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Lessons Learned by an Interdisciplinary Research Team Evaluating Medical-Legal Partnership with the Department of Veterans Affairs

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LESSONS LEARNED BY AN INTERDISCIPLINARY RESEARCH TEAM EVALUATING MEDICAL-LEGAL PARTNERSHIP WITH THE DEPARTMENT OF VETERANS AFFAIRS

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I. INTRODUCTION

Do veterans in VA care for mental illnesses and homelessness experience improved mental health and well-being when they get legal help integrated with their VA care? This question was the basis of a two-and-a-half-year study ("BMS VA MLP study") conducted by legal services programs Connecticut Veterans Legal Center (CVLC) and New York Legal Assistance Group's LegalHealth, and research partners at the Department of Veterans Affairs ("VA") New York Harbor Healthcare System and VA Connecticut Healthcare System, and funded by the Bristol-Myers Squibb Foundation.[1] Some data from the BMS VA MLP study have been published in a peer-reviewed medical journal[2] and the authors expect to publish on the outcomes after statistical analysis of the collected data is complete.

The purpose of this Article is to offer reflections[3] from the Connecticut-based partners on the research process from grant writing, study design and implementation, through data collection and analysis, for the purpose of sharing some experiential lessons learned with other interdisciplinary teams contemplating or involved in academic evaluation of their programs. Before digging in to the specifics of the study, some background on the study partners, the intervention and the state of the literature may be useful for readers unfamiliar with the medical-legal partnership approach to addressing the social determinants of health[4], the Department of Veterans Affairs, or the needs of low-income military veterans.

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1. For more information on this study, see Press Release, Bristol-Myers Squibb, Bristol-Myers Squibb Foundation Awards $3.28 Million in Grants to Support Mental Health Needs of U.S. Military Service Members Returning from Afghanistan and Iraq (Dec. 17, 2013), http://news.bms.com/press-release/philanthropy-news/bristol-myers-squibb-foundation-awards-328-million-grants-support-me. *See also* Peggy McCarthy, *Can Legal Services Lead to Better Health Outcomes for Veterans*, HARTFORD COURANT (Jan. 14, 2014), http://articles.courant.com/2014-01-14/health/hc-vet-services-20140114_1_va-care-margaret-middleton-connecticut-veterans-legal-center

2. For more information, see Jack Tsai, et al., *Partnerships Between Health Care and Legal Providers in the Veterans Health Administration*, PSYCHIATRY SERVS. (forthcoming 2017), http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201600486.

3. The authors would like to stress that every aspect of the study was very much a collaborative effort including our New York-based study partners to whom the authors are grateful for their model teamwork. The ideas and opinions expressed here should not be attributed to our terrific research partners as they may not be shared by all.

4. The Center for Disease Control describes the social determinants of health as "[c]onditions in the places where people live, learn, work, and play [that] affect a wide range

A. Background Information

1. Background on the Medical-Legal Partnership Approach

A medical-legal partnership (MLP) integrates civil legal aid into health care teams to address the social determinants of health, such as access to safe housing and sufficient resources to meet basic needs.[5] The partnerships typically place a legal aid lawyer on-site at a health care facility to address the patient's legal needs through legal advice, information, referral and representation, and by training medical-center staff to identify and address legal needs.[6] Common legal issues handled by medical-legal partnerships include poor housing conditions, landlord-tenant disputes, resolving consumer debts, preventing utility shut off, establishing eligibility for public income sources including VA and Social Security, and protecting legal status including veteran, immigrant and driving status.[7]

Although scholars have written extensively about medical-legal partnership, a 2013 literature review on medical-legal partnerships by the National Center for Medical-Legal Partnership found that there have been few robust evaluations of the approach.[8] Most articles are either needs or program descriptions.[9] Others assess the financial impact on service providers and patients or measure the extent of training health and law professionals in interdisciplinary practice.[10] As of the 2013 literature review, there were articles published reporting on health outcomes for pregnant women, asthma patients, cancer patients, HIV/AIDS patients and patients of a family medicine practice.[11] However, there were none assessing the legal needs of veterans, or their health outcomes.[12]

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of health risks and outcomes." CDC, SOCIAL DETERMINANTS OF HEALTH: KNOW WHAT AFFECTS HEALTH (2016), https://www.cdc.gov/socialdeterminants/.

5. Bharath Krishnamurthy et al., *What We Know and Need to Know About Medical-Legal Partnership*, 67 S.C. L. REV. 377, 379 (2016) ("[C]enters on a health care team that integrates civil legal aid expertise to address health-harming legal needs for low-income populations at risk for poor health and well-being.").

6. *Id.*

7. *Id.*

8. Tishra Beeson et al., *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, THE NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP, Feb. 2013, at 2–3, 5.

9. *Id.*

10. *Id.*

11. *Id.* at 6.

12. *Id.*

2. *Background on the VA Medical System's Research Capacity and Experience with Non-Medical Interventions*

The VA healthcare system is the largest single-payer health care system in the United States, serving over six-million veterans annually.[13] The CVLC partners with the VA Connecticut's Errera Community Care Center.[14] The Errera Center is a VA facility providing mental health, substance abuse, housing and employment assistance to indigent veterans. The Errera Center has been recognized by both congress and the VA for its innovation and leadership in the care of war-injured veterans.[15] Approximately 4,800 veterans visit the VA Connecticut's Errera Community Care Center in West Haven annually, seeking assistance with housing, mental health care and employment.

CVLC's research partners are VA researchers with joint appointments at the Yale School of Medicine. The affiliation of VA medical centers with the nation's medical schools dates back to the end of World War II when VA was seeking top quality physicians to staff its hospitals. Now that VA is the second largest federal agency by staff size after the Department of Defense,[16] this historic relationship means VA helps train a large percentage of the nations' doctors, psychologists, and other allied professions. Importantly, for this project, it also means that VA has extensive research expertise, as the majority of its medical staff have academic appointments and conduct research on veteran health outcomes. VA was an early developer and adopter of electronic medical record dating back to the 1970s, making longitudinal tracking of veteran health service use easier than in other contexts.

VA's health administration (VHA) provides services historically considered ancillary to health, including housing case management for homeless veterans moving into emergency, transitional and permanent

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13. The VA healthcare system served 6,163,101 veterans and eligible dependents in 2014. U.S. DEP'T OF VETERANS AFFAIRS, NATIONAL CENTER FOR VETERANS ANALYSIS AND STATISTICS (2014), https://www.va.gov/vetdata/Utilization.asp.

14. For more information, see ERRERA COMMUNITY CARE CENTER, http://www.erreraccc.com/ (last visited Feb. 4, 2017).

15. U.S. DEP'T OF VETERANS AFFAIRS, VA CONNECTICUT HEALTHCARE SYSTEM (2015), http://www.connecticut.va.gov/pressreleases/Connecticut_Veterans_Legal_Center_wins_national_VA_award.asp.

16. Dennis V. Damp, *Largest Federal Departments*, GOV. CENT., http://govcentral.monster.com/careers/articles/402 (last visited Feb. 6, 2017).

supportive housing,[17] and clinical outreach into the criminal justice system.[18] Evaluation of these programs puts VA researchers at the forefront of evaluating the health implications of non-medical interventions. This embrace of non-traditional health services provided by a health care system reached a peak in 2009, when VA Secretary Erik Shinseki established the goal of ending veteran homelessness by the end of 2015.[19] Connecticut was declared the first state to end chronic homelessness amongst veterans and the second state to have ended veteran homelessness or achieved "functional zero," which means that veteran homelessness will be "rare, brief and non-recurring" and that "no Veteran is forced to live on the street."[20]

3. *Background on the Connecticut Veterans Legal Center*

CVLC's mission is to help veterans recovering from homelessness and mental illness overcome legal barriers to housing, healthcare, and income.[21] CVLC's core program provides free legal services to low-income veterans in recovery, including legal advice, legal representation by CVLC staff, and representation by a CVLC volunteer attorney.[22] Under this program, CVLC serves veterans who are confronting a wide variety of legal issues, including family, housing, criminal record expungement, bankruptcy, consumer debt, securing Social Security and VA benefits, employment, estate planning and military discharge upgrades.[23] Since its founding, CVLC has served almost 2000 veterans with more than 2700 legal issues.[24]

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17. U.S. DEP'T OF VETERANS AFFAIRS, HUD-VASH, http://www.va.gov/homeless/hud-vash.asp.

18. U.S. DEP'T OF VETERANS AFFAIRS, GRANT AND PER DIEM PROGRAM, https://www.va.gov/homeless/gpd.asp.

19. Adam Archiable, *Eliminating Veteran Homelessness by 2015*, THE HILL (May 22, 2014), http://thehill.com/special-reports/2014-tribute-to-the-troops-may-22-2014/206874-eliminating-veteran-homelessness-by. *See also* U.S. DEP'T OF VETERANS AFFAIRS, SECRETARY SHINSESKI DETAILS PLAN TO END HOMELESSNESS FOR VETERANS, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=1807.

20. Lucy Nalpathanchil, *Gov. Malloy Says Connecticut Is Second State to End Veteran Homelessness*, WNPR (Feb. 18, 2016), http://wnpr.org/post/gov-malloy-says-connecticut-second-state-end-veteran-homelessness; ENDING HOMELESSNESS AMONG VETERANS OVERVIEW, https://www.va.gov/HOMELESS/ssvf/docs/Ending_Veterans_Homelessness_Overview.pdf.

21. CONNECTICUT VETERANS LEGAL CTR., https://ctveteranslegal.org/ (last visited Feb. 4, 2017).

22. *Id.*

23. *Id.*

24. *Id.*

CVLC started the first medical-legal partnership with the Department of Veterans Affairs in the country in the fall of 2009; this partnership was recognized with the VA's national community partnership award in 2015.[25] CVLC's attorneys work in interdisciplinary teams with VA clinicians to solve legal problems that affect veteran recovery and access to stable housing, healthcare, and income. This collaboration allows CVLC staff and volunteers to serve marginalized clients, many of whom are homeless and many of whom have serious mental illnesses including schizophrenia, bipolar and major depression. These clients often have difficulty securing transportation, recognizing and communicating their legal needs, and following up with appointments and documentation without assistance.

In addition to partnering with the Errera Center's programs, CVLC works onsite at the VA Connecticut's Newington Community Based Outpatient Clinic (CBOC) and takes referrals from the VA West Haven Hospital and the state's other CBOCs and the VA's Vet Centers.[26] CVLC also works with Columbus House (New Haven's largest homeless service provider) and WorkPlace, Inc. to serve clients under the VA's SSVF Program.[27]

4. *Background on the Unmet Legal Needs of Veterans and VA's and Community Providers' Responses to Those Needs*

Young men and women who choose to serve their country face a trifecta of serious challenges when they get home.

First, they are very likely to be mentally injured by their military service. According to a RAND study, 37% of Iraq and Afghanistan veterans who have been seen at a VA facility have been diagnosed with a mental health issue.[28]

Second, they have a hard time getting a job. According to The Institute for Veterans and Military Families at Syracuse University, in February 2013 the youngest post-9/11 veterans (aged 20-24) experienced the highest

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25. U.S. DEP'T OF VETERANS AFFAIRS, VA CONNECTICUT HEALTHCARE SYSTEM (2015), http://www.connecticut.va.gov/pressreleases/Connecticut_Veterans_Legal_Center_wins_national_VA_award.asp.

26. For more information, see CONNECTICUT VETERANS LEGAL CTR., file:///C:/Users/LAWSCLR.DS/Downloads/Connecticut%20Veterans%20Legal%20Center-Report.pdf (last visited Feb. 6, 2017).

27. *Id.*

28. Karen H. Seal et al., *Trends and Risk Factors for Mental Health Diagnoses Among Iraq and Afghanistan Veterans Using Department of Veterans Affairs Health Care, 2002–2008*, 99 AM. J. OF PUB. HEALTH 9, 9 (2008).

unemployment rate of all age groups, at 38%.[29] This joblessness rate is more than twice as high as their non-veteran counterparts.[30]

Finally, the demands of service place a substantial strain on veterans' intimate relationships. A 2011 study of recently discharged New York State veterans by the RAND Corporation reported that many marriages were in jeopardy due to veterans' mood changes (44%) and worry over the possibility of redeployment (42%).[31]

These three challenges—mental injury, unemployment, and family stress—result in an unacceptably high rate of homelessness amongst veterans. According to the Department of Housing and Urban Development (HUD), poor single veterans, female veterans, poor African-American veterans, and veterans aged 18-30 are all more than twice as likely to become homeless as similarly situated non-veterans.[32]

Homeless Veterans place legal assistance at the top of their list of unmet needs. In data from the 2015 VA-sponsored CHALENG Survey, homeless male veterans and their care providers ranked discharge upgrades (10), legal assistance to prevent eviction or foreclosure (3), addressing child support issues (5), restoring a drivers' license (4), and eliminating warrants and fines (7) as five out of ten of their highest unmet needs in a list of over 30 options.[33] Similarly, homeless female veterans and their care providers rank these five needs in the top ten unmet needs. Homeless or formerly homeless veterans rank these legal needs as less likely to be met than their needs for medical care, mental health care or food.[34] The CHALENG survey findings

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29. SYRACUSE UNIV. INST. FOR VETERANS AND MILITARY FAMILIES, http://ivmf.syracuse.edu/wp-content/uploads/2013/03/Employment-Situation-March-2013.pdf (last visited Feb. 4, 2016).

30. *Id.*

31. Carrie M. Farmer et al., *A Needs Assessment of New York State Veterans: Final Report to the New York State Health Foundation*, RAND CORP. (2011), http://www.rand.org/pubs/technical_reports/TR920.html.

32. U.S. DEP'T OF HOUS. AND URBAN DEV., VETERAN HOMELESSNESS: A SUPPLEMENTAL REPORT TO THE 2010 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS (2010), at 13, http://www.hudhre.info/documents/2010AHARVeteransReport.pdf

33. U.S. DEP'T OF VETERANS AFFAIRS, COMMUNITY HOMELESSNESS ASSESSMENT, LOCAL EDUCATION AND NETWORKING GROUPS (CHALENG) (June 2016), https://www.va.gov/HOMELESS/docs/CHALENG-2015-factsheet-FINAL-0616.pdf

34. Although not explicitly legal needs, three of the remaining items (registered sex offender housing, family reconciliation assistance, and financial guardianship) on the CHALENG survey's top ten unmet needs for male veterans are situated in legal systems and involve legal solutions. Homeless female veterans' unmet needs are similarly dominated by explicitly or implicitly legal issues including registered sex offender housing, family reconciliation assistance, credit counseling, legal assistance for child support issues,

are consistent with research that indicates that lacking money to cover basic needs is related to homelessness, criminal justice involvement and suicide amongst Iraq and Afghanistan War Era veterans.[35]

The Legal Services Corporation (LSC), a federal non-profit corporation that funds many legal services providers across the country, has recognized the importance of addressing the legal needs of veterans. Under an initiative commenced in 2010, LSC is trying to improve access to justice for low-income military veterans and military families.[36] While a growing number of LSC grantees are starting projects to serve the unique legal needs of veterans, most projects are in a start-phase and few programs handle veterans-specific matters, such as discharge upgrades or VA disability compensation and pension.

Despite demonstrated need for legal services for veterans, the VA does not provide legal assistance to veterans or any funding to community providers to address these needs. The VA's leadership has recognized the need and taken steps to support community-based service providers like CVLC. In 2011, the VA General Counsel's Office issued Directive 2011-034, which both encouraged VA facilities to provide space to legal service providers and forbid VA employees from referring veterans to legal service providers directly; even those co-located at their facilities.[37] Despite the confusion and inefficiencies this directive has caused both sides of VA medical-legal partnerships, the directive has helped VA facilities around the country welcome legal service providers on to their campuses. There are currently around 140 legal projects at VA facilities across the country.[38] These range from all-volunteer programs that meet with veterans once a month and offer advice only, to student-led programs and a small but growing group of full-fledged MLP's with dedicated paid legal staff working collaboratively with VA staff to resolve legal issues.

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preventing eviction and foreclosure, restoring a driver's license, outstanding warrants, fines, and financial guardianship. *Id.*

35. Elbogen EB, et al., *Financial Well-Being and Postdeployment Adjustment Among Iraq and Afghanistan War Veterans*, MIL. MED., June 2012, at 669–75.

36. Press Release, Legal Services Corporation, LSC Launches Initiatives to Help Veterans and Military Families (Nov. 24, 2010).

37. U.S. DEP'T OF VETERANS AFFAIRS, VHA DIRECTIVE 2011-034 (2011), file:///C:/Users/LAWSCLR.DS/Downloads/12011034.pdf.

38. See U.S. DEP'T OF VETERANS AFFAIRS, FREE LEGAL CLINICS IN VA FACILITIES (2017), https://www.va.gov/ogc/docs/LegalServices.pdf for a spreadsheet of legal services programs affiliated with VA facilities across the country.

5. Why CVLC pursued research on health outcomes

Without collaborating with professional evaluators, CVLC had some capacity to measure outcomes, but they were limited. Prior to the study, CVLC designed and implemented an outcome tracking system based on the principles of results-based accountability. CVLC's evaluation process is to track four outcomes derived directly from CVLC's mission, which is to help veterans recovering from homelessness and mental illness overcome legal barriers to housing, healthcare and income. These outcomes are tracked in a custom-programmed case-management database. At the close of every matter opened on behalf of a client, CVLC staff are required to record whether their work on behalf of a veteran: (1) improved financial status or employability; (2) improved housing stability; (3) improved access to healthcare; and/or (4) improved access to the legal system or legal advice/information. The following table summarizes the financial outcomes for veterans with a variety of CVLC case types opened by CVLC between June 1 2014 to Jan 31 2016.[39]

Legal Issue Type	**Number of Legal Issues**	**One-time Lump Sum Amount**	**Weekly or Monthly Amounts Projected for One Year**	**Total Annual Financial Improvement**
Consumer	79	$357,746	$0	$357,746
Criminal/Pardon	44	$3,080	$0	$3,080
Discharge Upgrade/Military	14	$0	$0	$0
Employment	17	$13,956	$35,880	$49,836
Estate/Probate	25	$0	$7,284	$7,284
Family	120	$57,561	$80,060	$137,621
Housing	145	$100,642	$32,496	$133,138
Other	4	$0	$0	$0
SSA/Public Benefits	55	$92,583	94,002	$186,584
Tax	28	$1,116	$0	$1,116
VA Benefits	132	$421,967	$343,122	$765,089
Total	**663**	**$1,048,650**	**$592,844**	**$1,641,494**

The cases on this table were resolved using full representation by a CVLC attorney, legal advice by a CVLC attorney, pro se assistance by a CVLC attorney and pro bono representation by a volunteer attorney. The

39. This data is based on information collected by the Author.

lump sum amounts are one-time amounts of income received or debt waived. The value of increases in income or decreases in debt that are ongoing at weekly or monthly intervals are projected over one year. This is a conservative estimate of the financial value of CVLC's work for its clients during this period of time because there are 149 cases from that period still open that will increase the financial value returned to veterans. It is also conservative because the monthly and weekly increases in income and decreases in debt are likely to impact veterans for much longer than one year. If these same numbers are projected out over ten years and added to the lump sum improvements, the total figure is $5,928,436. For comparison, CVLC spent a total of $899,912 dollars during the same time period.

Although the financial outcomes CVLC's achieves make a compelling case for the financial value of VA MLP for veterans, financial value is not the only way to measure value for veterans. From a veteran's point of view, he or she might prefer to know if CVLC's help will help them be happier, live longer or be less stressed. From a VA leader's point of view, they might like to know whether VA MLP lowers veteran health care utilization, days of hospitalization and homelessness or mental health and well-being. In pursuing a research partner, CVLC focused on this last measure of value—indicators of mental health and well-being—because veterans reported to CVLC staff and their VA healthcare partners that getting legal help relieved their stress and anxiety.

Framing the outcomes of legal aid in terms of health measures potentially broadens the interest in legal aid from the strained realm of overburdened court systems and underfunded state budgets, into the expansive terms of health care systems and the health care economy. Our country spends almost 20% of gross domestic product on health care[40] or 3.2 trillion dollars in 2015.[41] About 29% of that, or just under one-trillion dollars ($928 billion) was federal spending.[42] In contrast, Congress appropriated $375 million for legal services for the indigent in fiscal year 2015.[43] During the last decade, while legal aid funding has been in perpetual crisis, "growth in health expenditures has typically outpaced that for overall economic

40. CTRS. FOR MEDICARE AND MEDICAID SERVS., https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html (last visited Feb. 4, 2017).

41. *Id.*

42. *Id.*

43. PENN. LEGAL AID NETWORK, http://www.palegalaid.net/news/plan-e-news/federal-spending-bill-increases-funding-lsc-10-million (last visited Feb. 4, 2017).

output."[44] 84% of Americans see caring for the sick as a moral issue; more than a third have never heard of legal aid.[45]

To the extent that evidence demonstrates that legal aid improves health outcomes, legal aid providers like CVLC can seek funding from non-traditional sources, particularly health care funders. Specifically, CVLC hopes to demonstrate that VA MLP provided veterans cost-effective improvement of the same health care and well-being metrics VA uses to evaluate its own programs to make the case that legal aid for veterans should be funded as part of VA's spending on healthcare, which exceeded $68 billion in 2016.[46] Congress would only need to appropriate half of one percent (.5%) of the VA's healthcare spending to exceed federal funding of the Legal Services Corporation.

VA is well positioned to expand the work of medical-legal partnerships, which have grown out of local partnerships between individual legal service providers and individual hospitals to a national scale. Although the VA is a complex system, it has historically created many national programs by starting with a few demonstration sites and scaling them nationally, such as many of the VA's homeless programs and intensive programs for veterans with severe mental illness.

B. Study Goals and Design

The study partners collaborated on a study design proposing three goals: 1) to assess improvements in veteran mental health and quality of life resulting from reducing legal impediments to recovery; 2) to improve health care worker capacity to identify legal issues that affect veterans' quality of life and mental health; and 3) to provide empirical evidence supporting "best practices" that can be implemented and evaluated elsewhere in the VA and in other MLPs serving similar populations. The research will also describe the population of veterans getting legal help, including their demographic information, their health status and their legal needs.

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44. Aaron C. Caitlin & Cathy A. Cowan, *History of Health Spending in the United States, 1960-2013*, CMS (Nov. 19, 2015), at 4, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/NationalHealthExpendData/Downloads/Historical NHEPaper.pdf.

45. VOICES FOR CIVIL JUSTICE, https://voicesforciviljustice.org/pub/4664/expanding-civil-legal-aid-strategies-branding-communications-2/ (last visited Feb. 4, 2017).

46. U.S. DEP'T OF VETERANS AFFAIRS, OFFICE OF BUDGET (2017), https://www.va.gov/budget/products.asp.

A veteran enrolled in the study would have an electronic medical record maintained by the VA and accessible to researchers with the veteran's permission. However, the legal aid partners did not have an equally sophisticated system for tracking the legal intervention. Capturing that data required a collaborative redesign of the CVLC's administrative database to record a wealth of administrative data about the nature of the legal intervention. The research partners referred to this as measuring the "dose" of legal help. The newly designed database allowed legal aid lawyers and staff to track how much time they spent on each activity during a representation (for example on phone calls, research, writing, court appearances, etc.), the specific nature of the matter, the scope of assistance offered and provided, and allowed the client to set up to three goals for each legal issue identified so that the legal aid partners could track to what extent the client's goals were met. The study partners chose to track whether or not client goals were met after long discussions about the problem with measuring legal outcomes, which is that often an outcome that is good for a client—for example, a stipulated judgment in a housing case that avoids an eviction on record in the client's name, avoids an ongoing debt, and keeps the client housed avoiding emergency shelter—may not be a "win" in the strictest legal sense.

The study partners created two other instruments prior to implementation. One was a legal needs self-assessment which asked veterans to self-identify their civil and criminal legal histories, their current civil and criminal legal issues, and their sense of the importance or urgency of the current issues. This instrument allowed the partners to test to what extent veterans can accurately self-report legal issues compared to an attorney's assessment of their legal needs, and to compare the veteran versus the attorney's sense of the importance or urgency of the matter. The second instrument was a short test for clinicians given before and after a training on the medical-legal partnership approach to gauge their understanding of the model and willingness to participate.

The study designed included two groups of veterans referred to as Phase 1 and Phase 2. Phase 1 was all clients willing to participate. Phase 1 clients agreed to contribute their administrative and health data to be collected and used anonymously to describe the characteristics of veterans getting legal help and their legal and medical status. Phase 2 was a small subset of Phase 1, including only those veterans with a landlord-tenant, child support, student loan, or disability compensation issue or landlord-tenant issue as identified by a legal aid attorney. These issues were chosen because of their importance to veterans, the high potential impact that resolution of these issues may have on mental health and well-being, and in the case of all except VA disability, the relatively short time frame for resolving the issue.

Veterans who gave informed consent to a research assistant to enroll in Phase 2 were paid using gift cards for their time in filling out a battery of validated mental health and well-being measures. Phase 2 veterans completed the baseline assessment as close as possible to the initial legal appointment and then every three months afterwards for one year.

The enrollment processes across the two states were slightly different to accommodate the structural differences in the programs. The following chart shows how many veterans enrolled in the two phases across the two states.

	Connecticut sites	New York Sites
Phase 1 Enrollment	705	245
Phase 2 Enrollment	108	40

In Connecticut, veterans can contact CVLC through the phone, an in person visit at the office at the Errera Community Care Center, or by having a clinician refer them to CVLC. Veterans seeking assistance brought to the CVLC three forms: a signed VA release permitting their VA care team to talk with CVLC about their legal issues, a signed clinician referral form that identified what their primary health issues were, and through what program they were treated in VA, and a legal self-assessment form on which they identified their past and current legal issues. Despite the heavy paperwork burden, veterans almost universally complied with the increased documentation required by the study with only a small handful declining to provide the documentation.

After submitting these three forms, the veteran does a screening interview with a non-attorney staff member at CVLC that collects basic demographic data and legal information. All of these screenings are reviewed at a weekly triage meeting of the screening and legal staff to determine the plan for any given client. CVLC's eligibility criteria at the time of the study was income at or below 200% not including any income they get from VA and participation in some VA housing, case management, substance abuse or mental health program. At the time of the study, CVLC assisted veterans with all types of legal issues except questions of competency to manage their affairs, torts like employment discrimination, car accidents or personal injuries, or divorces. Clients meeting the eligibility criteria with a legal issue within CVLC's scope of practice were scheduled for a meeting, first with a CVLC's research assistant who got their informed consent to participate in the study, and administered a baseline assessment if they had a Phase 1 legal issue, and then with a CVLC attorney. After the initial meeting, the research assistant scheduled follow up visits to administer additional evaluations independently.

1. Challenges in Study Design

In the course of designing and conducting this study, we encountered several important questions or challenges in studying MLPs. These challenges stem from the intersections of the legal and healthcare fields. While the former is structured to achieve justice, the latter is focused on improving health, so research methodology used to study healthcare services may not be entirely applicable to studying legal services. This issue became evident as we conducted our study of MLPs.

In conducting an intervention study, one must define exactly what the intervention is and the appropriate "dose" or level of the intervention. In studying MLPs, we found there was wide variability in the MLP services veterans were receiving. Some veterans needed only a one-time legal consultation, while others needed full legal representation for an extended period of time. We collected data on the amount of time and the types of tasks MLP staff performed for veterans, but it was not clear which tasks were the critical aspects of the intervention. It was also hard to define the mechanism of action behind the MLP intervention—was it the legal services provided by the MLP lawyer? Was it really the emotional support or therapeutic effect of simply having a lawyer? Or was the information-sharing between the legal and healthcare provider the true intervention?

The challenge of defining the intervention can lead to questions about the outcomes of interest. In studying the effect of MLPs, there are various legal and health outcomes that can be measured. Researchers interested in MLPs need to conceptualize a logic model for not only what the intervention is but what the outcomes are and how might they be related. Are researchers interested in whether legal problems are resolved, or the health problems, or both? It may be that the resolution of legal problems improves health, or alternatively, the provision of legal services itself improves health. There are also various health outcomes that can be measured: is the outcome focused on reduction in symptoms, faster recovery, a cured condition? There are global health outcomes but also outcomes of specific health conditions, and researchers have to decide what to measure. With specificity comes the burden of having a theoretical framework to hypothesize the specific effects on particular health conditions.

There was also an issue of developing a timeline for the study that aligned with the MLP intervention. We chose to focus on four main legal issues—child support modification, disability compensation and pension, student debt and landlord-tenant disputes—based on considerations of the time frame for resolution and likely importance of outcomes. But even within these legal issues, the amount of time legal issues took to be resolved varied greatly between veterans. For example, one veteran's eviction case

may be resolved within three months while another takes nine months, and a VA disability claim can take over a year to resolve. This presented challenges with deciding the schedule of assessments and the length of follow-up. Ultimately, due to logistical reasons and expected attrition over time, we chose to conduct assessments every three months after baseline for a period of one-year. Future work is needed on determining the optimal assessment schedule and studies focused on one or two legal issues may be a better research design.

Finally, designing a cross-sector study required a huge amount of cross-disciplinary education between the legal and research teams and more collaboration with the service providers than is typical for research design. Understanding the nature of legal work in order for the research team to identify interesting and measurable research questions required a lot of cross-disciplinary education on the part of the legal teams. For example, the research teams were surprised by the relatively small amount of time legal aid lawyers spend arguing cases in courts in front of judges. The team spent a good deal of time talking about the different levels of service the legal teams provided (like one-time advice meetings, assistance with pro-se filings, referral to pro bono attorneys for representation and full representation) which are common to legal aid practices but not medical practices. Similarly, understanding the nature of health research in order to allocate scarce program resources to satisfy research objectives required a lot of cross-disciplinary education on the part of the research team. The teams were in weekly phone communication and daily email communication to set goals for Phase 1 and Phase 2 enrollments with the legal teams providing data on the types of legal issues for which veterans seek help, and the number of veterans the legal teams could reasonably serve given the financial constraints of the study. The research partners educated the legal providers on expected rates of follow up, statistically significant sample sizes, potential subgroups for study within the larger phases, and appropriate compensation for veteran time.

2. Lessons Learned for New VA-based Medical-legal Partnerships

At the time of writing this Article, data collection in both states is finished and data analysis is underway. The study partners have published one preliminary paper that describes the population of veterans seen across the four sites, their legal issues, the nature and amount of legal intervention they received and the impact of the MLPs on the VA's clinical staff

partnering with the legal teams.[47] While that paper does not publish statistically significant outcomes of the study, the descriptive data in that paper raises some considerations for those designing programs to serve the legal needs of veterans.

Medical-legal partnership with VA can effectively target high-need veterans without spending program resources on outreach.[48] Through partnership with VA, CVLC serves veterans who are low-income (average annual income for Connecticut is $19,620), have mental illness including PTSD (40% across all sites) and psychotic spectrum or bipolar disorder (15% across all sites), and are homeless or recovering from homelessness (Connecticut 57.3%).[49]

There is high demand for legal assistance with claims for VA disability compensation and pension; it was the most requested type of assistance across both programs at 27%.[50] VA clinicians and veteran-serving organizations often assume that the accredited non-attorney advocates (veterans service officers or VSOs) at the large congressionally chartered veterans' service agencies like the Disabled American Veteran (DAV), Veterans of Foreign Wars (VFW), and American Legion, and at state agencies like the Connecticut Department of Veterans Affairs, adequately address the needs of veterans for VA benefits assistance. The demand by study participants shows that contrary to this view, there is considerable veteran demand for help with VA claims from lawyers.

Partnership dynamics between legal aid programs and the VA can vary greatly. One of the most puzzling data points for the study partners was the greater rate of enrollment in the study of veterans seen by the MLP in Connecticut (653) versus the MLP in New York (138), despite both programs collaborating with VA programs with large patient panels and having similar numbers of clients seeking assistance. The study is not designed to measure why veterans at one MLP would be more likely to enroll in the study, but the study partners have several ideas that could provide fruitful avenues for further research into MLP best practices and are probably useful considerations for future VA MLP implementation. Keep in mind that these proposed factors are based on the partners' experience, are anecdotal, and mostly reflect the highly positive arrangement of the program in Connecticut rather than any failure or limitation of the program in New York.

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47. Tsai et. al., *supra* note 2.
48. *Id.*
49. *Id.*
50. *Id.*

First, consider the local culture of your partner VA facility when starting an MLP. VA clinicians commonly repeat the saying "if you've seen one VA, you've seen one VA." Within VA, there are big cultural differences at the state, facility, program and staff level in terms of interest and investment in innovative programs, community-based partnerships, and addressing the social determinants of health. This is not to say that the New York MLP programs were not open and receptive to MLP, but that the VA Connecticut's Errera Community Care Center's leadership and staff are off the charts in their full-throated embrace of community partnership and innovation. That culture is part of the reason why Connecticut was the first state to end chronic veteran homelessness, the second to reach functionally zero homeless veterans, and why the Errera Center was awarded the VA's National Community Partnership Award for its work with the CVLC. Legal Services providers would be wise to use their networks to identify "intraprenuers" within their local VA facilities to approach creating VA MLP.

Second, consider where and with which programs in VA a new MLP will partner with. The Connecticut Program is located in a community care center, co-located with housing, substance abuse, homeless, employment, case management, mental health, wellness, and primary care teams. There is a high level of synergistic partnership that comes from this level of co-location. The New York Bronx MLP, in contrast, was partnered and located with outpatient mental health. Referrals from other teams like HUD-VASH were made to the legal team in New York, but it is likely that rubbing elbows on a daily basis in Connecticut makes the relationships between the clinicians, veterans and lawyers stronger.[51]

Third, consider the physical and temporal availability of the legal team within the VA facility. The CVLC's small janitorial-closet-turned-office is visible from the front door of the Errera Center, from the front reception desk, and is in the primary hallway veterans use to move from the lobby to the group rooms, clinician's cubicles and, most importantly, the bathrooms. As we say only half-jokingly at CVLC, "you can't pee at the Errera Center without passing your lawyer's office first." CVLC keeps its office staffed every hour that the Errera Center is open with the exception of one morning a week when CVLC's staff meets. The combination of the central physical location and consistently open door means that veterans at the Errera Center

51. An interesting piece by former CVLC intern and Yale Law School student Mark Hanis explores the extent to which architecture influences the CVLC's MLP with VA. Mark Hanin, *The Architecture of Medical-Legal Partnerships*, 2 PAPRIKA XVI (Nov. 5, 2015), http://yalepaprika.com/the-architecture-of-medical-legal-partnerships/.

are accustomed to quick and easy access to the CVLC, which likely influenced their perception of CVLC's request for their participation in the study. In contrast, the New York Program in the Bronx is located on an upper floor of a hospital in an office behind a receptionist and was open for limited hours. While the Bronx arrangement is more common to MLPs, the enrollment figures may argue for more visibility and longer office hours.

3. *Lessons learned for VA-based Interdisciplinary Research Teams*

The study authors hope that this is the first project in the large research opportunity that VA MLP presents. For legal aid programs contemplating research projects we offer a few lessons we learned from our work together on the BMS Foundation-funded VA MLP study.

First, any legal aid program interested in studying health outcomes must partner with health researchers. CVLC's leadership approached researchers in several VA research programs and Yale departments over several years. This process helped CVLC understand how to talk about VA MLP in terms that would matter to potential research partners, what might be a viable research question, and how research funding works. It also educated a number of academic researchers in the medical-legal partnership approach so that when the opportunity to apply for a grant arose, there was a team versed enough in MLP to apply.

Legal aid programs should try to learn as much as possible from their research partners about the institutional review board (IRB) process at the facilities where they hope to conduct an evaluation. In Connecticut, there is one IRB that covered study participants at both Connecticut sites; New York had to get IRB approval at both sites independently. The ease of and timeframe for gaining IRB approval varied substantially; legal aid providers should have an understanding of these commitments in order to best allocate resources to the project.

Legal aid partners should also interrogate themselves about their ability and interest in supervising data integrity. While the New York and Connecticut legal teams had access to the same database for tracking legal data, the New York team also had to use their program's existing case management platform to manage their cases. The study design required the New York attorneys to enter case data twice into two different systems; instead they understandably asked their research assistant to cull study data from their own system to enter into the study-based system after the fact, making New York's data collection less robust. The problem of how to add additional data collection for research purposes for programs that already have lots of documentation and reporting requirements is a very central one

that will continue to cause challenges in multi-program studies. One way to avoid this problem in the future is for legal aid organizations to move towards a uniform case management platform, in the way that healthcare systems have coalesced around a few electronic health records systems out of the dozens that used to exist. Another is for programs to adopt the most flexible data management system that they can find so that it is easy to add and remove fields as needed. A third is to anticipate the burden of double data entry in budgeting. CVLC had a supervisor ensuring data integrity by reviewing attorneys' data entry; she would note empty fields during staff meetings and double check that they had been properly filled. This greatly improved the quality of CVLC's data collection. For future studies, we would recommend intermediate data production deadlines between sites to help the programs stay abreast of progress, or making one site responsible for data production and integrity with all programs reporting to one research supervisor on one of the legal aid teams. This kind of position might also be one way for the research funding, which generally will not cover the program costs, to cover the additional burden of the research on the legal aid provider without paying directly for legal services.

C. Conclusion

Participating in research was a multiple-win for CVLC's VA MLP; it provided funding, created strong professional relationships between the study partners, improved organizational standing with academic audiences, the legal aid community and VA, improved data collection tools and practices, and provided useful data for those interested in improving outcomes for high-need veterans. CVLC and its VA research partners have already sought funding for a follow-up study to build on the outcomes of this study. In particular, we hope to conduct a randomized control trial to study the causative value of the statistically significant relationships we hope to find with this study. In particular, we are interested to see whether legal assistance in evictions for veterans participating in medical-legal partnership improves housing and health outcomes compared to others facing eviction.

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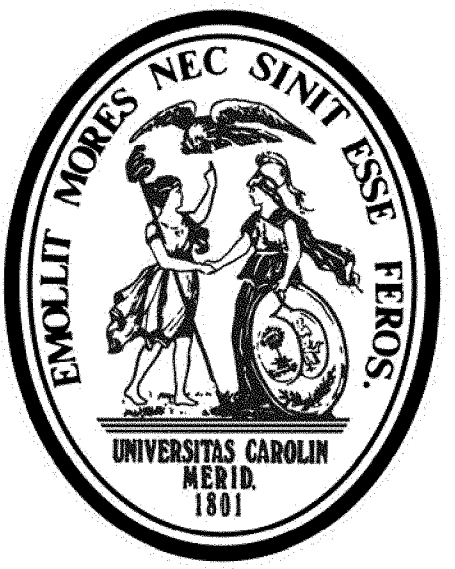

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