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YOU ARE AT: Home » Articles » Meet Them Where They Are



Left to right, Catherine Trimbur, Rahul Vanjani, Anthony Thigpen, and Teddy Wright (seated) at The Miriam Hospital's Transitions Clinic.

## Meet Them Where They Are

BY SARAH C. BALDWIN

*In courts and in clinics doctors and lawyers combine their power to keep people on the right side of health.*

On an early summer morning in Lower South Providence, community health worker Anthony Thigpen stands in the parking lot of the Lifespan Center for Primary Care while a stocky, agitated man with tattoos and a muscle T strides back and forth in front of him.

"What's goin' on, Teddy?" Thigpen says in a warm, low voice. "Talk to me."

Theodore "Teddy" Wright, one week into probation, says that he was explaining to his girlfriend Paula's landlord that he had tried to fix the broken windows in her apartment—where, by the way, the shower doesn't work, either—but they had a misunderstanding and the landlord hung up on him, and that just doesn't sit right.

Paula, a petite woman in leggings, paces nearby, occasionally adding details, such as the fact some windows are nailed shut but the one in her granddaughter's room is actually missing and they've been dealing with rain and bugs for four days. She wants to break the lease. He wants a showdown with the landlord.

For Thigpen, keeping Paula housed and Wright out of trouble are paramount. "Here's how we're going to move forward peacefully," he says quietly. Over the next 10 minutes tempers cool, fists are bumped, a plan is put in place. Thigpen heads for his SUV, ready to go on his next call. "Hey, Anthony!" Wright calls out across the parked cars. "Much love and respect." "Love you too, brother," Thigpen says.

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The Center for Primary Care serves as the outpatient site of The Warren Alpert Medical School's internal medicine residency program.

On Wednesdays, it's also home to the Transitions Clinic, where people leaving prison, most of whom are Medicaid recipients, can receive comprehensive support that starts with, but extends well beyond, primary care.

Established in 2018, the clinic is a partnership of the Lifespan Community Health Institute, the Center for Health and Justice Transformation (part of The Miriam Hospital), and the Center for Primary Care. Its three community health workers stand ready to help clients secure necessities like food, clothing, and even shelter; connect them with social services; facilitate their relationships with family members; provide transportation; and visit and advocate for them if they become hospitalized.

Like his fellow CHWs, Thigpen, 42, knows all about the challenges of reentry. In his 20s, he served eight years in federal prison. The holistic approach to health care that the CHWs make possible is at the heart of the clinic's mission. Over the past two decades, physicians and public health experts have come to understand the importance of the social determinants of health—the conditions under which we live, learn, work, play, and age—as well as the structural ones—the often racist economic and social policies that perpetuate inequity.

Indeed, research shows that 60 percent of our health is affected by these determinants, including income, housing, food security, family stability, neighborhood, legal status, and literacy. This is starkly underscored by the fact that health outcomes in the US, which spends more on health care than on social services, are significantly worse than in the majority of industrialized countries, which spend more on social services than on health care. Many justice-involved individuals are doubly affected by these facts: not only is engagement with the criminal legal system often a result of social determinants of health, it is also a cause of poorer health outcomes.

A study the CPC conducted recently found that 40 percent of their patients have a history of incarceration, and 46 percent have a family member with a history of incarceration. Sarah Martino, deputy director of the Center for Health and Justice Transformation, had long been aware of the Transitions Clinic model (there is a national network of them) and had been trying to start one in Rhode Island. Working with Dino Messina, MD, associate professor of medicine and medical director of the CPC; Carrie Bridges Feliz, MPH, director of the Lifespan Community Health Institute; and other colleagues, Martino obtained a seed grant to plan the clinic in 2016. Eventually,

through a combination of foundation, state, and federal funding, including a contract with the Rhode Island Department of Corrections, they were able to cover the salaries of a medical discharge planner and community health workers. Lifespan gave them a home in the CPC, and the Division of General Internal Medicine granted the physicians' time.

Then, Martino says, "the world just gifted me Rahul."

## THE MOMENT OF RELEASE

Rahul Vanjani, MD, an assistant professor of medicine, joined the Medical School faculty after doing his residency at Columbia University Medical Center, where he spent time at the Rikers Island jail complex, and working at San Quentin State Prison in California. He was a natural fit as the clinic's medical director: to him, the carceral system has been the "missing piece" in the biomedical community's growing interest in addressing social determinants of health. In a 2017 essay in the *New England Journal of Medicine*, he wrote that "incarceration itself is harmful to health" not only because of poor or negligent medical care, but because of "the material conditions of confinement ..., loss of social support, and a profound lack of control."

Put plainly, being behind bars can make you sick—or worse. Prisoners suffer from chronic and communicable diseases, mental illness, and substance use disorders at higher rates than those not in prison, and one year in prison has been shown to shrink life expectancy by two years. (Think about what that would mean for an individual serving a 10-, 20-, or 30-year sentence.)

But *leaving* prison can come at a cost, too: an individual is 12 times more likely to die—from homicide, suicide, overdose, or disease—within the first two weeks of release. What's more, once you're involved with the criminal legal system, it's hard to regain your footing. The burden of court costs, the taxing surveillance of parole or probation, the fear of being sent back, the interruption of drug or alcohol treatment, the damaged personal

relationships, the discrimination that comes from having a criminal record: such stressors often lead to repeated incarcerations, which in turn makes it more challenging to secure safe housing and stable employment, let alone get healthy.

The Transitions Clinic team seeks to address all these issues by intervening at this moment of extreme precarity. Before leaving prison, an individual who has been identified by a medical discharge planner at the Department of Corrections is assigned to a community health worker. Within two weeks of release, they are seen by one of two physicians, Assistant Professor of Medicine Catherine Trimbur '03 MD, MPH, or Vanjani (who are married). At weekly panel management meetings, staff—including the clinic's physicians, CHWs, the medical discharge planner, medical students in the Social Medicine elective, a postdoctoral research associate, Bridges Feliz, and Martino—gather around a conference table to talk through each patient's needs. They discuss how best to treat someone's diabetes, high blood pressure, or kidney disease and how to help them gain access to disability benefits, food stamps, and housing. They identify who needs a cell phone, who needs a shower chair, and who just needs some company. They strategize about next steps, everyone adding their own distinct perspective.

Sarah Kler MD'21 ScM'21, a graduate of the Primary Care- Population Medicine Program, spent her third year of medical school at the clinic as part of her longitudinal integrated clerkship. Working there opened her eyes to the extent that the legal system is an inherent part of how many people experience health and well-being, she says. She describes the panel management meetings as “a really creative space where they're constantly trying new things and working with community partners to maximize” the care they provide. Kler first met Vanjani when she was doing outreach with housing advocate Megan Smith '10. Smith had asked Vanjani to come to the Burger King on Broad Street to meet with a woman who was experiencing homelessness—and who was also a patient in his clinic. Vanjani soon arrived, accompanied by two CHWs. Kler recalls thinking: “That is how I want to do medicine. I want to be working with organizations who know their people and what they need, and with community health workers who have experienced what their patients have experienced and are working with them as peers.”

Kler is now a resident in primary care at Massachusetts General Hospital, where many of her patients face challenges similar to those at the Transitions Clinic.

## MUTUAL AID

It was at a panel management meeting almost three years ago that the team learned that one of their first patients was facing reincarceration. According to Vanjani, the group decided to draft a “strengths-based letter” detailing what the patient had accomplished since getting out of prison—and the ways his physical and mental health would suffer from going back.

“The community health worker took that letter to court and the public defender presented it to the judge,” Vanjani says. “We later learned that the judge largely based his decision to not reincarcerate our patient on the medical context we had provided in the letter.”

More successful letters followed, as did positive feedback from the judiciary. Eventually Vanjani, Martino, and others sat down with an attorney from the Office of the Rhode Island Public Defender and James Lawless, the office's social services casework supervisor, to brainstorm ways to formalize their collaboration.

The first step was to include the public defender office on the clinic's information-release form. That way, if a patient is facing charges (or has a legal issue in the future), the two entities are authorized to give each other information about their shared client. The team went on to create two customizable form letters explaining the harmful effects reincarceration and court fees could have on their patients. (They also created a website, docsforhealth.org, in partnership with the Roger Williams University School of Law's Pro Bono Collaborative, which makes available at no charge a library of fillable forms and templates—tools any provider can use to advocate for patients on a wide range of matters, such as missed court appearances, preventing utilities shut-off, deportation, access to shelter, and non-emergency medical transportation.)

According to Lawless, a judge has only what's readily available— a police report, a criminal record, the body of the person appearing before them—on which to base a decision. A letter from a physician explaining how incarceration could be harmful to the defendant's health may carry more weight than the same information would coming from the public defender. After all, Lawless explains, “it's our *job* to zealously advocate for our client.” Such a letter

enables an attorney to provide “credible information that for the court paints a much clearer picture of the person in front of them. It’s powerful,” he says.

The Transitions Clinic-Rhode Island Public Defender partnership is proof positive that two professions with a traditionally contentious relationship—think malpractice suits—can be mutually helpful: lawyers learn to focus on health outcomes for their clients, and physicians learn how to play a role in legal outcomes for their patients. It also demonstrates the need for diverse skills on a team: just as Thigpen gives the doctors valuable intel about a patient’s life at home or on the street, Lawless can find out the date and location of a patient’s court appearance, which the patient doesn’t always know.

As interest in this new paradigm has grown, Vanjani and Lawless have begun presenting it to groups across the country, including a National Legal Aid and Defender Association conference in June.

## WITH JUSTICE COMES HEALTH

While to his knowledge the partnership is the only one of its kind, Vanjani is quick to point out that medical-legal partnerships are part of a long tradition. The original MLP was established in 1993 at Boston Medical Center, the largest safety net hospital in New England. Frustrated by their ability to treat kids’ illnesses but not the conditions that were causing them, pediatricians brought lawyers into their clinic to help them more effectively fight the legal and administrative battles that would change their patients’ health for the better.

In 2001, first-year medical student Jyothi Marbin ’96 MD’06 approached Elizabeth Tobin-Tyler, JD, and Patricia Flanagan, MD, now a professor of pediatrics at the Medical School and chief of clinical affairs at Hasbro Children’s Hospital, to talk about doing something similar at Brown. Flanagan had helped start the Teen Moms (now Teens with Tots) program, whose staff included a social worker, a psychologist, a nurse, and a nurse practitioner.

“We realized that in order to help these young mothers and their children be healthy, we needed to be thinking about poverty, housing, food security, and helping them get to and from the doctors,” Flanagan says. “Working with this population I was struck by the fact that their opportunity for health was well outside the walls of a medical clinic, and that the circumstances in which they were raising their children had everything to do with how healthy their kids were.”

For her part, Tobin-Tyler’s interest in the intersection of race, poverty, and gender had inspired her to go to law school at 30; while there, she worked as a full-time legal intern at the Boston Medical Center legal clinic. When Marbin reached out, Tobin-Tyler had just finished a project investigating legal barriers related to lead poisoning among low-income children in Rhode Island. At Hasbro Children’s Hospital, the three of them, along with former Associate Dean for Diversity Alicia Monroe ’73, MD, created the third MLP in the nation, which they called the Rhode Island Family Advocacy Program.

Funding eventually ran out, but the pediatrics-based program was rekindled in 2011 as the Rhode Island Medical-Legal Partnership, with then-newly minted attorney Jeannine Casselman, JD, as its legal support. Casselman says, “One person cannot meet the needs of thousands of families who are followed at a single practice.”

To achieve maximum impact, she and Tobin-Tyler, RIMLP’s board chair, contacted MLPB (as the Boston model came to be called) to explore a merger. In 2017 Casselman joined MLPB, which provides capacity-building support to care teams in Massachusetts, Rhode Island, and beyond. Now, as MLPB’s law and policy director, she leads more upstream efforts, providing training and technical assistance on social drivers of health across the Ocean State. In its past work with the Transitions Clinic, MLPB was embedded in its interdisciplinary care team meetings.

To ensure their medical-legal partnership’s success over time, Tobin-Tyler says, they knew they had to train the next generation to work “interprofessionally.” So she, Flanagan, Monroe, and Professor of Emergency Medicine Jay Baruch, MD, designed a joint course for Roger Williams University law students and Brown medical students called Poverty, Health, and Law, which they taught for 10 years.

Meanwhile, as the MLP model gained traction nationally, Tobin-Tyler, now an associate professor of family medicine, was receiving more and more requests for syllabi. In response to that demand, in 2011 she co-edited the seminal textbook *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership*. She began to consult on

the development of MLPs nationally and internationally, and in 2019 she published *Essentials of Health Justice*, which focuses on the structural and legal determinants of health injustice.

Writing extensively on the positive health impacts of MLPs, which now number nearly 450 in the US, Tobin-Tyler has noted reduced stress, improved health care compliance, higher immunization rates, lower ER visits, and better outcomes for children with asthma and sickle cell disease (all of which can also translate to lower health care costs). She also points to a study that shows MLPs are good for docs, too: while most physicians who serve a low-income population say addressing their patients' social and legal needs is as important as their medical treatment, most also say they lack the confidence to do so. Having a legal partner gives them that confidence.

Early on, though, doctors resisted the idea of adding a lawyer to their team, Tobin-Tyler says: "We had to change the cultural understanding of what lawyers do. If our shared goals are social justice, public health, and good health for patients, what can each professional do to support them?"

After all, like Vanjani and Trimbur, public defenders are committed to helping the most vulnerable individuals. And just as the Transitions Clinic team takes a social determinants approach to health, Rhode Island public defenders practice "holistic representation," where lawyers look outside the courtroom to address underlying issues.

At the Medical School, Tobin-Tyler teaches medical and graduate students about the social and structural determinants of health, health policies affecting patient and population health, and physician advocacy. She helped design two new courses: one for all medical students, on how to write legislative testimony; the other for the Primary Care-Population Medicine Program. Students of the latter learn to write policy briefs on health-related legislation to persuade policymakers of the need for change, she says: "How do you structure an argument? How do you use medical evidence to support your arguments?" The students also are encouraged to testify at the Rhode Island State House.

"When I first came to Brown, in 2013, there was some hesitation among students," Tobin-Tyler says. "They'd say, 'If I'm going into surgery or cardiology, why do I need to know this?' Our response to that is, 'Just because you're only seeing patients when they need surgery doesn't mean they don't have contextual issues that are affecting their health, and you should know about those issues and facilitate support.'"

This is the basic premise of the Social Medicine elective, a month-long clinical experience that our group offers to medical students," Vanjani adds. "At the end of a month accompanying patients on their journeys outside of the clinic's walls, students usually feel a bit traumatized by the structural violence they've witnessed their patients face, but also invigorated by their newfound knowledge of social systems and their bureaucracies and empowered to address systems failures moving forward."

## 'I GOT YOU'

After talking with Teddy Wright, Thigpen heads out to meet Mr. M, who was released from a Florida prison on medical parole two years earlier because of cirrhosis of the liver and kidney disease. Along the way he fields a call from a court-appointed attorney who's trying to find a bed for another of his patients— he's about to get out of prison, and homelessness will likely jeopardize his drug treatment.

When Thigpen parks in front of the vinyl-sided triple-decker, a tall, frail-looking man with long skinny arms is just unfolding himself from the back seat of a taxi. (The clinic pays for his transportation to and from the dialysis center, a town away.) Together they climb the three flights of stairs, pausing often so Mr. M can catch his breath. Once in the apartment, Thigpen sets about connecting an outdated computer to a printer and helps Mr. M call Trimbur, his physician, so she can check on his medication supply.

As Thigpen leaves to go assist the next patient, Mr. M calls down the stairs after him: "I love you, bro." "Peace, brother," Thigpen calls back. "I got you."

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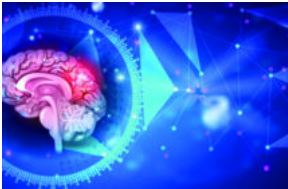


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