ORIGINAL RESEARCH

A Qualitative Analysis of a Primary Care Medical-Legal Partnership: Impact, Barriers, and Facilitators

Winston Liaw, MD, MPH, Christine Bakos-Block, PhD, LCSW, Thomas F. Northrup, PhD, Angela L. Stotts, PhD, Abigail Hernandez, BS, Lisandra Finzetto, BA, Pelumi Oloyede, BS, Bruno Moscoso Rodriguez, BA, Skye Johnson, BA, Lauren Gilbert, PhD, MPH, Jessica Dobbins, DrPH, LeChauncy Woodard, MD, MPH, and Thomas Murphy, MD

Background: **Certain health-related risk factors require legal interventions. Medical-legal partnerships (MLPs) are collaborations between clinics and lawyers that address these health-harming legal needs (HHLNs) and have been shown to improve health and reduce utilization.**

Objective: **The objective of this study is to explore the impact, barriers, and facilitators of MLP implementation in primary care clinics.**

Methods: **A qualitative design using a semistructured interview assessed the perceived impact, barriers, and facilitators of an MLP, among clinicians, clinic and MLP staff, and clinic patients. Open AI software (otter.ai) was used to transcribe interviews, and NVivo was used to code the data. Braun & Clarke's framework was used to identify themes and subthemes.**

Results: **Sixteen (n = 16) participants were included in this study. Most respondents were women (81%) and white (56%). Four respondents were clinic staff, and 4 were MLP staff while 8 were clinic patients. Several primary themes emerged including: Patients experienced legal issues that were pernicious, pervasive, and complex; through trusting relationships, the MLP was able to improve health and resolve legal issues, for some; mistrust, communication gaps, and inconsistent staffing limited the impact of the MLP; and, the MLP identified coordination and communication strategies to enhance trust and amplify its impact.**

Conclusion: **HHLNs can have a significant, negative impact on the physical and mental health of patients. Respondents perceived that MLPs improved health and resolved these needs, for some. Despite perceived successes, integration between the clinical and legal organizations was elusive. (J Am Board Fam Med 2024;37:637–649.)**

Keywords: **Communication, Jurisprudence, Medical-Legal Partnership, Primary Health Care, Qualitative Research, Social Determinants of Health, Social Factors, Social Problems, Trust**

Introduction

The US has lower life expectancy than other developed countries due in part to its underinvestment in social care.[1,2] Medical-legal partnerships (MLP) offer a promising model that brings together legal and clinical entities to address health-harming legal needs (HHLNs), including unsafe housing and employment discrimination. These HHLNs affect 3 in 4 low-income households, and few have

This article was externally peer reviewed.
Submitted 6 September 2023; revised 15 January 2024, 30 January 2024; accepted 19 February 2024.

From the Department of Health Systems and Population Health Sciences, University of Houston Tilman J. Fertitta Family College of Medicine, Houston, TX (WL); School of Biomedical Informatics, University of Texas Health Science Center at Houston, Houston, TX (CBB); Department of Family & Community Medicine, University of Texas Health Science Center at Houston, McGovern Medical School, Houston, TX (TFN); Department of Family & Community Medicine, University of Texas Health Science Center at Houston, McGovern Medical School, Houston, TX (ALS); Department of Medicine, University of Texas Health Science Center at Houston, McGovern Medical School, Houston, TX (AH); Department of Counseling, Wake Forest University, Winston-Salem, NC (LF); University of Houston Tilman J. Fertitta Family College of Medicine, Houston, TX (PO); University of Houston Tilman J. Fertitta Family College of Medicine, Houston, TX (BMR); University of Houston Tilman J. Fertitta Family College of Medicine (SJ); Division of Kinesiology and Health; University of Wyoming College of Health Sciences; Laramie, WY Dobbins: (LG); Humana, Inc., Louisville, KY (JD); Department of Medicine and Office of Community Engagement and Health Equity; Baylor College of Medicine; Houston, TX (LW); Department of Family & Community

resources to address them.[3] MLPs have the potential to fill-in these gaps.[4–9] Two randomized-controlled trials (RCTs) in pediatric populations provided participants with legal services and found that MLPs increased preventive services, reduced emergency department (ED) visits, and improved diabetes control.[9,10] In contrast, our previous trial in adults, which randomized participants to immediate or 6-month delayed MLP referrals, was mixed. The immediate referral group had lower stress and fewer ED visits but also higher anxiety and more hospital visits.[11] One limitation of our trial was that only 16% of participants received legal services after referral, highlighting the challenges of integration.[11]

Although others have examined the implementation of social needs screening,[12–21] this study differs from our predecessors in several ways. First, rather than focus on 1 stakeholder group,[12,20] we include patients, clinical staff, and legal staff. Second, we focus on MLPs specifically, rather than social needs screening generally.[14,19,20] Because of the unique features of legal organizations, we hypothesize that some challenges are unique to MLPs. Finally, this qualitative study includes participants of the aforementioned MLP RCT.[11] As a result, some interviewees had a standardized experience. Our aim was to qualitatively explore the impact, barriers, and facilitators of MLP implementation in primary care.

Methods

Study Design and Participants

The protocol was approved by the Committee for the Protection of Human Subjects at the University of Texas Health Science Center at Houston (UTHealth Institutional Review Board HSC-SPH-19 to 0480). Semistructured interviews qualitatively assessed MLP implementation. The inclusion criteria were individuals working in primary care clinics that implemented the MLP, those working for the partnering legal services organization, patients with appointments in clinics with the MLP, adults aged 18 and older, and English and Spanish speakers. Participants were recruited in-person and via e-mail and flyers.

RCT and Intervention

During the MLP RCT (February 2019 to September 2020), staff at the clinic screened participants for HHLNs using an instrument. When appropriate, clinicians, community health workers, and social workers referred patients based on the problems identified during encounters. The legal services organization made multiple attempts to contact participants via telephone (typically 5) and mail. If successful, they conducted intake for eligibility and identification of HHLNs. For accepted cases, an attorney and paralegal delivered advice and counsel, drafted documents, and provided legal representation at no cost. During the RCT, the paralegal was physically at the clinic 1 to 2 times per month. During the final, RCT assessment, participants were asked whether the investigators could contact them to participate in future studies, and we communicated with those who agreed (18/160, or 11.3%). The MLP was active in multiple sites across 2 institutions; thus, to increase the sample size, we also recruited participants not involved with the RCT. Patients not involved with the RCT were screened for HHLNs every 6 months.

Interview Procedures

Trained research staff completed semistructured interviews (see Appendix Table 1) between August, 2020 and January, 2023. Questions elicited the positive and negative consequences of the MLP, barriers and facilitators of adoption, extent to which the program was delivered as intended, and whether the model was maintained over time. Three of the authors (WL (medical doctor), CBB (PhD in social work), and LG (PhD in sociology)) trained research assistants to conduct the interviews. These 3 authors were research faculty at the time of the interviews, received training in qualitative methods, and have led qualitative studies. The training included reading materials about qualitative interviews, instruction regarding the protocol, mock interviews, direct observation, and feedback. All interviews were conducted via a web-based program in English (no participants preferred Spanish) and audio-recorded.

Medicine, University of Texas Health Science Center at Houston, McGovern Medical School, Houston, TX (TM).

Funding: The study was supported by a grant from the Texas Medical Center Foundation (PI=Liaw) and a gift from Humana Inc. The gift provided support for a research assistant. Humana patients were not included in this study. A Humana employee (JD) was involved with writing this manuscript.

Conflict of interest: WL received a gift from Humana, Inc.

Corresponding author: Winston Liaw, MD, MPH, 5055 Medical Circle, Houston, Texas 77204 (E-mail: wliaw@central.uh.edu).

Participants were compensated with up to $50 (the initial participants received $25 whereas subsequent participants received $50 to enhance recruitment). We collected demographic information, including age, gender, race, ethnicity, and professional role (for nonpatients).

Qualitative Data Analysis

Interviews were transcribed with otter.ai. then verified for accuracy, cleaned, and deidentified by the research assistants. Data were coded with NVivo (Version 12) using inductive thematic content analysis.[23] Two of the authors (WL and CBB) trained 3 research assistants to code the transcripts, and all 5 participated in coding. First-level coding was conducted by 2 members of the research team, who coded the same interviews and met to compare, discuss, and resolve differences in coding. The remaining interviews were then divided among the coders, who continued to meet throughout the process to ensure internal consistency. To increase the trustworthiness of the data, a third member of the research team reviewed the completed codes for validity. Finally, content analysis was used to identify themes and subthemes related to the impact of HHLNs, the impact of the MLP, and the barriers and facilitators to the MLP's implementation.

Results

Sixteen individuals participated (Table 1). Of note, 6 of the 8 patient respondents (75%) participated in the MLP RCT. The themes pertained to the effect of HHLNs on health, the impact of the MLP, and the barriers to and facilitators of implementation (Table 2, Figure 1).

Theme 1: Patients Experienced Legal Issues That Were Pernicious, Pervasive, and Complex

Participants described the destructive nature of HHLNs. Eviction, hazardous housing, and inadequate food and income all contributed to physical and mental distress, the exacerbation of diseases, and a reduced sense of safety. In response to not having a place to live, 1 patient said, "That is how I ended up in the hospital…it was very stressful." When HHLNs threatened basic, physiologic needs, patients lacked the resources to receive medical care. Regarding patients with diabetes, 1 clinician asked, if "they do not have housing, can [we give] them insulin…?"

Table 1. Participant Demographics*

Characteristic	# (%)
Gender	
Woman	13 (81.3%)
Man	2 (12.5%)
Transgender	1 (6.3%)
Race	
White	9 (56.3%)
Black or African American	6 (37.5%)
Other	1 (6.3%)
Ethnicity	
Hispanic, Latino/a, or Spanish origin	6 (37.5%)
Age	
18 to 24	1 (6.3%)
25 to 34	6 (37.5%)
35 to 49	4 (25.0%)
50 to 64	2 (12.5%)
65 and older	3 (18.8%)
Professional Role	
Clinician or staff	4 (25.0%)
Attorney or paralegal	4 (25.0%)
Patient	8 (50.0%)

*Due to the small cell sizes, we chose not to report gender, race, ethnicity, and age, by professional role.

HHLNs were not isolated to individuals, but rather, were distributed across patients' support networks. To address HHLNs, individuals sought help from friends and family members, which, in turn, strained households that were already vulnerable. For instance, 1 patient's mother could not afford to remove mold from her home as her savings were being allocated to cover unpaid taxes. Consequently, she had to move in with the interviewee. Meanwhile, the interviewee was grappling with her own financial difficulties, exacerbated by her own disability and that of her son. Custody and estate disputes also had harmful, long-lasting effects on families. Similar to chronic conditions, HHLNs accumulated and persisted, with 1 legal professional noting that "a lot of…legal aid clients…come back." For some, HHLNs lasted for years, created or exacerbated other problems, and were not easily resolved with a single legal action. One patient owned property in another state and struggled to evict a tenant. As a result of not being able to generate rental income, they themselves were evicted from their apartment.

Table 2. Identified Themes, Subthemes, and Quotes

Themes	Sub-themes	Additional Quotes (Representative quotes are listed under results)
The impact of health-harming legal needs on health		
Patients experienced legal issues that were pernicious, pervasive, and complex	Because they affected basic needs for survival, legal issues led to worse physical and mental health	"What I'm trying to do is get to a safe place. [W]hen I get to a safe place, my body reboots. . .the challenge has been trying to find that safe place and with my [apartment] that my mom gives me, there's always some type of chemicals. . .[R]ight now I'm sleeping in my car because when I go in the apartment. . .my throat, my chest, my nose everything burns." (Patient)
		"Because it allows things to go deeper, that connection with the topics of medical health and. . .legal issues that can actually affect your health. . .I didn't [know] it was affecting me. . .it wasn't until this opportunity came. . .[I]t. . .opened my eyes. . .This is really more serious than I thought it was." (Patient)
	Patients were not only dealing with their own issues but were also affected by the legal issues of friends and family members	"she [the patient's mother] needs help fixing her house up. . .she owes a lot [of] taxes on the house. And therefore it's hard for her to get somebody to help her fix the house because of the tax. . . [Her house has] been messed up [since Hurricane] Harvey. And. . .it's got mold in it. [So] she can't live in there. So she's staying with me. . .and we've been hoping and praying [for] somebody to help us" (Patient)
	For some, health-harming legal needs accumulated and persisted	"One thing that we've noticed is that a lot of. . .legal aid clients. . .come back. . .." (Attorney or paralegal)
The impact of the MLP		
Through trusting relationships, the MLP was able to improve health and resolve legal issues, for some	Addressing health-harming legal needs can help patients get the medical care they need and improve their physical and mental health	"I had been in and out of the hospital several times. . .I was talking to my doctor about it. . .And that's when he referred me so I was willing to try anything, because I was already looking for an attorney. But I was having so much trouble trying to find the [right] type of attorney that I needed. And so it I'd been looking for like a month and everybody was just like. . .[it was a] giant case. So I guess they didn't want to take it. Like I [said], I'm glad the person took it who did because he has been doing a phenomenal job" (Patient)
		"it was a difficult appeal case against [a health insurance company]. . .I did not even expect to get the outcome that we got for the client and she was just overjoyed. . .that experience sticks out because it was to provide care for her minor son." (Attorney or paralegal)
	The MLP addressed a broad range of legal issues related to poverty	"We're kind of generalists. . .Whereas other parts of [the legal services organization]. . .we have all specialized units. . .[W]hen you're working in the MLP. . .you get cases that can be anything from a housing issue, like mold in an apartment to a social security disability denial appeal. . .to a guardianship proceeding." (Attorney or paralegal)
	When they were able to connect with patients, the legal professionals served as advocates and gave patients hope	"it also gave. . .a sense of hope. [The patients] actually matter to somebody. . .[the patients] have somebody in their corner fighting for them as well." (Attorney or paralegal)
		"It made me feel like somebody cared. . .Some of the other attorneys who I've talked to. . .they were nowhere near as thorough. And I believe once. . .my apartment started acting crazy, then they probably would have [given] up on it. So I appreciate them sticking by and doing what they're doing." (Patient)

Continued

Table 2. Continued

Themes	Sub-themes	Additional Quotes (Representative quotes are listed under results)
Barriers to implementation		
Mistrust, communication gaps, and inconsistent staffing limited the impact of the MLP	Some clients did not trust the MLP due to a lack of follow-up or information, which contributed to suspicion and disappointment	"if a patient has a question about [the MLP], and [the clinic staff is] not. . .excited about it. . .I think that that could deter a client. . .And also, sometimes they will complete the form because they do need legal help. And so we'll have our intake person call them to begin the process. And they will be like, Oh, I had no idea what this was that I filled out. . .And then. . .we got to. . .deal with the distrust because like, Oh, how did you get my information? I don't remember filling this out." (Attorney or paralegal)
		"if they would have sent me a letter telling me [someone will call] at this hour. . .Because at [that] time. . .this phone belonged to my sister because she borrowed mine, [because hers needed a charger], she dropped it and broke mine. . .So this phone does not take messages, because she doesn't remember the code. . .I just look at missed calls. . .And I was very disappointed because I feel like. . .they say [they'll help] you." (Patient)
	The MLP had a difficult time getting in touch with patients, particularly those who did not speak English	"I [should have] kept up with it. . .that's. . .my fault. . .They contacted me. They [sent] me a letter and I should've. . .answered the phone call. . .I should've answered the letter. . .So, I mean, they did their part. . .I didn't do my part" (Patient)
		"We'll get the referral and try to contact them as soon as possible. A lot of times. . .we won't get a response. . .We call at least two to three times, and then we also send them a letter. . .We'll email them. . .So establishing that contact so that we actually can have an attorney, client relationship is a huge barrier." (Attorney or paralegal)
	A lack of buy-in and education at the individual staff and organizational leadership levels affected engagement	"at first there was more of a kind of like standoffish cold shoulder. . .here's. . .the referrals you handle it" (Attorney or paralegal)
		"one of the clinics. . .was hesitant. . .the clinic staff wasn't willing to. . .provide assistance. [They] were there like. . .we're already screening the clients for you." (Attorney or paralegal)
	Because of the number of people involved, coordination between legal and medical staff was challenging	"[There is] some challenge. . .being virtual. . .key players not being available when needed. . .for example. . .the legal counsel. And that person may not always be available whenever we're trying to make a decision, but we need their input to make a decision. . .it can linger on for weeks or months" (Attorney or paralegal)
		"you're gonna [face] a lot of administrative. . .hurdles. . .you're working with so many. . .cooks in the kitchen that you. . .have to really break down barriers, make time to look at processes and collaborate." (Attorney or paralegal)
	Laws governing medical and legal data affected the flow of information	"with the MLP. . .there's a lot of more. . .red tape. There's a lot of. . .data that [they need] to collect on the health care end, that we don't have to collect on our end at [the legal services organization]. And so I just noticed that sometimes it's kind of hard for me and my team at [the legal services organization] to understand why is this form needed? Why is this information being gathered?" (Attorney or paralegal)
		"[Clinics] have obligations under HIPAA. . .that. . .prohibits what we do. And so when you've got four different sets of legal counsel. . .it's

Continued

Table 2. Continued

Themes	Sub-themes	Additional Quotes (Representative quotes are listed under results)
		difficult to create processes and procedures to manage that flow of information that work for all parties. . .How are we getting the referrals? Are you guys sending them in a way that's HIPAA compliant, but are we able to access them?" (Attorney or paralegal)
	Referrals and staff capacity varied, and when referrals exceeded capacity, bottlenecks emerged	"So I was out for nine months. I just came back. . .in October. And we got new staff. So right now the challenge is just kind of figuring out what. . .the right balance is. . .how to divvy up. . .the tasks between myself and the other paralegal." (Attorney or paralegal) "the numbers [of referrals] go up and down. . .. [Ultimately, we hope that] we could get that more steady trickle of referrals versus. . .how it is now [where] some weeks we'll have five [and] some weeks we'll have 20. . .it just kind of is inconsistent." (Attorney or paralegal)
Facilitators of implementation		
The MLP identified coordination and communication strategies to enhance trust and amplify its impact	Language resources addressed communication gaps	"I also tried to make sure that we used qualified interpreters. We. . .have access to. . .language line so we can get interpreters for any call. . ..so making sure that the interpreters were available, that I used them in a way that wasn't. . .condescending or arduous. . .I called the interpreter first and then had them conference her. . .really just taking those extra steps and precautions to. . .get through to the client. . .And thankfully [the patient] did work with us. We were able to get her a positive outcome." (Attorney or paralegal)
	Co-location and predictable office hours expedited the intake process	"[W]henever the client was screened. . .they knew [the legal services organization was] going to be here on Fridays. . .Do you want to go in and just speak with [the legal services organization] and come in on Friday?. . .It was a lot easier than. . .trying to call them. . .once. . .twice, three times a week. . .I had them actually just coming into the clinic and. . .talking with us. . .even if it was. . .5, 10, 15 minutes. . .it. . .made the referral process a lot easier. . ., which is one of the main reasons why. . .we made those office hours once a week. . .there wasn't a lot of wait time towards the end." (Attorney or paralegal) "[R]eally incorporate the [MLP into] clinics. . .not doing [it] every day, but maybe. . .two or three times out of the week. . .we saw that sometimes. . .patients weren't available the days that the [legal services organization] staff was available. So giving them a wider option of. . .being able to have that [in-person] contact with the legal aid within the clinic would be. . .beneficial. [O]ne of the biggest [recommendations from] me is actually having. . .adequate space to. . .[house the MLP] within the. . .clinic." (Attorney or paralegal)
	Periodic meetings broke down organizational siloes	"making sure that the lines of communication are open and having meetings with all necessary parties have really helped. . .So not having siloed meetings where it's just us and one representative from the clinic that may not be authorized to consent to a change or without general counsel. . .on the call. . . [T]hat's the key to effective integration is just making sure that all necessary parties are communicating early [and] often." (Attorney or paralegal)

Continued

Table 2. Continued

Themes	Sub-themes	Additional Quotes (Representative quotes are listed under results)
	The reputation of the clinic facilitated patient recruitment	"one of. . .the positives of the actual partnership was. . .having those established clinics in the communities where we could come in and. . .piggyback off of their reputation to provide those services and get our organization into the community." (Attorney or paralegal)
	Having staff buy-in and a clinic champion improved communication and strengthened coordination	"[S]omeone has to be appointed to keeping the forms organized and making sure they're completed. . .That their [medical record numbers] and stickers are on the forms, because if there's not. . .they're incomplete. They don't have the full phone number on it. We can't read the patient's name. . .you can lose time and referrals. . .if more than four weeks lapse between a patient completing their form in the clinic, and us calling them, they're going to be highly suspicious." (Attorney or paralegal) "the social workers or the community workers that were. . .processing. . .the referrals. . .they got invested in the. . .program. . ...[B]y them getting invested. . .calling us up, trying to check up. . .on the status of their cases, that was one of the beneficial things[.]. . .[A]ctually building that relationship between. . .the medical side and the legal side, and. . .doing our best to work together, to resolve an actual problem [for] the client. . .was one of the best. . .improvements we did for the program." (Attorney or paralegal)
	Patient education about the MLP reduced uncertainty and confusion	"[W]e also created. . .a reference document that. . .tells them what happens next. So it's this. . .infographic flyer. . .that says,[the clinic] is gonna take this referral form that you completed. And they are going to provide it to [the legal services organization]. . .And then. . .[the legal services organization] is going to reach out to you. The call will be coming from a number starting with this, so that they'll recognize the phone number. [T]hen we'll collect your information, [to] make sure you qualify for our services and provide you. . .[with] free legal assistance. . .depending on your matter. . . [N]ow people know. . .this isn't a spam caller or a bill collector." (Attorney or paralegal)
	Sharing lessons across sites disseminated best practices	"with our other MLPs, there was also. . .that learning curve, and because we've already been through [implementation] with them. . .I'm able to bring [those lessons] to [this MLP]. [T]his has worked and the referrals are consistent over there. We have a great referral process over there. . .let's try to implement it here." (Attorney or paralegal)
	Effective data systems facilitated the timely exchange of information	"[We're using] [a web-based platform] to transmit referral forms, which their legal counsel is comfortable with. And it works so much better from the perspective [of the legal services organization] because [the web-based platform] is easy to use." (Attorney or paralegal)

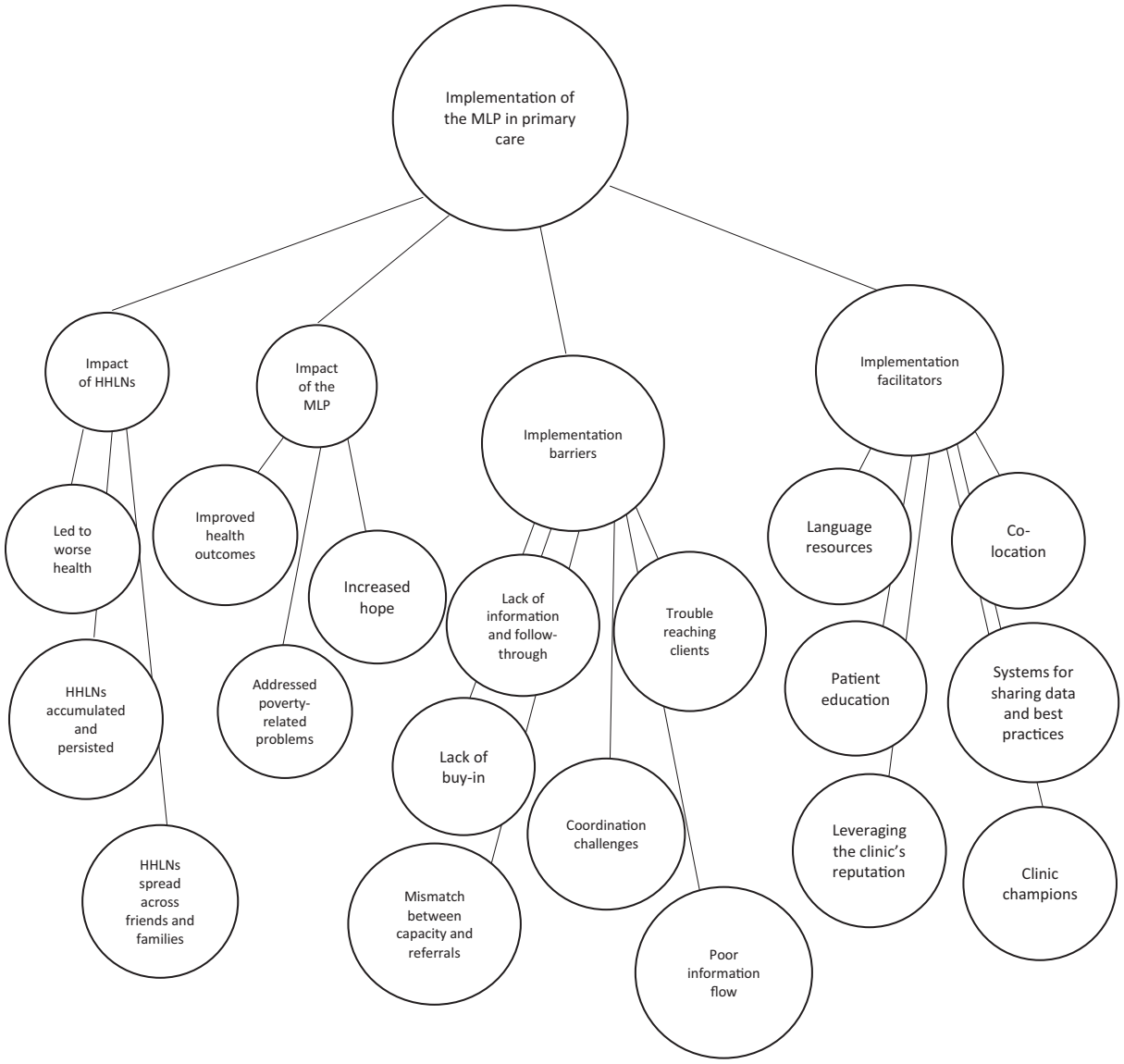
Theme 2: Through Trusting Relationships, MLP Involvement Improved Health and Resolved Legal Issues for Some

When the MLP could intervene, patients were able to address unmet social needs.

> [W]e represented three of the tenants. One of them had asthma and two of them were experiencing health complications already based on the mold, like a very long six week plus respiratory infection that just would not quit. And, um, we got basically. . .a positive [outcome] for the students. They were able to move out.

In another example, a patient received disability benefits as a result of the MLP's intervention.

Figure 1. Impact, barriers, and facilitators of the medical-legal partnership.



Notes: HHLN = Health-harming legal need; MLP = Medical-legal partnership

These benefits allowed them to receive a tax exemption for the property taxes that they were struggling to pay. These legal outcomes enabled patients to receive medical services, leading to improved health. Similar to primary care, which addresses the majority of health needs, the MLP offers a breadth of services, facilitating the resolution of patients' issues through a single legal team.

> [W]e're kind of generalists. So we do all different law types. Whereas other parts of [the legal services organization], they're more segmented by types. So we have a family law unit, a veterans unit, um, a victims of domestic violence unit. Um, so we have all specialized units. [W]hen you're working in the MLP. . .you get cases that can be anything from a housing issue, like mold in an apartment to a social security disability denial appeal. . .to a guardianship proceeding.

For some, the MLP offered critical advocacy. In reference to her MLP attorney, 1 patient said, "he fought for me." Another patient who had a successful case said, "he's been full force. . .once they took my case, he has been on it ever since. . .It made me

feel like somebody cared. . .” The legal professionals also emphasized the importance of “building. . .rapport” to overcome mistrust in the legal system and skepticism about its effectiveness. One paralegal said that it was important to convey to patients that “they have somebody in their corner fighting for them” and to give them “a sense of hope.”

Theme 3: Mistrust, Communication Gaps, and Inconsistent Staffing Limited the Impact of the MLP

Unfortunately, trust between the MLP and patients was not universally achieved, as a result of barriers and missteps. Some patients did not trust the MLP due to a lack of follow-up or information, which contributed to their suspicion and disappointment. One clinical staff noted, “the point where the patient fills out the form to the point where they actually get a phone call. . .can take some time.” These delays exacerbated underlying trust issues. One legal professional noted, “maybe it was a trust issue. . ..[T]hey did not know who we were. . .hadn’t heard of. . .legal aid.” Another legal professional observed that there’s inherent mistrust when it comes to legal organizations, with patients asking, “how did you get my information?[H]ow do you know I am having that issue?” The MLP had to overcome the fear that the legal professional was actually a “spam caller or a bill collector.”

A lack of reliable phone access contributed to these delays, with 1 patient reporting:

> [I]f they would have sent me a letter telling me [someone will call] at this hour. . .Because at [that] time. . .this phone belonged to my sister because she borrowed mine, [because hers needed a charger], she dropped it and broke mine. . .So this phone does not take messages, because she doesn’t remember the code. . .I just look at missed calls. . .And I was very disappointed because I feel like. . .they say [they’ll help] you.

The legal professionals had a process for contacting patients but were often unsuccessful:

> We’ll get the referral and try to contact them as soon as possible. A lot of times. . .we won’t get a response. . .We call at least two to three times, and then we also send them a letter. . .We’ll email them. . .So establishing that contact so that we actually can have an attorney, client relationship is a huge barrier.

Language was also a barrier. One legal professional observed, “I have noticed just a pattern of. . .typically Spanish speaking folks. . .are a little more hesitant with our calls.” As noted below, clinical staff could facilitate a connection between the legal professionals and patients; however, a lack of clinical staff buy-in and education affected the MLP’s implementation. One legal professional noted, “one of the clinics. . .was hesitant. . .the clinic staff was not willing to. . .provide assistance. [They] were there like. . .we’re already screening the clients for you.” Another legal professional commented, “if a patient has a question about [the MLP], and they are [the clinical staff] like, not maybe excited about it, or not super knowledgeable. . .about it, I think that that could deter a client or a patient from wanting to complete the form.” The clinical staff confirmed that the lack of information about the MLP affected implementation:

> [W]henever. . .[the patients] do ask me. . .What is this?. . .I kind of just read through it [the form] with them and just answer as much as I can. But sometimes. . .I feel like I’m not even sure what I’m saying to them. . .I honestly think that we they [the patients] [would be] probably more okay with [the MLP]. . .if we sounded like we actually knew what we’re talking about when we hand them these [forms].”

When the MLP attempted to improve the referral process, coordination was difficult because of the number of individuals involved:

> [There is] some challenge. . .being virtual. . .key players not being available when needed. . .for example. . .the legal counsel. And that person may not always be available whenever we’re trying to make a decision, but we need their input to make a decision. . .it can linger on for weeks or months.

Laws governing the legal and medical data further restricted communication, as noted by 1 of the legal professionals:

> [Clinics] have obligations under HIPAA. . .that. . . prohibits what we do. And so when you’ve got four different sets of legal counsel. . .it’s difficult to create processes and procedures to manage that flow of information that work for all parties. . .How are we getting the referrals? Are you guys sending them in a way that’s HIPAA compliant, but are we able to access them?

Even if the aforementioned barriers were overcome, the MLP suffered from staff turnover,

leaving gaps in coverage and reduced capacity while new staff were being trained. Concurrently, the demand for the MLP fluctuated over time, leading to periods of high demand with longer wait times (floods) and times of low demand when the MLP had more capacity than needed (droughts).

Theme 4: The MLP Identified Coordination and Communication Strategies to Enhance Trust Among Its Stakeholders and Amplify Its Impact

To address these challenges, the MLP pursued multiple strategies aimed at improving communication and enhancing trust. For example, the legal professionals used the language line to communicate with patients in their preferred languages.

> I also tried to make sure that we used qualified interpreters. We. . .have access to. . .language line so we can get interpreters for any call. . ..so making sure that the interpreters were available, that I used them in a way that wasn't. . .condescending or arduous. . .I called the interpreter first and then had them conference her. . .really just taking those extra steps and precautions to. . .get through to the client. . .And thankfully [the patient] did work with us. We were able to get her a positive outcome.

Because of the referral delays, the MLP experimented with colocation and predictable office hours in the clinic, both of which addressed communication barriers.

> [W]henever the client was screened. . .they knew [the legal services organization was] going to be here on Fridays. . .Do you want to go in and just speak with [the legal services organization] and come in on Friday?. . .It was a lot easier than. . .-trying to call them. . .once. . .twice, three times a week. . .I had them actually just coming into the clinic and. . .talking with us. . .even if it was. . .5, 10, 15 minutes. . .it. . .made the referral process a lot easier. . ., which is one of the main reasons why. . .we made those office hours once a week-. . .there wasn't a lot of wait time towards the end.

One legal professional believed that meeting people in-person was important for trust:

> [B]eing able to show them. . .Here's my face. Here's my. . .ID tag. I'm a real person that's trying to provide you services. . .So you [the patient] can see this person [the legal professional] is not trying to steal your identity.

Whereas colocation facilitated communication between legal professionals and patients, periodic meetings involving members of the MLP team ensured optimal communication between the legal and clinical teams. One legal professional noted, "we're able to resolve issues pretty quickly at these biweekly meetings." Another legal professional said that the meetings were important because they kept the "lines of communication. . .open." The partnership between the clinical and legal organizations was vital, as the legal professionals depended on the clinic's reputation to engage and communicate with patients. To mitigate the underlying mistrust, the legal organizations "piggyback off of [the clinic's] reputation." 1 patient confirmed this sentiment by reporting, "It was my PCP who actually told me about it. . .because I trust him. . .[He] actually. . .referred me to the. . .legal side."

When the clinical staff become active participants in the program, the processes are more efficient. Without clinic champions, delays can mount. One legal professional noted:

> [S]omeone has to be appointed to keeping the forms organized and making sure they're completed. . .That their [medical record numbers] and stickers are on the forms, because if there's not. . .they're incomplete. They don't have the full phone number on it. We can't read the patient's name. . .you can lose time and referrals. . .if more than four weeks lapse between a patient completing their form in the clinic, and us calling them, they're going to be highly suspicious.

To address gaps in knowledge about the program, the MLP created educational materials. One legal professional noted that this flyer answered questions and addressed potential concerns.

> [W]e also created. . .a reference document that. . . tells them what happens next. So it's this. . .infographic flyer. . .that says. . .[the clinic] is gonna take this referral form that you completed. And they are going to provide it to [the legal services organization]. . .And then. . .[the legal services organization] is going to reach out to you. The call will be coming from a number starting with this, so that they'll recognize the phone number. [T]hen we'll collect your information, [to] make sure you qualify for our services and provide you. . . [with] free legal assistance. . .depending on your matter. . .

Learning from other sites was also important for quality improvement. One legal professional reported, "the reason we started doing [office

hours] [is because] we were talking with [another MLP] program…where…the legal workers were actually housed inside the clinics 24/7." Similarly, the referral process was influenced by lessons learned from other MLP sites. One lesson pertained to the effective and efficient sharing of information between the legal and clinical organizations. Because of security concerns, the legal professionals initially had to "go and pick those referrals up in person on a weekly basis," a step that delayed the intake process. To address this, the MLP used a HIPAA-compliant data-sharing platform that could potentially speed up the referral process.

Discussion

This qualitative research found that HHLNs accumulate, persist, and have debilitating effects on health. For some, the MLP was critical to resolving these legal issues. For others, the 3 components of the MLP – patient, clinic, and legal - were disconnected and separated by time and space. As a result, clinical staff could not provide legal professionals with timely information, and legal professionals were unable to reach patients. Once connected, patients were suspicious. Coordination was elusive due to a lack of buy-in, laws governing legal and medical data, variation in referrals, and staffing disruptions. Teams overcame barriers by using technology to send referrals, meeting more frequently, and developing educational handouts.

Our results align with the findings of others and inform best practices for MLPs. For example, other researchers have confirmed the need for clinic champions (both administrative and clinical) with dedicated time to complete tasks related to the MLP.[19–21] These champions are critical for sustaining engagement, monitoring impact, and driving change. Other MLPs identified broad engagement as key because the program involves nearly all individuals within clinics.[21] To address problems, successful MLPs had recurring meetings and embraced the principles of continuous quality improvement.[19,21] Our participants noted that both decision makers and frontline personnel needed to be present. Multiple studies highlight the importance of a physical presence for building trust and coordinating care.[21] Being physically present reinforces the ties between the 2 organizations, as close proximity reduces barriers to enrollment and facilitates warm handoffs. Our participants reported that it was difficult to find mutually agreeable times to talk because of work, and many clients lacked reliable access to phones and internet. These factors similarly affected recruitment of participants for this study. Ultimately, these best practices (champions, recurring MLP-dedicated meetings, and a physical presence) must reduce the interval between screening and enrollment, as significant delays erode trust between patients and legal staff.

There are several limitations that should be considered. First, our sample size was small and skewed toward women and white individuals. We were limited by the number of legal professionals and clinicians at the sites and thus had difficulty recruiting more participants from those groups. Some of the individuals from the clinical and legal services organizations who participated in the MLP left their roles. Patients had phone numbers and e-mail addresses that were no longer up-to-date and reported a baseline mistrust of legal professionals. The COVID-19 pandemic affected our ability to recruit participants because clinics limited the presence of nonessential personnel and discouraged patients from seeking care for nonemergent issues. Furthermore, physical distancing restrictions affected the ability of the MLP to assist clients, which may have influenced their willingness to participate in subsequent studies like this. All these factors contributed to the sample size. Second, we failed to recruit any Spanish-speaking patients, who would likely have communicated novel concerns. Third, most, but not all, patient participants (6/8, or 75% of the patients) participated in the MLP RCT, which may have influenced their perception of the program. The RCT and this qualitative analysis were sequential and not concurrent; therefore, we only enrolled a small percentage (6/160, or 3.8%) of the RCT participants. Because only a portion of the patient participants enrolled in the RCT, we chose not to connect our findings to the RCT, though the linkage could have added context to the patient experience. Finally, we did not specifically investigate the financing of the MLP, though this would be an important topic for future studies. To examine this key issue, we would have needed to recruit different types of participants (eg, administrators rather than frontline professionals).

Conclusion

HHLNs contribute to poor health and affect families and social networks. MLPs are uniquely able to address these issues, though mistrust and communication gaps may impact engagement. Fortunately, several strategies, including clinic champions, recurring MLP-dedicated meetings, and colocation, can foster the trust needed for successful implementation.

The authors thank the participants of the study and our colleagues at Lone Star Legal Aid.

To see this article online, please go to: http://jabfm.org/content/37/4/637.full.

References

1. Woolf SH, others Aron L. US Health in International Perspective: Shorter Lives, Poorer Health. National Academies Press; 2013.
2. Bradley EH, Sipsma H, Taylor LA. American health care paradox - high spending on health care and poor health. QJM. Published online October 24, 2016, 110, 61, 65:hcw187.
3. Legal Services Corporation. *The Justice Gap: The Unmet Civil Legal Needs of Low-Income Americans*. 2022.
4. Martinez O, Boles J, Muñoz-Laboy M, et al. Bridging health disparity gaps through the use of medical legal partnerships in patient care: a systematic review. J Law Med Ethics. 2017;45(2):260–273.
5. Rosen Valverde JN, Backstrand J, Hills L, Tanuos H. Medical-legal partnership impact on parents' perceived stress: a pilot study. Behav Med. 2019;45-(1):70–77.
6. Ryan AM, Kutob RM, Suther E, Hansen M, Sandel M. Pilot Study of Impact of Medical-Legal Partnership Services on Patients' Perceived Stress and Wellbeing. J Health Care Poor Underserved. 2012;23(4):1536–1546.
7. Murphy C. *Making the case for medical-legal partnerships: an updated review of the evidence, 2013-2020.*; 2020. Accessed December 9, 2021. https://medical-legalpartnership.org/wp-content/uploads/2020/10/MLP-Literature-Review-2013-2020.pdf
8. Klein MD, Beck AF, Henize AW, Parrish DS, Fink EE, Kahn RS. Doctors and lawyers collaborating to HeLP children: outcomes from a successful partnership between professions. J Health Care Poor Underserved. 2013;24(3):1063–1073.
9. Malik FS, Yi-Frazier JP, Taplin CE, et al. Improving the care of youth with type 1 diabetes with a novel medical-legal community intervention: the Diabetes Community Care Ambassador Program. Diabetes Educ. 2018;44(2):168–177.
10. Sege R, Preer G, Morton SJ, et al. Medical-legal strategies to improve infant health care: a randomized trial. Pediatrics. 2015;136(1):97–106.
11. Liaw W, Northrup TF, Stotts AL, et al. Medical-legal partnership effects on mental health, health care use, and quality of life in primary care: a randomized clinical trial. J Am Board Fam Med. 2023;36(3):414–424.
12. Emengo VN, Williams MS, Odusanya R, et al. Qualitative program evaluation of social determinants of health screening and referral program. Perzynski AT, ed. PLOS ONE. 2020;15(12):e0242964.
13. De Marchis EH, Hessler D, Fichtenberg C, et al. Part I: a quantitative study of social risk screening acceptability in patients and caregivers. Am J Prev Med. 2019;57(6):S25–S37.
14. Byhoff E, De Marchis EH, Hessler D, et al. Part II: a qualitative study of social risk screening acceptability in patients and caregivers. Am J Prev Med. 2019;57(6):S38–S46.
15. Kamody RC, Kamody ES, Rosenthal A, Olezeski CL. Optimizing medical-legal partnerships in pediatric psychology to reduce health disparities. J Pediatr Psychol. 2022;47(1):69–74.
16. Berg D, Setrini A, Chan K, Cibulskis A, Ameji K, Hinami K. A care coordinator screening strategy to address health harming legal needs. BMC Health Serv Res. 2022;22(1):210.
17. Nohria R, Xiao N, Guardado R, et al. implementing health related social needs screening in an outpatient clinic. J Prim Care Community Health. 2022;13, 21501319221118809:215013192211188.
18. Aceves B, De Marchis E, Loomba V, Brown EM, Gottlieb LM. Stakeholder perspectives on social screening in US healthcare settings. BMC Health Serv Res. 2023;23(1):246.
19. Massar RE, Berry CA, Paul MM. Social needs screening and referral in pediatric primary care clinics: a multiple case study. BMC Health Serv Res. 2022;22(1):1369.
20. Greenwood-Ericksen M, DeJonckheere M, Syed F, Choudhury N, Cohen AJ, Tipirneni R. Implementation of health-related social needs screening at Michigan health centers: a qualitative study. Ann Fam Med. 2021;19(4):310–317.
21. Mantel J, Fowler L. A qualitative study of the promises and perils of medical-legal partnership. Northeast Univ Law Rev. 2020;12(1).
22. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. 1999;89(9):1322–1327.
23. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.

Appendix

Appendix Table 1. Semi-Structured Interview Questions

Attorneys and paralegals
Can you describe your experiences working in legal aid?
Can you describe your experiences working with the medical-legal partnership?
What are the differences between working in the medical-legal partnership and in legal aid, generally?
What are the challenges of integrating the medical-legal partnership? How were those barriers addressed (if applicable)?
How did you approach patients who were hesitant working with you?
How did you build rapport with those patients? What helped patients use legal services? What made it more difficult to connect with patients?
What helped the integration of the medical legal partnership?
Is there anything else you would like to add? Is there anything else that I did not ask you that you want me to know?
Patients
Tell me about your first impressions of the medical-legal partnership.
What were you thinking when you were asked to complete the medical-legal partnership screening form?
What were you thinking when you were approached about participating in the medical-legal partnership?
Did you have reservations about participating? (If yes) Can you describe what your hesitation was regarding participation?
Can you talk about your willingness to participate? What might have caused you to not want to participate?
Can you describe your experience with the medical-legal partnership?
How did having access to the medical-legal partnership at your doctor's office affect you?
Is there anything else that I did not ask you about that you want me to know?
Clinicians and staff
Tell me about your experiences working with this clinic population.
What non-medical problems affect your patient's health and access to healthcare?
What was your first impression of the medical-legal partnership?
How has that changed since its implementation?
What barriers and facilitators affected its integration?
What could change or improve its integration?
(For clinicians) How has having access to the medical-legal partnership affected your care decisions?
(For clinicians) How has knowing about your patients' legal needs affected your care decisions?
How has having access to the medical-legal partnership affected your patients?
Is there anything else that I did not ask you about that you want me to know?