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BRIEF REPORT

LEgal Guidance for Cancer Patients and CAREgivers (LEGACY CARE): A Pilot Clinical Trial

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ABSTRACT

Background: Medical-legal partnerships can address health-harming legal needs (HHLNs) but caregiver-inclusive models are understudied.

Aims: To evaluate the feasibility, acceptability, and preliminary efficacy in addressing HHLNs of proactive legal care for patient-caregiver dyads.

Methods: This single-arm pilot trial (NCT07153016) enrolled patients with advanced-stage colorectal cancer and their self-nominated caregiver. Cancer Legal Care (CLC) provided personalized legal checkups and 3-month follow-up at no cost. Feasibility was assessed by rates of initial checkup, 3-month engagement, and receipt of legal service. Acceptability was assessed by likelihood of recommending the intervention to others. Participant-reported outcomes, implementation measures, and interviews were summarized.

Results: We enrolled 9 of 10 planned dyads. Among the 9 enrolled, 8 completed baseline surveys, 7 completed initial legal checkups, and 7 completed 3-month assessments. Initial legal checkups lasted a median of 45 minutes, and CLC provided median 4 hours of legal service per dyad. At baseline, 7 of 16 participants self-identified HHLNs, while CLC identified 1.7 additional HHLNs per dyad. The study met predefined feasibility benchmarks [initial engagement (16/18, 89%), 3-month questionnaire completion (14/18, 78%), and receipt of $\geq$ 1 legal service (14/18, 78%)] and acceptability (12/14, 86% recommended the intervention) benchmarks. Dyads noted improvements in financial control, support-seeking, and maintaining daily activities; however, caregiver-specific needs were not consistently identified or prioritized.

Conclusions: Proactive legal care for recently diagnosed patient-caregiver dyads was feasible and acceptable, and identified and addressed HHLNs. However, caregiver-inclusive medical-legal partnership models may require caregiver-specific intake, longitudinal follow-up, and clearer distinction between patient, caregiver, and shared needs.

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The first two authors contributed equally to this article.

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1 | Background

Individuals with colorectal cancer and their caregivers often face financial, legal, and administrative burdens, including insurance denials, employment disruption, medical debt, estate planning, and housing instability [1–3]. While financial needs concern difficulty meeting expenses or accessing resources, health-harming legal needs (HHLNs) are social or economic problems with legal solutions that affect access to care, financial stability, well-being, and quality-of-life [2]. These needs may overlap, and although often framed around patients, frequently extend to caregiver(s) [4–6].

Caregivers provide emotional, logistical, practical, and financial support [7, 8]. Up to 50% of caregivers of patients with colorectal cancer experience financial toxicity, associated with treatment non-adherence and lower quality-of-life for both patients and caregivers [9]. Common caregiver HHLNs include paid employment leave, transferred medical debt, and future planning, requiring specialized legal knowledge amid evolving policy. Current care often overlooks caregivers.

Medical-legal partnerships can identify and resolve HHLNs, but prospective data for caregiver-inclusive models are limited [2, 10]. Cancer Legal Care (CLC) is a Minnesota-based nonprofit that provides free legal services to people affected by cancer, and has served $>$ 15,000 individuals. In a prior study of 20 patients, proactive CLC intervention was feasible and acceptable, identified a median of 3 legal needs per patient (e.g., employment, benefits, and estate-planning), and improved comfort with legal tasks [3]. A key recommendation was a request for caregiver inclusion.

We thus conducted LEGACY CARE to evaluate the feasibility, acceptability, and preliminary efficacy of proactive legal support for patient-caregiver dyads after a recent colorectal cancer diagnosis.

2 | Methods

We conducted a single-arm pilot trial (NCT07153016) at the University of Minnesota. Each dyad received personalized legal support from CLC over a 3-month period, with off-trial services available beyond this period. Trial participation did not affect routine cancer care. The UMN IRB approved the trial; all participants provided written consent.

2.1 | Participant Selection

Eligible patients were English-speaking adult (age $\geq$ 18 years) Minnesota residents diagnosed with advanced (AJCC stage III or IV) colorectal cancer within the past 3 months, estimated life expectancy $>$ 6 months, receiving systemic cancer therapy, and identifying a primary unpaid caregiver. Eligible caregivers were English-speaking adults identified by the patient. We planned to enroll 10 patients-caregiver dyads (total 20). Potential participants were identified by the care team and referred to the research team. We enrolled participants from 09/2025 to 01/2026.

2.2 | Study Design

After enrollment and baseline surveys, each dyad together met with a CLC attorney for an initial "legal checkup" over telephone or Zoom. Participants could self-report concerns and completed a standardized issue-spotting checklist to screen for additional HHLNs. CLC developed a personalized legal care plan for the patient and/or the caregiver and/or the dyad, which could include legal information, consultation, document preparation, representation, or referral. Services were provided at no cost.

Participants could contact CLC at any time during the study to raise new issues or request services. CLC provided legal support, revised legal care plans, and coordinated with the oncology team with participant permission (e.g., social work referral recommended). The CLC team did not have formal EMR documentation privileges. Participants completed 3-month questionnaires. Optional end-of-study interviews with participants and participant-facing CLC staff explored intervention experiences and opportunities for improvement. The study schema is shown in Supporting Information S1: Figure A1.

3 | Data Collection

Baseline participant data were obtained from self-report and EMR review. Participants completed electronic surveys in RedCAP before the checkup and at 3 $\pm$ 1 months. Surveys measured comfort with cancer- and legal-related tasks, financial toxicity, coping, self-efficacy, and perceived stress, using the Cancer Related Behavior Questionnaire, Comprehensive Score for Financial Toxicity (COST), Cancer Behavior Inventory-Brief Version (CBI-B), and Perceived Stress Scale (PSS-4), respectively; at 3 months, participants completed the CLC Services Questionnaire and Patient Satisfaction with Interpersonal Relationship with Navigator (PSN-I) [3]. Caregivers additionally completed the 13-item Modified Caregiver Strain Index (CSI) [11] and 12-item Zarit Burden Interview (ZBI) [12] (Supporting Information S1: Table A1). Interviews were audio-recorded and transcribed. Participants were offered $100 compensation.

3.1 | Outcomes and Statistical Methods

Feasibility was evaluated using individual participant rates of (1) initial engagement (met with CLC representative); (2) continued engagement (completed 3-month questionnaires); and (3) intervention completion (received a legal service). A priori feasibility thresholds were defined as $\geq$ 50% for each. Acceptability was defined as $\geq$ 50% of participants rating their likelihood of recommending the intervention to others as $\geq$ 4 on a 5-point Likert scale. At 3 months, participants also completed adapted Acceptability (AIM), Appropriateness (IAM), and Feasibility (FIM) of Intervention Measures to assess implementation outcomes [13]. Exploratory preliminary efficacy was evaluated descriptively. We recorded the nature and outcomes of HHLNs and CLC interventions. Interviews were reviewed for themes with illustrative quotations.

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4 | Results

4.1 | Enrollment and Sociodemographic Characteristics

Of 10 planned dyads, we enrolled 9. We closed the study before recruiting the final dyad after approximately 3 months of unsuccessful enrollment attempts; reasons included severe illness ($n = 4$), competing cancer care demands ($n = 2$), and concerns about the legitimacy of no-cost legal support ("it's too good to be true," $n = 2$). One dyad moved out-of-state, leaving 8 dyads with baseline data.

Among those, 4 patients (50%) and 5 caregivers (63%) were female, and 6 patients (75%) and 4 caregivers (50%) were employed full-time. Caregivers were spouses ($n = 5$), children ($n = 1$), siblings ($n = 1$), or parents ($n = 1$). One patient died shortly after enrolling; CLC supported the caregiver, but the caregiver opted to not complete 3-month surveys (Table 1).

4.2 | CLC Services and Engagement

Seven dyads completed an initial checkup by phone per their preference, median duration 45 (range, 30–60) minutes. At baseline, 5 patients and 2 caregivers self-identified a HHLN. Common self-identified needs involved employment leave, insurance, estate planning, debt or creditor issues, and public benefits. Through screening, CLC staff identified an average of 1.7 HHLNs per dyad (overwhelmingly patient-directed), including related to disability accommodation, advanced care planning, food stamp/cash eligibility, and financial grants. CLC consultation summary is provided in Supporting Information S1: Table A2. CLC provided 35 hours of pro-bono service time, median 4 hours/dyad.

4.3 | Feasibility and Acceptability Outcomes

All 3 individually assessed feasibility metrics: initial engagement 16/18 (89%); completion of 3-month questionnaires, 14/18 (77%); and receipt of legal service, 14/18 (77%), met the prespecified benchmark. At 3 months, 6/7 patients (86%) and 6/7 caregivers (86%) indicated that they were likely or very likely to recommend the intervention to others, meeting acceptability benchmark.

4.4 | Implementation Outcomes, Experience With CLC

Patient ratings were favorable across implementation measures, with at least 71% agreeing across feasibility and appropriateness items (e.g., "The CLC referral and follow-up process meet my approval"). Caregiver ratings were lower overall and more variable across these same constructs, especially for feasibility, where only 2 of 7 caregivers (29%) agreed that the process seemed implementable/practical. However, both patients and caregivers rated direct interactions with CLC contacts favorably, with 6 of 7 patients (86%) agreeing or completely agreeing that, "My CLC contact figures out important issues in my care," and 6 of 7 caregivers (86%) agreeing or completely agreeing that, "My CLC contact listens to my problems." [Supporting Information S1: Table A3].

4.5 | Preliminary Efficacy

Among patients, baseline moderate/severe financial hardship (5/8, 63%) and perceived stress (PSS-4 median 8.5) were high. At 3 months, median COST and PSS-4 scores differed minimally from baseline (COST, 23.0 vs. 23.5; PSS-4, 8.0 vs. 8.5). Select coping item scores improved, including confidence in seeking consolation/support in 4/7 patients (57%).

Among caregivers, baseline moderate/severe financial hardship was common (7/8, 88%), perceived stress was high (PSS-4 median, 8.5; IQR, 7.0–10.0), and caregiver burden was moderate (ZBI median, 22; IQR, 19–26). At 3 months, median COST scores were similar to baseline (22.0 vs. 23.0); however, median PSS-4 scores decreased from 8.5 to 4.0, with reduced perceived stress in 5/7 caregivers (71%). Caregiver strain and burden remained stable, with median paired change of 0 points on both the CSI and ZBI. Select financial toxicity item scores improved, including reduced worry about future financial problems in 4/7 caregivers (57%).

4.6 | Qualitative Findings

We conducted 10 interviews ($n = 4$ caregivers, 4 patients, 2 CLC staff; Table 2). Participants noted the intervention translated unfamiliar concerns into concrete next steps. Many described a sense of reassurance during a period marked by uncertainty, with value extended beyond task completion. Constructive feedback centered on making the model longitudinal and anticipatory, with clearer preparation before the checkup.

CLC staff observed that discussions remained largely patient-centered; caregivers rarely raised independent concerns. Staff suggested that caregivers may view their role primarily as supporting the patient, particularly soon after a serious diagnosis, and may have deprioritized their own needs. Staff also noted challenges with longitudinal engagement, including ambiguity around the primary point-of-contact (patient vs. caregiver).

5 | Discussion

In this pilot study, integrating legal care for dyads facing a new colorectal cancer diagnosis met feasibility and acceptability benchmarks. Although most dyads would recommend the intervention to others, caregivers rated implementation less favorably than patients. These findings suggest that while dyadic legal care is feasible and acceptable by liberal benchmarks, truly supporting caregivers with HHLNs requires more than just extending a medical-legal partnership model to them.

LEGACY CARE suggests that the major barrier to caregiver-centered legal care may not be caregiver absence, but caregiver invisibility within patient-centered systems. Caregivers were present, engaged, and performed the practical work that allowed cancer care to proceed, yet the intervention appeared easier to deliver and more favorably received from the patient side. Caregivers may be viewed as extensions of patient support rather than individuals with independent needs. The interdependence of these needs also varies by relationship; for example, spouses may share finances or insurance, whereas adult children may not. This pattern reflects a broader problem in oncology supportive care where caregivers are treated solely as

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TABLE 1 | Baseline participant sociodemographic and clinical characteristics.

Characteristic	Patients no. (%) Total number = 8	Caregivers no. (%) Total number = 8
Gender		
Male	4 (50%)	3 (38%)
Female	4 (50%)	5 (63%)
Race		
White	8 (100%)	8 (100%)
Ethnicity		
Hispanic/latino	0 (0%)	1 (13%)
Non-hispanic/latino	7 (88%)	7 (88%)
Unknown/chose not to answer	1 (13%)	0 (0%)
Highest education level		
High school graduate or equivalent	2 (25%)	3 (38%)
Some college credit, no degree	1 (13%)	1 (13%)
Trade/technical/vocational training	2 (25%)	0 (0%)
Bachelor's degree	1 (13%)	3 (38%)
Master's degree	2 (25%)	1 (13%)
Occupation		
Health care and social assistance	2 (29%)	0 (0%)
Repair and maintenance	1 (14%)	1 (17%)
Professional and science	4 (57%)	3 (50%)
Retired	0 (0%)	2 (33%)
Unknown	1	2
Travel time to health care (one-way)		
Less than 15 minutes	1 (13%)	1 (14%)
15–30 minutes	2 (25%)	1 (14%)
31–60 minutes	3 (38%)	3 (43%)
More than 60 minutes	2 (25%)	2 (29%)
Unknown	0	1
Rural or urban residence[a]		
Urban	5 (63%)	4 (57%)
Rural	3 (38%)	3 (43%)
Unknown	0	1
Annual household income, USD		
Under $15,000	2 (25%)	1 (13%)
$25,000 to $50,000	1 (13%)	2 (25%)
$50,000 to $100,000	1 (13%)	1 (13%)
More than $100,000	4 (50%)	4 (50%)
Work status		
Full time	6 (75%)	4 (50%)
Part time	1 (13%)	0 (0%)
Retired	0 (0%)	2 (25%)
Unemployed	1 (13%)	2 (25%)
Marital status		
Single, never married	0 (0%)	1 (13%)
Partnered or married	5 (63%)	6 (75%)
Divorced	2 (25%)	0 (0%)
Widowed	1 (13%)	1 (13%)
Care partner relationship		
Partner/spouse	5 (63%)	—
Child	1 (13%)	—
Sibling	1 (13%)	—
Parent	1 (13%)	—
Has dependents	4 (50%)	4 (50%)
Insurance		
Medicaid	1 (13%)	1 (13%)
Private	7 (88%)	7 (88%)

Abbreviation: USD, United States dollars.
[a]Using RUCA codes.

the delivery system for support rather than as individuals experiencing legal, financial, and emotional consequences of illness [6, 14]. Therefore, adding caregivers to a medical-legal partnership does not automatically make the model dyadic.

The Dyadic Cancer Outcomes Framework helps specify why this distinction matters. Whether needs become visible or actionable depends on the dyad's relationship structure, employment and insurance context, and position in the cancer trajectory [2, 15]. CLC consultation was intentionally delivered early after diagnosis to identify and address legal needs before they escalated. However, this timing may also limit engagement. Participants were still absorbing a new diagnosis, clarifying treatment plans, and adjusting family roles, while many HHLNs may not yet have become concrete. This was further complicated by the implementation of Minnesota Paid Leave policy (providing job-protected partial wage replacement starting January 1, 2026) for eligible workers needing leave for their own or a family members' health [16]. This evolving policy context may have made employment leave and caregiving-related needs a moving target. As a result, proactive legal support may have felt anticipatory for some dyads but premature for others, reinforcing the need for longitudinal support.

6 | Implications

Clinically, these findings suggest that caregiver-inclusive medical-legal partnerships should not rely on caregiver presence

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TABLE 2 | Themes identified during end-of-study qualitative interviews regarding experiences on the LEGACY trial.

Theme	Description/representative quotations
Timely support during a period of uncertainty	Many participants described LEGACY as arriving at a vulnerable point, often near diagnosis, or major life disruption. Patients and caregivers valued having a structured source of support at a time when the practical consequences of cancer were still unfolding. "These services were very timely. They came at the right time when I was going through emotional turmoil from my new diagnosis." (patient) "It was very helpful given navigating this new disease with the complexities of cancer care; it was not easy." (patient) "Going through cancer is not easy, and at times it feels like a lot. This support really helped my wife." (caregiver)
Knowledgeable, personalized guidance built trust	A consistent theme was the quality of the interaction with the legal team. Participants valued clear explanations, individualized guidance, and the sense that their specific circumstances were understood rather than treated generically. "My assigned person was very thorough in explaining and answering my questions." (patient) "The attorney who reached out was really very knowledgeable." (patient) "Where she did not know the answer, she reached out to other people and found the right answer for my situation." (patient) "They explained things very nicely, which was very helpful, because we were pretty new to the complexities of cancer care." (caregiver)
Practical help with employment, insurance, finances, and next steps	Participants often emphasized the intervention's concrete usefulness. Common areas of benefit included employer-related questions, insurance issues, financial resources, disability-related information, and help prioritizing what to address first. "The resources regarding access to financial assistance were very helpful, and I was able to benefit from those, as I was unable to go to work after surgery." (patient) "They gave me insights on how to handle my employer." (patient) "I had some difficulties with my insurance and CLC was able to help me out." (patient) "Information regarding Minnesota paid leave and work protection was super helpful, as my partner had just started a new job and we did not know how these things would work out." (caregiver)
Proactive issue-spotting uncovered needs and supported future planning	Several participants said the intervention identified issues they would not have identified on their own, especially around powers of attorney, health care directives, disability rules, and planning for future decline. This proactive element was viewed as one of the program's main strengths. "They shared a lot of information and things which I never thought about, like having a [power of attorney] (POA)." (patient) "I had no idea how important health care directives could be." (patient) "I learned a lot of rules around medicaid and disability... if my disease progresses in the future, this knowledge will be helpful." (patient) "They explained and simplified complex things and also brought up issues we had not really thought through before." (caregiver)
Emotional reassurance and peace of mind were important benefits	Beyond practical assistance, many participants described emotional benefit. The intervention helped reduce uncertainty, increased preparedness, and made patients and caregivers feel less alone while managing cancer-related stress. "I felt that I was not left out alone and I knew that I had support." (patient) "This gave me peace of mind and reduced my uncertainties and stress." (patient) "I felt supported and reassured." (patient) "This gave peace of mind to my partner. She felt taken care of." (caregiver) "This was like a safety net. It was relieving to know that we could call them whenever we needed help." (caregiver)
Cancer-related legal and administrative burden extended across the dyad and family	Interviews suggested that the impact of cancer-related legal and logistical burden was not confined to the patient. Caregivers described benefit from work-related guidance, practical planning, and reassurance, while some patients emphasized that the intervention helped reduce burden on loved ones. "My sister who was my caregiver also thought this was very helpful. They helped set up bank account so she could access the funds in a situation where I could not do it myself." (patient) "I was able to prepare myself in case something unfortunate happened, and I definitely did not want to create burden for my family." (patient) "Honestly speaking it affected the whole family equally, and having these types of resources was very comforting." (caregiver) "My partner was relieved that I had enough help available." (caregiver)
Perceived fit varied across dyads	Benefit was not uniform. Some participants with strong employment, insurance, or family support reported limited immediate need for services, though they still valued knowing that help was available if circumstances changed. Others felt the benefit was greater for the patient than for the caregiver, or vice versa. "My situation was different; I did not need much help from this service." (patient) "I personally have a great job and strong support system and

(Continues)

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TABLE 2 | (Continued)

Theme	Description/representative quotations
	did not need much help, but I can see that it can benefit a lot of patients." (patient) "I do not think this was helpful to my mom, who was my caregiver." (patient) "Fortunately my employer was very supportive, and I did not end up needing direct help, but talking to them still made me feel more at ease." (caregiver)
Participants identified opportunities to strengthen the model	Despite positive overall impressions, participants identified several areas for improvement. Common suggestions included longer follow-up, more ongoing check-ins, better preparation before the first meeting, broader estate-planning support, and more detailed guidance on newer work-protection policies. "I wish the duration would have been longer, like throughout my cancer care journey, because the situation can change in 6 months or 12 months." (patient) "It would really have been helpful if I could have continuous monthly checkups." (patient) "It would have helped if they had sent an information heads-up email before the first meeting so we could go prepared." (patient) "We wish free will and estate-planning services could have been provided." (caregiver) "Minnesota paid leave and work protection were very helpful, but we still would have liked more detailed guidance." (caregiver)
Limited caregiver-specific counsel despite dyadic participation	Although caregivers were present during legal encounters, CLC staff observed that discussions remained largely patient-centered. Caregivers rarely raised independent legal concerns, suggesting that dyadic inclusion alone may be insufficient to elicit caregiver-specific needs.
Caregivers may deprioritize their own needs after a serious diagnosis	CLC staff noted that caregivers often appeared to view their role as supporting the patient rather than identifying their own legal or social needs, particularly given the recency and seriousness of the patient's diagnosis.
Unclear communication roles challenged longitudinal engagement	Although nearly all dyads completed both legal care check-ins, CLC staff described challenges maintaining consistent engagement over time. Lack of a clearly designated primary contact may have created ambiguity around communication and follow-up.
Post-diagnosis timing affected readiness for preventive legal services	CLC staff noted that the timing of the study, soon after diagnosis, involves substantial medical, emotional, logistical, and time demands, which may have limited dyads' readiness to engage with a proactive legal service.

alone to identify caregiver needs. A more explicitly dyadic model could include a separate caregiver-facing intake addressing employment leave, transferred financial strain, and caregiving responsibilities, followed by flexible touchpoints [6, 17]. CLC has also developed an interactive legal-resource toolkit that could provide self-directed guidance for common concerns, with individualized consultations for more complex needs. Future studies should evaluate whether such approaches improve engagement, HHLN identification and resolution, dyad outcomes, and resource utilization.

7 | Limitations

This was a small, single-site pilot, limiting precision and generalizability. Recruitment and follow-up were more challenging than anticipated because the study enrolled recently diagnosed dyads during severe illness, logistical strain, and adjustment to cancer. Although early legal support may be preventive, immediate post-diagnosis delivery may have preceded dyads' capacity to identify or act on concerns. Prespecified benchmarks were intentionally lenient and do not establish implementation readiness. Finally, the cohort was demographically homogeneous and relatively resourced, the study lacked a control group, and 3-months follow-up was insufficient to determine longitudinal HHLN emergence.

8 | Conclusions

LEGACY CARE demonstrated that integrating legal care referral and follow-up for newly diagnosed colorectal cancer patient-caregiver dyads was feasible and acceptable by lenient benchmarks, but difficult to implement as a truly dyadic intervention. Caregiver support cannot be assumed just because caregivers are added to a patient-centered workflow. Future caregiver-inclusive medical-legal partnership models should intentionally identify caregiver-specific needs, provide longitudinal follow-up, and account for the practical burden of introducing support during early cancer care.

Author Contributions

All authors contributed to the design of the study. All authors directed the analyses, which were carried out by K.L., R.K., R.J.J., and A.G. All authors contributed to interpreting the results, drafting the manuscript, and critically revising the manuscript for important intellectual content.

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all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.
Supporting Information S1: pon70650-sup-0001-suppl-data.docx.

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