VIEWPOINT

Legal Aid Is Essential to Effective Social Care Integration

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Consider this case: a young woman with sickle cell disease is excited to be the first in her family to attend college. But after she graduates from high school, her Supplemental Security Income (SSI) benefits, which pay for her rent and food, are wrongfully terminated. Having experienced homelessness before, the stress of losing her home—and her college dreams—triggers a vaso-occlusive crisis and hospitalization.

Such cases highlight when the services required to promote health are legal, not medical. Here, after physicians' and social workers' efforts proved unsuccessful, a nonprofit legal aid attorney discovered SSI had sent renewal paperwork to the wrong address and secured a reinstatement of benefits. Unfortunately, such support is typically inaccessible: in 2022, 73% of low-income individuals had legal problems related to basic needs, but legal aid declined 92% of cases due to insufficient staffing.[1] Still, legal aid organizations hold the ultimate expertise in addressing health-related social needs (HRSNs) through their knowledge of policy, provision of technical support for nonlegal providers (eg, social workers), and direct client representation.

Legal aid organizations are thus natural partners for social care integration (SCI)—efforts within health care to detect and respond to HRSNs. However, amidst a proliferation of SCI interventions in response to new Centers for Medicare & Medicaid Services regulations and value-based models targeting the quality and cost outcomes associated with HRSNs, these interventions rarely include legal aid. Medical-legal partnerships exist but are small (median staffing, <1.5 attorneys), and their role within health care is not solidified. Simultaneously, SCI critiques have gained attention,[2] as common interventions, such as HRSN screening and referrals to outside agencies, have not consistently shown social or health care improvements.

We argue that these legitimate critiques and legal aid's limited role in SCI are interconnected. We delineate 3 major challenges for SCI: identifying actionable HRSNs, limited capacity among community-based organizations addressing HRSNs, and the structural roots of inequities. We describe how deeper collaborations with legal aid can help tackle each barrier, positing these organizations as essential to SCI design.

HRSN Identification

Ideal SCI processes, through either screening or social work assessments, would triage HRSNs (through specific questions that elicit needs patients may not know are intervenable) and facilitate referrals to social care providers with appropriate training and resources. However, available standardized screening tools (eg, PRAPARE) are ill-equipped to support patient-level social care. They lack tailoring to local resource landscapes and do not differentiate needs by acuity and complexity. Tailoring is needed to identify viable responses, and differentiation is needed for prioritization (especially when more severe HRSNs are associated with greater health care expenditures[3]). This leads to inconsistent use and limited efficacy of these tools.

Partnering with legal aid when developing SCI programs can address each of these concerns. Tracing social need progressions and identifying opportunities for advocacy along these pathways are integral legal aid functions. It requires up-to-date legal knowledge to discern how each potential right might be realized at different stages given how current laws and regulations are being enforced by local, state, and federal administrations. The **Table** illustrates the resulting con-

Table. Continuum of Individual-Level Social Care Delivery Services That Address Health-Related Social Needs (eg, Food and Housing Security)

Social care delivery landscape	Social services		Legal services (lawyers, students/paralegals under lawyer supervision)
	Lay (community health workers, peers, volunteers, navigators)	Skilled/professional (medical case workers, social workers, housing specialists)	
Information provision	• Walk through know-your-rights fact sheets • Provide basic information from internet searches • Provide phone numbers for government agencies	• Explain how to navigate specific benefit program bureaucracies • Provide phone numbers and information about government agencies	• Provide legal advice (identifying road maps to address social needs) • Conduct know-your-legal-rights community trainings
Informal advocacy	• Accompany client to appointments or trips to government agencies • Provide moral support at hearings or other formal meetings	• Provide assistance in calling organizations • Provide assistance in filling out applications • Coordinate paperwork such as medical letters	• Assist with filling out benefit applications affected by legal and regulatory frameworks • Draft letters referencing specific legal rights and ramifications that medical teams can provide patients for self-advocacy
Formal advocacy	• Make calls on behalf of client	• Make calls to government agencies on behalf of client • Represent client in administrative hearings (rare, but possible with specialized training)	• Represent client in negotiations in advance of hearings; obtain favorable prehearing resolutions • Represent client in court or administrative processes
Structural advocacy	• Detect trends in cases and by nonlegal community-based partners, mobilize responses • Lead class-action and impact litigation cases to achieve community-level outcomes • Consult with health care and other service clinicians seeking to advance equity-related changes to policies and priorities		

tinuum of social care delivery by acuity and complexity, distinguishing between lay, skilled/professional, and legal advocacy. For example, a patient sickened by rodent infestations may benefit from a housing specialist's informal advocacy, but if the landlord refuses to address the problem or initiates retaliatory eviction proceedings, formal legal representation would be needed. Legal aid thus designs intakes to identify and prioritize locally actionable needs and match these needs to appropriate interventions. Such approaches can be adapted to SCI contexts, and preliminary evidence is promising: a randomized trial of an SCI intervention integrating legal aid and triaging across the Table continuum found a 28% reduction in avoidable hospitalizations among adults,[4] and a retrospective cohort study among children found a 38% reduction in hospitalizations.[5]

Capacity

Most community-based social service agencies addressing HRSNs operate at capacity before receiving any referrals from health care. Platforms that identify local organizations (eg, One Degree) are rapidly expanding, but if SCI interventions only increase referrals, assistance will not increase—community organizations will simply have to turn more people away.

Legal aid's practice of expanding capacity throughout the social care continuum is critical here (via toolkits for social workers and know-your-rights handouts for navigators, for example). SCI interventions leveraging legal aid can develop targeted trainings and tools for SCI staff to address HRSNs at prelegal stages, preventing escalation in acuity and complexity. In one Los Angeles system from 2018 to 2021, for example, more than 6000 clinical staff received trainings from legal aid partners on topics specific to their service population (eg, local housing protections, pandemic-related barriers), indicating such approaches are feasible.

Structural Inequities

Health equity interventions can be conceptualized as removing injustices that act as barriers to health.[6] However, disentangling the impact of historical oppression woven into the lives of marginalized groups requires structural changes beyond health care systems or individual cases. Legal aid organizations thus use community-level trends and subject matter expertise from partners to inform broader advocacy. For example, legal aid organizations rapidly detected housing emergencies triggered by the Great Recession and COVID-19, leading to early mobilization and advocacy responses. Additional examples include impact litigation to prevent losses of affordable housing units and engaging with physicians hoping to change insurance policies related to fertility preservation during cancer treatment, with each having the ultimate goal of removing injustices that impact health.

Conclusions

As SCI expands, scalable models are yet to be proven. Headwinds related to HRSN identification, social services capacity, and structural factors will remain while demands for evidence grow. A critical opportunity to meet these challenges and realize SCI's promise lies with robust legal aid partnerships. Funding these will require both enhancing traditional resources supporting fixed-term partnerships (federal and state appropriations, community benefit dollars)[7] and replicating innovative models already funding larger, longer-term partnerships in 7 states (Medicaid §1115 waivers that support demonstration projects, Medicaid managed care contracts).[7] As social care delivery experts, legal aid organizations must be viewed as partners that can co-lead the design and implementation of SCI interventions to drive meaningful, but stubbornly elusive, population health improvements.

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