center and its applicable policies, rules, standards and practices. The Clinic shall inform such students to abide by those policies, rules, standards and practices.

9. *Erie Family Health Center Facilities.* The Center agrees to allow Clinic employees and students in any staff congregation areas in order to facilitate collaboration between partners and to allow the Clinic to instruct students. The Center is responsible for providing Loyola employees and students with access to: a confidential meeting space that includes access to telephone service and internet connection, a file cabinet that locks, and office supplies such as a fax machine and copier.

10. *Transportation.* University students participating in the Clinic shall be responsible for their transportation to and from the Center.

11. *Identification.* The Clinic shall advise its students to wear any appropriate identification provided by the Center and any uniform required by the Center while participating in the Clinic. Neither the identification nor the uniform shall indicate that such students are members of the Center’s staff. The Clinic shall inform its students to identify themselves to Center clients, staff members and visitors as students of the Clinic.

12. *Emergency Care.* In the event any student becomes ill, injured or is exposed to hazardous materials while on the Center premises and a Clinic staff member is not available, the Center shall, upon the request of such student or as appropriate in an emergency, provide or arrange for the provision of any necessary immediate or emergent care. The student receiving such care shall be responsible for the cost of such care.

13. *Information Sharing.* The Clinic and the Center will at all times comply with professional ethical codes, state law, and federal law concerning privacy and confidentiality. The Clinic and the Center will obtain appropriate releases from patients/clients that allow for the sharing of non-privileged information in legal files or medical records to the extent that it furthers the legal representation or medical care of the patient/client. With client release and waiver, Clinic staff may discuss the case or share medical records with other members of the Center or the University for the purposes of providing appropriate representation to clients or for the purposes of student supervision. The Center and the Clinic are responsible for identifying and developing appropriate release forms. The Center and the Clinic agree to cooperate on data collection and analysis. The Clinic retains the right to exclusive possession of the legal files of clients referred by the Center.

14. *Materials and Training.* The Clinic is responsible for creating, editing and publishing "Know Your Rights" manuals and referral guides for Center patients and employees. The Center is responsible for reviewing and prominently displaying resources and materials related to the Project. The Clinic will conduct trainings for doctors, medical students, and front-line staff
that emphasize not only screening and referrals but also physician engagement in the advocacy process. The Center is responsible for actively assisting in the development of curriculum for physicians, medical students and front-line staff training. The Center is responsible for setting aside fifteen minutes during grand rounds or other mandatory meeting times at least once per month for trainings facilitated by the Clinic and/or the Center to further affective collaboration.

15. Accreditation. Each party to the Agreement represents that it has received the appropriate current approvals and accreditation as required by state regulatory agencies and pertinent health care, institutional and professional accrediting bodies and will immediately notify the other party of any changes in such approvals or accreditations. The parties shall take reasonable measures to maintain the standards necessary for the Center, the University and the Clinic to be and remain eligible for accreditation by the appropriate agency or body.

16. Evaluation and Improvement. The Clinic and the Center agree to create an evaluation tool to measure the success and shortcomings of the medical-legal community partnership, which will adhere to existing national protocols for medical-legal partnership evaluations, and to participate in partnership development trainings as needed.

17. Development Support. The Center and the Clinic agree to collaboratively seek out additional funding and development support for the medical-legal community partnership as necessary.

18. Non-Discrimination. Neither party shall, in connection with any aspect of its performance pursuant to this Agreement, discriminate against any person by reason of race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability, marital or veteran status or any other characteristic protected by applicable law.

19. Independent Parties. In the performance of all work, duties, and obligations pursuant to this Agreement, the University and the Center are at all times acting as independent parties and neither of them nor their respective employees, faculty members or staff members shall be deemed to be the employee, agent or joint employee of the other. Neither party shall owe or be required to pay to or on behalf of any employee of the other party any compensation or benefits, including but not limited to the payment of any taxes related to employment, workers’ compensation or unemployment insurance.

20. Students as Learners. While participating in the Clinic, students shall have the status of learners and are not to replace Clinic or Center staff members. Nothing in this Agreement shall be deemed to create an employer-employee relationship between a student and the Center or Clinic. Students shall not be considered employees for any purpose while participating in the Clinic and are not entitled to any compensation or benefits, including but not limited to the payment of any taxes related to employment, workers’ compensation or unemployment insurance.

21. Insurance. During the term of this Agreement, the University shall maintain professional liability insurance with limits of $1,000,000 per occurrence/$3,000,000 in the aggregate
for the acts and omissions of Clinic students while participating in the Clinic pursuant to this Agreement. Upon the written request of the Center, the University shall furnish the Center with a current certificate of insurance or other evidence of coverage. Any certificate of insurance shall contain a clause stating that such insurance will not be modified or terminated without the insurer providing the Center with thirty days prior written notice.

22. Actions Adverse to Erie Family Health Center. The Clinic agrees not to provide legal representation to families or individuals as part of the medical-legal community partnership or otherwise where initial contact was made through the program, if the nature of the representation involves an action directly or indirectly adverse to the Center, or their employees, agents or directors either directly or indirectly.

23. Indemnification. Each party shall indemnify and hold harmless the other party and its affiliates, trustees, officers, directors and employees from and against any and all claims, liabilities, obligations, damages, costs, expenses, fines, demands and causes of action of every kind of character (including reasonable attorney's fees or, upon the option of the indemnified party, the indemnifying party shall provide a defense to the indemnified party) related to or arising out of any act or omission of the indemnifying party or its trustees, officers, directors or employees; provided, however, that the indemnified party provides the indemnifying party with prompt written notice of the claim and cooperates fully with the indemnifying party in the settlement or defense of the claim. This indemnification provision shall survive the termination of this Agreement.

24. General. Neither the University nor the Center may assign this Agreement without the prior written consent of the other party. Any attempt to assign this Agreement without such consent shall be void. This Agreement contains all the terms and conditions to which the parties have agreed and supersedes any and all prior understandings, agreements, promises, warranties and representations, whether oral or written, relating to the subject matter of this Agreement. This Agreement may be amended only upon the mutual written agreement of the parties. This Agreement shall be governed by and construed under the laws of the State of Illinois.

25. Termination of the Agreement. Either party may terminate the Agreement by giving the other party a ninety-day written notice addressed to the appropriate position of the party set forth below. In the event the termination date occurs during a school semester in which students are enrolled in the Clinic, the Agreement shall remain effective until the end of the semester in order to allow students to complete their work.

APPROVED AND ACCEPTED:

By: ____________________________

Lee Francis  Date __________________

President and CEO

Erie Family Health Center
By: ______________________________
John Pelissero Date ______________________________
Provost
Loyola University Chicago
By: ______________________________
David Yellen Date ______________________________
Dean
School of Law
(See .pdf for signatures)