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How Should We Measure Effectiveness of Medical-Legal Partnerships?

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Abstract

Medical-legal partnerships (MLPs) try to mitigate health inequity by uniting legal and health professionals to respond to legal determinants of patients' health. While there is a long tradition of "patients-to-policy" work in MLPs, the current empirical evidence base has evaluated MLP effectiveness by assessing benefits to individual patients, clinicians, and hospital and legal systems. This article calls for future research to measure how community power, which includes shifting power to impacted communities to develop and lead equity-focused agendas, is built as both a process and an outcome of MLPs.

Value of MLPs

Medical-legal partnerships (MLPs) are innovative collaborations between clinicians and lawyers to address "health-harming legal needs" (HHLNs) in health care settings.[1,2] Utility shutoffs, poor or unsafe housing conditions, and denial of health insurance can impact physical health through exposure to harmful materials, such as lead and asbestos, as well as mental health, and require legal assistance. Generally, MLPs work to address HHLNs through direct legal representation and advocacy.[1,2,3,4]

There is evidence that MLPs have a positive impact at the individual and institutional levels in the form of improved health outcomes, fewer emergency room visits, reduced hospital costs,[5,6,7,8] and increased access to legal services,[5,6,7] or "access to justice."[9] One unique aspect of MLPs is the commitment to aggregating the lessons learned from individual client representation in the service of advocating for policy-level changes in programs, laws, and regulations—an approach often referred to as "patients-to-policy" work.[9] Descriptive studies of the role that MLPs have played in shifting policy using clients' lived experiences are available in law review articles[9,10,11] and on the National Center for Medical-Legal Partnership's website.[6]

Nevertheless, scholars and practitioners face practical challenges in building an evidence base that is aligned with the full range of processes and health justice outcomes that MLPs can promote, and the current approach to MLP evaluation concentrates power within the same hospital and legal systems that play an active role

in creating and perpetuating health inequities.[12,13,14,15,16,17] Therefore, we need a significant paradigm shift in MLP research to advance our understanding of the full scope of the MLP model. MLPs should be evaluated on the basis of how they operationalize the values and principles underlying health justice—that is, on the extent to which their patients-to-policy work shifts power toward impacted communities to set, influence, and implement health equity agendas and thereby contribute to structural change.

In this article, we provide a brief description of the limitations of the current MLP evidence base and outline a health justice approach for MLP research and evaluation. In particular, we highlight the role of academic MLPs in advancing the conceptualization and measurement of community power as a process and outcome of MLP work.

Current State of MLP Evidence

Most of the empirical evidence on MLP effectiveness focuses on patient- and hospital-level outcomes. On the patient level, pilot studies—many of which use self-report to measure outcomes—show that MLPs can lower patient stress, increase patient access to financial resources, improve overall patient health, and increase patients' sense of empowerment.[5,6,7,18,19,20,21,22,23] Moreover, MLPs have demonstrated increased system-wide screening for legal needs and access to legal services for patients,[5,6,24,25,26,27,28,29] reduced health care spending, and increased return on investment for hospital systems.[30,31,32]

Very few randomized control trials (RCTs) evaluating the efficacy of MLPs exist. Although RCTs are often considered the gold standard for evaluating clinical interventions, a 2021 systematic review of experimental studies of MLPs identified only 6 such studies.[33] Some authors have argued that, given significant evidence of benefits associated with MLPs, it is difficult to "establish equipoise, a central ethical principle of randomized control trials, which holds that a subject may be enrolled in a RCT only if there is true uncertainty about which of the trial arms is most likely to benefit the patient."[34] Moreover, ethical reasons require the exclusion of people with complex, immediate, or serious legal needs from the study designs, which could yield a limited understanding and narrow evaluation of MLPs.[35]

While an argument can be made for continuing to gather evidence of the effects of MLPs on patients, clinicians, and systems, the momentum carrying the health justice movement toward radical structural reform calls on all of us to rethink our current research and evaluation approaches. Structural racism is deeply embedded within US health and legal systems, from segregation of care to who and what the law chooses to protect and exploit.[12,13,14,15,16,17] Thus, centering the effectiveness of MLPs on benefits to hospital or legal systems that play an active role in perpetuating health inequities—or maintaining the status quo—does little to unsettle power dynamics driving health inequities. As legal scholar Dina Shek notes: "creating perpetual clients within a traditional legal services model does little to change the power dynamics for vulnerable community members and hinders fully engaged citizenship."[11]

Building and Measuring Community Power

Public health scholars have increasingly highlighted the need for structural interventions that shift power toward minoritized communities in order to pursue health justice.[15,16,17,36,37] In 2 2023 articles, Heller et al build upon existing theories of power—for example, the "three faces of power" theory (introduced by social theorist Steven

Lukes) and the "four domains of power" theory (introduced by Black Feminist sociologist Patricia Hill Collins)—and offer key questions to consider for recognizing, analyzing, and shifting power within the context of public health interventions.[17,38] In particular, Heller et al call for developing public health actions that "grow power within marginalized communities to influence decisions, build the infrastructure necessary to set an equity-focused agenda, and change the narrative."[17] This concept of community power has been defined by Pastor et al:

> Community power is the ability of communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity.[39]

To address the root causes of health inequities, MLP researchers should consider the extent to which MLPs' patient-to-policy work challenges existing power structures and pushes for structural change. As Pastor et al emphasize, we must "think beyond policy wins and … consider changes in the broader institutional and community contexts that facilitate conditions for an equitable society."[40] Within the MLP context, the first author (P.B.) explains that the existing patient-to-policy approach concentrates power among lawyers and health care partners to identify the problem and propose remedies.[15] Building community power requires a shift in this approach to instead follow the leadership of directly impacted communities, who have always been at the forefront of justice movements. Using advocacy and organizing efforts led by agricultural workers as a case study, the first author proposes movement lawyering, which Hung defines as "lawyering that supports and advances social movements, defined as the building and exercise of collective power, led by the most directly impacted, to achieve systemic institutional and cultural change,"[41] as a model that MLPs can adopt to move beyond the existing patients-to-policy approach and build community power.[15]

Role of MLPs

The leadership of community members in designing and implementing evaluation protocols allows communities to not only challenge the existing power dynamics and imbalance, which drive health inequities, but also create space for developing a shared language and goals, which is important for ensuring sustainability of justice efforts. Academic MLPs (A-MLPs) are uniquely positioned to answer this call to action and center community power within MLP research and evaluation.[42,43] A-MLPs are those that have a university-based partner as one of the main collaborators (often a law or medical school). This specific type of MLP focuses on "1) educating pre-professional learners, 2) intentionally creating interprofessional learning environments, and 3) contributing to the evidence base for the MLP model as a health equity intervention."[42]

Due to their university affiliation, A-MLPs often have access to the research infrastructure necessary to evaluate the activities and outcomes of MLPs.[42] As the focus shifts to measuring whether and how MLPs build community power, A-MLPs can offer access to stable funding, trained researchers and staff, and physical space to local grassroots and movement organizations to co-create evaluation protocols using community-led methodologies and data collection practices, including listening circles.[44] With A-MLP organizational support and community-led evaluation efforts, grassroots and movement organizations can measure power as both a strategy and an outcome based on the specific needs of the communities.

Additionally, A-MLPs' focus on interdisciplinary and interprofessional education[10,42,45,46] can further strengthen the capacity of grassroots and movement organizations to lead MLP research and assessments. In particular, A-MLPs can integrate community-led sessions on the exploitative history of research and on community practices for data collection, analysis, and dissemination to build trust and accountability.[47,48,49] A-MLPs can also train pre-professional learners alongside community members in power-building strategies, including advocacy and grassroots lobbying, coalition and movement building, campaign development, impact litigation, and research and policy analysis.[50]

The method for measuring community power will vary based on the specific needs and goals of different communities. Thus, it is essential to facilitate community-driven processes for developing and implementing evaluation protocols instead of using a one-size-fits-all approach. Additionally, the focus on building community power, which challenges the concentration of power in the status quo, will help ensure that these academic partnerships do not reinforce or reify structural racism. Initiatives like the Association of American Medical Colleges Collaborative for Health Equity: Act, Research, Generate Evidence,[51] the Praxis Project,[44] and the Lead Local research project[40] highlight the importance of community-led research and evaluation, as well as offering concrete examples of how to center, build, and measure community power for health justice. The next evolution of MLP research and evaluation needs to adopt a similar structural approach of building community power.

Conclusion

This article offers a new paradigm for MLP research and evaluation. Currently, MLP research and evaluation determine effectiveness based on benefits to individual patients, clinicians, and hospitals. In doing so, the existing model maintains power within the same hospital and legal systems that perpetuate health inequities. To advance health justice, MLPs—together with the leadership of impacted communities—should build, measure, and evaluate community power as a variable. A-MLPs are uniquely positioned to center community power within MLP research and evaluation by leveraging their educational and research resources in collaboration with grassroots and movement organizations.

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