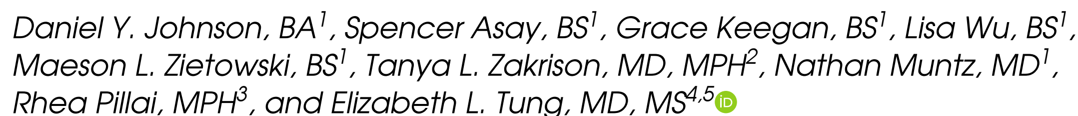
US Medical-Legal Partnerships to Address Health-Harming Legal Needs: Closing the Health Injustice Gap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ABSTRACT

The medical-legal partnership (MLP) model is emerging across the USA as a powerful tool to address the adverse social conditions underlying health injustice. MLPs embed legal experts into healthcare teams to address health-harming legal needs with civil legal remedies. We conducted a narrative review of peer-reviewed articles published between 2007 and 2022 to characterize the structure and impacts of US MLPs on patients, providers, and healthcare systems. We found that MLPs largely serve vulnerable patient populations by integrating legal experts into community-based clinical settings or children's hospitals, although patient populations and settings varied widely. In most models, healthcare providers were trained to screen patients for legal needs and refer them to legal experts. MLPs provided a wide range of services, such as assistance accessing public benefits (e.g., Social Security, Medicaid, cash assistance) and legal representation for immigration and family law matters. Patients and their families also benefited from increased knowledge about legal rights and systems. Though the evidence base remains nascent, available studies show MLPs to be associated with greater access to care, fewer hospitalizations, and improved physical and mental health outcomes. Medical and legal providers who were engaged in MLPs reported interdisciplinary learning, and healthcare systems often experienced high returns on investment through cost savings and increased Medicaid reimbursement. Many MLPs also conducted advocacy and education to effect broader policy changes related to population health and social needs. To optimize the MLP model, more rigorous research, systematic implementation practices, evaluation metrics, and sustainable funding mechanisms are recommended. Broader integration of MLPs into healthcare systems could help address root causes of health inequity among historically marginalized populations in the USA.

KEY WORDS: medical-legal; social determinants of health; health-harming legal needs; health equity; health justice

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INTRODUCTION

Recent social and political movements have increased awareness of the structural inequities that impact health and healthcare. In the USA, governmental policies and programs exist to address some structural inequities, such as nutrition assistance, utilities assistance, and healthcare for low-income populations. Yet, the complexity of enrolling in many of these programs has rendered them inaccessible to people lacking resources and legal expertise.[1] Health-harming legal needs (HHLNs) include social and economic problems, such as access to public benefits or housing, that are ideally resolved through coordinated legal and healthcare services.[2–4] These needs have become a special category of health-related social needs (HRSNs),[5] in part, due to recognition that populations with historical exclusion from governmental programs and entitlements often require legal advocacy to resolve their needs.[6–8]

Increased recognition of HHLNs and other HRSNs is occurring at a time of rapid transformation of policies and priorities pertaining to health equity in the US healthcare system. The Patient Protection and Affordable Care Act, passed in 2010, emphasized addressing HRSNs in delivering coordinated, team-based primary care and value-based healthcare.[4] The Institute for Healthcare Improvement's "triple aim"—improving patients' experience of care, population health, and healthcare costs—added health equity as a core aim in 2022.[9, 10] Even more recently, the Centers for Medicaid & Medicare Services introduced health equity metrics, which can impact quality measurement and reimbursement for healthcare systems as of 2023.[11]

Medical-legal partnerships (MLPs), which embed legal experts into healthcare teams to address HHLNs with civil legal remedies, represent one strategy to promote health equity.[2–4] MLPs are designed to address HHLNs, such as unlawfully denied public benefits, inequitable housing opportunities, or unenforced environmental regulations.[2–4] As these

HHLNs have been implicated in adverse health outcomes, MLPs have the potential to advance high-quality healthcare, especially for historically marginalized patient populations.[2, 12]

The first formal MLP was developed to serve pediatric populations at Boston Medical Center in 1993.[1] The National Center for Medical–Legal Partnership (NCMLP) was created in 2006 to support MLP research, best practices, and scaling of interventions.[13] MLPs have since been implemented across a spectrum of healthcare settings to serve a variety of patient populations.[14–18] Today, over 450 US healthcare organizations have developed MLPs in 49 states and the District of Columbia, helping an estimated 75,000 patients.[19, 20] Various governmental and professional organizations, including the US Health Resources and Services Administration (HRSA), the Association of American Medical Colleges, and the American Bar Association, have endorsed the MLP approach.[21–23] Although evidence on MLPs is still developing, studies have documented a range of positive outcomes for patients, providers, and healthcare organizations, such as improvements in mental and physical health,[24, 25] education for providers to identify and address HHLNs,[26, 27] and financial savings for healthcare organizations.[15, 16]

A 2023 scoping review reported outcomes from 30 studies of MLPs across four countries in the Organization for Economic Cooperation and Development;[28] and in 2020, the NCMLP updated its self-published review, "Making the case for medical-legal partnerships," which emphasizes five high-level outcomes based on evidence from 13 observational studies.[29, 30] This narrative review aims to provide an independent synthesis of a wider range of existing literature on MLPs in the USA, focusing on not only outcomes but also the structure and function of MLPs. First, we describe the structure and function of existing MLPs. We summarize staffing and training requirements, HHLN screening and referral processes, settings in which MLPs operate, services provided by MLPs, and populations served. Next, we review existing research on MLPs, summarizing patient, provider, and healthcare system outcomes, and focusing on exemplary studies rather than an exhaustive review of the literature. Finally, we highlight advocacy and policy efforts of MLPs, discuss the role of MLPs in education, and describe opportunities for future work.

METHODS

We searched the PubMed and Medline databases using the following keywords: "medical-legal partnership," "health-harming legal needs," "HHLNs," and "legal aid." Papers published in the past 15 years containing these keywords in the title or abstract were selected. Only papers published in English were reviewed. We included qualitative and quantitative evaluations of MLPs in the USA and excluded review papers, commentaries, and analyses of MLPs outside of the USA. After reading the abstracts of articles meeting these criteria, we identified articles that provided comprehensive descriptions of the structure and function of each MLP, as well as rigorous analyses of MLP outcomes. We identified themes regarding MLP practices, including the prevalent HHLNs and legal services offered. We categorized outcomes based on the groups of focus, which included patients, providers, and healthcare systems.

RESULTS

We identified 135 articles published between June 1, 2007, and June 1, 2022, meeting our search criteria. Out of these articles, we identified 20 exemplary articles that provided comprehensive information and analyses of the MLPs under study (Fig. 1). Although there was a wide range of measured outcomes and a paucity of randomized controlled trials in the literature, we included qualitative and quantitative observational studies with relatively rigorous designs and analyses (Table 1). This purposeful sample also reflected a diverse array of settings and patient populations.

MLP Structure and Function

MLPs apply a multidisciplinary approach, integrating resources and knowledge from a variety of experts. The traditional cornerstones of MLPs are healthcare providers and lawyers, but many MLPs have successfully integrated other professionals across the continuum of care. Some commonly integrated healthcare professionals include social workers, nurses, and medical students.[17, 35, 39] Additionally, paralegals, law students, project coordinators, case managers, psychologists, medical trainees, dietitians, and business students have been cited as MLP team members.[17, 33, 41] Some MLPs have on-site legal staff working at the clinic or hospital, while others have off-site legal staff. On-site legal staff are often embedded into the healthcare team, which can promote transitions of care from medical to legal services, while programs with off-site legal staff often utilize a referral mechanism to connect patients to legal services. These differing levels of integration can translate to differing types and levels of services provided to patients.

Most often, medical professionals identify and refer patients likely to benefit from legal services to the legal team during routine medical visits.[15, 33] However, in some cases, a team of medical and legal professionals decide which patients are likely to benefit from a legal aid referral.[36] In other cases, patients are given written information about legal services and can personally request legal counsel.[42] After a referral, the legal team provides services until the legal need has been resolved. MLPs can then assess cases to identify population-wide needs that may benefit from policy intervention, including amicus briefs, consent decrees, legislation, administrative rule changes, and advocacy to impact the practices of government officials.[43]

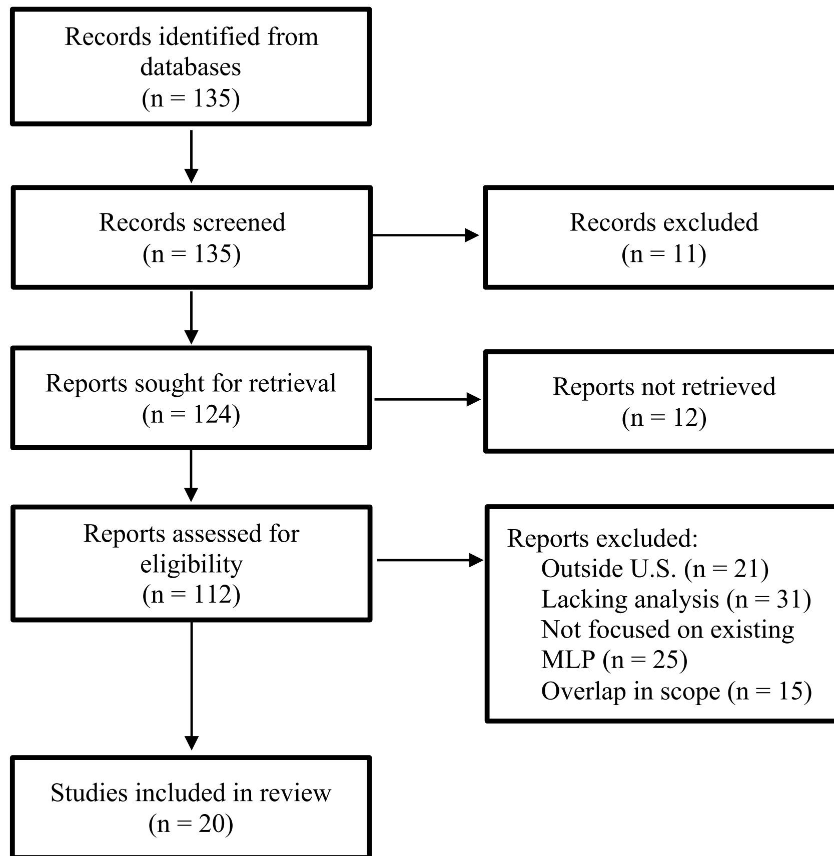

Figure 1 PRISMA flow diagram of study selection. Abbreviation: MLP, medical-legal partnership.

Types and Settings of MLPs. Current US-based MLPs cover a broad range of patient populations and care needs in a variety of settings. Most are in community settings, particularly among populations made vulnerable due to systemic and socioeconomic marginalization. These populations include, but are not limited to, families with young children,[34, 37] immigrants,[17, 18] women,[24, 32] unhoused persons,[40] low-income/Medicaid-eligible persons,[15, 16, 25] veterans,[14] and formerly incarcerated persons.[17] A large number of hospital-based MLPs are located in children's hospitals.[33, 35, 38] Other MLPs in acute care settings are housed in veterans hospitals, safety net hospitals, and trauma centers.[17, 31] MLPs are largely located in major cities near academic medical centers, but there are a few examples of MLPs in rural areas.[15, 39] One rural MLP in southern Illinois focused on low-income communities.[15] Finally, a few MLPs have been described in alternative healthcare settings, such as mobile medical vans and schools.[16, 41]

Screening for HHLNs. Literature describing a detailed screening process for legal referrals is limited, but the implementation of formal screening processes is widely noted. Legal needs screening was most commonly accomplished using interviews or questionnaires, either directly through healthcare providers or built into electronic health records.[14, 33, 41] A pediatric MLP in Boston used a modified version of the Fragile Families Screening Tool as their legal needs screener.[38] At a primary care-based MLP in Colorado, healthcare providers referred patients when they identified a legal need in an I-HELP (*I*ncome, *H*ousing and utilities, *E*ducation and employment, *L*egal status, or *P*ersonal and family stability) area.[24, 44] In a group of primary care MLPs in Ohio, the legal and medical teams collaboratively developed an electronic health record-based social history questionnaire to assess needs that could be addressed through the MLP.[16, 45]

MLP Services. Services provided by MLPs include legal representation for a wide range of social and economic needs. The level of legal representation spanned from a single session of legal counseling to full legal representation over months to years. This may also include letter-writing (e.g., to landlords in response to eviction), preparation of evidence related to legal conditions, and administrative tasks (e.g., collecting medical documentation).[14, 15, 41] Common types of legal services include insurance denials/registration, acquisition of government benefits, incorrect medical billing, family law (divorce, domestic violence, adoption, immigration), and housing issues.[17, 25, 39] A broader listing of legal services is provided in Table 2.

MLP Training. The NCMLP proposed flexible training guidelines for MLPs in 2020,[43] although none of the studies

Table 1 Medical-Legal Partnership Outcomes Evaluated by Study

Study	Sample population	Evaluation methodology	Patient outcomes	Provider outcomes	Healthcare system outcomes
Beck et al. (2022)[16]	2303 urban, low-income pediatric patients	Retrospective cohort study	Pediatric patients who were referred to the MLP had 37.9% fewer hospitalizations in the year after referral compared to those not referred to the MLP	Not evaluated	Estimated savings of the MLP were approximately $40,000 for every 100 patients referred each year
Benfer et al. (2018)[17]	5 MLPs serving children, immigrants, formerly incarcerated individuals, patients with cancer in palliative care, and veterans	Qualitative case study	Those who participated in the MLP reported increased access to public benefits and legal representation and had less stress	Not evaluated	Not evaluated
Hall et al. (2022)[31]	566 trauma center patients	Cross-sectional survey	Overall, 73% of respondents had at least one health-harming legal need that could benefit from an MLP	Not evaluated	Not evaluated
Hernández et al. (2016)[32]	72 low-income, adult patients	Comparative case study	Patients who received MLP assistance were more likely to achieve adequate, affordable, and stable housing than patients who did not receive MLP assistance	Not evaluated	Not evaluated
Keene et al. (2020)[26]	20 parents/guardians in a pediatric MLP	Qualitative interviews	Parents/guardians who participated in the MLP reported improvements in identification of legal needs, awareness of legal rights, access to legal advice and assistance, trust and confidence in the legal system, and affordability of basic needs	Members of the medical team who engaged with the MLP reported improvements in their ability to identify legal needs and engage in basic advocacy; lawyers reported increased knowledge and skills to provide nonlegal assistance	Not evaluated
Klein et al. (2013)[33]	1614 urban, low-income pediatric patients	Implementation study	MLP referrals resulted in 1945 legal outcomes, of which 89% were positive, translating to nearly $200,000 in recovered benefits	Healthcare providers improved social risk identification	Not evaluated
Malik et al. (2018)[34]	89 pediatric patients with type 1 diabetes	Implementation study, retrospective cohort study	Pediatric patients enrolled in the MLP exhibited a greater reduction in A1C compared to the traditional care group	Not evaluated	Not evaluated
Pettignano et al. (2011)[35]	71 parents/guardians with 76 children with sickle cell disease	Retrospective cohort study	MLP referrals resulted in 106 cases, of which 93% were closed after 77 months and 21% resulted in a measurable increase in benefits	Not evaluated	Not evaluated
Pettignano et al. (2013)[36]	295 parents/guardians with 313 children with asthma	Retrospective cohort study	The MLP provided $501,209 in financial benefits for children with asthma over 7 years	Not evaluated	Not evaluated
Regenstein et al. (2017)[37]	232 healthcare and legal organizations engaged in MLPs	Cross-sectional survey	MLPs reported that the median financial benefit to their patients was $81,595	Not evaluated	MLPs reported that healthcare partners recovered a median of $119,013
Ryan et al. (2012)[25]	67 low-income, adult patients	Prospective cohort study	Patients who participated in the MLP exhibited decreased stress levels by 8.1 points and increased wellbeing scores by1.8 points	Not evaluated	Not evaluated
Sauaia et al. (2022)[24]	115 low-income, adult patients	Prospective cohort study	Patients who participated in the MLP demonstrated improvements in all client-reported health outcomes, including days with poor physical and mental health, feelings of stress, and self reported missed appointments	Not evaluated	Not evaluated

Table 1 (continued)

Study	Sample population	Evaluation methodology	Patient outcomes	Provider outcomes	Healthcare system outcomes
Sege et al. (2015)[38]	330 families of healthy newborns	Randomized controlled trial	Infants who received MLP support were less likely to have an ED visit by age 6 months and more likely to have received DTaP immunizations on time or delayed by no more than 1 month	Not evaluated	Not evaluated
Shek et al. (2019)[18]	1 MLP serving low-income, pediatric patients	Qualitative case study	The MLP trained public housing residents about their legal rights, provided advocacy opportunities, built trust, and provided the legal and health knowledge needed to access benefits	The legal staff learned from clients how employment and healthcare laws were experienced 'in the real world'	Not evaluated
Shin et al. (2010)[12]	10 MLPs	Mixed-methods study	Health center patients requiring some type of health related legal assistance was estimated at approximately 50-85%; a large proportion ofhealth centers reported income (98%), housing (94%), and personal and family stability (90%) needs	Not evaluated	Not evaluated
Teufel et al. (2009)[39]	1 MLP serving rural, adult patients	Cost-effectiveness analysis	Of the closed cases, 95 (25·5%) resulted in positive outcomes for clients and 159 (42·7%) resulted in clients receiving legal advice and/or referrals to an appropriate legal assistance entity	Medical staff were trained to identify legal issues and refer patients to legal staff	Because of Medicaid reimbursements, the ROI for the funding healthcare organization was $172,135 or 149% more than the amount invested
Teufel et al. (2012)[15]	1 MLP serving rural, adult patients	Cost-effectiveness analysis	Patients had $1,537,208 of their healthcare debt relieved ($307,442 per year) from 2002 through 2006 and $2,390,490 during the years of 2007 and 2009 ($796,830 per year)	Not evaluated	For 2002–2006, the cost–benefit ratio was 321% and the ROI was 221% and increased for the 2007–2009 period to a cost to benefit ratio of 419% and ROI of 319%
Tsai et al. (2017)[40]	48 homeless service sites	Cross-sectional survey	Not evaluated	Not evaluated	In a survey of homeless service sites, 93% of sites reported that their patients experience legal needs, yet only 10% had an MLP
Tsai et al. (2017)[14]	950 veterans	Prospective cohort study	Veterans who received full legal representation showed improvements in general and mental health, housing status, and total income. More time spent receiving MLP services was associated with greater improvements in housing, mental health, and income	Not evaluated	The average total cost was $270–$405, less than the average annual direct costs of $10,000–$60,000 to care for a person who is chronically homeless or has a severe mental illness, or both
Weintraub et al. (2010)[41]	54 low-income, adult patients	Prospective cohort study	Patients who participated in the MLP benefited from increased welfare receipt and decreased healthcare avoidance for their child; 66.1% of participants thought their children's health and well-being improved	Not evaluated	Not evaluated

Table 2 Common Legal Services Provided by US Medical-Legal Partnerships

Common service types	Examples	Studies
Economic stability and public benefits	Medicare or Medicaid, disability, cash assistance, child care assistance, food stamps, unemployment, child support, medical debt	12, 14–18, 24–26, 28–32, 35, 39
Housing stability	Housing discrimination, utility assistance, eviction, renter protections, conditions of subsidized housing	12, 14–18, 24–26, 29–32, 35, 37, 39
Employment and education needs	Wrongful termination, employment discrimination, unpaid wages, employment protection, special education services	12, 14–17, 24, 26, 29–32, 35
Legal status	Expungement or sealing of criminal records, documentation status, asylum application, obtaining birth certificate or government ID	12, 14, 17, 24
Personal and family stability	Protective orders, child protection investigations or appeals, non-parent guardianship of child, advanced directives	12, 14–18, 24, 25, 28–32

Service types adapted from the I-HELP screening tool (available at: https://medical-legalpartnership.org/mlp-resources/i-help-screening-tool/)

specifically reference these guidelines. Most MLPs offer training for healthcare providers, but descriptions of formal training in the literature are scarce.[15, 41, 46] One primary care-based MLP in Hawai'i provided quarterly workshops for a wide variety of clinical staff.[18] A pediatric MLP in Ohio required training during staff meetings and at yearly refresher sessions. This MLP also expanded their training to include education for residents during their outpatient rotations.[33] In other cases, lawyers led educational workshops for their medical partners. Outside of a few examples, the scope and rigor of most training programs were not detailed, indicating a need for more research and greater standardization of MLP training.

Summary of the Evidence

Across the wide range of MLPs reviewed, numerous outcomes emerged for patients, providers, and healthcare systems. These findings corroborate the ability of MLPs to support growing calls to include health equity as a core tenant of healthcare delivery.

Patient Outcomes. ***Legal Benefits*** Studies have documented that MLPs empowered patients to learn about their legal rights and the legal system. The learning opportunities provided by MLPs are frequently tailored to the needs of the patient community. For example, the Tucson Family Advocacy Program hosted special programs on advance directives and supporting refugee health; other MLPs have focused on ameliorating housing conditions that precipitate childhood asthma.[36] While there is a paucity of measured outcomes related to patients' understanding of legal systems and rights, one qualitative case study of a Hawai'i-based MLP reported that participants shared the knowledge they gained with family members and friends, suggesting that education about legal rights can diffuse to the broader community.[18]

Across studies, MLPs served as an access point to the legal system for patients and families who may not have otherwise had access to legal assistance. By connecting patients to the legal system, MLPs helped patients obtain benefits that are often challenging to navigate.[18, 26] In a prospective cohort study of an MLP in Ohio, 1808 referrals were initiated and led to cases for 1614 patients, of which 89% resulted in positive outcomes. The benefits obtained by MLPs also extended to the patients' families and households. Investigators estimated that the legal services provided for 1614 patients extended to nearly 6000 cohabitating family members.[33]

The range of legal services provided by MLPs was broad (Table 2).[17, 39, 41] Common economic benefits included Social Security, Medicaid, and medical debt relief.[14, 15, 36] At an MLP in Georgia, a retrospective cohort study found that the resolution of 65 cases led to an estimated annualized benefit of $501,209 for families. Most of this was attributed to obtaining Supplemental Security Income and other public benefits.[36] Furthermore, patients who engaged with MLPs were more likely to achieve stable housing, utilities, and other benefits than patients who did not.[14, 32, 38] One California-based MLP surveyed patients at baseline and 6 months after receiving legal assistance, and found significant increases in receipt of the Special Supplemental Nutrition Program for Women, Infants, and Children and Child Support.[41] Overall, the assistance and representation provided by MLPs conferred legal and socioeconomic benefits to patients.

Health and Healthcare Benefits Outside of legal benefits, multiple studies reported that MLPs also improved patient satisfaction, as well as healthcare utilization and access. In one prospective cohort study of an MLP in California, 86.8% of participants said the information provided by the MLP was useful, and 88.7% reported that they would continue to use MLP services. In the 6 months after receiving MLP assistance, participants also reported decreased avoidance of healthcare for their children due to a lack of health insurance or cost, as well as fewer difficulties with transportation.[41] At an MLP serving urban, low-income children in Ohio, a retrospective cohort study found that patients referred to the MLP had 37.9% fewer hospitalizations one year after the referral compared to those receiving usual care.[16]

MLPs were also associated with a range of health outcomes. Prospective cohort studies found that low-income patients reported significant reductions in days with poor physical or mental health and improvements in perceived stress and well-being.[24, 25] One retrospective cohort study of an MLP targeting pediatric patients with type 1 diabetes reported improved glycemic control compared to patients receiving traditional care.[34] In a prospective cohort study of 148 veterans at four MLPs in Connecticut and New York, participants showed significant improvements in substance use and symptoms of anxiety and post-traumatic stress disorder.[14]

Provider Outcomes. Although most studies focused on patient outcomes, some studies reported that MLPs benefited medical and legal providers by empowering them to identify HHLNs. Participating in MLPs improved structural competency, defined as the interaction between a patient's health and all the forces outside individual interactions.[47] Such structural competency equipped healthcare providers to identify and advocate for patients' rights.[26, 27] At an Illinois-based MLP, the legal staff provided educational seminars to healthcare providers about the legal process and how to identify cases for referral. Physicians in this MLP were also trained to help their patients navigate the healthcare, public aid, and legal systems.[39] One Georgia-based MLP taught their healthcare providers to integrate screening for legal needs into appointments through a "legal checkup" designed to emulate medical histories and physical exams.[35, 36]

In turn, the legal staff at MLPs had the opportunity to learn more about the medical system through their interactions with medical teams. There were few reports of the perspectives of legal staff, but in a qualitative study of a pediatric MLP in Hawai'i, the legal staff reported acquiring new knowledge about how healthcare laws and employment protections played out in the real world.[18] MLPs appeared to facilitate stronger connections between medical and legal service providers and create opportunities for interdisciplinary learning.

Healthcare System Outcomes. MLPs often benefitted their affiliated healthcare organizations by reducing costs and increasing Medicaid reimbursement. In a retrospective cohort study, an MLP affiliated with an urban pediatric hospital in Ohio significantly lowered hospitalization rates among children. In turn, the lower hospitalization rates were estimated to yield $40,000 in healthcare savings for every 100 patients referred each year.[16] Teufel et al. conducted a detailed cost–benefit analysis of a rural MLP in Illinois. The MLP assisted with 723 cases over three years, with an estimated cost benefit of $674 per case due to recovered Medicaid dollars, translating to a 319% return on investment for the hospital system during the study period.[39] Although the costs and benefits of MLPs warrant further investigation, early evidence indicates that MLPs may yield fiscal benefits for healthcare organizations.

Limitations of the Evidence

The studies discussed in this review article have reported promising evidence that MLPs can improve health and healthcare. However, research in the field remains limited and contains significant gaps. First, there is a need for more rigorous and comprehensive evaluation studies to assess the long-term impacts of MLPs on patient, provider, and healthcare outcomes. Many existing studies focus on short-term outcomes, making it challenging to draw conclusive insights about their effectiveness. For example, the five prospective studies included in this review had follow-up durations lasting between 6 and 12 months. Second, much of the existing literature is observational and there are few randomized controlled trials or quasi-experimental studies comparing MLPs to standard care. Third, all studies included in this review had positive findings, suggesting the potential for publication bias. It is likely that both researchers and editors have been reticent to publish negative studies for this more nascent area of research.

Lastly, measures of success are broad and poorly defined, making it difficult to compare MLP performance across sites. Nerlinger et al. proposed a series of metrics related to patient and provider outcomes to evaluate MLPs, including patients' ability to navigate healthcare and legal systems and wellbeing across multiple domains, as well as providers' knowledge of HHLNs.[46] The NCMLP has also proposed a limited set of performance measures for MLPs, largely focusing on legal screening, legal assistance, and benefits for patients and healthcare organizations.[48] Future research should aim to address these gaps and provide a more robust evidence base for MLPs.

The Role of MLPs in Advocacy

Many MLPs mention advocacy as a core goal of their programs. MLPs conduct their advocacy by working with healthcare professionals to promote broader change within public health, or within a specific policy area that affects the MLP's patient population.[15, 41] "Patients-to-Policy," used to describe the translational arc from patient research to health policy change, may have very concrete applications for MLPs. For example, in response to local policies that caused uninsured patients to accrue more out-of-pocket costs relative to other demographic groups, one MLP in rural Illinois began advocating for changes to Medicaid access and reimbursement.[15]While some MLPs describe their advocacy in broad terms, sometimes without specific aims,[26] other MLPs have formulated detailed advocacy goals. An MLP in Hawai'i created "Advocacy Academy," a series of monthly workshops that educated patients about their basic legal rights in family law, housing, public benefits, and other self-selected topics. This MLP also created a program to support community-led campaigns for state and federal health policy changes benefitting Hawaiians of Micronesian descent.[18]

Opportunities for Future Work and Sustainability

MLPs have been traditionally implemented in primary care settings, particularly those caring for historically marginalized populations, likely because such settings enable longitudinal care of patients and families. There is a paucity of literature on MLP implementation and outcomes in acute care settings, though some research has shown that acute care settings may facilitate engagement with patients who have a high level of HHLNs.[31, 49] At a level I trauma center in Washington D.C., 73% of participants reported at least one HHLN,[31] which is substantially higher than the 1–8% prevalence of HHLNs among the general population.[3] Addressing HHLNs may be especially salient in acute care settings that serve marginalized patients who face structural and legal barriers to accessing public benefits, including routine healthcare.

Despite the potential benefits of MLPs reported in the literature, many MLPs rely on a patchwork of insufficient funding. Some healthcare organizations provide funding for MLPs in their operating budget, and non-profit hospitals can feature MLP funding in community benefit reports to qualify for tax-exempt status.[50] Healthcare organizations can also include civil legal aid as an enabling service in federal grants from HRSA.[21, 50] However, MLPs are primarily funded by legal aid organizations.[3, 50, 51] The Legal Services Corporation, a congressionally funded non-profit organization that provides competitive grants for civil legal aid, makes up a significant amount of funding for MLPs. Yet, the Legal Services Corporation has been chronically underfunded, which restricts the scope of legal services MLPs can offer.[3, 50] Other MLPs are funded by legal aid organizations through grants from the nonprofit sector, in addition to public interest legal fellowships and law school collaborations.[3, 50, 51] In at least seven states, new funding mechanisms incorporate payment for legal services in Medicaid payments, Medicaid managed care contracts, or innovative delivery system reform models.[3, 50] Other unique funding streams include the Supportive Services for Veteran Families program, which gives grants to MLPs serving veterans with housing insecurity,[52] and the U.S. Fiscal Year 2023 Omnibus Appropriations Bill, which allocated $2 million in federal funding for MLPs.[53] The outcomes of these novel funding mechanisms remain to be seen, and in the future, continued innovation and policy reform and more sustainable funding streams from the healthcare, legal, and social service sectors will be required to make MLPs financially sustainable.

CONCLUSIONS

In recent years, MLPs have gained attention as a novel strategy for delivering health and social care to historically marginalized patient populations with intersecting medical, social, and legal needs. MLPs have been implemented in various settings and have been found to provide benefits to patients and their families, medical and legal providers, and health systems. MLPs have come to play a role in education and advocacy related to population health and social needs. Nevertheless, the empiric evidence on MLPs remains limited, with relatively little rigorous research to draw upon, and would benefit from utilizing a standardized framework for comparing effectiveness across sites.[43, 48, 54] Lastly, broader integration of MLPs into acute care and alternative care settings and more sustainable funding could help fill a critical gap in caring for patient populations with unequal access to care and disproportionately high prevalence of HHLNs.

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Author Contribution: *ELT, TLZ, DYJ, SA, GK, LW and MLZ conceptualized the study. DYJ coordinated all review activities. DYJ, SA, GK, LW, and MLZ collaborated on study searching, screening, data extraction, and quality appraisal. All authors critically revised the article for important intellectual content and approved the final version. All authors had full access to the data in the study and had final responsibility for the decision to submit for publication.*

Data Availability *The dataset generated during the current study is available from the corresponding author on reasonable request.*

Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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