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Fostering Sustainability through Performance Measurement in Health Center Medical-Legal Partnerships: Insights from a Diverse Learning Collaborative

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What is a health center?

HEALTH CENTERS:

- Are community-based and serve more than 30 million people, about 90% of whom have incomes less than 200% of the federal poverty level.
- Provide access to medical, dental, behavioral, and other health care services.
- Provide care for all, with special initiatives for people experiencing homelessness, agricultural workers, and residents of public housing.
- A public or nonprofit entity can become a HRSA-supported health center by applying for Health Center Program funding or receiving designation as a Health Center Program look-alike. HRSA's Bureau of Primary Health Care (BPHC) oversees the Health Center Program and funds nearly 1,400 health centers providing affordable, accessible, and high-quality primary health care to underserved communities at more than 15,000 sites.

LEARN MORE ABOUT HEALTH CENTERS AT:
https://bphc.hrsa.gov/about-health-center-program

Summary

This paper underscores the vital role of sustainability in clinical settings, focusing on medical-legal partnerships (MLPs) within health centers (HCs). Drawing insights from a learning collaborative initiative facilitated by the National Center for Medical-Legal Partnership (NCMLP), supported by the U.S. Health Resources & Services Administration (HRSA), we introduce performance measures and metrics across eight dimensions aimed at assessing sustainability within MLPs. Building on the NCMLP Performance Measures Handbook (April 2016), these measures and metrics emphasize both financial and nonfinancial elements in MLP sustainability at HCs. Furthermore, this paper highlights the importance of addressing resistance to innovation and advocates for multiple performance measures to enhance sustainability, especially in areas such as communicating value, long-term planning, and securing funding.

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

Contents

I.

Introduction to Innovation Sustainability in Clinical Settings

Understanding project sustainability is essential for the success of innovation. The majority of innovations or new ventures fail to sustain, yet sustainability significantly contributes to scalability of services.[1,2,3] Research emphasizes the extended timeline from conceiving an idea to establishing it as a common practice in clinical settings — a process that often spans decades and is influenced by how we define and embrace the initial concept.[4] Embracing and sustaining innovations is a multifaceted process that requires accounting for policies, environments, social networks, norms, organizational characteristics, trainings, readiness for change, and characteristics of both the innovation and the community adopting it.[5] To ensure the lasting impact of innovations, it is important to account for financial and non-financial factors.[6] Since the popularization of the concept of diffusion of innovation, it has been clear that people do not adopt innovation solely based on economic considerations.[7] This report focuses on eight factors for medical-legal partnership (MLP) sustainability in clinical settings, with a focus on health centers (HCs). Performance metrics were developed as part of a HRSA-sponsored learning collaborative of the National Center for Medical-Legal Partnership (NCMLP).[8]

Most ideas regarding services do not launch into nascent services, and most nascent services do not sustain nor scale. Sustainability is the foundation for scalability.

A previous evaluation of more than 60 MLPs in 2015 (using an adaptation of the Program Sustainability Assessment Tool [PSAT]) indicated that, on average, MLPs had sustainability strengths and weaknesses.[9, 10, 11, 12] Based on this evaluation, weaknesses for MLP sustainability included lack of community involvement, communicating value to external stakeholders, funding instability, and difficulty developing long-term financial and sustainability plans. The strengths for MLP sustainability included organizational capacity/expertise to implement, supportive environmental support, program evaluation capability, program adaptability, and short-term operational and tactical plans.[13, 14]

The Medical-Legal Partnership (MLP) Approach

Many complex health-related social problems are entrenched in federal, state, and local policies and laws that require expertise in poverty law and administrative law. Attorneys in general — and poverty lawyers in particular — have an in-depth understanding of relevant policies, laws, and systems, and seek out solutions at the individual and policy levels to a range of health-related social and legal needs.

MLP is an innovative and collaborative approach to health care delivery which embeds lawyers as specialists in health care settings to directly resolve specific problems for individual patients, while also helping clinical and non-clinical staff navigate system and policy barriers and transform institutional practices.

Using legal expertise and services, the health care system can disrupt the cycle of returning people to the unhealthy conditions.

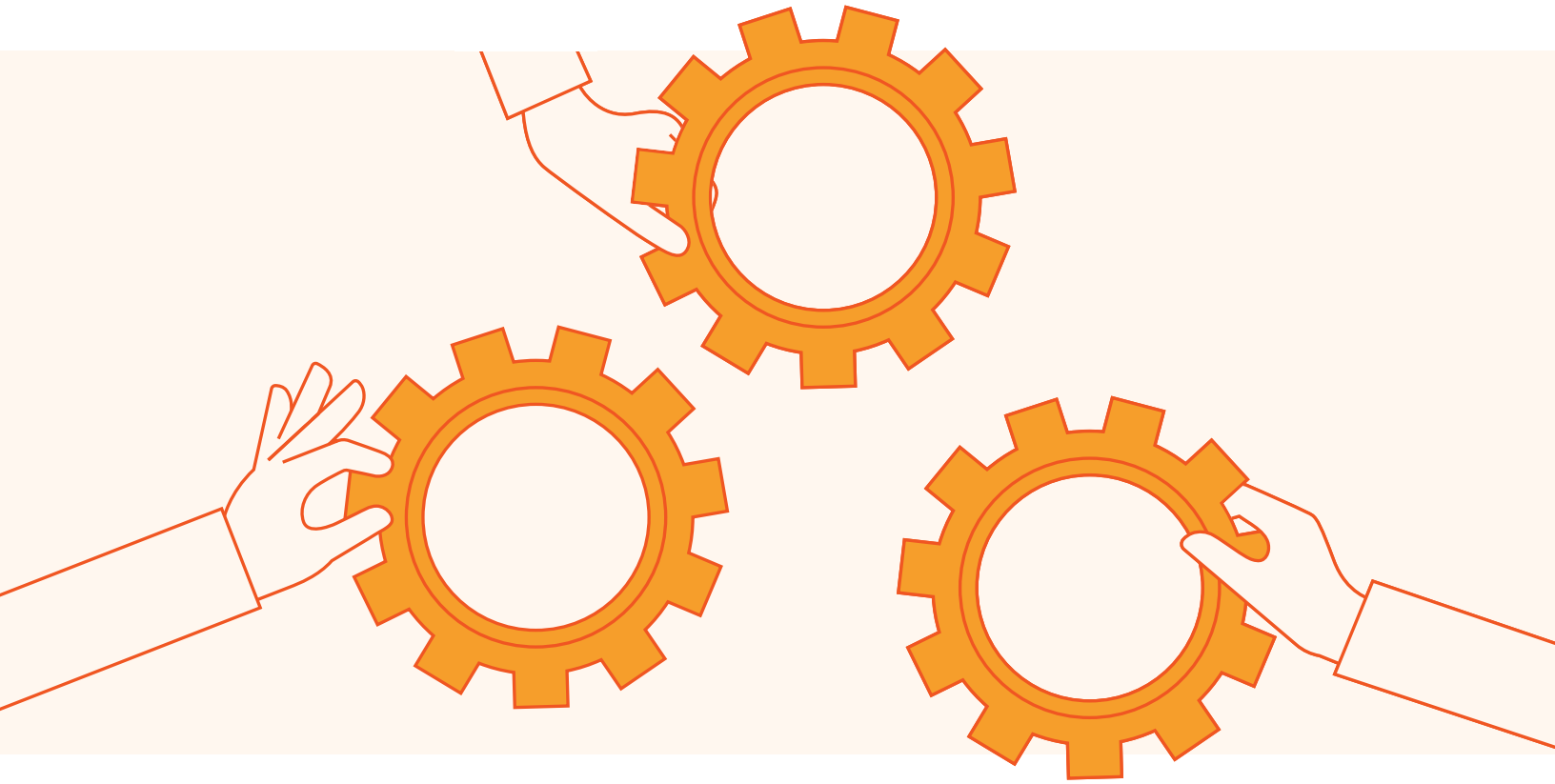
LEARN MORE ABOUT THE MLP APPROACH AT:
https://medical-legalpartnership.org/response/

II.

Convening Diverse MLP Stakeholders to Identify Performance Measures Relevant to HC MLPs

Approximately 50 stakeholders participated in a learning collaborative, sponsored by HRSA. The group focused on discussing the sustainability of MLPs, particularly in HC settings. Representatives of Federally Qualified Health Centers (FQHCs)[15], hospitals, legal services organizations, universities, and health plans participated in the learning collaborative. The learning collaborative group convened for 90–120 minutes per session over five sessions and received preparatory materials before each session. The learning collaborative focused on eight dimensions of sustainability. During 2016, NCMLP developed a performance measures handbook (herein referred to as the *NCMLP Performance Measures* Handbook)[16], focused on evaluation and outcomes as well as tracking multidisciplinary trainings. The learning collaborative expands upon the handbook by adding performance measures across a broader range of sustainability factors.

Diverse MLP practitioners contributed to developing performance measures related to program stability in clinical settings.



III.

Eight Dimensions of Sustainability

Between 2015 and 2023, the Clinical Sustainability Assessment Tool (CSAT) was developed. This clinical assessment has refined the PSAT in response to significant interest from clinical providers in the area of program sustainability. The eight dimensions of sustainability that framed the learning collaborative's discussion were an extension and adaptation of the CSAT, developed by Washington University in Saint Louis' Implementation Science Center for Cancer Control.[17, 18] The CSAT includes 35 items and is a reliable and valid survey that includes seven dimensions for innovative program sustainability in clinical settings.[19] During the learning collaborative and due to the innovative and multidisciplinary nature of MLPs, an eighth dimension of funding was added, as supported by the PSAT, also developed by Washington University in Saint Louis' Implementation Science Center for Cancer Control.[20, 21] The clinical sustainability factors are listed and exemplified in **Table 1**. The assessment tool included relevant questions pertaining to sustainability that guided each learning collaborative session.

TABLE 1. CSAT FACTORS PLUS FUNDING

	CSAT PLUS FUNDING FACTORS	EXEMPLIFY QUESTIONS FOR EACH FACTOR
	ENGAGED STAFF AND LEADERSHIP	How have you gained support for MLP from frontline clinical staff and management within the HC?
	ENGAGED STAFF AND LEADERSHIP	How have you increased external support for and engagement with the MLP in the HC setting?
	ORGANIZATIONAL READINESS	What internal support and resources have been secured to effectively manage the MLP in the clinical setting (i.e., HC)?
	WORKFLOW INTEGRATION	How has the MLP been designed to fit into existing HC practices and technologies?
	IMPLEMENTATION AND TRAINING	What processes have been used to guide the direction, goals, and strategies of the clinical practice to implement MLP?
	MONITORING AND EVALUATION	What is measured by the MLP (inputs, processes, outputs, and outcomes)?
	OUTCOMES AND EFFECTIVENESS	How are data (measures and metrics) used to inform meaningful outcomes and impacts of the MLP in the clinical setting?
	FUNDING AND FINANCIAL STABILITY	How is the HC MLP financed, and what are the types, qualities, and quantities of funding?

IV.

Extending the 2016 NCMLP Performance Measures

The *NCMLP Performance Measures* Handbook included seven performance measures. From a diffusion of innovation perspective, which is a theory that explores how new ideas, innovations, or technologies spread and are adopted within a society or social system, the 2016 measures help support the arguments of relative advantage for engaging in MLPs.[22, 23] Relative advantage refers to "the degree to which an innovation is seen as better than the idea, program, or product it replaces."[24] Addressing the value barrier of relative advantage addresses or prevents active resistance. Active resistance occurs when a person is engaged in evaluating the qualities of an innovation (i.e., in this case MLPs in clinical settings).[25] The following is a list of the seven performance metrics from the handbook.

1. Percent of healthcare partner staff trained in MLP
2. Percent of patients screened for health-harming legal needs in a given population
3. Percent of patients with at least one health-harming legal need (HHLN) who are treated/addressed by the healthcare organization
4. Percent of patients who are referred to civil legal aid services and receive a legal screening
5. Percent of total MLP patient-clients with health-harming legal needs in each "I-HELP" category
6. The average financial benefit received by a MLP patient-client
7. The estimated financial benefit received by the MLP healthcare partner(s) due to the MLP intervention(s)

Previous NCMLP performance measures were associated with three of the seven CSAT factors. **Table 2** links previous MLP performance measures to CSAT factors (i.e., training and implementation, monitoring and evaluation [what data should be collected], and outcomes and effectiveness [how or why collected data matters]).

TABLE 2. COMPARING CSAT PLUS FUNDING FACTORS TO 2016 NCMLP PERFORMANCE MEASURES.

CSAT PLUS FUNDING FACTORS	2016 NCMLP PERFORMANCE MEASURES
ENGAGED STAFF AND LEADERSHIP	Not applicable
ENGAGED STAKEHOLDERS	Not applicable
ORGANIZATIONAL READINESS	Not applicable
WORKFLOW INTEGRATION	Not applicable
IMPLEMENTATION AND TRAINING	1. Percent of healthcare partner staff trained in MLP
MONITORING AND EVALUATION	2. Percent of patients screened for health-harming legal needs in a given population 3. Percent of patients with at least one health-harming legal need (HHLN) who are treated/addressed by the healthcare organization 4. Percent of patients who are referred to civil legal aid services and receive a legal screening 5. Percent of total MLP patient-clients with health-harming legal needs in each "I-HELP" category
OUTCOMES AND EFFECTIVENESS	6. The average financial benefit received by a MLP patient-client 7. The estimated financial benefit received by the MLP healthcare partner(s) due to the MLP intervention(s)
FUNDING AND FINANCIAL STABILITY	Not applicable

V.

Eight Dimensions of MLP Clinical Sustainability and Supporting Research

Previous research has supported the idea that sustainability of clinical practice innovations is more challenging in HCs than hospitals or academic medical centers.[26, 27] However, clinical innovations initiate, sustain, and scale across all clinical settings, with varying success over time. Confidence to engage in innovation should be supplemented with a framework to monitor key factors linked to sustaining innovations. Confidence is important to engage in innovation, but it is important to avoid overconfidence once engaged.[28] It is impactful to plan, implement, and evaluate clinical innovations with confidence and a framework that takes multiple factors of sustainability into account. It is likely that no single performance measure is necessary nor sufficient. It is more likely that engaging in sustainability measures additively contribute to the success of MLPs in HCs.[29] This also means that engaging in multiple sustainability measures reasonably well contributes more to successful sustainability rather than perfectly completing one measure. The following is a list of measures and metrics across eight sustainability factors, with funding being added to the 7 CSAT factors.

V.A. Engaged Staff and Leadership Performance Measures and Metrics

Engaged staff and leadership includes gaining support from frontline clinical staff and management within the healthcare organization (e.g., medical champions, frontline staff, medical providers, and interprofessional clinical engagement). Previous research[30, 31] based on expert ratings of the 7 CSAT factors (excluding funding and financial stability) supported that this factor ranked fifth for feasibility and fifth for importance (out of seven).

TABLE 3. ENGAGED STAFF AND LEADERSHIP PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
A.1. Maintain active engagement of more than one community health center physician to advocate for the value of MLP in the community health center setting.	A.1. Number of actively engaged physicians within a community health center *Note that active engagement of a physician champion can vary based on the level of maturity and needs of the specific medical-legal partnership.*
A.2. Sustain functional relationships with social workers, case managers, health navigators, and/or community health workers for community health center patient MLP referrals.	A.2. Identify pertinent staff within the community health center and subjectively monitor the quality of those relationships related to medical-legal partnership activities.
A.3. Integrate MLP representatives or advocates into leadership teams, groups, or committees that have decision making capability over operations within the community health center [32]	A.3. Number and type of MLP representatives in leadership roles in the community health center.

V.B. Engaged Stakeholders Performance Measures and Metrics

Engaging stakeholders involves increasing external support for and engagement with the MLP in the clinical setting (e.g., patients, families, and community partners). Based on ratings of the 7 clinical factors (excluding funding and financial stability) engaged stakeholders ranked fourth for feasibility and second for importance. Additionally, based on the 2015 evaluation of MLPs, using the PSAT, and feedback during the 2023 learning collaborative, it is expected that this dimension may be challenging.

TABLE 4. ENGAGED STAKEHOLDERS PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
B.1. Develop methods to engage community health center patients in the planning, implementation, and evaluation of MLPs (people-centered justice).	B.1. Document methods used to engage patients of health centers in planning, implementation, and/or evaluation, not only service utilization. *Note that this is a measure to explore methods to engage patients using participatory or person-centered approaches in which patients contribute to service production and adaptation.*
B.2. Create and participate in a community advisory council that includes community membership, with a maximum of 40% of MLP representatives on the advisory council. The MLP community advisory council guides the mission of the HC MLP and communicates the value of MLP across various community organizations.	B.2. Create an MLP community advisory council and document the members including community and organizational affiliations.
B.3. Create and participate in an MLP community health center ad hoc committee, with diverse but relevant expertise, that performs HC MLP tasks that are not completed by standing committees of the HC. The MLP ad hoc committee communicates the value and operations of the HC MLP to the HC Board.	B.3. Create a HC MLP ad hoc committee and document the members and activities of that committee.

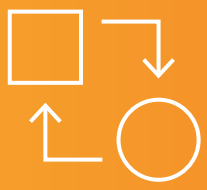
MEASURE	METRIC
B.4 Develop and implement methods to collect, analyze, and report on external stakeholder feedback related to the HC MLP on an ongoing basis.	B.4. Develop feedback methods to collect and utilize external stakeholder feedback. *Note that methods could be structured like net promoter scores (how likely would a patient be to refer MLP to a friend) or unstructured like periodic discussions with representative external stakeholders. Of particular interest would be including the perspective of potential consumers of services (i.e., patients and their families) and to align with people-centered justice.*[33]
B.5 Engage potential consumers of MLP services in community settings outside of traditional service delivery sites.	B.5. Identify and monitor opportunities to engage patients in the community setting. *Note that engagement of potential MLP utilizers can occur in community settings (e.g., health fairs, outreach events, and mobile medicine) in addition to the physical setting of health centers. Further, prior research on MLPs supported the idea that medical staff typically refer patients for legal services when an MLP is available. However, a minority of legal staff refer clients for medical services, which could enable linking legal aid clients to medical/ MLP services.*[34]

V.C. Organizational Readiness Performance Measures and Metrics

Organizational readiness is securing internal support and resources needed to effectively manage the MLP in the clinical setting (e.g., adequate staffing, work culture, supportive organizational systems, and sufficient resources like time, space, staffing). Based on ratings of the 7 clinical sustainability factors (excluding funding and financial stability) organizational readiness ranked first for feasibility and sixth for importance. In rating sustainability, preliminary evidence suggested that organizational readiness is the greatest challenge for clinical innovation sustainability.[35] This indicates, though people believe organizational readiness is relatively less challenging, in practice that organizational readiness can become one of the bigger challenges to sustainability across time.

TABLE 5. ORGANIZATIONAL READINESS PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
C.1A. Integrate MLP or legal service delivery language into the values, pillars, priorities, goals, or objectives of the HC strategic plan.	N/A
C.1B. Include MLP or legal services language in the community health center project work plan's objectives, actions, outcomes, data, and responsibilities.	C.1. Identify and promote MLP language included in community health center strategic plans or work plans.
C.2. Build trust for lawyers in a HC setting through periodic trainings that include lawyers and HC stakeholders.	C.2. Monitor trust in MLP lawyers among HC patients, staff, and administrators who participate in MLP trainings. *Note that there are various methods to measure trust and guidelines for measuring trust.[36] From this perspective, limited interpersonal trust would be the primary metric (i.e., trust in an MLP lawyer for whom the HC stakeholders have interacted with) and secondarily, trust in lawyers generally, or tertiarily, trust in the governmental institution of justice broadly.*
C.3. Have a project manager, preferably a nonlawyer with applicable experience, dedicated to completing HC MLP administrative, management, and coordination activities.	C.3. Number of full-time equivalent MLP nonlawyer staff with project management experience engaged in MLP administrative, management, and coordination activities. *Note that research supports the combination of management experience and content area expertise is impactful for sustaining and scaling nascent ventures.[37]*
C.4. Include dedicated space within the HC for legal providers to securely deliver confidential legal services.	C.4. Identify the amount and type of space dedicated to MLP in the community health center setting.



V.D. Workflow Integration Performance Measures and Metrics

Workflow integration occurs when MLP has been designed to fit into existing practices and technologies (e.g., clinical workflow, ease of use by clinicians, integration into EMR/EHR, and consistency of processes). Based on ratings of the 7 clinical sustainability factors (excluding funding and financial stability) workflow integration ranked sixth for feasibility and seventh for importance.[38] Previous evaluations of MLP and feedback during the learning collaborative indicates that a minority of MLPs are fully integrated into an EMR/EHR.[39]

TABLE 6. WORKFLOW INTEGRATION PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
D.1. Develop communication and referral methods that fit the culture of the HC and the capabilities of the legal provider.	D.1. Tailor referral methods to the MLP HC context that reasonably balance feasibility and utility. *Note that the learning collaborative recommended against making an isolated or sole effort to integrate referrals into EHR/EMRs. EHR/EMR integration could contribute to referrals, if feasible. However, other community relevant methods could better balance feasibility and utility to improve the effectiveness of referrals. Referral methods can be formal or informal and technology-based or person-based but should balance feasibility and importance.*
D.2. Establish group trainings, lawyer "office hours", targeted legal information, and/or issue spotting guides that better focus lawyer consultations on priority complex legal needs.	D.2. Identify and increase the proportion of consultations that were focused on priority complex legal needs. *Note that out of scope and simple legal issues can often be addressed in group trainings, issuing spotting guides, offering legal information, or legal office hours, as opposed to legal provider consultations, thereby improving the efficiency and effectiveness of lawyer consultation time.*
D.3. Develop and adjust rules of thumb or decision trees for consultation and referrals across time.	D.3. Establish effective rules of thumb and decision trees to improve the accuracy of consultations and referrals. *Note that adjustments to rules of thumb or decision trees should be linked to feedback with the referrer and referral recipients. In this case accuracy of referrals and consultations could be estimated by lawyers by comparing perceived hits (proper referrals or proper consultations) relative to perceived false alarms (improper referrals or consultations). A better metric would also include an audit of avoided referrals and consultations to also account for correct rejections (not making a referral nor engaging in a consultation when a referral or consultation should not be made) and misses (not making a referral nor engaging in a consultation when a referral or consultation should have been made).*

V.E. Implementation and Training Performance Measures and Metrics

This factor focuses on training and feedback that enable staff to understand the purpose of MLP as well as their roles and responsibilities (e.g., roles, responsibilities, staff expectation management, training, feedback, and interdisciplinary/continuing education). Based on ratings of the 7 clinical sustainability factors (excluding funding and financial stability) implementation and training ranked seventh for feasibility and fourth for importance.[40] MLP has traditionally highlighted the importance of interdisciplinary training and was recognized in the *NCMLP Performance Measures Handbook*.

TABLE 7. IMPLEMENTATION AND TRAINING PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
E.1. Identify research- and evidence-based training and mentoring approaches.	E.1. Document research- and evidence-based practices in training and mentoring. *Note that training or mentoring foci should include screening, referrals, case management, and MLP successes.*
E.2. At a minimum, communicate potential community impact and success stories during trainings, including dollars saved, insurance coverage gained, and improved health outcomes.	E.2. Document training in which local MLP successes and impacts were shared with participants and note the type of successes and impacts shared. *Note that performance measure one of NCMLP Performance Measures Handbook could be integrated here as well (Percent of healthcare partner staff trained in MLP).*
E.3. Clearly outline, describe, and communicate roles and responsibilities for MLP HC staff.	E.3. Document the roles and responsibilities of MLP HC staff.
E.4. Develop and implement methods to collect and respond to Board members, staff, administrators, and patients with the aim of adapting MLP implementation.	E.4. Develop process evaluation methods with an aim of adjusting implementation of MLP across time as appropriate.

V.F. Monitoring and Evaluation Performance Measures and Metrics

Monitoring and evaluation as a sustainability factor focuses on what data is collected and how it is collected (e.g., measures, metrics, monitoring, reporting, evaluation methods). Monitoring and evaluation highlights what is measured (inputs, outputs, and outcomes). Based on ratings of the 7 clinical sustainability factors (excluding funding and financial stability) monitoring and evaluation ranked third for feasibility and third for importance.[41] Interestingly what is being collected (monitoring and evaluation) is ranked as less feasible and important than how data is used to support impacts (outcomes and effectiveness), which could create bottlenecks where impacts based on data are perceived to be important and possible but the data may not be collected or may not be in a useable format (a cart before the horse problem).

TABLE 8. MONITORING AND EVALUATION PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
F.1. Collect descriptive data including demographics, type of case, referral sources, hours worked on a case, legal issues/needs addressed, types of legal services offered, and case resolution/outcome.	F.1. Feasibly collect key demographic and legal service level data. *Note that the descriptive data in this measure could align with performance measures two, three, four, and five in the NCMLP Performance Measures Handbook.*
F.2. Link HC MLP activities to ICD-10 t- and z-codes (and other pertinent ICD-10 codes) and Health Center Program Uniform Data System (UDS) Data.	F.2. Map MLP service codes to comparable or relevant ICD-10 codes International Classification of Diseases codes) and UDS codes. *Note that this exemplifies shared values across law and medicine in a manner that is clinically relevant. Additionally, linking MLP work to UDS data aligns MLP services with HRSA FQHC coding.*
F.3. Have the capability to utilize collected data to inform analyses and reports for relevant stakeholders on a regular basis (monthly or quarterly).	F.3. Be able to transform collected data into a form useful for analyses and reporting.

V.G. Outcomes and Effectiveness Performance Measures and Metrics

The outcomes and effectiveness factor focuses on interpreting data and supporting outcomes or impacts of MLP services.[42] What impact or outcome does data inform (e.g., benefits, harms, productivity, health outcomes, clinical impacts, cost-effectiveness, cost savings, return on investment, and relative advantage)? Based on ratings of the 7 clinical sustainability factors (excluding funding and financial stability) outcomes and effectiveness ranked second for feasibility and first for importance.[43] In rating sustainability, preliminary evidence indicated that outcomes and effectiveness is the least challenging factor for clinical innovation sustainability.[44]

TABLE 9. OUTCOMES AND EFFECTIVENESS PERFORMANCE MEASURES AND METRIC

MEASURE	METRIC
G.1. Monitor material results, such as debt averted, dollar amount recovered, property retained, utilization costs, and benefit gained.	G.1. Collect material results of legal services. *Note that the financial results monitored in this measure inform performance measures six and seven in the NCMLP Performance Measures Handbook.*
G.2. Monitor psychosocial results, such as client/patient goals (consumer wishes) and related goal achievement.	G.2. Collect data on goals of MLP participants and the goals achieved as relevant to those participants. *Note that this process aligns with person- or people-centered justice, where justice is aligned with the interests of people experiencing justiciable events.*
G.3. Align reporting of priority-clinically-relevant measures and metrics with appropriate community needs assessments and community priorities, especially community health needs assessments.	G.3. Map clinically relevant community needs and priorities to MLP HC collected data and outcomes.
G.4. Positively impact provider experience in HCs and indirectly staff retention.	G.4. In alignment with the "quadruple aims"[45] of healthcare, monitor HC provider and staff experience relevant to the adoption of MLP on an ongoing basis. *Note the quadruple aim of healthcare recognizes provider experience in addition to patient experiences, care quality, and costs. HC provider/staff experience and productivity are potentially key levers in the HC setting. Improving provider/staff experience improves productivity and retention.*

MEASURE	METRIC
G.5. Assess and report on access to care based on insurance coverage, service engagement (e.g., medication management, no show rates, exposure access to hot/cold weather), and timeliness of services (e.g., decreased wait times in referrals, transitions, or transfers for care).	G.5. Assess and report on clinically relevant access to care metrics.
G.6. Deliver integrated services from a trauma-informed perspective to streamline intake.	G.6. Identify and implement trauma-informed approaches to deliver interdisciplinary MLP services. *Note that trauma-informed approaches reduce unnecessary barriers to service and are empathetic to patients' experiences (a person-centered approach that recognizes personal trauma experiences and responses to those experiences). Trauma-informed approaches aim to heal as opposed to re-traumatizing people.*
G.7. Report on social return on investment or more narrowly financial return on investment.	G.7. Estimate benefits of MLP services relative to costs of those services. *Note that social return on investment includes outcomes to communities on and off the monetary scale relative to inputs and activities, whereas financial return on investment explores monetary only outcomes that are also realized by the investor.*

V.H. Funding and Financial Stability Performance Measures and Metrics

The types, quality, and quantity of MLP funding in the clinical setting (e.g., grants, contracts, fee for service, capitated payments, reimbursement, licensing, insurance, bundled payments, enabling service payments) should be monitored and planned. Beyond the quantity of funding, the type and quality of funding matter.

TABLE 10. FUNDING AND FINANCIAL STABILITY PERFORMANCE MEASURES AND METRICS

MEASURE	METRIC
H.1. Diversify substantial external funding across 2 or more funding sources.	H.1. Identify and tally substantial external funding on at least an annual basis. *Note that lack of diverse funding sources and failure to anticipate challenges to acquiring external funds presents a potential precipice effect, especially when external funding makes up a large portion of an MLP's fundings.*
H.2. MLP HCs leverage Health Center funding allocated for "enabling services" as outlined in Section 330 of the Public Health Services Act (PHSA) to facilitate the provision of legal services to patients.	H.2. Track the amount of Section 330, PHSA, "enabling services" funding at least on an annual basis. *Note that offsetting enabling services such as case management, care coordination, translation/interpretation, transportation, health education, environmental health risk reduction, and/or outreach through external grants or contracts could possibly allow for shifting more enabling service funding toward legal services.*
H.3. Diversify funding and support across sectors (i.e., public, nonprofit, for-profit, and voluntary persons/communities).	H.3. Estimate the funding, or more generally support, across sectors (public, for-profit, nonprofits, and voluntary persons/communities) *Note that hospitals can be engaged as a community benefit opportunity, philanthropic organization as supports for special projects, insurers as a cost savings opportunity, local/state government as aligned with justice and welfare, federal government via HRSA enabling services, and people could opt to pay nominal amount toward services (e.g., a co-pay). Additionally, time banks could be used as a method to further integrate and account for community volunteer support.*
H.4. Engage funding from Medicaid waiver (e.g., 1115), state plan amendments, and system reform incentives as well as Managed Care Organizations.	H.4. Identify, document, and pursue Medicaid and Managed Care Organization funding opportunities as relevant.[46]

VI.

Conclusion

The learning collaborative contributed to developing financial and nonfinancial performance measures related to MLP sustainability. Given the interdisciplinary approach of MLP and the lack of a typical ongoing payer source (e.g., public or private insurance), a set of performance measures on "funding and financial stability" was added to supplement the seven clinical sustainability assessment tool factors validated by Washington University in Saint Louis' Implementation Science Center for Cancer Control.[47, 48] The performance measures developed by the learning collaborative supplements to the *NCMLP Performance Measures* Handbook by adding financial and nonfinancial factors for MLP sustainability. NCMLP has previously contributed to solutions for financing MLP by promoting the use of HRSA enabling service and Medicaid waiver funding.[49, 50]

Additionally, the eight factors for MLP sustainability enhance the potential to overcome both active and passive resistance to innovation. Passive resistance occurs due to people's risk averse disposition and interest in maintaining the status quo. Passive resistance precedes an evaluation of the qualities of the innovation itself. Active resistance can emerge when people engage in evaluating the quality of a product and after a negative evaluation of a service. Active resistance to innovation can emerge from functional barriers such as compatibility, complexity, trialability, and value (i.e., relative advantage) and psychological barriers such as norms, economic risk, social risk, and information barriers.[51] The performance measures identified by the learning collaborative provide greater opportunity to address passive and active resistance. Overcoming passive resistance due to risk averse dispositions often requires appropriate mental stimulation to imagine using an MLP, whereas overcoming status quo bias occurs by increasing the perceived benefits to engage with MLP.[52] Moreover, diffusion of innovation has largely been linked to social connections, increased trust in others, and communication rather than awareness raising alone.[53] The performance measures reinforce social connections and communication of value to diverse stakeholders.

> Participating in a greater number of performance measures is anticipated to lead to greater sustainability compared to engaging in fewer measures.

The 33 performance measures across 8 sustainability factors address financial and nonfinancial barriers as well as active and passive resistance to innovation. Participating in a greater number of performance measures is anticipated to lead to greater sustainability compared to engaging in fewer measures. A performance measure contributes to sustainability, though none are expected to be universally necessary nor sufficient. Furthermore, performance measures were written broadly to enable tailoring to the local context. Based on prior evaluations of MLPs, it is expected that communicating value to external stakeholders, engaging in long-term planning, including external stakeholders, and developing sustainable funding could pose greater challenges than performance measures focused on internal capabilities, internal organizational champions, internal support, and ability to evaluate capacity. NCMLP has historically focused on building champions within MLPs (including appropriate expertise in the MLP) and promoting evaluation of MLPs, which could indicate that greater focus on other dimensions of sustainability would also improve over time.

Endnotes

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Our mission is to help health organizations leverage legal services as a standard part of the way they respond to patients' social needs. With funding from the Health Resources and Services Administration (HRSA), we provide free technical assistance to health centers, primary care associations, and Health Center-Controlled Networks interested in developing a medical-legal partnership.

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