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Physicians, Nurse Practitioners and ODSP Applications: Towards a New Model of Partnership with Community Legal Clinics

NICHOLAS HAY*

When completing the Ontario Disability Support Program (ODSP) application for their low-income patients, physicians and nurse practitioners are met with the difficult task of mapping their clients’ unique medical conditions onto an unfamiliar legal test. Accordingly, an inordinate number of ODSP applications are denied at the outset because the information healthcare professionals provide in the application is insufficient. While some blame physicians for this shortcoming, interviews conducted by the author with healthcare professionals reveal their side of the story and offer insights into how community legal clinics can work with healthcare professionals to improve the legal and medical services low-income patients receive. The author argues that in order to facilitate a long-term solution what is required is a model of cooperation between those in the legal and medical professions, particularly in the form of medical-legal partnerships (MLPs).

THE ODSP APPLICATION, “replete with boxes to be checked and blanks to be filled in, inscriptively characterizin[g] bodies cruelly as either disability eligible, or not,” leaves physicians and nurse practitioners with the unenviable task of mapping the unique ways that disability is embodied in the everyday lives of low-income individuals onto an unfamiliar legal test. ODSP is one of Ontario’s social assistance programs. It provides income and employment supports to Ontario residents who have disabilities and are in financial need, helping to pay for

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living expenses such as food and housing, as well as health benefits, including drug and dental coverage. Every ODSP applicant must submit a “Disability Determination Package,” portions of which must be completed with an approved healthcare professional, to the Disability Adjudication Unit (DAU). The package is designed to collect information about the applicant’s medical condition, associated impairments and restrictions, and the expected duration, as well as the impact of the impairments on the applicant’s ability to work, perform self care, and participate in the community.

In the fall of 2016, as part of the Poverty Law Intensive Program at Osgoode Hall Law School, I worked as a caseworker in the Social Assistance, Violence, and Health (SAVAH) division at Parkdale Community Legal Services (PCLS), a community-based legal clinic for low-income residents of the Parkdale and Swansea neighbourhoods in west Toronto. A large majority of my clients were ODSP applicants who had been denied ODSP after submitting an initial application. My colleagues and I were then responsible for contacting physicians and nurse practitioners to collect medical information and records that had not been included in the original application, or to ask the healthcare provider who had completed the application to fill in sections of the application left blank. While cooperative, almost every healthcare provider I spoke with expressed frustration with the nebulous application. I sought out a more collaborative way of completing the application process and providing health and legal services to low-income patients and clients.

Through conducting interviews with physicians and nurse practitioners, I sought to better understand their frustrations with the ODSP application process and what could be done to enhance the quality and completeness of applications, and more broadly to improve services and outcomes for low-income patients and clients. In light of the responses from the participants, I argue that the solutions transcend the deficiencies of the ODSP application process. More specifically, while providing doctors with information and pamphlets about how to complete ODSP applications is helpful, I believe that this approach only offers a semblance of progress. Instead, a more systemic approach is required, one that shifts the nature of the relationship between community legal clinics, such as PCLS, on the one hand, and the medical profession on the other, from one of opposition, to one of cooperation. I contend that MLPs between community legal clinics and local hospitals or healthcare centres are integral to creating an environment that will facilitate more successful ODSP applications and improve patient well-being. The opinions of the doctors and nurse practitioners in this article are not meant to be representative of their respective professions. Rather, the goal of this article is to start a conversation about the ways in which healthcare providers and community legal clinics can work together to provide better services for low-income patients and clients.

I. EXPLORING A NEW PERSPECTIVE: A BRIEF OVERVIEW OF EXISTING RESEARCH

While legal scholars have dealt extensively with the shortcomings of the ODSP application process, what is absent from scholarship around improving health services for low-income patients, particularly regarding completing ODSP applications, are the perspectives of physicians and nurse practitioners. This study acts as an initial foray into the topic. The solutions that have been offered to the process’s deficiencies so far are legal-centric and based in law reform. For example, Lorne Sossin has examined the “bureaucratic disentitlement” of the ODSP service delivery model, calling it “not only unfair and unreasonable, [but] also unsavoury, invidious, and
oppressive” in furtherance of his argument that the rule of law should extend to the broken administrative structures through which ODSP mediates its decisions.²

Further, the few qualitative studies that have been conducted in this area make little reference to the opinions of healthcare providers about, or their role in, the process. A study by Peter Houghton interviewed ODSP applicants and their advocates to understand how a client’s voice is transmitted through their advocate, from the beginning of the process to their hearing at the Social Benefits Tribunal. During Houghton’s study, the participants and their advocates shared examples of the many medical barriers to ODSP, leading Houghton to aptly observe that “doctors were thought to be essential allies in their efforts to access benefits on their [the advocates’] clients’ behalf … . Despite the doctor’s and advocate’s best intentions, only so much can be done prior to the application as in many cases it is not completely clear what exactly the DAU expects in applications.”³

The closest scholarship comes to exploring the perspectives of healthcare providers is the work of Carolyn Dewa et al, who interviewed physicians and other clinicians about the difficulties they encounter in assessing public long-term work disability benefits related to mental disorders.⁴ In their article, Dewa et al are clear: “[a]lthough essential to the work disability process … there [remains] a gap in the literature regarding how physicians or other clinicians … perform [their] duties when addressing … disability benefits. Yet … this type of information is essential to develop[ing] processes to support providers who participate in the assessments.”⁵ While Dewa et al’s article is helpful—in particular, its conclusion that in the ODSP process, clinicians “experience conflict emerging from the two roles of advocate and medical expert”—it is extremely limited in scope, and as the authors astutely recognize, still leaves a gap in the scholarship in regard to how physicians generally perceive and interact with the ODSP application process.⁶ This project will attempt to fill that void.

II. MEDICAL-LEGAL PARTNERSHIPS: A NEW MODEL, A NEW WAY FORWARD

MLPs, also known as Justice & Health Partnerships (JHPs) are “collaborations between healthcare providers and legal professionals designed to build legal awareness and literacy, increase access to legal services, reduce health disparities, and improve health outcomes.”⁷ There

⁵ Ibid at 2.
⁶ Ibid at 13.
are two main models of MLPs: 1) a referral model, where the lawyers and healthcare providers work together, but in separate buildings; and 2) an on-site model, where the lawyer works at the medical centre, approximately once a week. While MLPs have proliferated elsewhere—as in Australia, or especially the United States, where nearly 300 hospitals and health centres have established MLPs—this concept is new to Canada. In Ontario, the first MLP project began in 2009 when the Hospital for Sick Children (SickKids) and Pro Bono Law Ontario teamed up to launch the Family Legal Health Program, aimed at assisting families with some of the non-medical challenges that impact the health of children. Since then, only a handful of other MLPs have developed in Ontario, notably at other paediatric hospitals and at the St. Michael’s Family Health Team. Ultimately, I will argue that MLPs provide a way for community legal clinics to address many of the issues highlighted by the participants in this study, and the potential to transform the way healthcare providers and legal clinics work together to improve patient well-being.

III. THE STUDY

I conducted a total of twenty interviews between 16 November and 9 December 2016. The interviews ranged in length from approximately fifteen minutes to an hour, with an average duration of thirty-five minutes. The participants represented the two main clinical disciplines that are authorized to complete all of the ODSP forms: physicians (n=14) and nurse practitioners (n=6). In lieu of the participants’ names, “NP” (for the nurse practitioners) and “DR” (for the physicians) are used in order to maintain their anonymity. An important caveat to this study is that the participants were only from a small portion of the various healthcare models: community health centres (n=15); family health teams (n=2); and hospitals (n=3), and had an interest in improving health services for those in poverty. More specifically, the inclusion criteria stipulated

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9 Pamela C Tames et al, “Medical-Legal Partnership: Evolution or Revolution?” (2011) 45:2 Clearinghouse Rev 124. As Tames et al mention, the MLP is the brainchild of Dr. Barry Zuckerman, who was frustrated with “the numerous instances of paediatric patients who had asthma and suffered repeated attacks and hospitalizations due to abysmal housing conditions. [He] realized that patient health would not improve without remediation of those housing conditions through the intervention of a lawyer” (at 124).
10 More specifically, an in-house lawyer is available to meet with families at SickKids, sometimes at the child’s bedside, to provide legal advice and guide families through legal processes, or to connect them with a lawyer in the community who can provide the necessary legal services, all free of charge. Although this partnership is not about ODSP applications in particular, but rather, an on-site hospital service, it has since expanded to other children’s hospitals in London and Ottawa. See SickKids, “Celebrating five years of partnership with Pro Bono Law Ontario,” online: <www.sickkids.ca/AboutSickKids/Newsroom/Press/2014/PBLO-SickKids-celebrate-five-years-of-partnership.html> [perma.cc/Y48H42PN].
12 Interviews of physicians and nurse practitioners who serve low-income patients or have worked in a medical-legal partnership (16 November - 9 December 2016) (on file with author) [Interviews]. Seventeen of the interviews were conducted by telephone, while the other three were conducted in person. Each interview was recorded and transcribed verbatim.
13 I think it is important to note here that, interestingly, the responses from the NPs and the DRs to all of the questions were nearly impossible to differentiate. I have identified them by their profession to display these similarities, and of course, to allow readers to draw their own conclusions.
that they must either serve the Parkdale community, regularly serve low-income patients, or have worked within a medical-legal partnership.

The first section of my interview was aimed at ascertaining the provider’s experience with ODSP applications, including questions about how often they complete ODSP applications, how long it takes them to complete an application, and what they believe are some of the difficulties they and their patients experience in completing an application. The questions in the second and third sections of my interview were aimed at whether the providers had received any education around completing ODSP applications, or treating low-income patients, either during medical school, or as part of their Continuing Medical Education requirement mandated by the College of Physicians and Surgeons. The fourth and final section of the interview asked the healthcare providers who were involved in an MLP what they thought were some of the benefits and shortcomings of the partnership.

An important limitation of this study is its relatively narrow sample. While I solicited interviews from healthcare providers throughout the Parkdale area, the healthcare providers who were willing to speak to me were those who have worked closely with PCLS, and on the whole, complete strong ODSP applications. However, as this study will show, even these healthcare providers struggle on a daily basis with navigating the application process. This study invites the reader to consider how these struggles might be exacerbated for doctors who do not work as closely with a community legal clinic or serve low-income patients regularly.

Another important qualification to this study is that it should not be read as furthering the medicalization of poverty. The closer community legal clinics work with healthcare providers, the greater the danger that the solution veers toward getting low-income patients onto ODSP, and labelling poverty an illness rather than approaching the issues of poverty and empowerment strategically and systematically. I make an observation in this article that MLPs may provide a viable solution to the issues facing the ODSP process, but that contention is subject to further research, beyond the scope of this article, on the relationship between MLPs and the medicalization of poverty.

A. FINDINGS FROM THE STUDY

1. FREQUENCY AND DURATION

In terms of how often the interviewees complete ODSP applications, one physician responded, “Does ‘too often’ count as an answer? Frankly, I dread them.” The answers of the other healthcare providers reflected a similar sentiment that their completion rate is affected by the laboriousness of the application. In total, eighteen out of the twenty participants fell within the range of completing one to three ODSP applications per month. The two outliers had higher rates, both completing approximately two ODSP applications per week. Several of the participants also said that they were behind. Comments such as, “I have twelve [applications] in various stages,” or, “I have seven sitting on my desk right now” were common.

14 Also known as the Continuing Professional Development (CPD) requirement, members of the College of Physicians and Surgeons of Ontario must attend a certain number of hours of CPD workshops throughout the year. Nurse practitioners must meet a similar requirement.
15 Interviews, supra note 12 (DR8 Interview).
16 Ibid (DR5 Interview; and NP2 Interview).
17 Ibid (NP2 Interview).
Many of the interviewees also pointed out that they believe they complete more ODSP applications than the average healthcare provider.\(^\text{19}\)

In response to the question of how long it takes them to complete an ODSP application, every participant responded with, “it varies.” The most common variables were: 1) how long the provider had known the patient; and 2) whether the patient’s medical records were readily accessible. As NP4 explained, “Honestly, I could do all of it in an hour for sure, if everything’s together, but if it’s … somebody I don’t know well, it could take weeks, because of gathering medical documentation, getting the patient to fill out their piece, and to get my piece done.”\(^\text{20}\) Particularly astounding was that none of the interviewees said they spend less than forty-five minutes on an application,\(^\text{21}\) and interestingly, there were no disparities between the amount of time the nurse practitioners and the physicians afford the application. In fact, the interviewee who said they spend the most time on the application was a physician, who commented:

> I’ll tell [my patients], ‘look, the government really likes to reject these applications. I think it makes more sense for us to take three months and do this properly and put in all the effort and get you approved’…. The worst-case scenario is that we only put in 80% of the effort and we later find out that they have all these hospitalizations and records that we could’ve gotten, and that would have made a difference, and now we’ve waited four months just for a rejection.\(^\text{22}\)

Further, it should be noted that several of the interviewees mentioned that they must complete the applications on their own time. As NP5 put it, “I’ll take it home on the weekend and work on it. I don’t have the concentration at work with everything else that’s going on, so I often do it on some of my own time, or I have to cut off clients to do this. It takes some concentration if you’re going to do it justice, do it properly.”\(^\text{23}\) In an MLP, caseworkers at the legal clinic could assist doctors in gathering medical evidence. Presently, caseworkers at legal clinics such as PCLS assist with much of the “evidence collecting” but at a much later stage in the process: once a client has been denied and an appeal has been filed. Earlier intervention by caseworkers would not only free up time and resources for the providers, but lead to fewer ODSP appeals, which would save valuable legal clinic resources.

2. DIFFICULTIES FOR HEALTHCARE PROVIDERS

i. An Adversarial Process

\(^{18}\) Ibid (NP6 Interview).

\(^{19}\) While I was not able to corroborate this assertion given the limited scope of this study, I think this point is still salient: that many of my interviewees believed they were more experienced in this area than their average colleague is likely—at least, in part—what drew them to this study.

\(^{20}\) Interviews, supra note 122 (NP4 Interview).

\(^{21}\) NP6 and DR14 were the only two healthcare providers that said they spend less than an hour, and they both said they spend forty-five minutes on the application.

\(^{22}\) Interviews, supra note 122 (DR13 Interview). It should be noted here that this doctor also said they will help the patient request an extension for more time so they can collect medical evidence.

\(^{23}\) Ibid (NP5 Interview). DR8 and DR6 made similar comments.
The most common frustration for the interviewees was that the ODSP process does not value their professional opinion. NP1 explained that, “it’s not that [healthcare providers] aren’t compassionate. They’re just not used to being questioned [and] frankly, they should just be able to write ‘disabled’ and that should be okay, because that comes with being a physician.”

Or, as NP2 suggested, “have it policed through our college. If you think I’m really willy-nilly with ODSP, just like if I was prescribing something willy-nilly, it’s the college that people complain to … If I am not comfortable doing an ODSP application, then I just don’t do them. And then the people that got rejected, I just think, ‘who reviewed that, and how do they know them better than me?’”

The participants expressed that this devaluation is most evident in cases of mental illness. As DR8 pointed out:

One thing I’ve learned, unfortunately, over the years is that … if a mental illness or an addiction is [the patient’s] main disability, ODSP doesn’t believe what the heck I say as a family doctor. They think I’m making it up, so there has to be a psychiatrist’s report …. I mean it’s sort of weird, they’ll believe me as a [general practitioner] if I say the patient has cancer, [but] as a [general practitioner] in a [community health centre] I know way less about cancer than I do about schizophrenia. It’s a very odd professional divide … [and] frankly, it’s disrespectful to family doctors, especially to those of us who work a lot with people with mental illness.

Much like DR8, many of the interviewees expressed the belief that doubt about their professional opinion is woven into the fabric of the process itself. This then creates significant barriers for their patients who do not feel comfortable going to see a psychiatrist:

Mental illness is a spectrum … and so my personal feeling is that [ODSP believes] that as family doctors we may be too attached to the patient, and perhaps, we may be over-diagnosing things …. I think from the beginning [ODSP] did not accept psychiatric diagnoses from family doctors, that was something that was built right into [the process], and I’m not sure on what grounds.

[…] [We always get asked for an] updated psychiatrist’s report … that’s where it would be nice if we could just be taken at face value …. Us NPs, we’re not psychiatrists but we do mental health assessments all the time. [Our patients] trust us, and like us. We’re the ones providing all their psychiatric care. They’re not going to a psychiatrist, they can’t get there, we’re it. But our reports will not count. That has been a real barrier to many of our patients.

24 Ibid (NP1 Interview).
25 Ibid (NP2 Interview).
26 Ibid (DR8 Interview).
27 Ibid.
28 Ibid (NP1 Interview). DR3 made a similar observation: “There’s a need to get a psychiatrist’s report because a psychiatrist’s word is privileged over that of a family doctor, … but] not everybody needs a psychiatrist’s report. … Or they might not have been to see a psychiatrist in a couple of years … [while] their family doctor has been
During my time at Parkdale, I saw several applications that were denied because of the absence of a psychiatrist’s report. One wonders to what extent this is a product of the stigma still attached to mental health, and in particular, the misconception that if a patient has not been to a psychiatrist, then they cannot be suffering from a mental illness. Or, as NP1 points out, there is a general insensitivity on the part of the DAU, and a lack of understanding around the barriers that the low-income patient faces and who simply “can’t get [to a psychiatrist].” Or as NP3 described, the patients who “are cut off from services like psychiatry because they miss too many appointments . . . I have not been able to find a psychiatrist in the city that has walk-in hours. And our patients often don’t have telephones . . . or health cards which are huge barriers to making appointments.” Several of the healthcare providers I spoke with highlighted a lack of accessibility to psychiatrists, even for community health centres, due to a general shortage of psychiatrists, and a lack of translation services as a further barrier.

Many interviewees expressed this discounting of their professionalism and their capabilities as disempowering. However, other healthcare providers mentioned that it is simply a matter of knowing what the DAU is looking for: if the healthcare provider provides reasons for why their patient has been unable to see a psychiatrist, the DAU will often accept that. What this shows is that if legal clinics and healthcare providers could work together on these issues, then the process would seem less disempowering to healthcare providers and better results could be achieved. The opportunity for such collaboration was perhaps most evident in the situation NP2 described: “[one of my patients] can’t get a health card because [they] don’t have an address, so I can’t send [them] to either the neurologist or the psychologist. So it’s fallen to a standstill [and] now, it’s about, how do we get you housing, to get you an address, to get you a health card?” As I will postulate further later in this piece, I believe that MLPs can provide the sufficient nexus, the necessary interdisciplinary approach, that is required to effectively address these issues.

ii. The Gatekeeper Phenomenon and The Fear of Imposing Lifelong Sentences

A common point of discomfort described by several of the healthcare providers in my study was filling out an ODSP application for a patient they did not believe had a disability. What often accompanied this discomfort was the perception that ODSP is a lifelong benefit and confusion

following them for fifteen years. The family doctor probably still has a sense of whether they’re depressed or not” (Ibid (DR3 Interview)).

29 Ibid (NP3 Interview). NP3 added: “Getting past medical history, like psychiatric assessments, to substantiate the application, is a huge barrier for people. There are many people who don’t have those assessments but are still low-functioning.” It should also be noted here that other participants, like DR1, expressed concern that it is equally difficult for low-income patients to access other treatment modalities like physiotherapy and chiropractic services.

30 Ibid (DR3 Interview; and DR8 Interview). As DR8 articulated: “Community health centres have had very, very limited access to psychiatric assessments. At the moment in our community health centre we actually have a psychiatrist who works a couple of days a month, so our access is fantastic at the moment, meaning the patient only has to wait three or four months to get an appointment . . . these are the glory days for us. [In terms of translation] we’ve tried to use community services for psychiatric assessments . . . [but] I remember working with an ODSP support worker to get a French-speaking patient a psychiatric assessment, and it took us over a year.”

31 Ibid (NP3 Interview; and NP2 Interview).

32 Ibid (NP2 Interview).
about the healthcare provider’s role in the process. DR8 shared a sentiment that was common among the participants:

For some of [my] patients I’m not so surprised they get rejected, and others, I’m very surprised. For the most part, it’s the former. They haven’t rejected a lot of people I thought really needed to be on ODSP. They rejected a few people where … they have some knee arthritis or diabetes, and that’s really probably not enough to be disabled for the rest of your life… . Some doctors feel really uncomfortable because they see patients and they think: ‘the worst thing possible for you is to be on ODSP. Really, you need to go to work,’ and then they feel like they are in this total bind.33

[…]

There’s a number of patients out there that want ODSP and they probably don’t deserve it. I don’t like to use that language, but there are some people that are just like, you know, ‘my back is a bit sore for six weeks or whatever, I want to get on disability forever’ and … they push and push and it really makes you feel compromised because you feel like there are some people that truly need this program and then there’s some people that just want everything for free and that kind of thing burns [health care providers] out.34

These perspectives are, at least in part, a product of a funding regimen that thrusts onto healthcare providers an elaborate legal process in which their role is ill-defined.35 As a result, many of the participants experienced what I have termed “the gatekeeper phenomenon,” captured by the comments of DR12: “it’s hard being the gatekeeper for that, right? Me not doing this form for you means that you can’t pay your rent. That’s not really a nice position to be in …. We’re prescribing people’s rent and their food.”36 Because of this feeling of being the gatekeeper, some of the participants said they will refuse to fill out the form altogether, or, if they believe the person should not be on ODSP, they will complete it but with less effort.37 Conversely, when a patient they believed deserved ODSP is not successful, many of the participants expressed a feeling akin to that described by DR11: “I feel like it’s my fault, I feel like I let them down.”38

33 Ibid (DR8 Interview).
34 Ibid (NP4 Interview).
35 As DR14 explains: “I suspect there’s also a sense of conservatism … in terms of like, I don’t want to overstate this person’s disability because then I’m considered an accomplice to this person being approved for, and getting a benefit that they in fact shouldn’t be getting, and ‘abusing the system,’ so I think there’s a lot of fear around that” (Ibid (DR14 Interview)).
36 Ibid (DR12 Interview). NP4 described something similar: “I’m always trying to prescribe income … Ontario Works is not enough for somebody to get by at all, and ODSP doubles peoples’ income, and it’s really important for some people to pull them out of the worst poverty, you know? Right now, it’s such a piecemeal approach, and so much of it is in our hands here” (Ibid (NP4 Interview)).
37 As DR2 observed, “I certainly know that there are a lot of doctors who don’t put very much effort into the applications and part of the reason is that they don’t really believe their patient should be on disability” (Ibid (DR2 Interview)).
38 Ibid (DR11 Interview). NP1 also mentions, “It’s probably multifactorial why physicians don’t like these forms. I know that they feel rejected when their patients are rejected. It’s emotional for everybody” (Ibid (NP1 Interview)).
In reality, however, ODSP is not a lifelong sentence. A primary function of the ODSP process is to “provide employment supports to help people with disabilities prepare for, obtain or maintain a job.”\textsuperscript{39} Also, medical review dates are set when a person’s condition might improve over time, and approximately 600 medical reviews are sent out by the DAU per month.\textsuperscript{40} In fact, NP6 describes it as part of her patients’ treatment:

A lot of clinicians have the idea that once someone is on ODSP that’s it forever, but I often will say to the [patient] … ‘I’m not writing you off, but right now, you are disabled by your [condition]’ … I will frame it to people [and ODSP] as part of their treatment. [In terms of] the social determinants of health, if I can get you $1300 per month, then you can actually rent a half-decent room somewhere, and then you are not dealing with welfare every three months harassing you to fill in that stupid employment form, and you can maybe engage in some counseling, or some therapy, or go into a treatment program. But if you’re constantly trying to live on $600 per month, that’s never going to happen.\textsuperscript{41}

The role of healthcare providers as “gatekeepers” is also a misconception, albeit a completely understandable one. As DR14 described,

At our workshops, this [belief] always comes up, so I know a lot of providers struggle with it. And the way we always respond to that is, ‘look, we are not the gatekeepers; we are actually not making the decision on whether or not the person is approved. Your job is to just complete the application accurately and then let the patient know they may or may not be approved. It’s not in our hands.’\textsuperscript{42}

These misconceptions are particularly concerning in light of my experiences at PCLS with those who have disabilities that are less “visible.” Given how time-consuming the application is, the limited amount of time healthcare providers have with each patient, and the perceived pressures of being “the gatekeeper,” the process itself seems to force healthcare

\textsuperscript{40} Ministry of Community and Social Services, “Bulletin: Ontario Improving ODSP Medical Reviews,” <news.ontario.ca/mcss/en/2016/02/ontario-improving-odsp-medical-reviews.html> [perma.cc/JBJ7-4GGS].
\textsuperscript{41} Interviews, supra note 12 (NP6 Interview). NP5 was of a similar opinion: “Understanding that complexity—understanding the reality, what that little bit of money means—I think is also a part of the education for providers, to understand ‘this is what your client has to contend with, this is the amount of money that they’re left with, and this is the kind of housing he/she can afford, and this is how little money they have left for food, if any.’ Those kind of realities, that unless you work in [a community health centre] like ours, most independent providers probably don’t have a good understanding of, or don’t have the time to get, that contextual understanding” (Ibid (NP5 Interview)).
\textsuperscript{42} Ibid (DR14 Interview). DR14 adds that given the high burden to meet in order to be eligible for ODSP, there is very little room for conservatism: “I think physicians swing on the end of being unnecessarily conservative in the application, and the way that the application is set up is really like: unless you’re basically in a wheelchair and completely unable to bathe and toilet and do your basic [activities of daily living] … [you] get declined.”
providers into quick and premature decisions about whether the patient in front of them is disabled or not, and thus, less “visible” conditions might be missed. As DR5 describes, “some applications are really easy, you can figure out, ‘this is a person who should be on disability’ [but] maybe they’re claiming they have a chronic pain issue [when] really they have an underlying addiction issue … that still might qualify them for ODSP, but you have to sort of dig, before you even get there.”

DR6 explains something similar:

Sometimes patients can’t identify why they can’t work. It sounds strange but some people, they’ll come in for their chronic back pain, and they’ll want to do the ODSP application, but they kind of seem to be walking okay, and you don’t know if that’s a true barrier to work, or it’s disabling them to meet the criteria of ‘severe and prolonged.’ But then you explore further, and you find out that actually part of this pain experience is that they have alcohol use disorder, and they started drinking because they have social anxiety disorder … or they had trauma. So [that’s] one of the barriers … for people who access walk-in clinics … because you don’t have that full history and context, you can’t appreciate at first glance why they should have ODSP.

An MLP would facilitate conversations in which legal clinic caseworkers could help healthcare providers to better understand their role in the process, by assisting them in completing the application, or by helping them to understand the value of some oft-ignored parts of the application, such as the Self Report—a key section in which the patient is allowed to tell their story—which several of the interviewees mentioned they rely on heavily to determine if their patient has a condition they did not know they had, or one they had trouble expressing.

iii. Unclear Criteria

Perhaps the most surprising aspect of the study was that many of the interviewees commented that it is unclear what criteria are used to determine ODSP eligibility. The reason this was so surprising was that, again, my interviewees consisted of healthcare providers who complete ODSP applications more regularly than the average healthcare provider. And yet, through no fault of their own, this sentiment was prominent throughout the study:

As a doctor, I’m busy trying to second-guess what ODSP is going to want. I don’t really know what they’re looking for all the time. I know that they want severe restrictions, and I know that they want a psych[iatrist’s] report, but other than that it’s never clear to me what degree of evidence they’re going to want. The elephant in the

43 Ibid (DR5 Interview). NP2 also commented on the fact that for many of their patients, “there’s really no diagnosis. It’s probably a little fetal alcohol syndrome, it’s probably a little developmental delay, but nobody wants to do the really expensive testing to ascertain that” (Ibid (NP2 Interview)).

44 Ibid (DR6 Interview). Or, as DR5 put it, “A lot of our patients have head injuries, they have post-traumatic stress disorder, they might have been intoxicated, all kinds of things happen to them, they can’t even tell you what hospital they’ve been to. Sometimes I’ll get a note from a psychiatrist at another hospital and I’ll be like, ‘you’ve been seeing a psychiatrist!??” (Ibid (DR5 Interview)).

45 In my experience at PCLS, the Self Report is not often read by healthcare providers.
room is that the forms are pathetic, and don’t speak a language that most doctors speak. And the adjudication criteria are so opaque.46

[…]

Most of these review processes and forms have no input by physicians… . The adjudicators who look over the forms are not physicians … so I might not include blood work or diagnostic imaging because I know the person that’s reviewing it won’t understand it.47

[…]

I don’t even know what kind of criteria these applications are judged on … like what do you really need?48

[…]

I find that a lot of providers get stuck on—in terms of the level of disability—the checkmark boxes, and that really makes some people uncomfortable.49

[…]

I feel a bit mystified in terms of what they’re looking for in the application, but I feel like what I try to get at [are] concrete, specific, objective observations or functional limitations that can be verified from my end. I feel like that might be my purpose …50

[…]

It would be nice to know exactly what is required, for example, for something like back pain. What does ODSP want done even prior to applying to ODSP? … If you had a condition-specific cheat sheet of what tests need to be done prior to even applying it would save a lot of time and frustration.51

Almost every participant made the comment that the forms, and in particular, the check boxes that make up the Activities of Daily Living (ADLs)52 and Intellectual and Emotional

46 Interviews, supra note 12 (DR8 Interview).
47 Ibid (DR5 Interview).
48 Ibid (NP3 Interview).
49 Ibid (NP1 Interview).
50 Ibid (DR1 Interview).
51 Ibid (DR4 Interview).
52 The ADLs are intended to collect information on the applicant’s ability to perform “daily living” activities, such as eating, grooming, shopping, socializing, taking care of her/his home, going to work, and handling finances. The healthcare provider completing the form is asked to rate the applicant’s abilities on a scale of 1 (no limitations) to 4 (severe or complete limitations on most occasions to completion of the task). In order to be eligible, the applicant
Wellness Scale (IEWS) sections, are not organized in the way a healthcare provider would think, nor are they sensitive to medical terminology. This lack of clarity is then compounded by the fact that healthcare providers do not receive any feedback as to why their patients were rejected or successful. As DR5 put it, “No one ever follows up with the physician … . If the adjudicators have questions, I would happily explain the significance of a grey area.” What is clear here, is that through an MLP, community legal clinics would have the ability to assist healthcare providers from the outset, to build a repertoire of criteria and the tests that need to be performed ahead of time to satisfy those criteria, and to act as intermediaries between the DAU and the healthcare providers in terms of what makes an application successful or unsuccessful. Ideally, the healthcare providers in the MLP could then pass on their knowledge to others in the medical profession to teach them what criteria the DAU is looking for.

iv. Time and Remuneration

Unsurprisingly, comments about lack of time to complete the applications arose frequently. As mentioned previously, many healthcare providers working in community health centres are forced to do the applications on their own time. Ultimately, several providers pointed out that while time concerns may be prevalent across all healthcare models, the remuneration of $100 to complete the ODSP forms for providers outside of the community health centre system is inadequate. DR5 made it clear that,

the remuneration for [the applications], if you’re in private practice, is terrible. If you’re going to do a good application, it doesn’t reflect the time and work that is put in. … [At my community health centre] I get paid an hourly rate, I don’t pay overhead, I don’t bill anything. … But if I’m in my own practice where I have to pay my own secretary, and my own overhead. … [that’s] the stuff that makes you hate the [ODSP] patient.

Through an MLP, community legal clinics can not only assist healthcare providers in advocating for greater remuneration but can work together to come up with ways in which the workload can be shared.

3. BARRIERS FOR LOW-INCOME PATIENTS

must: have a substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more; the direct and cumulative effect of the impairment must result in a substantial restriction in one or more of the ADLs; and the impairment has to be verified by the appropriate healthcare providers.

The IEWS provides additional questions, similar to the ADLs, that relate to psychological functioning. The IEWS also uses a scale of 1 (no symptoms) to 4 (unsafe/severe symptoms or signs).

Interviews, supra note 12 (DR3 Interview).

Ibid (DR2 Interview; NP1 Interview; and DR5 Interview). See also: John Fraser, Cynthia Wilkey & JoAnne Frenschkowksi, “Denial By Design…The Ontario Disability Support Program,” online: Income Security Advocacy Centre <odspaction.ca/sites/odspaction.ca/files/denialbydesign.pdf> [perma.cc/28TR-J8KP]. Fraser, Wilkey and Frenschkowksi argue that the Disability Adjudication Unit has a duty to follow up with healthcare providers (at 21).

Interviews, supra note 122 (DR5 Interview).
The participants in my study were also asked what they believe to be some of the barriers low-income patients face in completing ODSP applications. I have organized these barriers in somewhat of a chronological order that follows the steps in the ODSP process.

i. Getting the Forms

Interestingly, several interviewees commented that they have had to do extensive advocacy work just to convince workers at Ontario Works to provide their patients with the ODSP forms. Then, the application is mailed to the patient, which as DR5 describes, presents further issues: “I see a lot of folks whose housing is unstable. They lose forms all the time. And it’s the most incredibly frustrating thing to have to go to the ODSP office and get another form. It causes [the patient] tremendous harm. And, for whatever reason, the government does not give us the forms, or we cannot download them.” This last point, that the forms are inaccessible to providers, was brought up repeatedly throughout the study. Moreover, when the forms are finally in the hands of the provider and the patient, the wording on certain aspects of the form, such as the Self Report portion is, as NP6 describes, “written in such a language that, with the literacy level of most people I work with, they don’t understand the Self Report … and many people I work with don’t even have a place to sit and write it, or any privacy, because they live in a rooming house.” In an MLP, because of the experience community legal clinics have in advocating to Ontario Works on behalf of their clients, they would be well positioned to get these forms, and then to provide spaces to have them completed.

ii. Keeping Appointments

Almost every participant in the study highlighted the difficulties their low-income patients face in keeping appointments. DR2 explains that this can have more severe ramifications for patients when their healthcare provider is working within a fee-for-service payment model as opposed to a community health centre:

Lower income patients have higher no-show rates for appointments either because they’re dependent on public transit which fails, or other various reasons why income makes it more difficult for them to get to appointments on time. No-show rates are a bigger problem if you’re in the fee-for-service environment because that can be seen as a half-hour block that was reserved for that patient. You’re now not making any money in that time, as opposed to, if your patient is rostered to you, you’re paid an

59 Interviews, supra note 12 (DR11 Interview; DR14 Interview; NP6 Interview; and DR5 Interview).
60 Ibid (DR5 Interview).
61 In particular, by DR8 (Ibid (DR8 Interview)).
62 Ibid (NP6 Interview).
63 While there are numerous models, the following are the most common: the fee-for-service model (where healthcare providers are paid for each service they provide); the community health centre (where healthcare providers are salaried); and the capitation model (where healthcare providers are paid per individual under their care).
annual fee to be that patient’s family doctor, so it’s less of a hit if they miss their appointment.\textsuperscript{64}

But even at community health centres, DR1 pointed out, “funders are always looking at the number of patients we’re seeing, so [when a patient misses an appointment] it does take away a little bit from our clinic, because I could be seeing other rostered patients.”\textsuperscript{65}

As many of the providers observed, there is a lot of coordination required between themselves and their patients to get the application submitted. Oftentimes, a provider will need one appointment to explain the form to a patient, another to help them complete the Self Report, and then a final appointment to review the Self Report, ADLs, and IEWS with the patient to make sure everything aligns well.\textsuperscript{66} Providers like NP1 and NP4 noted that some of their patients very rarely leave their house due to their mental health conditions.\textsuperscript{67} Furthermore, a couple of participants noted that the stigma attached to poverty, and in particular the prospect of “someone accus[ing] you of lying, and mak[ing] you feel like you shouldn’t be on ODSP” is alone enough to discourage people from attending their appointments.\textsuperscript{68} As will be discussed in further detail below, an MLP would allow healthcare providers and caseworkers to work together to find ways to limit the number of appointments.

iii. Lack of a Primary Care Provider

The participants in this study also spoke to barriers created by the fact that many low-income patients do not have primary-care providers. Several of the healthcare providers I interviewed described their efforts to reach out to their communities to find and assist those without a primary-care provider and described some of the challenges those people face in getting on ODSP. NP1 pointed out that “typically, [these patients] aren’t going to one place. They’re [going to] walk-in clinics, and most of them are in and out of emergency [rooms]. Our social worker [finds them], gets the consent to release [form signed], and then tries to find each and every place that they’ve been … . My patients can’t [do that for themselves], the entire process is just so overwhelming.”\textsuperscript{69} DR2 recounted a similar experience: “getting all the medical records, and the time it takes to do that, and getting all of that done while they’re still at the same shelter, before they move somewhere else, can be challenging.”\textsuperscript{70} Further, NP3 provided a unique perspective on how this is particularly common with those suffering from substance abuse and mental illness:

I work with people who are substance abusers, and as a result, live a very chaotic lifestyle. They have a lot of competing priorities: trying to get food, shelter, whatever

\textsuperscript{64} Interviews, \textit{supra} note 122 (DR2 Interview). DR6 also noted, “Often people who need ODSP live chaotic lives, so they might not be able to make it to appointments or might have barriers, like racism, to accessing care” (DR6 Interview).

\textsuperscript{65} \textit{Ibid} (DR1 Interview).

\textsuperscript{66} \textit{Ibid} (DR8 Interview; and NP4 Interview).

\textsuperscript{67} \textit{Ibid} (NP1 Interview; and NP4 Interview). NP1 described those patients as “the real need that we’re missing … those people who can’t even come [into the clinic], who can’t even leave their rooming house.”

\textsuperscript{68} \textit{Ibid} (DR6 Interview; and NP1 Interview).

\textsuperscript{69} \textit{Ibid} (NP1 Interview).

\textsuperscript{70} \textit{Ibid} (DR2 Interview).
... [and] if you have somebody who is suffering from severe mental health issues, or drug withdrawal, they'll have trouble expressing what’s bothering them, building trust with their care provider and even getting in to see the care provider. ... There are [also] some [of my] clients who are barred from places for non-violent incidents, verbal outbursts and missed appointments, that sort of stuff. We have one client who was barred [from a community health centre] for a verbal outburst as long as ten years ago. So they have to carry on to multiple clinics ... because they’re barred on an indefinite basis, with no review.  

Ultimately, these patients are left to search endlessly for a provider to fill out the form for them, and are often rejected, because of the work involved in compiling their past medical records. Moreover, even if the patient is fortunate enough to find a provider willing to take them on, the participants reported that the cost of getting their past medical records is often astronomical. As will be discussed later in this piece, these observations by the participants have made me think about the ways in which caseworkers at community legal clinics, through an MLP, can work with doctors to overcome these difficulties and reach out to those in the community without a primary-care provider.

iv. A Traumatic Experience

Several participants also pointed out that the process can be traumatic for their patients. DR12 described the ODSP process as “degrading, humiliating, and often re-traumatizing ... having to tell your whole story ... with someone you don’t know, is really hard to do.” DR14 made a similar observation about the ways in which the ODSP process forces individuals to share private, intimate information:

> There’s too much information that is requested in the form, and looking at the ODSP Act, it’s not required. I’m thinking about [private] details like medications and details of the patient’s history, like abuse. I have had instances where providing that information or not ... has seemingly affected the decision. Asking us for all this information doesn’t seem to be appropriate ... it really does undermine [the doctor-patient relationship] when I have to turn over all the information I have.

The traumatic nature of the process is yet another reason for caseworkers, who have an intimate understanding of how to assist clients through the process, to become involved earlier in the process.

71 Ibid (NP3 Interview).
72 Ibid (NP3 Interview; and DR5 Interview). Both NP3 and DR5 stated that their patients are denied for this reason. NP2 also described instances where, even if a patient has a primary care provider, that provider might still decline to complete the application because there is too much work involved (Ibid (NP2 Interview)).
73 Ibid (NP4 Interview). I encountered these astronomical prices first-hand during my time at PCLS.
74 NP1 compared it to “drug seeking”: “I feel like I’m drug-seeking when I have to go to a doctor to get them to sign off on a prescription. I can’t imagine what the patient feels like when they have to do the same thing with ODSP forms” (Ibid (NP1 Interview)).
75 Ibid (DR12 Interview).
76 Ibid (DR14 Interview).
4. EDUCATION, TRAINING AND POSSIBLE SOLUTIONS

The third and fourth segments of my interview asked participants questions about whether they had received any education around how to complete ODSP applications or treat low-income patients during medical school, or as part of their Continuing Medical Education (CME) requirement. Alarmingly, only one of the participants had received any sort of training during their studies, and that training was limited to a half-day workshop, for family medicine residents, on treating poverty. The other participants commented on how peculiar it is that family medicine residents do not receive more of this type of training. As DR7 commented, “from a medical perspective, we don’t get very much training about how to speak the legalese that we need to speak to be able to do the application for disability.” DR1 made a similar observation in stating, “I’ve received literally zero training on this in my medical education, which is astounding given how important this is for people. Anything I know is from the little bit I found on the Community Legal Education Ontario (CLEO) website. … The best place, the best angle, would be the family medicine residency program. It would be a tougher sell to do it as a general medical training.” DR8 also stated that residency would be the place to do more training around these issues, and that they currently train the residents at their community health centre how to complete ODSP applications.

In terms of the CME requirement, while there are opportunities for education on poverty in the CME, as DR2 pointed out, “those who are going to attend poverty CMEs are those who are already interested in poverty. So you’re not going to reach the kind of breadth [needed].” Moreover, DR1 added, even though poverty workshops are allotted a “ridiculously high number of CME credits for [those attending]” it’s still “really, really hard to get physician buy-in.” Most pertinent to this study perhaps, is that DR1, who attended a poverty law workshop as part of their CME, found that “the people who are running it, despite the fact that they’ve done however many of these … they’re not getting the same quantity of rejected forms, or feedback that someone in a legal clinic would, for example. Having the opportunity to ask direct questions to someone [in a legal clinic], to get live feedback, would be really helpful.” This “live feedback” DR1 desires is what Liz Curran has coined “secondary consultation” (i.e., a healthcare

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77 Ibid (DR2 Interview).
78 Ibid (DR7 Interview).
79 Ibid (DR1 Interview). DR8 similarly pointed out that residency would be the place to do more training around these issues, and that they currently train the residents at their CHC how to complete ODSP applications (Ibid (DR8 Interview).
80 Ibid (DR8 Interview). It should be noted here that DR3, along with many others, stressed that while education is important, the practical experience, as suggested by DR8, is irreplaceable when it comes to ODSP applications.
81 Ibid (DR2 Interview).
82 Ibid (DR1 Interview).
83 Ibid. DR8 provided a similar comment: “I did seek out a session once at a CME about how to complete disability forms. … it was interesting but it didn’t really seem to speak to my questions about ODSP. … [But] we [once] had a lawyer from a legal clinic come in and talk to us for a couple hours and [they] gave us some tips and explained the process. That was memorable because it was the first time anyone had ever told us how to do something like this” (Ibid (DR8 Interview). However, it must be mentioned that Health Providers Against Poverty (HPAP) and Gary Bloch (a family physician with St. Michael’s Hospital and an Assistant Professor with the Department of Family and Community Medicine at the University of Toronto), have done substantial work to fill this void by providing the necessary training for health providers.
provider calling in to a legal clinic for information without a client present) which she argues “builds capacity and confidence in [medical] professionals to identify legal issues so they [can] either support a client or, where appropriate, refer clients who would otherwise not get help because of a range of inhibitors.” It should also be noted here that the participants encountered similar frustrations with the ODSP pamphlets administered by organizations such as CLEO, viewing them as too limited in scope: “CLEO was somewhat helpful,” DR1 commented, “but it’s very general information, so it doesn’t get into some of those specific questions … about how to present [a condition], or what to include or not include.” As NP1 observed, while pamphlets and CME workshops are helpful, a greater, more comprehensive response is needed: “everyone’s busy, the forms are due when they’re due, and a lot of times [we’re] scrambling at the last minute. It just needs a bigger system, like a medical-legal partnership.” Over the remainder of this article, I will explore this final idea, that an MLP can assist community legal clinics in addressing many of the issues raised by the participants in this study, and in providing healthcare providers with invaluable “live feedback.”

IV. DISCUSSION: POVERTY, HEALTH & LAW: MAKING THE CONNECTIONS

A. THE SOCIAL DETERMINANTS OF HEALTH, LEGAL CLINICS AND MEDICAL-LEGAL PARTNERSHIPS

During our interview together, NP4 provided a memorable perspective on how poverty affects her patients: “One thing that has been really noticeable is how much people [in poverty] age, how I have to re-frame their health risks differently than I would if they were not living in poverty, and how it easily increases their health risks by at least ten years …. Income is the number one determinant of health.” NP4 was making reference to the social determinants of health, which Dr. Bährer-Kohler describes as the study of “the conditions in which people are born, grow up, live, work and age, which includes the health system” and how they affect health outcomes. Michael Compton and Ruth Shim situate MLPs as part of a growing understanding in the healthcare profession about the social determinants of health and a greater need for patient advocacy: “in a healthcare environment that is increasingly pressed for time, in which physicians’ roles are often reduced to rapid medication checks, we need to move from a culture of witnessing the negative impact of the social environment on [client] health and thinking

85 Interviews, supra note 12 (DR1 Interview). However, this commentary should not discourage the reader from relying on the CLEO pamphlets generally. During my time at PCLS, I found these pamphlets tremendously useful in several different respects. The pamphlets can be found here, online: <cleo.on.ca/en/resources-publications/resources-and-publications> [perma.cc/4HUS-FPV6].
86 Interviews, supra note 12 (NP1 Interview).
87 Ibid (NP4 Interview).
‘someone should do something about this’ to ‘I should do something about this’.” As Wendy Parmet, Lauren Smith, and Meredith Benedict explain,

The foundation underlying the development of medical-legal partnerships is the understanding of the connections between social determinants, health disparities and the law. The MLP is premised on the idea that bringing healthcare professionals and legal professionals together to address the social determinants of health not only addresses the immediate health concerns of patients through legal intervention, but also changes systems – both within and outside the healthcare system – to improve the health of populations.90

Jane Wettach, moreover, cites law school-run community clinics like PCLS as the preeminent site for a fruitful medical-legal partnership.91 However, it is important to first turn to a case study to determine what an MLP at PCLS or other community legal clinic might look like.

B. CASE STUDY: COMMUNITY ADVOCACY & LEGAL CENTRE

The JHP at the Community Advocacy & Legal Centre (CALC) provides an excellent example of the MLP model. CALC is a non-profit community legal clinic providing free legal services to low-income residents of the Belleville area. Like other community legal clinics in Ontario, CALC practices poverty law services, including income security, housing, and employment. In January 2016, CALC began a pilot of their own JHP, with six primary-care organizations.92 As part of the JHP, they provide on-site legal clinics for patients, education sessions for healthcare providers, assistance with completing forms, and a streamlined referrals process, including a “hotline” healthcare providers can call for advice when completing ODSP applications.93 To measure the success of their project, they developed the following goals:

1. Improve access to justice for low-income clients, particularly in rural and remote areas;

92 Turik & Leering, “Phase II,” supra note 11 at 3.
93 *Ibid.* CALC also accepts nursing students on placement from Queen’s University, and has hosted four Occupational Therapy students from Queen’s University School of Rehabilitation Therapy. During their time at CALC, the Occupational Therapy students have investigated “occupational justice” issues and legal rights, and also conducted interviews with local occupational therapists to determine what they know about the legal services available, and how CALC can facilitate referrals.
2. Support early intervention in, and the prevention of, escalating legal problems, thereby improving clients’ overall health and well-being;

3. Support healthcare providers to identify legal issues and refer clients to CALC by providing quality education sessions and producing useful resources and tools; and

4. Reduce the Ontario Disability Support Program (ODSP) appeals burden, which would allow clinic and healthcare resources to be re-allocated to other areas of need.\footnote{Ibid at 4.}

So far, CALC’s JHP has seen great success. Between 1 January 2016 and 30 June 2016, CALC received ninety-three referrals from healthcare providers. Of these referrals, 55% were new clients, and 20% were previous clients CALC had not spoken to in five years or more.\footnote{Ibid at 5.} In terms of their goal of supporting early intervention, 93% of all healthcare provider referrals came at an early or middle stage of the legal issue, while only 7% of referrals were considered to be at the late/crisis stage.\footnote{Ibid.} CALC has also held seven different workshops for healthcare providers during that time on the services they provide. Following a workshop, 97% of attendees said they understood how to refer a client to CALC, and so far, healthcare providers have been using the variety of options CALC offers for making referrals, with an almost even number of referrals coming as: 1) Secondary consultations (30% of referrals); 2) “Warm hand-offs” (i.e., a healthcare provider calling with their client, or faxing a referral form to CALC (43% of referrals); and 3) “Traditional referrals” (i.e., clients calling in by themselves after being told to call by a healthcare provider) (27% of referrals).\footnote{Ibid at 7.} While the referred clients presented a mix of legal issues from different areas of law, 37% were referred for an income-maintenance issue (Canada Pension Plan Disability, ODSP, Ontario Works), 14% for employment, and 11% for housing.\footnote{Ibid at 11.}

In terms of ODSP, CALC offered to review ODSP applications completed by healthcare providers before they were submitted to the DAU or complete them over the phone with healthcare providers while they were with their patient. The goal of these reviews was to “ensure the application contained all the information the DAU would look for when making their decision, keeping in mind the applications completed by healthcare providers are adjudicated using a legal test.”\footnote{Ibid.} While the success of CALC’s JHP is encouraging, it should be kept in mind that CALC’s service area primarily consists of remote, rural communities, and two small cities. One wonders how its success would translate into a larger market like Toronto.\footnote{Further, due to the length of time it takes for ODSP applications to make their way through the review process, CALC has pointed out that it is too soon to tell whether their JHP is successfully reducing the overall number of ODSP appeals. CALC hopes to release these results at a future date.} At the very
least however, CALC’s JHP and its success is sufficient foundation and a strong model for a similar pilot project at other community legal clinics.101

C. WHAT DO HEALTHCARE PROVIDERS THINK OF MLPs?

Every provider interviewed in my study who worked in a medical-legal partnership (n=7) spoke highly of their experiences.102 One provider mentioned, “I would never want to work in a setting where I didn’t have legal colleagues to share opinions with … now I just consider our lawyer another member of the healthcare team, with a very specific set of skills.”103 The participants worked in both the referral and on-site models of an MLP. Even the providers who were not involved in an MLP mentioned the potential benefits of working with a legal clinic.

The participants identified numerous benefits of MLPs. First, they appreciated the opportunity to have someone review their application before submission.104 DR11, although not in an MLP, referred to this model as “a true partnership … that would really improve the odds of [patients] getting accepted.”105 DR10 also added a perspective from a different payment model: “I work in fee-for-service and at least for me, that consultation would be really helpful. I would learn each time … and in fact, it would be time-saving … . I wouldn’t just give you a shoebox of their medical records, [but] I would give you my best draft [of the application].”106 Perhaps what the providers appreciated most, however, was the way in which the MLP transformed their practice into a “one-stop shop” for their patients, which, as highlighted by other areas of this study, is crucial given the difficulties low-income patients sometimes face in keeping appointments:

I think the access piece of having the [legal] service on-site is a huge, huge benefit in terms of people being likely to follow through on [appointments]. I’ve referred people to legal clinics lots of times, but they don’t necessarily go through. A lot of times I will make the appointment for them, but even then, sometimes it happens and sometimes it doesn’t.107

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101 See CALC’s website for the current status of, and information about, their constantly evolving JHP, as well as practical tools and resources for developing an MLP/JHP: <www.communitylegalcentre.ca/JHP/default.htm> [perma.cc/WM6A-BYHL].
102 NP1 commented, “I’m very proud of [it], I feel like I actually make a difference” (Interviews, supra note 12 (NP1 Interview)).
103 Ibid (DR6 Interview).
104 Ibid (DR8 Interview).
105 Ibid (DR11 Interview). Full quote: “For example, I do the application, and I run it by the lawyer first, and the lawyer says ‘reword this’ or ‘this is a sentence that helps’ or ‘can you put this in?’ That’s a better application. To me, that’s a true partnership.” DR1 also mentioned that “we could really use a resource … [someone] to be available to assist physicians in doing forms and helping patients in accessing income resources generally” (Ibid (DR1 Interview)).
106 Ibid (DR10 Interview).
107 Ibid (DR13 Interview). DR3 also mentioned this: “any time you have clinicians and lawyers working together more closely it can be really helpful. The more we can create partnerships where we’re increasing access for our clients [by] increasing the communication between the clinician and the legal system is beneficial. Because right now you often have the patient running around between all these different services” (Ibid (DR3 Interview)).
Another provider envisioned law students assisting the healthcare providers early in the process, helping to compile past medical records for those without a primary-care provider. Ultimately, many of the providers highlighted the fact that there are presently poor supports in place for providers who are not as experienced with the forms:

I think … there are some [providers] that don’t give a [care]… . Those people, no matter what you give them in terms of support, they’re probably not going to care. But there’s a lot in the middle, and I would say they’re in the majority, that wouldn’t mind doing it well, but they just don’t know the best way of doing it.

[…]

I think [an MLP] would be useful especially for the person who doesn’t often complete ODSP forms … . There needs to be more support for people who try to do these forms but aren’t doing it as commonly. I think having a legal clinic providing feedback on whether the form is complete would be very helpful.

Some critics of applying this model to community legal clinics may say that many community legal clinics already have something like an “on-site” MLP because community health centres are close by. DR7, who offered perhaps the most interesting perspective on MLPs, addressed this:

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108 Ibid (DR8 Interview). As DR7 points out, “It used to be, when I grew up, in my education—I’m thirty years out now—that your patient was the person who walked into your waiting room. Now we know that your patients are those that we need to reach out to and engage on a regular basis. We did a needs’ assessment in our neighbourhood, a neighbourhood with a community health centre and two hospitals, and the number one problem we found was access to care. So we decided to fund a community health worker program within our family medicine centre…. We then reached out into our neighbourhood with these two community health workers, and started developing relationships … and what we found out is that 53% of the people we reached out to didn’t have a medical home, or a primary-care provider, despite the fact that they lived right beside two hospitals and a community health centre. A lot of that was [due to] a lack of relationship, lack of trust, some of it was isolation. So what we did with these community health workers was we started developing relationships, getting to know the organizations already within the neighbourhood, the churches, etc., and really started working with them to find patients that needed a medical home and started developing that trust. We’ve had all kinds of various different [successful] outcome measures [from those efforts], like reduced emergency room visits and the like, but also, things like recidivism rates. We have within this neighbourhood twenty-six people that were parolees, and of that group … we ended up housing a lot of those folks and getting them medical care. The recidivism [rate] for parolees [country-wide] is about 57% percent. For our group here, it was 17%. So just providing some medical care, just providing some housing, it’s amazing what that can do…. It’s about reducing the isolation, it’s about connecting and developing a relationship, hooking people up with a medical home, making sure that they have the transportation to get there. We’re seeing lower no-show rates for appointments, we’re seeing more engagement and self-management, it’s incredible. And the MLP has been central to that. Because a lot of those issues we saw were things that we couldn’t do alone as medical providers, but we could with legal help” (Ibid (DR7 Interview)).

109 Ibid (NP4 Interview).

110 Ibid (NP3 Interview). DR6 also noted part of the problem as lack of resources: “I wonder if family health teams, or CHCs are a good place to start because they’re already set up in the interdisciplinary model … although something that private practitioners could access would be helpful because I do feel like these [community health centre] teams get all the resources” (Ibid (DR6 Interview)).
We have partnered with a legal clinic that has always been in our community. At any point [before the partnership], I could have said, ‘go over and see our friends at the legal clinic,’ but, they weren’t embedded within our medical home, within the primary-care setting. Besides it being more convenient for the patients, it also teaches us as providers and our residents … what the lawyer does as far as addressing health-harming legal needs.¹¹¹ And the bigger the team gets—we have care coordinators, we have community health workers, we have behaviourists [and] now the MLP folks—there’s a synergy that begins to develop in that team as they look at the social determinants of health for our patients, and it grows what we’re able to do for those patients.¹¹²

When asked about whether they foresaw any shortcomings of an MLP, several doctors mentioned that in order to avoid “stepping on providers’ toes professionally” it is crucial to “keep it an open and easy relationship … the important thing would be to act as a resource, and have an open-door policy.”¹¹³ Moreover, several of the participants mentioned the importance of having the right “medical champion … [because without them] it’s much harder to break into that medical world.”¹¹⁴

For these reasons, I think a referral model, with an open-door policy, modelled after the one established at CALC, with the right medical champion, would provide a strong starting point for MLPs at community legal clinics that would work to effectively address the social determinants of health in low-income communities. Additionally, while my study focused particularly on how MLPs can improve the ODSP application process, the participants also pointed out that their patients present many other legal issues to them, such as housing and immigration issues, that could also be addressed through MLPs.

V. LIMITATIONS AND FUTURE RESEARCH

The greatest limitation to this study was the selective population sample. While I attempted to reach out to providers from a variety of different healthcare models, the ones who responded to me were those who are working in CHCs or involved in various initiatives that are already

¹¹¹ I would like to make a note here of another fantastic initiative DR7 has championed involving law students and medical residents that is really the stuff of MLP dreams: “we have done a lot of work of surrounding those folks with … an inter-professional group of ‘hot spotting.’ We’ve done that with our students, where we have everything from a nursing student, a medical student, a pharmacy student, a social work student, a business student … and they surround that patient, and really drill deeply into what the issues are—most of them social determinants of health—and how they can help that patient to improve their health” (Ibid (DR7 Interview)).

¹¹² Ibid. DR7 goes on to say, “It used to be ‘oh well, I’m so sorry, I can’t help you, I’m treating your asthma here with an inhaler, but you can’t breathe because there’s mould growing on the walls in your apartment … and I’m sorry, I don’t have any way to [fix that].’ It’s a very helpless feeling for us as providers, and [causes] high burnout because you’re caring for these people, trying to make a difference, but you couldn’t. So this is one more tool, with the MLP, to be able to actually make an impact on the patient in front of you. And then also as a medical school, we were able to take that a step further and hopefully go upstream, and find out where these issues stem from, and try to stop these issues before they occur. It’s a wonderful partnership.”

¹¹³ Ibid (DR1 Interview).

¹¹⁴ Ibid (DR13 Interview). DR13 added: “Medicine is a very insular culture … if you want to shift that culture, it has to come from within.”
interested in the question of how services for low-income patients can be improved. Moreover, the qualitative nature of my study inherently limited my research to a smaller population sample.

In terms of future research, there is still a significant amount of work to be done. Several of the participants lauded their social workers as integral to better ODSP applications and stronger MLPs.115 While social workers did not fit into the scope of this study as members of the medical community, their perspective would be vital to a larger study on the ODSP process and MLPs.

Before an MLP is implemented, I also think it is crucial to find a way to gain the perspective of the patient/client, and to be attentive to their thoughts and opinions on the partnership. As legal and healthcare professionals our aspiration is not only to provide high quality services, but to ensure we couple those services with opportunities for our clients/patients to be empowered and to avoid “the dependency-fostering effects of the traditional lawyering and social service models.”116 Julie Devaney, in her book, My Leaky Body: Tales from the Gurney, offers a powerful account of the ways in which as a patient, she has found the healthcare system to be disempowering and victimizing.117 Frazee, Gilmour & Mykitiuk’s, “Now You See Her, Now You Don’t: How Law Shapes Disabled Women’s Experience of Exposure, Surveillance and Assessment in the Clinical Encounter,” also provides critical guidance.118 By analyzing three focus group discussions in which women discussed their encounters with health and social support systems, the authors provide a sketch “from the vantage point of women who experience disability, [of] the outline and contours of a system reliant on a physician-defined disability status.”119 Their work provides a crucial caution: in a system where “the patient [already depends] on her physician as an applicant to the social assistance system, rather than as a patient requiring treatment,”120 those in the legal and medical professions must ensure that “the distinctive authority of the patient’s voice” is acknowledged.121 As one woman in the study explained, without this acknowledgment, “there are all these people looking at you like you’re a science experiment.”122 As the authors make clear, “the purpose of the [healthcare encounter] is to benefit [the] patient. Implicit in this encounter is the need for an open dialogue between physician and patient, one in which patients are consulted, listened to, and heard, and in which their embodied [or, lived] experience forms the basis of clinical assessment.”123

117 Julie Devaney, My Leaky Body: Tales from the Gurney (New Brunswick: Goose Lane Editions, 2012).
119 Frazee, Gilmour & Mykitiuk, supra note 118 at 244 [emphasis in original].
120 Ibid at 243.
121 Ibid at 244.
122 Ibid at 235.
123 Ibid.
It is essential that the perspectives and insight of the persons concerned are considered before any community legal clinic adopts an MLP.

VI. CONCLUSION

The nature of the ODSP application process forces legal clinics and healthcare providers into opposition. Many of the participants in this study expressed fear over “the dreaded lawyer’s letter” they would receive following a denied application, requesting further clarification.124 Much of my time as a student caseworker was spent writing those letters, or haggling doctors over the phone. As DR13 aptly surmised, to produce better applications, and to effect greater change, a more cooperative, interdisciplinary approach that shifts the relationship between legal clinics and healthcare providers is required:

When you empower [providers] to actually understand how the system works and what is actually successful in terms of the application, I think they’re more likely to see themselves in that role of an advocate, whereas otherwise I think people feel frustrated because there’s this weird and complicated form that they’ve never been trained on completing, they have no idea if what they’re doing actually matters or not and then you get [DAU] decisions that don’t make sense, right?125

Healthcare providers form an essential part of the ODSP application process, and yet we know very little about how they perceive the process or the state of health services for low-income patients. Instead, we hand them more pamphlets to read, and send them more letters. While some MLPs might have to start with a referral model like CALC’s, one can envision an on-site model in the future where student caseworkers, for one afternoon a week, work alongside medical residents to provide more comprehensive care for those in their community.126 While this study is not meant to be representative of the opinions of providers generally, it is meant to encourage conversation about the ways in which community legal clinics can work with healthcare providers to improve health outcomes, provide earlier intervention in legal issues and ultimately, improve the well-being of those in our community.

124 Interviews, supra note 122 (DR8 Interview).
125 Ibid (DR13 Interview).
126 The idea for this kind of collaborative effort derived from suggestions of the participants, and in particular, their belief that the residency program is an opportune access point for greater education around health and legal services for low-income patients.