The Medical–Legal Partnership Approach to Teaching Social Determinants of Health and Structural Competency in Residency Programs

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Abstract

Medical–legal partnerships (MLPs) embed civil legal services lawyers into health care settings and interprofessional health care teams delivering care to low-income or otherwise vulnerable patients and communities. MLPs present the opportunity to instill in residents a practical understanding of the social determinants of health and provide them with concrete tools to address them. MLP training helps residents develop structural competency and build the skills necessary to address barriers to health at the patient, institutional, and population levels. Through a case study, this Perspective explores how residents can address health-harming legal needs working in partnership with interprofessional health care teams that include lawyers, and illustrates how such MLP experiences can relate to competency-based Milestones that are applicable to training residents in all specialties.

Powerful social, environmental, and political forces influence health outcomes and the health of communities. In the United States, at least 60% of health outcomes are attributable to forces outside of medical care, and glaring health disparities exist among socioeconomic groups.[1] One factor contributing to the persistence of health disparities in the United States is the small proportion of health care expenditures spent on social services compared with the social services spending among the other 34 member countries of the Organisation for Economic Cooperation and Development, most of which achieve better health outcomes at lower cost.[1,2] Given the role that nonmedical factors play in health outcomes, physicians-in-training in the United States are increasingly being asked to understand the impact of these forces on their patients' health and to become active participants in their practices and their communities in addressing structural contributions to the social determinants of health. Integrated health care delivery models such as accountable care organizations and patient-centered medical homes, supported by the Affordable Care Act of 2010, require training for physicians about effective ways to integrate social determinants of health into medical care and payment reforms. Graduate medical education (GME) programs are now expected not only to produce physicians with clinical and research expertise but also to train residents to identify and actively address the multiple determinants that affect health outcomes.

As the breadth of the physician's role expands, so too must the complement of members of the interprofessional teams in which new physicians train. As a growing number of health care organizations and providers are discovering, expanding the health care team to include attorneys who understand and can help address patients' legal needs is an effective approach to caring for vulnerable patients. In this Perspective, we will discuss the importance of bringing together health and legal professionals in the GME setting and highlight the medical–legal partnership (MLP) as a powerful approach for addressing social determinants of health and health disparities. We will also consider how implementation of Milestones in the Accreditation Council for Graduate Medical Education's (ACGME's) Next Accreditation System (NAS)[3] in U.S. residency programs provides an opportunity to integrate attorneys into training teams through MLPs. Specifically, an MLP presents an opportunity for residents to understand and develop a functional, practical approach to addressing the social determinants of health through a lens of *structural competency*, defined by Metzl and Hansen[4] as

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.

What Are MLPs?

MLPs integrate lawyers trained in poverty law into health care teams to detect and address health-harming legal needs to improve health outcomes at the patient, institutional, and population levels. The MLP approach was initiated in Boston Medical Center's Department of Pediatrics in 1993 when pediatricians recognized the nonmedical barriers, and

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specifically the legal barriers, that were affecting the health of their low-income patients.[5] This approach recognizes that the social determinants of health are often created or influenced by laws that are enforced unfairly or underenforced.[6] MLP lawyers provide legal care to resolve patients' health-harming legal needs in the wide variety of civil matters commonly described as the I-HELP domains: income/insurance, housing, education/employment, legal status/immigration, and personal and family stability.[7]

Typically, MLPs are partnerships between a civil legal services or public interest law nonprofit organization and one or more health care entities. MLP lawyers consult with health care staff and meet with patients to address patients' unmet legal needs. In some MLPs, lawyers are located full time on-site within a clinic; in others they maintain scheduled hours at a clinic. Though MLP lawyers are employed by a separate organization, they are often integrated into the health care team in various ways, including participation in faculty meetings, grand rounds, and other health care staff meetings. Many MLPs also incorporate pro bono lawyers from the private legal sector as well as students and trainees from law school clinics and medical and other health professions schools.

Similar to public defenders who represent low-income individuals at no charge in criminal cases, civil legal services lawyers represent low-income individuals at no charge in civil matters including appeals of federal Social Security and Veterans disability benefits; housing cases fighting eviction and enforcing health and safety codes; negotiations with school districts on providing educational services required for children with disabilities; applications for documented immigration status by immigrant victims of crime; and filings for protective orders for survivors of interpersonal violence. Furthermore, as we will discuss in detail below, the legal advocacy delivered by MLPs often includes not only direct service or representation for an individual patient–client but also institutional and policy interventions designed to improve population health.

Although the MLP approach began primarily in pediatric settings,[8] it has expanded into a number of other specialties and subspecialties, including endocrinology,[9] family medicine,[10] internal medicine,[11] obstetrics–gynecology,[12] oncology,[13] palliative care,[14] pulmonology,[15] and psychiatry.[16,17] As of October 2016, MLPs were operating within nearly 300 medical institutions, including hospitals, community health centers, and clinics.[18] (The development of new MLPs is outside the scope of this article, but resources are available to guide interested individuals and institutions.[19])

Many MLPs participate in resident training to some degree.[18] For example, MLP Boston conducts an advocacy boot camp for the combined residency program in pediatrics at Boston Medical Center and Boston Children's Hospital. Although MLP training is most common in pediatrics and family medicine residency programs, the expansion of the MLP approach into other specialties and population-focused clinics means that residents in a wide range of programs are being trained about legal determinants of health. This training includes strategies for identifying and addressing unmet legal needs with an impact on patient health—for example, how to contact the appropriate local enforcement agency when a patient's housing conditions are affecting family health or how to write effective advocacy letters for patients. Partnerships between local civil legal services organizations and clinics that begin as opportunities for training on patients' legal rights often lead to the development of full-fledged MLPs as the medical staff comes to see the value of incorporating attorneys into the health care team.

As we will argue below, MLP lawyers' on-the-ground and policy-level expertise in the social determinants of health makes the MLP an ideal method for training residents to recognize the structural and legal barriers that affect their patients' health, as well as what physicians can do, in partnership with lawyers, to address these barriers.

MLPs and Milestones in GME

Ensuring that all residents are adequately prepared to practice medicine in an increasingly complex environment is crucial. The NAS,[3] which has been fully implemented across all specialties, is a natural progression of the work on the six core competencies implemented by the ACGME in 1999. In addition to teaching and ensuring competence in clinical problem solving, communication skills, and professionalism, the NAS expects residency programs to produce physicians who are facile with electronic medical records, understand and practice triple aim principles,[20] and function as participants in team-oriented care. Milestones, a key component of the NAS, are statements of knowledge, skills, attitudes, and other attributes written in practical language that allow faculty to assess the development of residents in key dimensions of the elements of physician competency as they progress through training.[3]

Integration of the MLP approach has been shown to be an especially effective and innovative model for teaching residents the four "cross-cutting" core competencies of systems-based practice, practice-based learning and improvement, interpersonal and communication skills, and professionalism that are common across specialties[21] and have been further clarified by the implementation of Milestones.[22] The MLP approach teaches important knowledge and a new skill set to residents as they are forming their medical identities. Residents who are trained through an MLP to recognize the legal barriers faced by their patients and to understand the complex social service and government systems with which their patients interact will be better prepared to practice medicine in continually changing health care delivery systems, especially in primary care settings. They will also learn the values and skills inherent in team-based care.

Addressing the Milestones adequately demands opening the door to new methods and experiences. MLPs offer unique experiences to trainees that broaden their perspective of health and align neatly with the Milestones framework (see Figure 1).

MLP Training in Residency Programs

MLP training in residency programs can be delivered through several mechanisms, including grand rounds, noontime conferences, regularly scheduled didactic sessions, and advocacy- or policy-focused rotations. Lawyers, often in partnership with medical faculty, provide training on health-harming legal needs as well

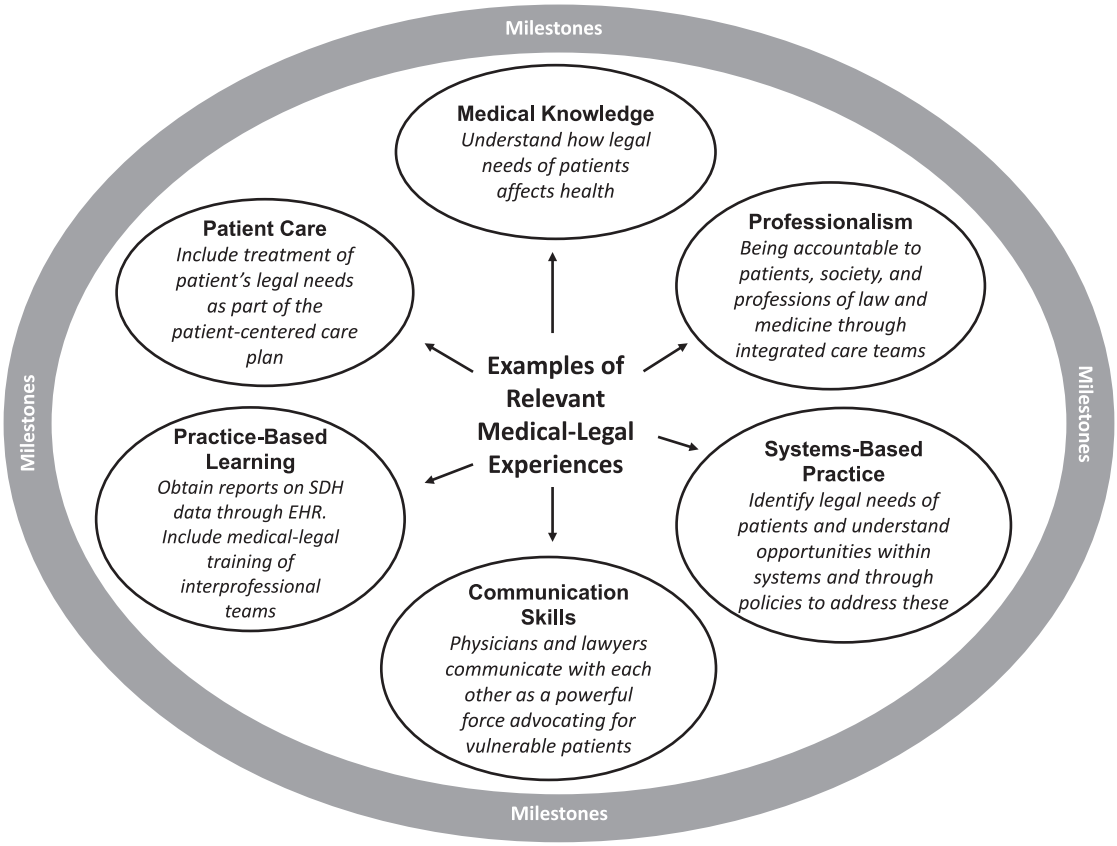

Figure 1 Examples of medical–legal partnership (MLP) experiences in residency training relevant to each of the Accreditation Council for Graduate Medical Education's six core competencies.[28] The circle encompassing all six competencies, labeled "Milestones," represents the descriptive statements of knowledge, skills, and attitudes and other attributes that are specific to each competency and to each specialty. The examples of MLP experiences here are specifically attributable to core competencies and to Milestones. For examples of how these MLP experiences relate to psychiatry Milestones, see Table 1.

as how to screen for social and legal determinants of health and when to seek consultation from the legal partner or refer a patient to the MLP for assistance.

Many of the MLPs nationwide offer some type of residency training, which is typically focused on the five I-HELP domains. For example, the MLP in Cincinnati, Ohio, developed a video curriculum to teach residents how to screen for and address the social determinants of health, including unmet legal needs. This curriculum uses patient stories and role-playing to demonstrate both appropriate and inappropriate approaches.[23]

One study evaluating MLP training in residency programs found that, in posttests, residents who received the training were more comfortable discussing the social determinants of health with patients, more knowledgeable about resources, and more likely to document issues such as public benefits, housing, and education, as compared with a control group.[24] Another study conducted in three New York hospitals showed that residents who received MLP training were more likely to refer patients to legal services than residents who did not receive the training.[11]

Through didactic sessions and hands-on experience working in partnership with lawyers, MLP training reinforces for physicians the importance of structural competency. It is worth noting that MLP training is becoming an important mechanism for teaching structural competency in undergraduate medical education as well. Many medical schools now offer interdisciplinary preclinical electives for law students, medical students, and other health professions students as well as clerkships, rotations, and volunteer opportunities at MLPs.[25]

Requisites for Integrating MLPs Into Residency Programs

There are several factors that, in our experience, lead to successful integration of MLPs into residency programs. First, the residency program faculty must have a strong understanding of how addressing the legal needs of patients has a direct impact on their health. Integration is unlikely to be successful if the faculty do not highlight and discuss the concept of health-harming legal needs as an important health determinant regularly, including during precepting and rounds in ambulatory and hospital settings. As health networks, insurers, and accountable care organizations strive to achieve triple aim and value-based objectives, medical educators are being asked to fully understand the health care of the individual in the context of community and population health, as well as their potential impact as patient advocates. The medical community, driven to model and teach efficiency and patient-centered care, is embracing interdisciplinary partnerships that can identify and address social and legal needs of patients and families effectively. Medical schools are already incorporating elements of Milestones into their curricula, in response to the same forces, and many first-year residents are arriving at their programs with a strong grounding in these concepts.

Second, at least one member of the faculty must serve as a "medical champion" for the MLP. This individual builds relationships with the lawyers and educates the residents, staff, and institutional leadership about the value of the partnership. Most physicians have a limited understanding of what lawyers do in the context of health, public policy, and assisting patients in need. An internal medical champion can recognize and teach the impact of patients' legal needs on their health and well-being and can help focus the resources of the MLP—that is, the services of lawyers in consultation with physicians—to assist the patients and families with the greatest need.

Third, the institution or department that sponsors the residency program must commit scarce time and space resources to support the MLP. For example, time needs to be found in busy conference schedules to insert MLP topics such as a primer on legal forms, an explanation of the disability application process, or a poverty simulation workshop. (For these and other reasons, it is often helpful to have the residency program director serve as one of the MLP's medical champions.) Physical resources, such as space for an office for the lawyer to meet with clients and providers, are essential. Ideally, financial resources will be provided to support protected time for the medical champion or champions to devote to the development and success of the MLP.

Finally, it is wise for the organizational partners who make up the MLP to draft and sign a memorandum of understanding that outlines expectations, documents responsibilities, and anticipates how potential conflicts of interest should be resolved.[26]

Case Study: MLPs, Residency Programs, and Structural Competency in Action

Here, we will use the case study presented in Box 1 to demonstrate how MLP training serves as an effective means for integrating structural competency into residency training and to explore what an MLP intervention could look like at the patient, institutional, and population levels. In this case, Ms. Williams, a patient with anxiety, is at high risk of eviction and homelessness in a few days. She has been seeing Dr. Freeman, a second-year psychiatry resident at a mental health clinic, for psychopharmacology and psychotherapy for the past three months. At the resident's recommendation, Ms. Williams has also been participating in group therapy sessions led by a social worker at the clinic. The social worker shares with Dr. Freeman an eviction notice that Ms. Williams brought to the group session.

Box 1

Medical–Legal Partnership Case Study: A Patient Facing Eviction

Ms. Williams, a 35-year-old former teacher with severe anxiety, is a patient at the mental health clinic. Dr. Freeman, a second-year psychiatry resident, has been her primary provider for psychopharmacology and psychotherapy since she started coming to the clinic three months ago; at that time, she reengaged in mental health care following two years of no clinical treatment. Upon Dr. Freeman's recommendation, Ms. Williams is also participating in group therapy sessions on a weekly basis. Dr. Freeman feels good about the course of Ms. Williams's care and expects to reduce the frequency of her psychiatry visits to once every three months (Milestone: SBP2: Resource management[a]).

One morning, Ms. Santos, the social worker who facilitates the group therapy session, comes to Dr. Freeman with a pink piece of paper—an eviction notice. Ms. Santos reports that Ms. Williams came to group extremely upset, saying that she will become homeless in three days. Ms. Santos explains that, with Ms. Williams's consent, she has already called the housing court clerk, who told her that Ms. Williams missed a court date and that the sheriff is scheduled to remove her belongings from the apartment. The social worker mentioned that Ms. Williams has a disability and asked the clerk what could be done at this point, to which the clerk replied, "Not much. Those people need to learn to pay their rent," and then hung up.

Dr. Freeman discusses Ms. Williams's situation with the social worker, the MLP attorney, and her supervising faculty psychiatrist, and then meets with Ms. Williams that afternoon (Milestones: PC3: Treatment planning and management; SBP4: Consultation to non-psychiatric medical providers and non-medical systems). Ms. Williams explains that she failed to pay two months of rent about six months ago; her mother died and Ms. Williams needed to use her own Social Security Disability Insurance checks to cover the funeral expenses and did not have enough money left to pay her rent. After that, several letters had arrived from her landlord, and then from the housing court. She was so anxious at the sight of letters that she did not open any of them. Until she saw the eviction notice posted on her door, she had been hoping it would all just go away. When Dr. Freeman asks why she did not tell anyone at the clinic about the issue, she says, "I know you are really busy, and I didn't want to bother you with all of my problems."[b]

After learning about Ms. Williams's situation, Dr. Freeman makes a commitment to identify and assist future patients at risk for homelessness, and elicits further discussion within the clinic about clinic policies and procedures[c] (Milestone: MK6: Practice of psychiatry).

Abbreviations: SBP indicates systems-based practice; PC, patient care; MK, medical knowledge.
[a]The psychiatry Milestones[27] relevant to this case are presented in parentheses. For descriptors and details regarding the resident's experience related to each of these Milestones, see Table 1.
[b]See the text for a description of a typical MLP patient-level intervention in a case such as this.
[c]See the text for descriptions of Dr. Freeman's proposed institution-level changes resulting from these discussions and the MLP's approach to effecting population-level change by working with the housing court.

Although the patient described in the case study is being seen by a psychiatry resident, a similar patient could easily present with the same problem in family medicine, obstetrics–gynecology, oncology, and other clinical settings.

At the *patient* level

MLP intervention. The MLP in operation at the mental health clinic where Dr. Freeman is a resident can provide legal care in a number of ways to assist Ms. Williams. A typical patient-level MLP intervention is described below.

First, Dr. Freeman refers Ms. Williams to meet with an MLP attorney on-site at the clinic to review her eviction-related paperwork and discuss her options to try to pause or reverse the eviction order. The MLP attorney, who sees the clinic's patients for free, is able to meet with Ms. Williams within 24 hours. The attorney explains to Ms. Williams (and later, with Ms. Williams's permission, to Dr. Freeman) which federal, state, and local laws relate to the situation. The attorney describes how Ms. Williams might be eligible to have her original housing court date rescheduled because of an "excusable default" or as a "reasonable accommodation" because her disability of anxiety directly affected her ability to engage in the court process. The attorney helps Ms. Williams decide on her next steps and helps the resident write a letter of support for Ms. Williams to bring with her to court in her attempt to have her case reopened.

Second, the MLP attorney advises Ms. Williams on how to apply for an emergency grant from the local welfare agency to help pay off the two months of back rent she owes. The attorney also works with Ms. Santos, the clinic's social worker, to ensure that Ms. Williams has all the supporting paperwork she will need for an approval.

With this assistance, Ms. Williams will be able to show the housing court the documents from her psychiatrist confirming the link between her disability and her difficulty engaging in the court process, proof that she has been approved for a grant to pay off her rental arrears, and documentation that she has the ability to pay rent going forward. There is a good chance that she will be able to stop the eviction before the sheriff arrives in three days and to settle the case with her landlord within a few weeks, thus saving her apartment and avoiding homelessness.

Structural competency insights and analysis. This case study presents a number of opportunities for the psychiatry resident to analyze the patient's situation through the lens of structural competency. For example, required reading for the resident could include studies detailing the impacts of unstable housing and homelessness on mental health, including the effect that housing instability or homelessness has on a patient's likelihood of remaining engaged in treatment, adhering to treatment plans (including filling and taking prescription medications), or being hospitalized. The resident would learn to articulate, in a case presentation or for grand rounds, the ways in which Ms. Williams's anxiety affected her ability to engage in the court process. Finally, through communication with the clinic's social worker and the MLP attorney, the resident would demonstrate an understanding of the importance of governmental and other community resources and their availability to help those who have temporarily fallen behind in their rent. (For examples of the relationship between the resident's development of these various skills and specific Milestones, see Table 1.)

At the *institutional* level

MLP intervention. In the most effective MLPs, "legal care" is not limited to individual patients. Rather, interventions also occur at the clinic or institutional level. A possible institutional-level intervention in this case study is described below.

Following the resolution of Ms. Williams's case, Dr. Freeman meets with the legal team and mental health clinic staff members involved in the MLP to review the clinic's policies and procedures related to screening for housing instability and explore how the clinic's internal institutional systems affected this patient.

In a meeting with the MLP attorney, Dr. Freeman learns the basics of several federal antidiscrimination statutes, including the Americans with Disabilities Act (ADA), and how those laws can be used to protect tenants with mental illness and other disabilities both inside and outside the housing court process. The attorney also educates the resident about the importance of providing documentation of a disability to help invoke these laws. Subsequently, the resident does some research and identifies several validated homelessness risk assessment tools. In reviewing the clinic's intake forms and the data collected in the electronic health record (EHR), the resident discovers that although there are some screening questions about housing, none of them align with any risk assessment tools or appear to be specific enough to effectively identify a risk of homelessness.

After conferring with an attending psychiatrist, Dr. Freeman makes two recommendations for improvement within the clinic. First, the resident recommends adding validated screening questions to the intake process for new patients and periodically asking established patients more detailed questions about their housing, including whether they are behind in rent, have a housing court case pending, or have received papers from housing court. Second, the resident recommends creating a template in the EHR to help physicians generate the documentation necessary for patients to provide to landlords and housing court judges to request a reasonable accommodation as an individual with a mental illness, such as a request to reschedule a missed court date or for more time to make up rental arrears.

Structural competency insights and analysis. By going through the process described above, the resident has the opportunity to recognize the ways in which the structure of the clinic's intake procedures and policies are not designed to identify and assist patients with these issues. By analyzing the clinic's policies and procedures, the resident gains experience in viewing an internal system through a structural competency lens. The resident learns that by not asking patients the right screening questions about their housing status, the clinic staff are missing opportunities for early intervention into housing problems that may lead to homelessness. The resident also identifies missed opportunities for documenting medical need for reasonable accommodations to be made by landlords, the housing court, and others. The resident's recommendations for specific improvements to the clinic's policies and procedures, which will allow the clinic to better identify patients at risk for homelessness, are a direct and concrete result of analyzing a single patient's problem through a structural competency lens. (For relationships between skills and specific Milestones, see Table 1.)

At the *population* level

MLP intervention. High-functioning MLPs also look at opportunities to improve systems and policies affecting population health. A possible MLP-based population-level intervention related to this case study is described below.

In the aforementioned meeting to explore how the clinic structures affected Ms. Williams, the resident, the MLP attorney, and other clinic staff involved in the MLP also discuss the housing court clerk's response to the clinic's social worker when Ms. Santos called to discuss Ms. Williams's situation. As detailed in the case study (Box 1), the clerk inappropriately provided an incorrect legal option (that there was "not much" that could be done to remedy the situation) and then referred to "those people," a dismissive and offensive term with implications of stigma and judgment.

At the meeting, the MLP attorney explains that in this community there is a long-standing problem with housing court personnel not providing legally mandated accommodations to people with disabilities. The MLP attorney also shares that many litigants, including those with disabilities, are treated in

Table 1

How a Medical–Legal Partnership (MLP) Approach to Care Could Contribute to the Case Study's Resident Achieving Advanced Levels of Competency in Certain Psychiatry Milestones[a,b]

Psychiatry milestone	Subsection	Level[c]	Descriptor	Resident experience under MLP model
PC3: Treatment planning and management[27(p4)]	A: Creates treatment plan	4	4.2/A: Integrates multiple modalities and providers in comprehensive approach	In treating the patient described in the case study, the resident integrates multiple modalities and providers. These include a social worker who facilitates a group session and the lawyer who is integrated at the clinic as a type of "provider" (of "legal care" to complement medical and behavioral health care).
MK6: Practice of psychiatry[27(p20)]	C: Professional development and frameworks	4	4.2/C: Describes professional advocacy[d]	The resident explores specific opportunities for advocacy related to potential homelessness at the patient, institutional, and population levels.
		5	5.2/C: Proposes advocacy activities, policy development, or scholarly contributions related to professional standards	In partnership with an attending psychiatrist and the MLP lawyer, the resident proposes and participates in concrete advocacy activities. These include providing documentation for a patient to use in court, developing new policies and procedures to identify risk of homelessness among clinic patients, and engaging in reform of a major community institution, the housing court. The MLP affords the resident the opportunity to gain an advanced experience beyond what is expected of a graduating resident (level 4).
SBP2: Resource management[27(p23)]	A: Costs of care and resource management	3	3.2/A: Coordinates patient access to community and system resources	The resident coordinates the patient's access to resources, including to the clinic's MLP.
		5	5.2/A Advocates for improved access to and additional resources within systems of care	The resident advocates for improved access to the housing court for the patient and, over a period of time, for people with mental illness throughout the community. Again, the MLP affords the resident an advanced experience.
SBP4. Consultation to non-psychiatric medical providers and non-medical systems[27(p26)]	C: Specific consultative activities	3	3.2/C Identifies system issues in clinical care and provides recommendations	The resident, in discussion with an attending psychiatrist and social worker, identifies concrete improvements that should be implemented in the clinic's screening for patients with a risk of homelessness.

Abbreviations: PC indicates patient care; MK, medical knowledge; SBP, systems-based practice.

[a]For the case study, see Box 1; for the description of the steps taken to address the patient's situation, see the article text.

[b]Psychiatry milestones, subsections, levels, and descriptors are from "The Psychiatry Milestone Project, A Joint Initiative of the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology."[27]

[c]The Psychiatry Milestone Project interprets Milestone performance levels 3–5 as follows: level 3 = "demonstrates the majority of milestones targeted for residency in this subcompetency"; level 4 = "substantially demonstrates the milestones targeted for residency … designed as the graduation target"; level 5 = "demonstrating 'aspirational' goals."[27(p iv)]

[d]"Advocacy includes efforts to promote the well-being and interests of patients and their families, the mental health care system, and the profession of psychiatry. While advocacy can include work on behalf of specific individuals, it is usually focused on broader system issues, such as access to mental health care services or public awareness of mental health issues. The focus on larger societal problems typically involves work with policy makers (state and federal legislators) and peer or professional organizations (American Psychiatry Association (APA), National Alliance on Mental Illness (NAMI), etc.)."[27(p20–21,fn 2)]

a disrespectful way by some court personnel.

Recognizing that both evictions and the functioning of the housing court directly and indirectly affect the health of low-income patients, the team determines that improvements within that court could improve population health throughout their community. Using the incident involving Ms. Williams as an opportunity, the executive director of the civil legal services organization involved in the MLP and the director of the mental health clinic request a meeting with the chief judge of the housing court. The meeting is also attended by the MLP attorney and Dr. Freeman. This group both raises concerns and offers potential solutions. As a result of the meeting, the chief judge convenes a task force to address concerns related to litigants with mental illness. The MLP attorney and Dr. Freeman contribute to a new court directive issued by the chief judge. When a training series is created for court personnel the following year, the MLP attorney and Dr. Freeman are among those who conduct the training.

Structural competency insights and analysis. The housing court's lack of accommodations for and discrimination against people with disabilities is likely increasing evictions and subsequent homelessness among people with mental illness throughout the community, negatively affecting the mental health of patients of the mental health clinic and beyond. By working with the MLP to improve the ability of people with mental illness to access the housing court—including by meeting with the chief judge from the housing court, contributing to a court-issued directive, and conducting training for court personnel—Dr. Freeman is working to improve community structures that have

a significant impact on population health. (For relationships between skills and specific Milestones, see Table 1.)

The MLP Approach and the Psychiatry Milestones

By engaging in a structural-competency-informed analysis of the difficulties faced by Ms. Williams through the MLP approach, Dr. Freeman met more advanced levels of the subcompetencies within a number of psychiatry Milestones.[27] Table 1 summarizes the ways in which Dr. Freeman's experiences with the MLP helped the resident achieve these subcompetencies. As exemplified in this case, residents who are oriented toward including lawyers as members of the health care team learn each profession's key role identifying and addressing legal needs that directly affect the health of patients and the communities they serve.

Conclusion

MLPs bring health care and legal providers together to effectively address the social and legal needs that affect the health of patients, communities, and populations. Using the MLP approach in residency programs not only expands residents' understanding of the social determinants of health but also provides physicians-in-training with specific actionable steps they can take in partnership with lawyers to address structural barriers to health. The central themes of working within an interdisciplinary team, resource management, patient advocacy, and systemic advocacy are represented in Milestones in many specialties. MLPs can provide unique opportunities to teach the knowledge, skills, attitudes, and other attributes of these Milestones and help create residency graduates who are informed and capable participants in today's changing and future health care delivery systems.

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