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FY 2016 Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Legal Services** Revision Date: 03/03/14	
HRSA Service Category Title: **RWGA Only**	**Legal Services** **Permanency Planning**
Local Service Category Title:	**Legal Assistance**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Only time spent by the Attorney working on a client's case may be billed under this contract. Travel time to and from a client's residence is not billable. Criminal matters are not eligible for reimbursement. The clients' legal representative and/or affected significant other is no longer eligible for Ryan White-funded legal assistance services if the HIV-infected individual is deceased (i.e. eligibility for Ryan White-funded legal services ceases upon death of the HIV-positive client). $50,000 is designated to provide Legal Assistance Services to eligible PLWHA who reside in the Houston EMA/HSDA outside of Harris County (i.e. in the rural area).
HRSA Service Category Definition: **RWGA Only**	**1. *Legal services*** are the provision of services to individuals with respect to powers of attorney and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. **2. *Permanency planning*** is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
Local Service Category Definition:	Ryan White allowable legal and permanency planning services provided to HIV-infected individuals and/or their legal representatives by an Attorney licensed to practice in Texas.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected persons living within the Houston Eligible Metropolitan Area (EMA) and/or their legal representatives.
Services to be Provided:	Comprehensive legal assistance must include but is not limited to estate planning, permanency planning, discrimination, entitlement, and insurance disputes.

Service Unit Definition(s): **RWGA Only**	A unit of service is defined as one (1) hour of service provided by an Attorney licensed to practice in Texas.
Financial Eligibility:	Refer to the RWPC's approved *FY 2015 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected residents of the Houston EMA/HSDA.
Agency Requirements:	Not applicable.
Staff Requirements:	Staff attorney must be licensed by the State of Texas and have a minimum educational level of a doctorate in Jurisprudence.
Special Requirements: **RWGA Only**	None.

FY 2016 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2016**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2016**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2016**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #3**		Date: **04/27/2016**
Recommendations:	Financial Eligibility: 500%	
1. Update the name of the service category to Other Professional Services.		
2. Set the financial eligibility for Other Professional Services, including Legal Services and Tax Preparation Services, at 500%.		
3.		

FY 2017 Houston EMA/HSDA Ryan White Part A Service Definition

Other Professional Services - Income Tax Preparation Services (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	Other Professional Services - Income tax preparation services
Local Service Category Title:	Income Tax Preparation Services
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	TBD
HRSA Service Category Definition: **RWGA Only**	*Other Professional Services* allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits
Local Service Category Definition:	Federal tax preparation and filing services for HIV-infected individuals with ***Marketplace Health insurance plans*** delivered by licensed and/or certified professionals accordance with Federal, State and/or local guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with ***Marketplace Health insurance plans***, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Comprehensive tax preparation assistance must include but is not limited to federal tax preparation and filing.
Service Unit Definition(s): **RWGA Only**	A unit of service is defined as one (1) hour of service provided by qualified tax preparation professional.
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected residents of the Houston EMA/HSDA with *Marketplace Health insurance plans*.
Agency Requirements:	Not Applicable.
Staff Requirements:	Must meet all applicable Federal/State/local requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV* seeks to identify the status- unaware and link them into care. **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months. **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2014 Needs Assessment, 2012-2016 Comp Plan, 2015 Outcome Measures, 2015 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency: Can we make this service more efficient? For: a) Providers b) Clients. Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-14-16							
Legal Assistance Part A ***Workgroup 3*** ***Motion #1:*** *(Pruitt/Kennedy)* *Votes: Y=9; N=0;* *Abstentions = Kelly* ***Motion #2:*** *(Collins-Nelson/Bellard)* *Votes: Y=6; N=5;* *Abstentions = none*	__Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing barriers to HIV care for those who are eligible for public benefits (including public health insurance). Continuum of Care: Legal Assistance facilitates maintenance/retention in care and viral suppression by removing barriers to HIV care for those who are eligible for public benefits (including public health insurance), thereby preventing lapses in care	Need (2015): Current # of living HIV cases in EMA: 26,041 Rank w/in 5 Support Services: #5 Service Utilization (2015): # clients served: 237 *(14% increase v. 2014)* Outcomes (FY2015): 47% of all completed public benefits cases resulted in access (or continued access) to benefits upon completion	Other non-HIV-specific legal aid services are available in the Houston EMA/HSDA Covered under QHP? __Yes ✔ No	Per HRSA HAB Policy Clarification Notice #16-02, Legal Services, Permanency Planning, and Income Tax Preparation Services were combined into one service category for Other Professional Services. Legal Services is no longer a HRSA-defined service category.	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Update the name of the service category to Other Professional Services. **Motion 2:** Set the financial eligibility for Other Professional Services/Tax Preparation Services, at 500%. RWGA will prepare the service definition to be reviewed and approved by the Quality Improvement Committee. **See *Other Professional Services***
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV* seeks to identify the status- unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2014 Needs Assessment, 2012-2016 Comp Plan, 2015 Outcome Measures, 2015 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Other Professional Services Part A ***Quality Improvement Motion #1:*** *(Rodriguez/Boyle)* *Votes: Y=10; N=0;* *Abstentions = none* ***Motion #2:*** *(Boyle/Torrente)* *Votes: Y=8; N=2;* *Abstentions = none*	__Yes _✔_No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Income tax preparation and filing services allow people living with HIV with Marketplace plans to maintain health insurance coverage. Maintenance of health insurance coverage reduces unmet need by increasing retention in care and re-linkage. Continuum of Care: Income tax preparation and filing services allow people living with HIV with Marketplace plans to maintain health insurance coverage. Maintenance of health insurance coverage reduces unmet need by increasing retention in care and re-linkage. Additionally, health insurance coverage increases access medications which support viral suppression.	This is a new service category. Data below reflect documentation of need for Legal Services: Need (2015): Current # of living HIV cases in EMA: 26,041 Rank w/in 5 Support Services: #5 Service Utilization (2015): # clients served: 237 (14% increase v. 2014) Outcomes (FY2015): 47% of all completed public benefits cases resulted in access (or continued access) to benefits upon completion	Several free and low-cost tax preparation services exist in the Houston area, though none are exclusively dedicated to PLWH. Covered under QHP? __Yes _✔_No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - The Houston HSDA **Is this a duplicative service or activity?** Similar services are available in the community, though none are exclusively dedicated to PLWH.	**Can we make this service more efficient?** No **Can we bundle this service?** No **Has a recent capacity issue been identified?** No	**Motion 1:** Accept the service category definition as presented. **Motion 2:** Set the financial eligibility at 400%. **See also *Legal Services***

‡ Service Category for Part B/State Services only.

Bridging the legal gap between needs and solutions.

Houston Volunteer Lawyers is the pro bono legal aid arm of the Houston Bar Association

www.makejusticehappen.org

How to Get Help

Need help?

*Due to the growing concerns regarding COVID-19, Houston Volunteer Lawyers' staff will be working remotely. If you need legal assistance, please fill out HVL's application and email it to info@hvlp.org

Starting on Friday, March 27, HVL staff attorneys and volunteer attorneys will conduct legal advice interviews over the phone to those who submit an application and are eligible for HVL's services. Legal advice interviews will take place from 2 pm - 5 pm on Friday afternoons.

*** To be eligible for free legal services, you must:**

(1) reside in Harris County,

(2) have household income at or below 200% of the Federal Poverty Guidelines, and

(3) have limited assets.

Houston Volunteer Lawyers normal process will resume when our staff is able to return to the office and it is deemed safe to host in person legal advice clinics. Normal process is as follows:

* **Call our Intake Line at (713) 228-0732 or view Upcoming Events on the homepage** to learn the dates and times of our upcoming legal clinics, where you can meet with a licensed Texas attorney about your legal problem and apply for longer term service.

- If your application is accepted, we will attempt to refer your case to a volunteer attorney. **We cannot guarantee that we will be able to find a volunteer willing to take your case.** If, after 3 months on our waiting list, no attorney volunteers to take your case, we will close

your file and notify you.

- We do not accept applications or provide legal advice over the phone. Free legal advice is available by phone through the Houston Bar Association's LegalLine program at (713) 759-1133. LegalLine is open on the first and third Wednesday of every month between 5 pm and 9 pm, and is available for Spanish speakers on the first Thursday of every month, between 6 pm and 8 pm.

* **Accommodations.** If you do not speak English, a translator is available in person or via telephone service. If you need other accommodations, call our office at (713) 228-0735 or email info@hvlp.org.

* **We provide the following legal advice clinics on an ongoing basis:**

- **Saturday Clinic**: walk-in clinic held twice monthly on Saturdays at various locations for the first 75 people in line. Clinics begin at 9:00 am. Applicants are encouraged to come early (at or before 8:00 am) to secure a place in line. We do not hold Saturday clinics in December.

- **Veterans Clinic**: walk-in clinic every Friday from 1 - 5 pm at the Michael E. DeBakey VA Medical Center, for U.S. Veterans and spouses of deceased Veterans

- **Low Income Taxpayer Clinic**: by appointment, for assistance with IRS issues. Call (713) 255-1TAX.

- **Self Help Information Offices**: for help representing yourself in court, go to the 17th floor of the Civil Courthouse (located at 201 Caroline Street, downtown), weekdays from 8:30 am until 12:00 pm on a first come, first serve basis. You can now also visit our Harris County Law Library location for self help: 1019 Congress basement, open weekdays from 8:30 am until 5:00 pm on a first come, first serve basis. At these locations, legal information only is provided, specific case advice is not.

- **Self Help Divorce Clinics**: held quarterly by appointment. To schedule, please fill out our Screening Form to ensure your situation meets the forms we have available. If so, you'll be asked to leave a phone number and we will call you back to make the appointment.

* **To be eligible for free legal services, you must:**

(1) reside in Harris County,

(2) have household income at or below 200% of the Federal Poverty Guidelines, and

(3) have limited assets.

* **Exceptions:**

* United States Veterans and spouses of deceased Veterans who reside in Austin County, Bell, Brazoria, Brazos, Chambers, Galveston, Grimes, Fort Bend, Hardin, Harris, Liberty, Matagorda, Montgomery, San Jacinto,Walker, Waller, or Washington counties *and* have a

household income at or below 300% of the Federal Poverty Guidelines.

* Persons with HIV or AIDS who reside in Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, or Waller counties *and* have household income at or below 300% of the Federal Poverty Guidelines.

* Persons with IRS disputes who have household income at or below 250% of the Federal Poverty Guidelines.

NOTE: We do not accept criminal, traffic, or fee-generating cases.

Printed:April 5, 2020
http://www.makejusticehappen.org/node/24/how-get-help
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WE'RE HERE TO HELP. OUR LEGAL HELP DESK IS OPEN. CONTACT

HIV

People living with HIV continue to face discrimination in employment, health care, insurance, parenting and other areas of life. Lambda Legal won the first HIV discrimination lawsuit in the nation, and since then we have helped maintain or expand protections across the country for people living with HIV. Through our HIV Project we pursue impact litigation, education and advocacy to combat misconceptions, stigma and bias and to ensure that people are treated fairly by employers, health care providers and others.

Know Your Rights: HIV

East vs. Blue Cross Blue Shield of Louisiana

Rhoades v. Iowa

Publications: HIV

The ACLU HIV Project

Advances in medical treatment mean that an HIV diagnosis is no longer the death sentence it seemed to be in the 1980s. People living with HIV are thriving in every walk of life. Nonetheless, people living with HIV continue to suffer the effects of stigma, prejudice, and misunderstanding about HIV.

The ACLU works to defend and advance the civil rights and civil liberties of people living with HIV. We're committed to fighting against laws that criminalize living with HIV. We also seek to make sure that people living with HIV in prison or jail have access to the medical care they need and have their medical confidentiality respected. Over the years, we have also worked to address and prevent HIV-based discrimination by employers, medical providers, and others through litigation and advocacy toward better laws and policies.

The ACLU HIV Project seeks to create a just society for all people living with HIV regardless of race or income. Through litigation, lobbying, public education, and organizing, we work to build a country where our communities can live openly without discrimination and enjoy equal rights, personal autonomy, and freedom of expression and association.

Need help?
FILL OUT OUR CONFIDENTIAL ONLINE FORM

More

U.S. Department of Justice
Civil Rights Division
Disability Rights Section

PROTECTING THE RIGHTS OF PERSONS LIVING WITH HIV/AIDS

FIGHTING DISCRIMINATION

The Americans with Disabilities Act (ADA) guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. People with HIV, both symptomatic and asymptomatic, are protected by the ADA. The ADA also protects persons who are discriminated against because they have a record of or are regarded as having HIV, or they have a known association or relationship with an individual who has HIV.

EMPLOYMENT

The ADA prohibits disability discrimination by all public employers and all private employers with 15 or more employees. Discrimination against qualified individuals with disabilities (i.e., an individual who can perform the essential functions of the job with or without reasonable accommodations) is prohibited in hiring, firing, application procedures, job assignments, reassignments, training, benefits, and promotions.

Reasonable Accommodations

Employers must provide reasonable accommodations to the known disability of any qualified individual, unless doing so would impose an undue hardship. A reasonable accommodation is any modification or adjustment to a job, the job application process, or the work environment that will enable a qualified applicant or employee with a disability to perform the essential functions of the job, participate in the application process, or enjoy the benefits and privileges of employment. An undue hardship is defined as significant difficulty or expense.

Filing an Employment Discrimination Complaint with the EEOC

An applicant or employee who believes that he or she has been subjected to discrimination on the basis of having HIV or AIDS should file a complaint with the Equal Employment Opportunity Commission (EEOC) within 180 days (or in many states 300 days) of when the discrimination occurred.

For technical assistance on employment discrimination or to file a complaint of employment discrimination, contact the EEOC at 800-669-4000 (Voice) or 800-669-6820 (TTY) or visit www.eeoc.gov.

BUSINESSES AND NONPROFIT SERVICE ORGANIZATIONS

The ADA prohibits discrimination by public accommodations, which include businesses and nonprofit service organizations that provide goods or services to the public, such as restaurants, hotels, theaters, doctors' offices, dentists' offices, hospitals, retail stores, health clubs, museums, libraries, private schools, and day care centers.

Public accommodations generally:

— *Must* give a person with a disability an equal opportunity to use or enjoy the entity's goods, services, and facilities.
—*Must* make reasonable modifications in policies, practices, or procedures when necessary to afford goods and services to individuals with disabilities, unless the public accommodation can demonstrate that making such modifications would fundamentally alter the nature of the goods and services.
— *Must* provide auxiliary aids and services when necessary to ensure that communication with individuals with disabilities is as effective as with others, unless the public accommodation can demonstrate that providing such aids and services would fundamentally alter the nature of the goods and services being offered or would result in an undue burden.
— *Must* ensure that no individual with a disability is screened out, denied the opportunity to participate, segregated, or otherwise treated differently than other individuals, unless doing so is necessary for the provision of goods or services or necessary for safe operation.

STATE AND LOCAL GOVERNMENTS

The ADA applies to all State and local government programs, services, and activities. State and local governments include a wide range of entities and services, such as public schools, county hospitals, emergency responders, and county recreation centers. State and local governments generally must reasonably modify their policies, practices, and procedures when necessary to avoid discrimination unless doing so would fundamentally alter the service, program, or activity; must provide auxiliary aids and services when necessary to ensure that communication with people with disabilities is as effective as with others, unless doing so would fundamentally alter the nature of the program, service or activity or would result in an undue burden; and must make programs, services, and activities equally available to individuals with disabilities.

Health Care Providers

A health care provider, whether public or private:

—*May* not generally refer a patient with HIV or AIDS to another provider simply because the person has HIV or AIDS.
—*May* refer a person who requests or requires treatment or services outside the provider's area of expertise and such referrals are routinely made.

Exclusion of Individuals with HIV or AIDS

A public or private entity may exclude a person with HIV or AIDS from participation in an activity if that individual’s participation would result in a "direct threat" to the health or safety of others. A direct threat is a significant risk to the health or safety of others that cannot be eliminated by a modification to policies,

practices, or procedures or by the provision of appropriate auxiliary aids or services. The determination that a person poses a direct threat to the health or safety of others must be an individualized assessment based on reasonable judgment that relies on current medical knowledge or the best available objective evidence.

Entities may also impose necessary legitimate safety requirements, but must ensure that such requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about a person with HIV or AIDS.

Filing a Discrimination Complaint with DOJ

A person who believes that he or she is being or has been discriminated against because of HIV or AIDS by a public accommodation or a State or local government may file a complaint with the U.S. Department of Justice (DOJ). Individuals are also entitled to bring private lawsuits under the ADA.

To file a complaint with DOJ, visit www.ada.gov/HIV

Complaints may also be sent as follows:

By Mail:

U.S. Department of Justice
Civil Rights Division
Disability Rights Section
950 Pennsylvania Ave., NW
Washington, D.C.20530

By Fax:

(202) 307-1197

HOUSING

The Fair Housing Act (FHA) prohibits discrimination against individuals with disabilities, including HIV or AIDS. The FHA prohibits discrimination in the sale or rental of housing (such as apartments, houses, mobile homes, nursing homes, assisted living centers, group homes, student housing, and homeless shelters), and in other residential real estate transactions.

Filing a Housing Discrimination Complaint with HUD

For complaints concerning housing-related discrimination, contact the U.S. Department of Housing and Urban Development (HUD) at 800-669-9777 (Voice) or 800-927-9275 (TTY) or visit www.hud.gov/complaints.

ADA INFORMATION LINE

For more information on the ADA and the rights of persons living with HIV/AIDS, or to request this publication in an alternative format, call our ADA Information Line Monday through Wednesday, Friday 9:30 a.m. - 5:30 p.m., Thursday 12:30 p.m. - 5:30 p.m. (Eastern Time) to speak with an ADA specialist. Calls are confidential.

800-514-0301 (Voice)
800-514-0383 (TTY)

ADDITIONAL RESOURCES

For advice to employers on how to reasonably accommodate individuals with disabilities in the workplace, contact the Job Accommodation Network (JAN) at 800-526-7234 (Voice) or 877-781-9401 (TTY) or visit www.askjan.org.

For more Federal government resources and information on HIV/AIDS, including about prevention, testing, treatment, research, and the National HIV/AIDS Strategy, visit www.aids.gov.

The Americans with Disabilities Act authorizes the Department of Justice (the Department) to provide technical assistance to individuals and entities that have rights or responsibilities under the Act. This document provides informal guidance to assist you in understanding the ADA and the Department's regulations.

This guidance document is not intended to be a final agency action, has no legally binding effect, and may be rescinded or modified in the Department's complete discretion, in accordance with applicable laws. The Department's guidance documents, including this guidance, do not establish legally enforceable responsibilities beyond what is required by the terms of the applicable statutes, regulations, or binding judicial precedent.

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https://doi.org/10.1186/s12913-019-4632-x

BMC Health Services Research

STUDY PROTOCOL Open Access

Examining the impact of medical legal partnerships in improving outcomes on the HIV care continuum: rationale, design and methods

Miguel Muñoz-Laboy[1*], Omar Martinez[2], Robin Davison[2] and Isa Fernandez[3]

Abstract

Background: Over the past two decades, we have seen a nationwide increase in the use of medical-legal partnerships (MLPs) to address health disparities affecting vulnerable populations. These partnerships increase medical teams' capacity to address social and environmental threats to patients' health, such as unsafe housing conditions, through partnership with legal professionals. Despite expansions in the use of MLP care models in health care settings, the health outcomes efficacy of MLPs has yet to be examined, particularly for complex chronic conditions such as HIV.

Methods: This on-going mixed-methods study utilizes institutional case study and intervention mapping methodologies to develop an HIV-specific medical legal partnership logic model. Up-to-date, the organizational qualitative data has been collected. The next steps of this study consists of: (1) recruitment of 100 MLP providers through a national survey of clinics, community-based organizations, and hospitals; (2) in-depth interviewing of 50 dyads of MLP service providers and clients living with HIV to gauge the potential large-scale impact of legal partnerships on addressing the unmet needs of this population; and, (3) the development of an MLP intervention model to improve HIV care continuum outcomes using intervention mapping.

Discussion: The proposed study is highly significant because it targets a vulnerable population, PLWHA, and consists of formative and developmental work to investigate the impact of MLPs on health, legal, and psychosocial outcomes within this population. MLPs offer an integrated approach to healthcare delivery that seems promising for meeting the needs of PLWHA, but has yet to be rigorously assessed within this population.

Keywords: Medical legal partnerships, HIV care continuum, Institutional case study, Intervention mapping legal epidemiology

Background

Four in five physicians in the US agrees that patients' social and legal needs are as important to address as their medical issues. Eighty-five percent of primary care providers nationwide report that unmet social and legal needs lead directly to inferior health outcomes. Yet 80% of physicians surveyed lacked confidence in their ability to address such needs, impeding their ability to provide quality care [1]. In response to this systemic need, legal epidemiology, defined as the scientific study and deployment of law as a factor in the cause, distribution, and prevention of disease and injury in a population [2], provides a structural framework to better understand the health-harming legal needs of people with chronic illness. Thus, medical-legal partnerships (MLPs) were developed to help medical providers better identify and meet vulnerable patients' legal needs [3]. Since 1993, MLPs have been established in 294 healthcare institutions in 41 states in the United States. These MLPs provide a multi-faceted approach to health care delivery by

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integrating legal services and legal advocacy into medicine and health care practices [3–5]. Though the MLP is a promising approach to address the health-harming legal needs of people living with HIV (PLWH), no study prior to our current project has rigorously examined how to build effective MLPs that facilitate positive outcomes in the HIV continuum of care.

In June 2018, the authors were awarded a two-year R21 study funded by the National Institute of Mental Health (#1R21MH115820–01) to develop a culturally-appropriate MLP intervention package to HIV continuum of care outcomes. The specific objectives of this ongoing study are: (1) To identify existing best practices among current MLPs that can be tested, replicated, and scaled-up as evidence-based practices for serving the plurality of PLWH; (2) To assess the effects of the identified MLP practices on: a) appropriately addressing the legal issues through clients' satisfaction and case outcomes, b) reducing the legally-related psychosocial burdens for PLWH, and, c) increasing positive movement in the HIV continuum of care (including retention in care and viral load suppression) among PLWH. (3) To develop an MLP-comprehensive HIV care diffusion model and its benchmarks of success to achieve positive movement in the HIV continuum of care (including retention in care and viral load suppression) for diverse sectors of PLWH.

Methods/design

The aim of this paper is to describe the methodology to design a structural intervention to improve HIV care continuum outcomes for people living with HIV. Structural interventions in the field of HIV are usually reported post-hoc with limited or no insights into how they are built and implemented. Drawing on the fields of implementation science in public health and medical anthropology, our study protocol draws on institutional ethnography and intervention mapping methodologies.

Operationalizing medical-legal partnerships for HIV treatment and care

HIV treatment and outcome disparities in the US and globally are attributed to syndemic factors, including lack of testing and access to care, discrimination, poor mental health, substance use, violence, and economic hardship [6–9]. Fig. 1 illustrates our legal epidemiological framework that builds on the concepts of structural violence and HIV syndemics [10, 11]. The first column identifies social policies with documented effects on patient wellbeing. We posit that under a legal epidemiological framework, we must address both social and legal needs in order to improve HIV outcomes and reduce excess mortality (i.e., highly preventable deaths below the life expectancy for the individual's demographic group). MLPs offer a structural, integrated intervention that could tackle these factors. This approach is all the more promising given the potential for HIV status and stigma to exacerbate legal needs. A recent study of people living with HIV/AIDS found that 98% of participants reported at least one legal need within the last year [12]. PLWH face discrimination in their social and work environments because of their HIV status, sexual orientation, and/or substance use [13]. For example, 31 % reported experiencing HIV-based discrimination in employment, housing, and health care settings [12]. Coupled with the medical complications associated with HIV/AIDS, these social issues may have a pernicious impact upon the wellbeing of HIV-affected populations.

Institutional ethnography is an inductive method of inquiry that begins by looking at specific experiences,

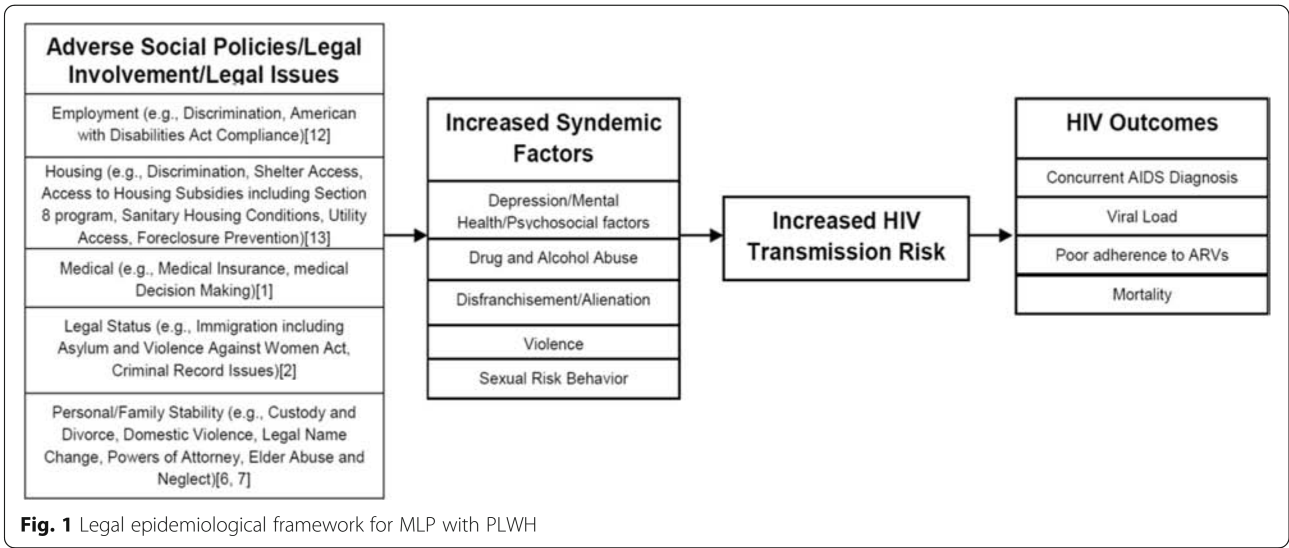

Fig. 1 Legal epidemiological framework for MLP with PLWH

behaviors, and practices of individuals and then works outward to draw conclusions about the codes, systems, and structures by which they are governed [14, 15]. This "dual focus," Elizabeth Quinlan notes in "The 'actualities' of knowledge work: an institutional ethnography of multi-disciplinary primary health care teams," is part of what distinguishes it from other types of ethnography (p. 628) [14].

Our institutional ethnographic methodology draws on this dual focus by examining larger social phenomena from the perspective of multiple social actors and institutions. In our study, the social phenomena are the interactions and formal and informal systems governing medical-legal partnerships. The institutions are health care facilities inclusive of hospitals, federally qualified health centers, community health centers, and, HIV/AIDS service organizations. The social actors include: lawyers, legal aid staff, health care and social service providers screening for health-harming legal needs. Using the outward institutional methodological strategy that Smith and others have argued allow us to build institutional case studies of MLPs for PLWH on two main levels: the organizational and community levels [16–18]. The cornerstone of our methodological innovation is combining institutional case studies with a rigorous implementation science methodology in order to build an evidence-based structural intervention to enhance HIV treatment and care.

In order to build our MLP intervention model for PLWH, we are incorporating institutional case studies and Intervention Mapping [19–21]. Intervention mapping is an implementation approach that is based on an ecological framework, that is focused on the multi-level influences on health-promoting behavior, and develops strategies to address them [19]. Intervention mapping has been used to develop programs for a variety of health behaviors, including early detection practices and linking individuals to the continuum of health services [22–25]. This technique specifies processes for integrating theoretical constructs and empirical evidence for the purpose of intervention planning, and helps connect determinants, the identification of proximal behavioral and environmental factors related to a target health outcomes, and the selection of the most appropriate intervention strategies [20]. This approach has been demonstrated to increase the cultural relevance, proper adaptability, and effective uptake of interventions [20].

We began collecting data for our institutional case studies in August 2018 and will continue until May 31, 2019. Our institutional case study methods are divided into three components: 1) organizational qualitative data; 2) organizational-provider-client quantitative data; and, 3) provider-client qualitative data.

Component 1. Organizational qualitative data

We conducted interviews with 19 MLP key informants, visited four organizations involved in MLPs, and conducted four structured meetings with a Scientific Collaborative Board. Data was collected from July 2018 to January 2019.

Based on the formative work conducted prior to the start of the study and meetings with the leadership at the National Center for Medical Legal Partnerships, we selected an initial sample of six MLPs working with PLWH within 100 miles radius of the authors' host institution and, through referral, we contacted four additional MLPs. These ten MLPs are located in New York, Pennsylvania, Massachusetts, Hawaii, Wisconsin, Texas, Florida, New Jersey, and Washington, DC.

Key informants

Consisted of providers involved in MLPs that provide services to people living with HIV. We conducted interviews with 19 key informants. Key informants represented: lawyers, health providers, social workers, administrators, and researchers with specific expertise and experience in the MLP approach to care. These key informants, selected because of their first-hand knowledge and understanding of the community, provided insight into the issues facing PLWH and the MLPs that serve them and suggested various ways to address these challenges. When possible, we attempted to interview two key informants per MLP. The levels of experience with MLP services for PLWH ranged from 4 years to more than 20 years.

Interview guide and procedures

The interview guide was designed by the authors and it contained ten questions and four probing questions. Sample questions included: How would you describe the MLP approach in your agency? What factors contribute to the success of the MLP and why? What are the main challenges associated with MLP implementation? The interviews were conducted in person or by phone, with the authors taking turns asking questions. Unscripted probing and follow-up questions are customary in key informant interviewing. During each interview, the authors took notes independently and subsequently compared recorded informant responses for accuracy. Discrepancies in the notes were clarified within the same week of conducting the informant interviews.

Scientific collaborative board

The SCB consisted of a core group of MLP practitioners who are experts in their fields, including clinical care, legal services, administration, and social services. The SCB met to review findings from interviews and site visits and to provide guidance on next steps, including

preparation for subsequent NIH grant submissions. The SCB meeting with the full board lasted approximately 2 hours. We also had subsequent individual meetings with SCB members. The authors took notes from the meetings.

Data analysis strategy

The analysis for organizational qualitative data followed a comparative approach, viewing data collection and analysis as a single concurrent process in which the method is fluid and evolves as the understanding unfolds from the data, a common approach in institutional ethnography. We first focused on "within" differences among key informants' MLPs with regard to the provision of HIV services. Once we determined the organizational structure and organizational goals, we identified the various approaches to MLP HIV services and the rationale behind each approach. The researchers identified key components of MLP structure and implementation that were later validated by the SCB. We also gathered field notes and reflections from the sites visits. The authors listed, described, and discussed organizational-level best practices, including practices related to the continua of care and screening strategies for health harming legal needs; agency structure and staffing, including staffing of legal aid providers and operational hours; communication and information sharing among partners within the MLP; and written informational materials for clients and providers, including content of biomedical HIV prevention marketing initiatives. The above analysis was completed by February 15, 2019.

Component 2. Organizational-provider quantitative data

From February 1 – May 15, 2019 we will conduct an online quantitative survey with 100 health and legal MLP service providers to collect organizational-provider data on MLPs serving PLWH.

Sample, eligibility and recruitment

We identified MLP providers through the NCMLP database. The database includes names of existing MLPs, geographic locations (i.e., city and state), and voluntary contact information (e.g., email addresses). A total of 294 MLPs have been registered by the NCMLP. Using a script approved by Temple University IRB, we are soliciting MLP service providers' participation via email, one 3-min phone call, and one follow-up email. This personal approach will likely increase survey completion. The recruitment phone script and email contain information about the study and benefits associated with completion. We are also creating a moderate study-specific website page, which will include an attractive and interactive introduction and overview of the study, and hypertext-enabled links that allow viewers to contact study staff to inquire about participation, ask questions, and solicit feedback. Those who consent and complete the enrollment process will be asked for contact information (name, e-mail, and phone number) to arrange compensation and/or express interest to be contacted for the dyad in-depth interviews (Component #3). At the conclusion of the survey, participants will be offered a $30 gift card and thanked for their time.

Measures

Overall, questions will assess best practices, identify new tools, and serve to develop effective MLP approaches to addressing disparities in HIV treatment and health outcomes. The survey instrument consists of five parts. **Part I** inquires about general MLP information (e.g., geographic location, year of establishment, team structure) and providers' characteristics (e.g., age, occupation, duties and responsibilities to the MLP). **Part II** focuses on seven standard NCMLP performance measures for the prior 12 months (e.g., proportion of patients who were referred to civil legal aid services and received a legal screening; proportion of patient-clients with health-harming legal needs). **Part III** will focus on identifying any existing services specifically geared towards PLWH and frequency of contextual barriers and facilitators to HIV medical adherence for their client population. **Part IV** focuses on examining health-harming legal, legal challenges affecting patient-clients, barriers to accessing legal services, and strategies for engaging PLWH. **Part V** consists of assessing MLPs level of readiness to adopt, implement and sustain a potential MLP HIV specific model of practice.

Completion time

The piloting of the above survey with attorneys, graduate students of health and social services, members of the Scientific Collaborative Board, suggest a completion time between 15 and 20 min. At the end of the survey all participants will be asked if they would be willing to participate in a follow-up research component (Component 3, described below).

Data analyses

Using the quantitative data generated, we will conduct two primary analyses. The first level of analysis will focus on identifying what MLPs consider organizational best practices (e.g., innovative practices, evidence-based practices) for HIV treatment and care. To achieve this, we will rank MLPs based on their level of exposure to HIV patients and services provided to HIV patients (answers to questions in Part III) vs. the level of performance as determine by the NCMLP performance measures (Part II of the survey). Using this composite

indicator of MLP performance on HIV services, we will conduct a series of basic monomial logistic regression analyses to determine differences between MLPs with high and low performance (i.e., background differences by clientele or geography – Part I measures; differences in barriers and facilitators to HIV medical adherence – Part III measures; and, differences in legal services and challenges - Part IV measures).

The second level of analysis will focus on proximal and distal determinants of health-harming needs. We will also conduct exploratory logistic and linear regression modeling, after assessing that that the appropriate assumptions are met, to test the following hypotheses: H_1: MLP service structural variables will not be associated with the likelihood of patients with at least one health-harming legal need who were treated by the healthcare organization; H_2: Providers' characteristics will not be associated with the likelihood of patients with at least one health-harming legal need who were treated by the healthcare organization; and, H_3: The frequency of health-harming legal needs will be lower among providers with high exposure to HIV positive clients than their counterparts with lower exposure. If the evidence supports hypotheses 1 and 2, there is no need for tailoring the intervention to reduce the likelihood of health-harming legal needs. If H_1 and H_2 are rejected, we will conduct further analyses to determine determinants within MLP structure and provider characteristics that may reduce the likelihood of health-harming legal needs. The findings from testing H_3 will provide insights into the relevance of exposure to HIV positive cases during the training of MLP providers as part of the development of the HIV MLP diffusion model.

Sample size justification

We will recruit a sample of 100 MLP providers divided into four categories by type of function within MLPs: (a) health and social services providers ($n = 25$); medical and clinical providers ($n = 25$); (c) legal services providers; and, (d) administrators ($n = 25$). This sampling approach will allow us to have equal representation of the sectors within MLP practices. A sample size of 100 will allow us to conduct the above proposed exploratory analyses between continuous variables, where there should be at least 10 observations per variable; thus, if conducting an analysis of four independent variables, there should be a minimum sample size of 40. Moreover, before conducting the above exploratory regression analyses, we will examine the variance in each variable to make sure that the basic assumptions for regression analysis are met. We will use the Bonferroni correction, a multiple-comparison correction used when several dependent or independent statistical tests are being performed simultaneously to adjust the alpha coefficient to minimize Type 1 error in our analyses. Because of the exploratory nature of the proposed protocol, it was not appropriate to conduct power sampling calculations. We will conduct post-hoc power calculations to determine the likelihood of Type 2 error to our analyses.

Component 3. Provider-client qualitative data

Concurrent to component #2 above, we will conduct dyad interviews with MLP providers and PLWH patients/clients. Dyad interviews have been essential elements in the development of empirical data on doctor-patient communication models and interventions to improve provider-patient communication [26–28]. From March 1 to April 30, 2019, we will conduct in-depth interviews with dyads of MLP providers and their PLWH clients.

Interview guide

We will use a personal narrative approach to conduct the in-depth interviews with MLP providers and PLWH to allow participants to explain, describe events and experiences in the everyday contexts in which they occur [29–31]. Additional file 1 list the guiding questions for the dyad interviews that will be pilot tested, revised, and approved by the Scientific and Community Collaborative Boards of the study on February 28, 2019.

Recruitment sequence, eligibility and sampling for dyad interviews

First, we will recruit 50 MLP providers (25 legal providers and 25 health or social service providers) who complete the online survey under Component #2, based on the answers to the last question in the survey. After consent procedures, MLP providers will participate in the in-depth interview through phone, on-line visual-teleconferencing, and/or in person. MLP providers will recruit PLWH clients into the study by providing the potential participants with a unique ID number (to allow us to trace back the individual's MLP provider). Fifty PLWH-MLP clients (or recent former clients, within 3 months) will participate in in-depth interviews after completing consent procedures.

We are seeking to recruit a diverse sample of PLWH in terms of sex, age, race/ethnicity, risk to sexual health, and representativeness of a larger population of HIV positive individuals. To be eligible PLWH have to meet the following criteria: 1) Have received MLP services in the past year by MLP provider who participated in the dyad interview; 2) Self-reported being HIV-positive when receiving MLP services; 3) Age 18 or older; 4) Able to speak English and/or Spanish. To achieve a diverse sample of PLWH, we will engage MLP providers in following a theoretically relevant quota sampling frame to select participants [32, 33]. We will ask MLP

providers to invite individuals into the dyads interviews according to the following quota sampling frame, until there is a minimum of 2 PLWH per cell: (a) female of reproductive age and/or mothers ($n = 5$), (b) elderly, 60 years and older, sexual minorities ($n = 5$), (c) young and adult sexual minorities ($n = 5$), (d) injecting substance users ($n = 5$), (e) non-injecting substance users ($n = 5$), (f) transgender young and adult men and women ($n = 5$), (g) individuals involved in sex worker ($n = 5$), (h) recent (documented or undocumented) migrants ($n = 5$), (i) ethnic minority individuals ($n = 5$), and, (j) dual diagnosis with HIV and another chronic illness or mental health condition ($n = 5$).

Data analyses

Interviews will be transcribed (and translated into English for Spanish speaking interviews) and entered into Dboose, a cloud-based software package specifically designed to handle textual data and its analysis. A codebook will be constructed by two independent coders, including coding families based on the above 6 primary topics. We will take a sample of 10 transcripts, which will be coded collectively by two independent coders, members of the research team, and a research assistant. This will serve to refine the codebook. From this coding exercise, a thematic matrix will be developed. We will conduct 4 analyses using the dyads interviews:

(1) *Qualitative impacts of MLPs on HIV care* will focus on identifying illustrative case studies, briefly defined as cases within the dyads narratives that represent the most typical and most deviant, as defined by Yin (2017) within the sample demonstrating the range of variations in MLPs addressing the legal issues through clients' satisfaction and case outcomes [34].
(2) *Concordant-discordant perspectives on reach and effectiveness of MLPs for HIV care* will focus on examining each dyad answer, and classify the answers in terms of concordance to determine the level of agreement on MLP effects in increasing positive movement in the HIV continuum of care [35] among PLWH, and, in reducing the legally-related psychosocial burdens for PLWH.
(3) *Confirming and disconfirming cases – cross validation analysis* will allow us to detect MLP cases that demonstrate and support findings and inferences from Components 1 and 2 on the structure and MLP practices, while simultaneously actively searching in the qualitative data cases that contradict, disconfirm and/or provide alternative explanations for researchers' working inferences on the quantitative analysis under Component 2 [36, 37].
(4) *Recommendations for HIV MLP diffusion model.* We will conduct content analysis on domains #4–6 (i.e., 4) Information process exchange; 5) Provider-patient communication: shortcomings and successes; and, 6) Current HIV strategies at MLP), to specify recurrent themes, lessons learned (dos and don'ts), determinants of behavioral change and concrete strategies used and/or experienced by participants to promote positive movement in the HIV continuum of care. The content analysis technique has been used before for identifying different elements of programs and interventions [38]. These will be incorporated into the intervention mapping methodology described below.

In order to conduct the above analyses, the qualitative data will be recoded according to each of the four analyses, thus expanding the original thematic matrix. This second level of advanced coding will be conducted by the investigative team.

Intervention mapping methods

The institutional case studies and mixed methods data generated through components 1 to 3 will serve as the evidentiary foundation for the design of the MLP intervention. The process of designing interventions is as important and must be as rigorous as the evidence collected. For this reason, we selected using the intervention mapping approach [20]. In a recent NIH sponsored webinar on implementation and dissemination science, the presenter, Dr. María Fernández, from University of Texas (one of the authors of Intervention Mapping), provided empirical evidence for the use of intervention mapping as an innovative methodological approach for building intervention models that can be diffuse and tested [39].

In general terms, intervention mapping consists of using an iterative path from problem identification to problem solving or mitigation. Each of the six steps of intervention mapping comprises several tasks each of which integrates theory and evidence. The completion of all of the steps will serve as the blueprint for the HIV-MLP model based on a foundation of theoretical, empirical and practical information.

Table 1 lists the agenda for the Community Collaborative Board (CCB) [40–42] working meetings based on the six steps of intervention mapping. The CCB will have ten representatives of HIV-affected communities and service providers, including local community leaders and leaders in the provision of HIV legal and other services. They will be recruited through our existing community and MLP organizational networks by extending personal email or mail invitation. The

Table 1 Intervention mapping CCB meetings for MLP on HIV continuum of care

Intervention Mapping	CCB Working Meeting Topics	Sources of data for IM process from Components 1–3	Schedule
Step1. Conduct a problem analysis, identifying what, if anything, needs to be changed	#1. Logic of the problem – Social services and legal needs of diverse PLWH	• Preliminary logic model of positive change in HIV continuum of care (Component 1) • Descriptive statistics from Part III of online survey (Component 2) • Findings from *Determinants of health-harming needs analyses* (Component 2)	May 15, 2019
Step 2. Create matrices of change objectives by combining performance objectives with determinants of change	#2. Logic of change – Winnable organizational MLP changes to address needs of PLWH	• Findings from *Detecting best practices analysis* (Component 2) • Findings from *Qualitative impacts of MLPs on HIV care* (Component 3)	May 30, 2019
Step 3. Select theory-based intervention methods that match the determinants, and translate these into practical applications	#3. Educational strategies – Concrete learning activities that can have a direct positive impact in increasing integrative HIV care	• Findings from *Detecting best practices analysis* (Component 2) • Findings from *Concordant-discordant perspectives on reach and effectiveness of MLPs for HIV care* (Component 3) • Findings from *Recommendations for HIV MLP diffusion model* (Component 3)	June 15, 2019
Step 4. Integrate methods and the practical applications into an organized program	#4. Building MLP-HIV intervention model package components	Findings from *Recommendations for HIV MLP diffusion model* (Component 3)	June 30, 2019
Step 5. Plan for adoption and sustainability in real-life contexts	#5. Building diffusion strategies for MLP-HIV model	• Descriptive statistics from Parts I and II of survey (Component 2) • Consultations with Scientific Collaborative Board	July 15, 2019
Step 6. Generate an evaluation plan to conduct effect and process evaluations	#6. Building benchmark of success and evaluation indicators for MLP-HIV model	• Findings from Confirming and disconfirming cases – cross validation analysis (Component 3) • Consultations with Scientific Collaborative Board	July 30, 2019

investigative team will prepare the preparatory materials prior to each CCB meeting.

The intervention mapping steps in Table 1 will be accomplished through hybrid online Zoom-in person meetings. The members of the Scientific Collaborative Board will join the last weekend CCB meetings to offer advice on steps 5 and 6. Our intervention mapping approach will continue to be informed by the EPIS implementation science framework stages, particularly step 5, where we will discuss with the CCB how internal and external contextual factors may affect the actual execution of the MLP-HIV model, and factors that could potentially influence the sustainability and scalability of the model.

Discussion

Intervention mapping has been a successful implementation science methodology for the development of in health-risk reduction and health promoting behaviors. Most of the interventions designed using intervention mapping range in levels of intervention from individual, families, and practitioners to organizational and community levels practices; and in types of conditions ranging from prevention of communicable diseases and early detection of chronic conditions to behavioral management of long-term chronic conditions [19, 20, 22–25]. However, intervention mapping has not been applied to the design of legal interventions in health. Thus, our methodology will allow us to expand the application of intervention mapping to the development of interventions beyond what has been the customary use of intervention mapping. Combining intervention mapping based on data collected through institutional case study methodology can serve as the road map to developing structural interventions in the field of HIV treatment and care, and related fields of highly complex diseases that combine communicable and chronic conditions such as untreated hepatitis C virus (HCV) and untreated substance use disorders.

Because of prior studies design limitations, prior assessments of MLPs cannot isolate the specific effects of MLP services on health outcomes. Most published MLP studies do not measure patient health outcomes or specify the causal connections between MLP and observed effects. To our knowledge, this study is the first U.S. federally funded study on medical legal partnerships. Our methodology is one of the first to empirically document best practices for delivering MLP services to PLWH, outcomes in the HIV care continuum and related psychosocial issues. Our study methodology considers the

legal continuum as key component in the delivery of structural interventions. By developing an MLP HIV specific diffusion model, this study will contribute towards the field of HIV structural interventions. The findings from this study will provide insights into the relationships among legal challenges, legal involvement and HIV outcomes for PLWH. The lack of studies of the impact of medical legal partnerships on PLWH, despite their increased use, gives our methodology the potential to be of high public health impact.

Supplementary information

Supplementary information accompanies this paper at https://doi.org/10.1186/s12913-019-4632-x.

Additional file 1. Data collection instrument.

Abbreviations

CCB: Community Collaborative Board; EPIS: Explore Preparation Implementation Sustainability framework; HCV: Hepatitis C virus; HIV: Human Immunodeficiency Virus; MLP: Medical-legal partnerships; NCMLP: National Center for Medical-Legal Partnerships; PLWH: People living with HIV

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Authors' contributions

MML and OM led the writing of the article. RD and MIF provided feedback on the article. OM, MML, and MIF conceptualized the study. RD led the study field implementation. All authors read and approved the final manuscript.

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Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

Ethics approval and consent to participate

The study Examining the Impact of Medical Legal Partnerships in Improving Outcomes on the HIV Care Continuum was approved by the Institutional Review Board of Temple University (TU IRB #25205). Participants of the online survey data collection will provide written consent prior to initiate the survey. Participants of the dyad interviews and group discussions will provide verbal consent and a copy of the consent form will be provided to the participants. Temple University Institutional Review Board deemed not necessary to collect written consent of participants of the qualitative components because of the study itself was considered at minimal risk level, collecting signatures increase the threat to privacy violations for providers, and the identities of people living with HIV, and because the interviews and group discussions will not be about the personal lives of the participants but rather about their experiences and perspectives of medical-legal partnerships in addressing the needs of people living with HIV.

Consent for publication

Not applicable.

Competing interests

All the authors declare that they have no competing interests.

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