SOCIALLY VULNERABLE OLDER ADULTS & MEDICAL-LEGAL PARTNERSHIP

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The National Center for Medical-Legal Partnership leads education, research, and technical assistance efforts to help every health organization in the United States leverage legal services as a standard part of the way they respond to social needs. Our mission is to foster a system in which all health organizations can leverage these services. Over the last decade, the National Center's work has helped cultivate programs that do just that at nearly 350 hospitals and health centers across the U.S. Learn more at www.medical-legalpartnership.org.

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SOCIALLY VULNERABLE OLDER ADULTS AT-A-GLANCE

1. **7.2 MILLION (14.1 PERCENT) OF ADULTS** ages 65 and older lived in poverty in 2017.
2. **NEARLY HALF (46.5 PERCENT) OF OLDER WOMEN** have incomes below 200 percent of the supplemental poverty measure.
3. **AT LEAST 6 IN 10 OLDER BLACK AND HISPANIC ADULTS** have incomes below 200 percent of the supplemental poverty measure, compared to percent of older white adults.
4. **57 PERCENT OF OLDER ADULTS** in fair or poor health live in poverty, while 30 percent of those with excellent or very good health do.[7]
5. **50 PERCENT OF OLDER PATIENTS** using the emergency department (ED) reported feeling socially disconnected in a study at two EDs — one urban and one rural.[8]

Introduction

The population of adults over age 65 is expected to grow from 56.4 million in 2020 to 98.2 million in 2060. As the American population continues to age in the 21st century, health care, social service, community, and family resources should be deployed with person-centered goals that maximize older adults' independence and control over their priorities.

Older Americans may experience a range of complex and overlapping health care and social challenges, such as chronic disease and polypharmacy management, functional limitations, access to desired long term care options, navigation of confusing and poorly aligned insurance plans, and especially for low-income older adults, a wide range of social, economic, and environmental determinants of health.[1] Many older adults report social isolation and significant barriers to accessing the care they desire.[2] For socially vulnerable older adults,[3] particularly those living in poverty, cross-sector care management and alignment of health, social, and legal services is even more critical.

The War on Poverty, and particularly the enactment of Medicare in 1965, significantly reduced poverty among older Americans.[4] Nonetheless, the Kaiser Family Foundation estimates that 14 percent of these individuals lived in poverty in 2017. The poverty rate among older adults is higher for women, blacks and Hispanics, and people in relatively poor health.[5] Older adults with complex health care and social needs are also more likely to have low health literacy, demanding effective care coordination and supports. Challenges related to navigation of long-term care increases older adults' health and social risks, including poorly managed chronic disease, injury, homelessness, abuse and neglect, and exploitation. Social isolation, coupled with the complexity and fragmentation of the health care and social service systems, undermine person-centered care that promotes older adults' self-determination. Overburdened health and social service providers struggle to help older adults navigate systems of care, often hitting brick walls due to convoluted regulatory and insurance requirements and complex government agency rules.

Supporting older adults to achieve their desired goals through autonomous decision-making may also involve ethically challenging relationships with family members and other caregivers. As described in this report, addressing the multiple and complex legal issues experienced by older adults can help to streamline access to appropriate services, support autonomous decision-making, and maintain dignity and quality of life. Yet, many older adults, especially those living in poverty, experience significant barriers to accessing legal assistance.[6]

Addressing the multiple and complex legal issues experienced by older adults can help to streamline access to appropriate services, support autonomous decision-making, and maintain dignity and quality of life.

Because medical-legal partnerships (MLPs) incorporate legal services and expertise into holistic health teams, they provide a unique opportunity to identify older adults with complex unmet social and legal needs and to assist them in fulfilling their values and goals. In a medical-legal partnership, lawyers become an important part of the health care team, taking referrals and providing consultations just like any other specialist. Health care and legal professionals identify health-harming social problems, and together, they establish protocols and interventions at the health care site to facilitate housing stability and safety, appropriate long term care services, access to community-based social supports, advance care and financial planning, and prevention of abuse, neglect and exploitation. MLP is a highly flexible intervention that can be adapted to meet the needs of a specific population and setting. While MLPs are adaptable and customizable, these partnerships typically have eight core elements in common.[9] Most partnerships:

1. **HAVE A "LAWYER IN RESIDENCE"** who works on-site at the health care organization;
2. **HAVE A FORMAL AGREEMENT** between the participating health and legal organizations outlining responsibilities and services;
3. **DEFINE A TARGET POPULATION** to receive services;
4. **SCREEN PATIENTS FOR HEALTH-HARMING LEGAL NEEDS** to find those patients who might not otherwise have their health-harming legal needs identified or addressed;
5. **HAVE DEDICATED LEGAL STAFFING** to provide MLP services at the health care organization;
6. **TRAIN HEALTH CARE PROVIDERS ON COMMON SOCIAL DETERMINANTS OF HEALTH** and how legal expertise and services can help mitigate the negative impact of social determinants on health and health care;
7. **SHARE INFORMATION** about patients between health and legal staff to solve health-harming legal problems or address social determinants; and
8. **DESIGNATE FINANCIAL RESOURCES** to support medical-legal partnership activities.

Few MLPs currently focus specifically on older adults. Nonetheless, roughly one third of MLPs report that they serve at least some older adults.[10] Given the unique barriers many older adults face in accessing legal assistance and the fundamental role that legal support plays in fostering autonomous decision-making, protecting health and safety, and facilitating access to health care and other health-promoting services and programs, MLPs are poised to have a significant impact in improving quality of life for this population.

This report starts by presenting the complex health care and social services landscape for older Americans and some of the challenges older adults face in accessing these services. It then outlines some of the unique legal issues and barriers that are more pronounced for low-income and socially vulnerable older adults. Finally, it discusses the benefits of MLP services for this population and highlights three MLP models, each supporting the health, well-being, and empowerment of older adults through a different approach.

Understanding the Health Care and Social Services Landscape for Older Adults

Coordinating Health, Social, and Legal Care to Maximize Independence

More than 40 percent of all Medicare beneficiaries have multiple chronic conditions.[11] Many older individuals experience care that is fragmented, uncoordinated and that leads to unnecessary hospitalizations, adverse drug interactions, conflicting and confusing medical advice, and higher costs.[12] The complex health and health care needs of older adults coupled with social determinants of health–including social isolation, low health literacy, functional limitations, poor access to transportation, food insecurity and low-income–increase the need for effective partnerships across and among the health care, social service, and legal sectors.

Effective care coordination also engages older adults and their caregivers in collaborative goal setting to maximize the older person's independent decision-making, participation in the community, and dignity.[13] Designing a collaborative care plan that is responsive to an older adult's health care, social, and legal needs can allow her to stay in her own home and community as well as reduce unnecessary and costly care, including institutionalization.

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Dual Eligibles

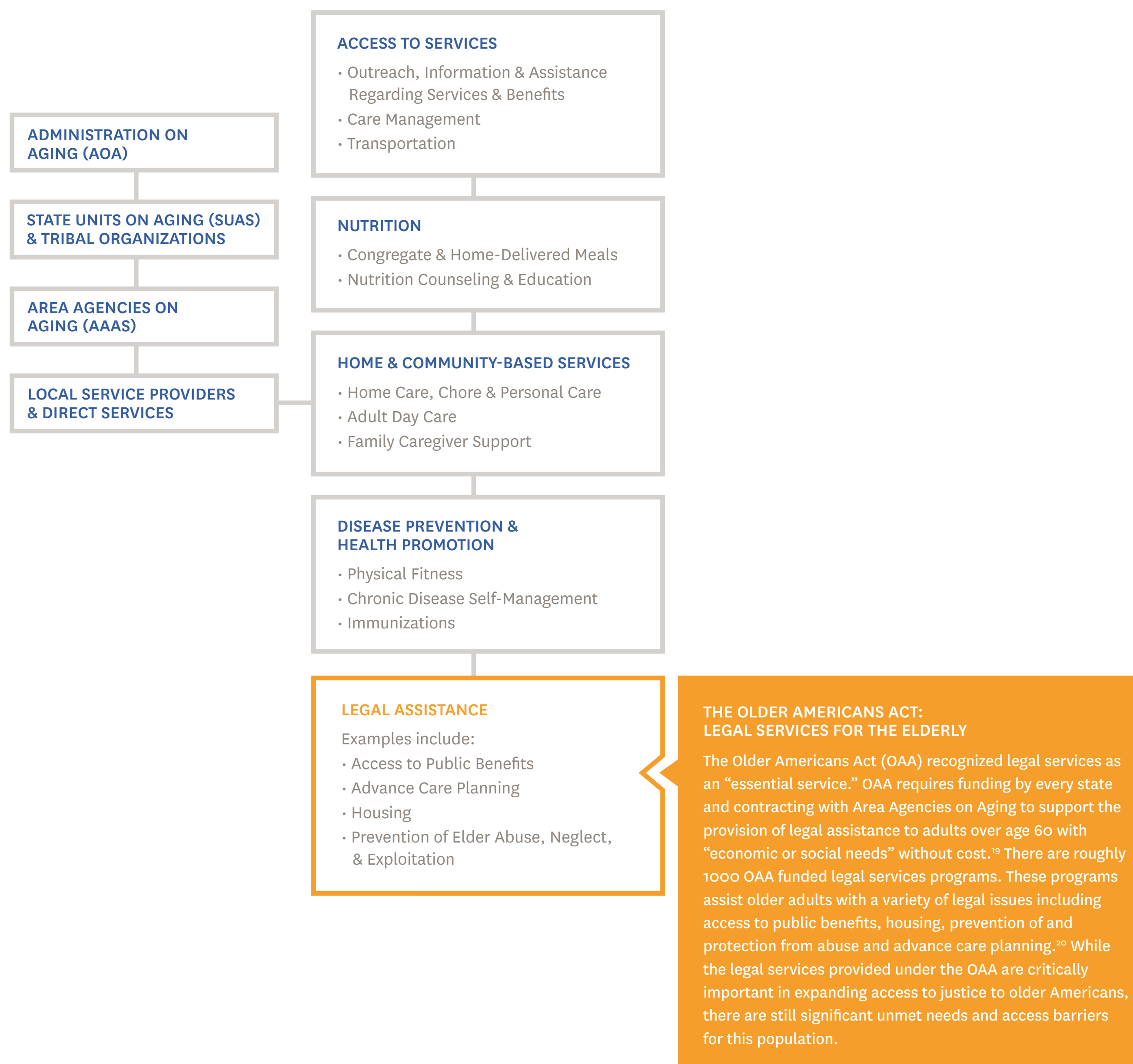
Low-income older adults and those with disabilities tend to be the most socially vulnerable; therefore, effective care planning is crucial. Termed "dual eligibles" because they are eligible for both Medicare and Medicaid, people over 65 who qualify based on age for Medicare and based on income and/or disability for Medicaid, not only have more complex health care and social needs, they also interact with a number of complex and often disconnected programs to receive care. For example, a dual eligible older adult requiring a custom wheelchair may experience significant barriers in obtaining it because the Medicare and Medicaid rules do not align around coverage of durable medical equipment.

In an effort to respond to the disconnect between Medicare and Medicaid, the Affordable Care Act created a new office within the Department of Health and Human Services, the Medicare-Medicaid Coordination Office (MMCO), to explicitly focus on improving integration and alignment between the programs to deliver coordinated care and reduce costs. MMCO is supporting states to implement delivery system reforms to better integrate care, avoid cost shifting and develop models that address regulatory conflicts between the two programs.[14] Thirteen states are working with MMCO to develop new models of integrated care.[15] While this is a positive development, in most states, there remain significant challenges in obtaining and navigating services for dual eligibles. State and federal rules are often administered inconsistently, leaving many older adults and their families to fend for themselves.[16]

The Older Americans Act (OAA)

Along with establishment of Medicare and Medicaid, the Older Americans Act (OAA) was passed as part of President Lyndon Johnson's Great Society reforms in 1965. It was the first federal effort to provide comprehensive services to older adults. The OAA established the federal Administration on Aging, which distributes grants to state and area agencies on aging to provide social and nutrition services.[17] OAA is the most common vehicle through which older adults access services, including "information and referral, congregate and home-delivered meals, health and wellness programs, in-home care, transportation, elder abuse prevention, caregiver support and adult day care."[18]

The Aging Network



THE OLDER AMERICANS ACT: LEGAL SERVICES FOR THE ELDERLY

The Older Americans Act (OAA) recognized legal services as an "essential service." OAA requires funding by every state and contracting with Area Agencies on Aging to support the provision of legal assistance to adults over age 60 with "economic or social needs" without cost.[19] There are roughly 1000 OAA funded legal services programs. These programs assist older adults with a variety of legal issues including access to public benefits, housing, prevention of and protection from abuse and advance care planning.[20] While the legal services provided under the OAA are critically important in expanding access to justice to older Americans, there are still significant unmet needs and access barriers for this population.

Source: Adapted from Congressional Research Service. Older Americans Act: Overview and Funding. November 18, 2018. Available at https://fas.org/sgp/crs/misc/R43414.pdf

What We Know About Caregivers in the United States

According to the Family Caregiver Alliance at the National Center on Caregiving:

THE "TYPICAL" U.S. CAREGIVER IS A 46-YEAR-OLD WOMAN

who works outside the home and spends more than 20 hours per week providing unpaid care to her mother.

CAREGIVERS ARE MOSTLY EMPLOYED.

60% of caregivers age 50-64 years-old work full or part-time.

ETHNIC MINORITIES PROVIDE MORE CARE

and report worse physical health than white counterparts.

CAREGIVERS OFTEN HAVE REDUCED INCOME AMIDST RISING CAREGIVING COSTS.

In addition to loss of the care recipient's income, if a caregiver reduces their hours or leaves their job, they have less income and face the loss of employer-based medical benefits, shrinking of savings, and a threat to their retirement income due to fewer contributions.

THEY ARE OFTEN ILL-PREPARED FOR THEIR ROLE AND PROVIDE CARE WITH LITTLE OR NO SUPPORT.

1/3 of caregivers continue to provide intense care to others while suffering from poor health themselves.

Long Term Services and Supports (LTSS)

Eligible older adults with chronic disease or disability may receive Long Term Services and Supports (LTSS)–clinical and social services–to support them in their daily living. Medicaid is the primary payer for these services. LTSS may be delivered through institutional settings (including nursing homes) as well as at home.[21] Service needs are determined by assessment of the older adult's ability to perform and manage daily self-care and household tasks. Access to and coordination of LTSS can enable older adults to stay in their homes and communities.

It is estimated that half of all Americans will need LTSS at some point in their lives after reaching age 65. For women, individuals with low-income and/or in poor or fair health, the needs are even greater.[22] One study found that those with income in the bottom quartile were overrepresented "across all levels of assistance, particularly among those receiving help with 3 or more self-care or mobility activities."[23]

Protecting the right of older adults to make decisions about long term care is critical, yet it is not uncommon for individuals to be discharged from the hospital to a nursing care facility, with little information about their options or the quality of the facility.[24] Individuals who are placed in a nursing home or other long term care facility or their family members, have the right to file complaints with the Long Term Care Ombudsman Program. The program operates in all fifty states; each state has an Office of the State LTC Ombudsman, headed by a full-time State LTC Ombudsman. In 2016, the five most common complaints received by the LTC Ombudsman program were:

- Improper eviction or inadequate discharge/planning;
- Incorrect administration and organization of medications;
- Poor quality, quantity, variation, and choice of food;
- Lack of respect for residents, poor staff attitudes; and
- Building or equipment in disrepair or hazardous.[25]

Through a number of different mechanisms (e.g., Medicaid waivers, state plan amendments, and the Community First Choice program[26]), states have the option to cover home and community-based services (HCBS) as an alternative to nursing home care. Ideally, LTSS should be well coordinated with community resources such as housing and transportation and with health care services. New standards from the Centers for Medicare and Medicaid Services require that providers and organizations provide "full access to individuals receiving Medicaid HCBS to the greater community," and that recipients maintain the ability to make decisions about the services that they receive.[27]

Family Caregivers

Older adults and their families bear the costs associated with health and social care systems that are not well integrated or comprehensive. Roughly 17 million Americans provide care to an older adult living at home based on health, mental health or reduced capacity; nearly half of these are caring for a high-need older adult.[29] In addition to providing direct care, family caregivers are often charged with navigating the complex systems of medical care and LTSS on behalf of the older adult. For low-income families with fewer financial resources, the challenges and stress of managing care and navigating services can be enormous and have substantial financial repercussions.

Title III-E of the OAA, the National Family Caregiver Support Program, provides funding to state and local programs to assist caregivers, including counseling, training, respite care, and supplemental services to support those provided by the caregiver.[30] In 2018, Congress passed the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act requiring the Secretary of Health and Human Services to develop, maintain, and update a strategy to recognize and support family caregivers. An advisory committee of stakeholders, including older adults, family caregivers, health care and LTSS providers, employers and government agency officials will make recommendations on issues such as promoting greater adoption of person- and family-centered care, service planning, education, referral and care coordination, respite options and financial security and workplace issues.[31]

Meeting Older Adults' Basic Needs

MEDICARE AND MEDICAID

Adults over the age of 65 are eligible (regardless of income or health status) for Medicare, a federal insurance program that covers certain medical expenses. Medicare has four parts. Parts A & B (traditional Medicare) cover many inpatient and outpatient services. To be covered, services must be considered medically necessary. Part D covers prescription drugs through private plans. Part C known at "Medicare Advantage" is a delivery system option that allows individuals to have their care managed through private plans. Because Medicare does not cover all medical expenses, most beneficiaries have supplemental coverage. Medicaid is critically important for low-income adults because it covers the gaps in Medicare coverage as well as Medicare premiums and co-pays. Medicaid also funds more than half of all long-term care expenses, which are not covered by Medicare.

INCOME SUPPORTS

The primary income support for older adults is Social Security. Without Social Security, roughly 40 percent of older Americans would have an income below the federal poverty level. Nonetheless, Social Security benefits are quite modest, averaging $1361 per month or about $16,000 per year in January 2018[32]. Many older adults without other income rely on Supplemental Security Income (SSI). SSI is dependent on other income and the monthly benefit only averages about $430.[33] Maintaining access to income supports is vital to ensure that low-income older adults can meet their basic needs.

ELDERLY NUTRITION PROGRAM

Food insecurity is a critical social determinant of health for older adults. Food insecurity can lead to or exacerbate poor health, especially chronic disease. There are a number nutritional assistance programs geared toward older adults. Yet, like other social service and government assistance programs, they can be difficult for some older adults to access.

The Administration on Aging (AoA) provides grants and support to state, county and community meal services, including home-delivered and congregate meals through senior centers, faith-based centers and area schools.

- **Meals on Wheels:** Meals on Wheels is the oldest and largest food assistance program for older adults, with over 5,000 programs across the U.S., delivering more than 1 million meals per day.[34] Older Americans Act funds support roughly one third of the costs, with state, local, and philanthropic funds supporting the rest.[35]
- **SNAP:** The Supplemental Nutrition Assistance Program (SNAP) helps low-income Americans pay for food. About 10 percent of SNAP recipients are age 60 or older. Older adults are the least likely demographic to take advantage of SNAP:[36] less than half of older adults eligible for SNAP participate.[37] Helping older adults to access SNAP may require knowledge of the particular eligibility rules that apply to them. For example, many older adults are not aware of the special rules that apply to older adults, including the SNAP Excess Medical Expenses Deduction which allows individuals over the age of 60 to deduct medical expenses over $35 per month in order to qualify for SNAP benefits.[38]

HOUSING

The Department of Housing and Urban Development administers low-income housing programs, some of which focus on older adults. Specifically, Section 202 provides funding to non-profit organizations for supportive housing for adults age 62 or older. Residents of Section 202 housing also have access to wrap-around services that help them to age in place. In 2015, the average Section 202 resident's annual income was slightly over $13,000. In addition to Section 202 housing, low-income older adults are eligible for rental assistance programs, such as Section 8 or public housing, which base rent on household income.[39] In 2016, roughly 16 percent of public housing residents and 10 percent of Section 8 residents were over age 62.[40]

The Justice Gap: The Unmet Civil Legal Needs of Older Adults

According to a 2017 study by the Legal Services Corporation,[41] low-income adults of all ages struggle to access civil legal services to meet a range of basic needs.

56% PERCENT of low-income older adult households experienced a civil legal problem in the past year.

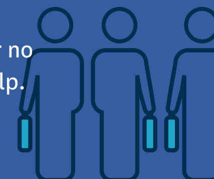
10% EXPERIENCED 6+ PROBLEMS.

The **MOST COMMON PROBLEMS** reported in these households were related to:

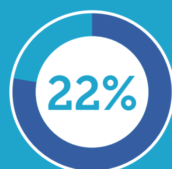
- **33% HEALTH**
- **23% CONSUMER & FINANCE**
- **13% INCOME MAINTENANCE**
- **12% WILLS & ESTATES**

LOW-INCOME OLDER ADULTS only seek professional legal help for **19% OF THEIR CIVIL LEGAL PROBLEMS.**

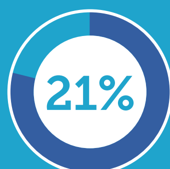
87% OF PROBLEMS receive inadequate or no professional legal help.



THE TOP REASONS THIS POPULATION GIVES FOR NOT SEEKING LEGAL HELP ARE:

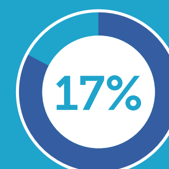


Not knowing where to look or what resources were available



Deciding to deal with the problem on their own

Not having time



Not being sure if it is a legal issue

The lack of access to legal assistance evident in the data above can implicate a range of basic needs detailed below, including housing, access to income, food and health care, and safety. For older adults, the inability to exercise legal rights can undermine autonomy and self-determination. Despite the designated funding for legal assistance under the Older Adults Act, many low-income adults go without help. As the Legal Services Corporation study highlights, many older adults experience barriers to accessing civil legal assistance, some of which — like being unsure if their problem is a legal one or being unsure how to access resources — can be mitigated by the integration of legal assistance into health care teams. When health care teams understand the critical role that social determinants play in health and partner with lawyers, they can help older adults to not only determine if they have a legal problem, but accelerate assistance before the problem becomes a crisis.[41]

Legal Issues Affecting Older Adults

In addition to experiencing the same types of legal issues faced by younger adults, there are some legal issues that are more pronounced for older adults and that may involve a different approach to legal advocacy. Some of these are described below.

ABUSE AND EXPLOITATION

The Older Americans Act defines elder abuse as “the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.”[42] Elder abuse includes physical, psychological, and sexual abuse as well as neglect and financial exploitation, which is the most common form of abuse. There may be both civil and criminal remedies available to older adults who experience abuse. The perpetrator is most often a family member, complicating legal advocacy, particularly if the person experiencing abuse perceives that she or he is dependent upon the abuser.

DIMINISHED CAPACITY AND SUPPORTED DECISION-MAKING

All adults should be presumed to have capacity to make decisions on their own behalf. “[A]ge itself does not imply diminished capacity or greater ‘permission’ to be protective or paternalistic.”[43] An objective assessment of capacity is required before any limits are placed on an individual’s right to self-determination. Capacity assessments should carefully assess specific functional abilities relevant to legal capacities, not provide a blanket determination than an individual can no longer make decisions. While there are many tools to support decision-making,[44] lawyers and courts are increasingly encouraging supported decision-making as an alternative to guardianship. Supported decision-making allows individuals with diminished capacity to select a trusted person to support them in making their own decisions and in exercising their legal capacity by providing relevant information and helping to communicate decisions to others, such as health care providers.[45]

ADVANCE CARE PLANNING

While all adults should engage in advance care planning, it is vitally important for older adults, particularly those nearing the end of life. Frequently, older adults end up in the hospital without advance care planning, leaving health care providers with little or no information about the patient’s care goals or wishes. For older adults with diminished capacity, advance care planning presents unique challenges and demands thoughtful advocacy and assistance. For non-English speaking adults or those with low literacy, ensuring access to appropriate planning resources and assistance is necessary to ensure that wishes are met.[46]

HOUSING AND ENERGY ACCESS

Many low-income adults and families struggle with finding and sustaining safe, affordable housing and energy access. For low-income older adults, lack of access to appropriate, safe and affordable housing may mean the difference between aging in place, moving to a nursing home, or homelessness. Sometimes failure to pay rent or make utility payments is the result of diminishing capacity or health, leaving the older adult vulnerable to eviction or utility shut off. Some states have age-related and disability protections from utility shut-off. Helping low-income older adults to access financial supports (such as the Low-Income Home Energy Assistance Program), can protect them from health-harming conditions and/or homelessness. Supporting older adults to maintain safe, appropriate housing helps to preserve dignity and self-sufficiency.

LONG TERM CARE

Accessing and navigating long term care options–both in congregate settings (e.g. nursing homes, assisted living facilities) and in-home with community-based services — is one of the most important aspects of legal assistance for older adults. Deciding when an older adult is no longer able to live at home is fraught, often subjective, and can have serious legal implications. It may also invoke disagreements between an individual and a hospital or other health care provider and/or between the elder and caregivers, both informal and professional. A whole host of issues are implicated in long-term care planning. These issues exist on both ends of the spectrum–getting into an appropriate long-term care facility, when desired, and getting out of one, when desired. For example, a person with dementia, who is no longer able to live at home can experience a range of barriers to accessing a setting with appropriate services, while an older adult who wishes to return home after a short stay in a residential facility may need assistance to ensure that appropriate community based services are in place. Medicaid generally covers nursing home care and is less likely to cover community-based care (though, as noted earlier, some states are moving in this direction through state waivers). Because of the complexity of Medicaid and Medicare rules, legal assistance is necessary to fulfill the older adult’s desired course of action or to support a family caregiver in navigating options, when appropriate.

IMMIGRATION STATUS

Immigration status plays an important role in access to care as well as care management for older adults. Older adults who have come to the U.S. later in life may find significant barriers in accessing Medicare or Social Security income if they have no work history or are undocumented. Documented older adults may be cared for by an undocumented son or daughter, who may not wish to engage with systems of care for fear or deportation. The Trump Administration’s proposed changes to “public charge” rules,[47] including counting receipt of Medicaid, Medicare Part D premium and cost sharing subsidies, housing assistance and SNAP,[48] as potential grounds to deny entry into the U.S. or adjustment to legal permanent resident status, also threaten the well-being of older immigrants, if enacted.

Health-Related Legal Needs of Socially Vulnerable Older Adults

Older adults' legal needs directly touch on their health and well-being. The table below provides examples of select health indicators and associated legal interventions. Legal advocacy not only helps to improve access to services and preserve autonomous decision-making, it also supports, health, safety, and the ability of an older adult to age in place.

SELECT HEALTH INDICATORS	ASSOCIATED LEGAL INTERVENTIONS
Risk of falls	• Housing advocacy • Counseling and advocacy for long term care supports
Asthma	• Housing advocacy (e.g. mold mitigation for asthma, eviction prevention) • Utilities advocacy
Mild cognitive impairment, dementia, functional limitations, frailty	• Decisional capacity assessment • Advance care planning • Appointment of legally-recognized financial caregiver • Counseling and advocacy for long term care supports • Guardianship prevention/alternatives
Caregiver burden	• Counseling and advocacy for long term care supports • Elder abuse risk assessment • Employment advocacy (leave/flex time) • Income/economic security assessment and advocacy • Immigration status/stability
Elder abuse & exploitation	Legal interventions are highly situation-dependent: • Removal of perpetrator as legal agent or guardian • Guardianship or supported decision-making • Restraining orders • Asset recovery • Public benefits advocacy • Consumer protection advocacy • Mediation • Civil litigation

Source: Adapted from Hooper S, Teitelbaum JB. A Missing Competency: Integrating Legal Advocacy into Care for Complex Older Adults (unpublished manuscript currently under development, on file with the authors).

Two Unique Considerations in Legal Advocacy for Older Adults

ACCESS BARRIERS

Many older adults are unaware that the problems they experience may have a legal remedy or that they are legal problems at all. Those who know they have a legal problem may not know how or where to access assistance. In addition, older adults may have difficulty accessing legal assistance due to a lack of transportation, gatekeeper caregivers who do not support seeking legal help, physical disabilities or mobility issues, cognitive impairment, or not having a phone or not using technology (common modes of communication for appointments). Ensuring access to legal services for older adults means identifying these barriers, meeting clients where they are, and providing legal help as part of health and/or social services.

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ETHICAL ISSUES

Because many older adults depend on caregivers, negotiating independent decision-making is complex. Advocacy should focus on empowering the individual and enabling caregivers to support the older adult's decisions. In the realm of health care decision-making, two-thirds of older adults with disabilities receive assistance from a family caregiver in managing their care.[49] Health care providers must carefully manage respect for patient autonomy, while recognizing the importance of the family caregiver role. In the realm of legal assistance, lawyers also confront complex questions of client autonomy and decision-making. Lawyers need to be especially sensitive to and skilled at managing the "four C's": client identification, conflicts of interest, confidentiality, and competency in order to protect the older adult's interests and preserve autonomous decision-making to the full extent possible.[50] Lawyers assisting older adults with issues that may implicate family members, such as advance care planning, abuse and exploitation, must clearly answer the question: "who is the client" before moving forward with legal advocacy.[51]

The Need for Coordination of Health Care, Legal, and Social Services

Given the unique challenges faced by older adults and their families in accessing appropriate care and services, combined with the enormous complexity of the systems they encounter, integrated models of service delivery are crucial. When it comes to navigating the health care and social needs of older adults, legal barriers are often front and center. Because of the often siloed nature of legal assistance and the unique barriers faced by older adults in accessing help, integration of legal services into health and human services accelerates more effective and comprehensive problem-solving. Specific examples of where integrated medical-legal partnership services can improve care and well-being are detailed below.

Advance Care Planning

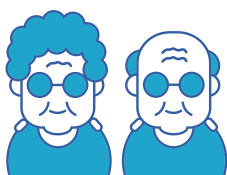
Person-centered advance care planning (ACP) protects an older person's right to self-determination and respects his or her desires and values. Yet, studies suggest that only about a quarter to a third of adults have an advance care directive and minorities and those with less education are even less likely to have one.[52] The legal approach to ACP has traditionally been viewed as transactional–the drafting of documents that represent the wishes of the client. However, more recently the focus has shifted toward supporting a thoughtful planning process which assists a person to articulate and communicate their goals and values to their loved ones and health care providers. But communication among interested parties in ACP and the development of advance directives is frequently lacking. For example, a lawyer may draft an advance directive in a law office and the document may never be shared with the patient's health care provider, or the document is placed in a file that is inaccessible when it is most needed. A patient may appoint a health care proxy and never have a conversation with the appointed surrogate decision-maker about his or her wishes. The medical and legal professions rarely coordinate their efforts to advise patients and clients about advance care planning. At best, this creates inefficiency in the system; at worst it leads to patients not receiving the care they expressly want.

Under the Patient Self-Determination Act of 1990, health care institutions are required to provide information to patients about their health care decision-making rights.[53] Additionally, changes to federal rules now allow health care providers to bill Medicare for advance care planning conversations.[54] Decision-making tools that focus on helping individuals to discuss their values and goals with loved ones help to support a process that is less focused on document drafting and more on communication of wishes.[55] Coordination and better communication between lawyers and health care providers is important in providing consistent advice and support for individuals based on respecting and best documenting wishes. Because low-income patients are less likely to have an advanced directive,[56] providing legal support for advance planning within a trusted health care setting can facilitate the process.

Financial Planning

While health care institutions are increasingly attentive to assisting with development of health care directives, most providers do not have the expertise (or time) to assist patients and their families with financial planning, which often plays a key role in access to care as well as long-term care decision making. For example, an older adult may need assistance in figuring out how to pay for out-of-pocket health care expenses not covered by Medicare or how to

navigate eligibility for Medicaid for a spouse. For low-income older adults, financial planning is just as important as for those with more resources, as it more likely involves navigation of a range of public programs and has important implications for self-determination. A more holistic approach to ACP that includes both support for health care and financial decision-making can alleviate barriers to care. Legal professionals are natural allies for health care providers in this more comprehensive approach to planning.



Abuse and Exploitation Prevention and Intervention

One in ten older adults experiences some kind of abuse, such as physical, psychological, sexual, and financial abuse, and neglect.[57] Health care providers are often on the front line in identifying elder abuse. Recently, more attention has focused on the role of health care providers in screening for elder abuse and in connecting patients to services and supports. For example, the National Co-Laboratory to Address Elder Mistreatment, funded by the John A. Hartford Foundation, is convening national experts in four states to develop, test, and evaluate a model intervention for older adult victims of mistreatment in hospitals, including emergency rooms. The intervention will assess for mistreatment and provide appropriate treatment and referral.[58] As more health care providers routinely screen for elder abuse, having access to legal supports will be increasingly important to help patients navigate their options.

As mandatory reporters of elder abuse and neglect, health care providers also engage with Adult Protective Services (APS) and other government agencies. Supporting an older adult in navigating protective services often involves a whole host of issues including income maintenance, housing, and addressing issues of financial exploitation in order to preserve independence and autonomy. For example, an older adult should not be forced to move out of his or her home in order to escape mistreatment. Collaboration between health care and legal professionals can support older adults through the APS process, ensuring that their rights are protected while promoting autonomy and safety.

Poverty-Related Social Determinants of Health

Low-income older adults face many poverty-related social determinants of health (e.g. access to government assistance programs, housing instability and safety, energy access, immigration status, and/or isolation). While the Older Americans Act requires agencies to target legal services to older adults with social and economic needs, funding has not kept pace with the need, especially as the population of adults over age 60 grows.[59] There is also enormous variation across states in how the OAA's targeting mandate is interpreted. Therefore, services are typically directed to the most acute needs, such as eviction or unnecessary nursing home placement, rather than directed toward prevention and upstream problem-solving to avoid crisis. Integrating legal experts into health care teams promotes upstream problem-solving, helping to avert crisis.

Medical-Legal Partnership in Practice for Socially Vulnerable Older Adults

While older adults make up about a third of adults served by medical-legal partnerships (MLPs) nationally,[60] relatively few MLPs, to date, have focused specifically on this population. The MLPs that do focus on older adults demonstrate the value of a holistic approach to problem-solving and assistance. This section outlines three medical-legal partnership models serving older adults.

Location	Health Care Org / Legal Partner	Years in Operation	Description
SAN FRANCISCO CALIFORNIA	**HEALTH CARE ORG** UCSF **LEGAL PARTNER** UC Hastings College of Law	**YEARS IN OPERATION** 6	Law School Clinic provides training and consults to health care partners and holistic legal assistance to low-income older patients
BOSTON MASSACHUSETTS	**HEALTH CARE ORG** Boston Medical Center, Elders Living at Home Program **LEGAL PARTNER** MLPB	**YEARS IN OPERATION** 5	Legal expertise is embedded within "extreme case management" team serving older adults at risk for homelessness with the primary goal of preserving their current housing in the community. The project also supports homeless or housing unstable older adults to access healthy housing. Includes lay advocate capacity building through integration within standing interdisciplinary Case Review meetings and rapid response consults. Also facilitates direct legal representation in a subset of cases.
GAINESVILLE FLORIDA	**HEALTH CARE ORG** UF Shands Hospital **LEGAL PARTNER** Three Rivers Legal Services	**YEARS IN OPERATION** 1	MLP includes training for social workers, discharge planners and other hospital staff, as well as, pro bono legal assistance for older adults, with a strong emphasis on facilitating appropriate long term care options.

MEDICAL-LEGAL PARTNERSHIP FOR SENIORS, SAN FRANCISCO

Medical-Legal Partnership for Seniors (MLPS) is a partnership of the University of California Hastings College of Law (UC Hastings) and the University of California San Francisco (UCSF). Housed at UC Hastings College of Law, MLPS educates eight law students per semester in the MLP approach to providing holistic legal services aimed at improving the health and well-being of older adults. The UC Hasting legal team (faculty and students) train a range of partnering health care providers (geriatricians, palliative care teams, primary care teams, social workers, and discharge planners) at several sites including, UCSF Center for Geriatric Care, UCSF Care at Home, the PACE program at the Institute on Aging, San Francisco Health Network clinics, and the San Francisco VA Geriatric and Palliative Care clinics, to understand and identify the legal needs of older adults. They also consult with health care providers and social workers on patients' legal needs and accept referrals for legal assistance for individual patients as needed.

Recognizing the particular challenges inherent in reaching socially vulnerable older adults–such as isolation, functional limitations, or poor access to transportation–the team meet with clients in UCSF geriatric clinics, hospitals, long-term care facilities or through home visits, in which they use a "mobile legal office." Because older adults are often solicited and exploited, they are

MLPS Planning and Financial Stability Outcomes

JANUARY 2015 – DECEMBER 31, 2018

Among 667 patient referrals from 64 referring providers, MLPS helped secure:

556
ADVANCE PLANNING DOCUMENTS
(219 Advanced Health Care Directives, 227 Durable Power of Attorneys, 101 Wills, 9 Trusts)

$206,803
IN TOTAL CASH FINANCIAL BENEFITS FOR MLPS CLIENTS, INCLUDING:

- $12,327 in new (or restored) monthly income, representing an average income increase of 134 percent (range 7.3 – 909 percent for 21 clients)
- $26,818 in retroactive or 1 time public benefits
- $73,900 in waived debt
- $29,314 in negotiated owner move-in eviction payments
- $5,462 of Medi-Cal/In Home Supportive Services (IHSS) Share of Cost eliminated
- $58,000 in restored assets in financial abuse advocacy
- $982 in monthly rent increases prevented

32 **NEW OR RESTORED PUBLIC BENEFITS**
(Medi-Cal, VA, IHSS, etc., including +345 IHSS hours)

2 **PROBATE COURT CONSERVATORSHIPS**

1 **PROBATE COURT PROPERTY TRANSFER**

6 **PREVENTED EVICTIONS**

3 **GREEN CARD APPLICATIONS AND FEE WAIVERS**

1 **DEFENSE OF DEBT COLLECTION LAWSUIT**
Investigation into student loan discharge due to predatory lending practices

6
Average number of meetings with each fully-represented client

4.6 hours
Average advocate face-time with each fully-represented client

"Older adults bring an array of needs to their medical appointments because doctor's appointments are the only kind they get help paying for. The MLP has given me confidence as a health care provider to identify and help attend to financial, housing, and legal needs of my patients–all of which impact their health."

Dr. Anne Fabiny
PROFESSOR OF MEDICINE, ASSOCIATE CHIEF OF STAFF FOR GERIATRICS, PALLIATIVE & EXTENDED CARE SERVICE, SAN FRANCISCO VA MEDICAL CENTER

often wary of lawyers. The health care provider is a "bridge of trust" as a trusted caregiver. When possible, visits include the law student, faculty, medical provider, and social worker. At the UCSF Center for Geriatric Care, law students participate in multidisciplinary case rounds with pharmacy, nursing, and medical students, and residents.

Because a capacity assessment is often necessary to moving forward with planning and action, the partnership between the health care and legal teams facilitates a timely and efficient process for capacity assessments for patients who may need additional support in decision-making, or whose family members may need to step in to help make decisions. Further upstream, MLPS integrates comprehensive advance care planning into geriatric primary care to help patients plan for future incapacity. As medical advance care planning moves more into the health care realm, support from the legal team around financial planning can be critical to comprehensive planning. For example, with no durable power of attorney in place, a long term care facility may deny admission. Having a durable power of attorney in place enables a family member to access financial resources needed to pay for care in a nursing or assisted living facility, reducing delays and unnecessary hospitalization.

KEEPING YOUR HOME AND REDUCING HEALTH CARE COSTS: A PATIENT CASE EXAMPLE*

Ms. A is an 84-year old, wheelchair-bound woman with dementia who lives alone in her rent-controlled apartment in San Francisco. With already high medical costs, when capital improvements increased her rent, she became unable to afford her apartment and received an eviction notice.

To help Ms. A stay in her home, MLPS students worked closely with medical providers to write a letter to the landlord explaining her medical needs. They then successfully appealed to the San Francisco Rent Board, which reduced Ms. A's rent and issued over $1400 in a retroactive rental payment.

Working with Ms. A to reduce her health-related expenses, MLPS helped her access a little-known Medi-Cal income deduction rule that saved $600 per month in Medi-Cal costs, and saved an additional $114/month in Medicare premiums. Ms. A was also able to receive $100 in additional food stamps per month, access free medical and in-home care, and complete all of her advance planning, including a will and powers of attorney for health and finances.

*Note: The person in this example consented to have their case shared in this report, and chose to remain anonymous.

AGING RIGHT IN THE COMMUNITY (ARC): MLPB AND BOSTON MEDICAL CENTER

Through a partnership between Boston Medical Center's Elders Living at Home Program (ELAHP) and MLPB (f/k/a Medical-Legal Partnership | Boston), *Aging Right in the Community* (ARC) seeks to reach Greater Boston's most vulnerable, isolated older adults (over age 55) at risk of homelessness through "high touch" case management that integrates a legal advocate into the case management team. Focused on upstream prevention of homelessness, ELAHP aims to thwart threats to socially vulnerable older adults' housing stability through "extreme case management". By including legal expertise within the team, clinical, social, and legal services are coordinated to best support the needs of the individual.

By the Numbers: ARC and Homelessness Prevention

YEAR	# INDIVIDUALS SERVED	RATE OF HOMELESSNESS PREVENTED AMONG CASES CLOSED
1	45	91%
2	70 (46 new; 24 from year 1)	93%
3	58 (29 new; 29 previous)	96%

*Of the cases successfully resolved in year 1 and year 2, 96% remained housed at the end of year 3.

ARC focuses on the *aging* adult, offering services to individuals in their 50's, a decade sooner than many other elder-focused programs. ARC aims to address the individual's need for supports based on "medical age" and functioning, rather than limiting services to those who have reached their 60's. For very vulnerable adults, particularly those who are or are at risk of homelessness, the aging process is often accelerated by poverty, trauma and/or neglected cognitive or behavioral health needs.[61] Reaching these adults in their 50's, therefore, may be critical to preventive problem-solving with implications later in life.

ARC identifies older adults "who have aged on the margins of society due to poverty, trauma history, mental illness, and addiction, among other risk factors."[62] The median age of homelessness increased from 35 in 1990 to 50 in 2010, so to fully address homelessness, attention to aging adults is imperative.[63] By maximizing benefits, home-based health care and supportive services, the project helps tenants and homeowners to remain housed in the community.

Because older adults' housing problems, such as falling behind in rent or hoarding often have their roots in health problems such as mental illness, substance use disorder or progressive dementia, ARC provides support around those root causes, rather than waiting for an eviction crisis. The ARC model is designed intentionally for case managers to lead advocacy efforts which are planned in consultation with legal and clinical partners. By embedding the legal team member in standing interdisciplinary team meetings where newly enrolled individuals' circumstances are discussed, ARC case managers learn about opportunities to

"Extreme Case Management can set a foundation that helps prevent expensive and inhumane cycles of hospitalization and homelessness: the success of the Aging Right in the Community pilot — greater than a 90% rate of averting homelessness and shelter placement in each year of our two-year collaboration with ELAHP — promises downstream benefits that flow from its upstream investment in a low client-to-advocate ratio compared with other models."

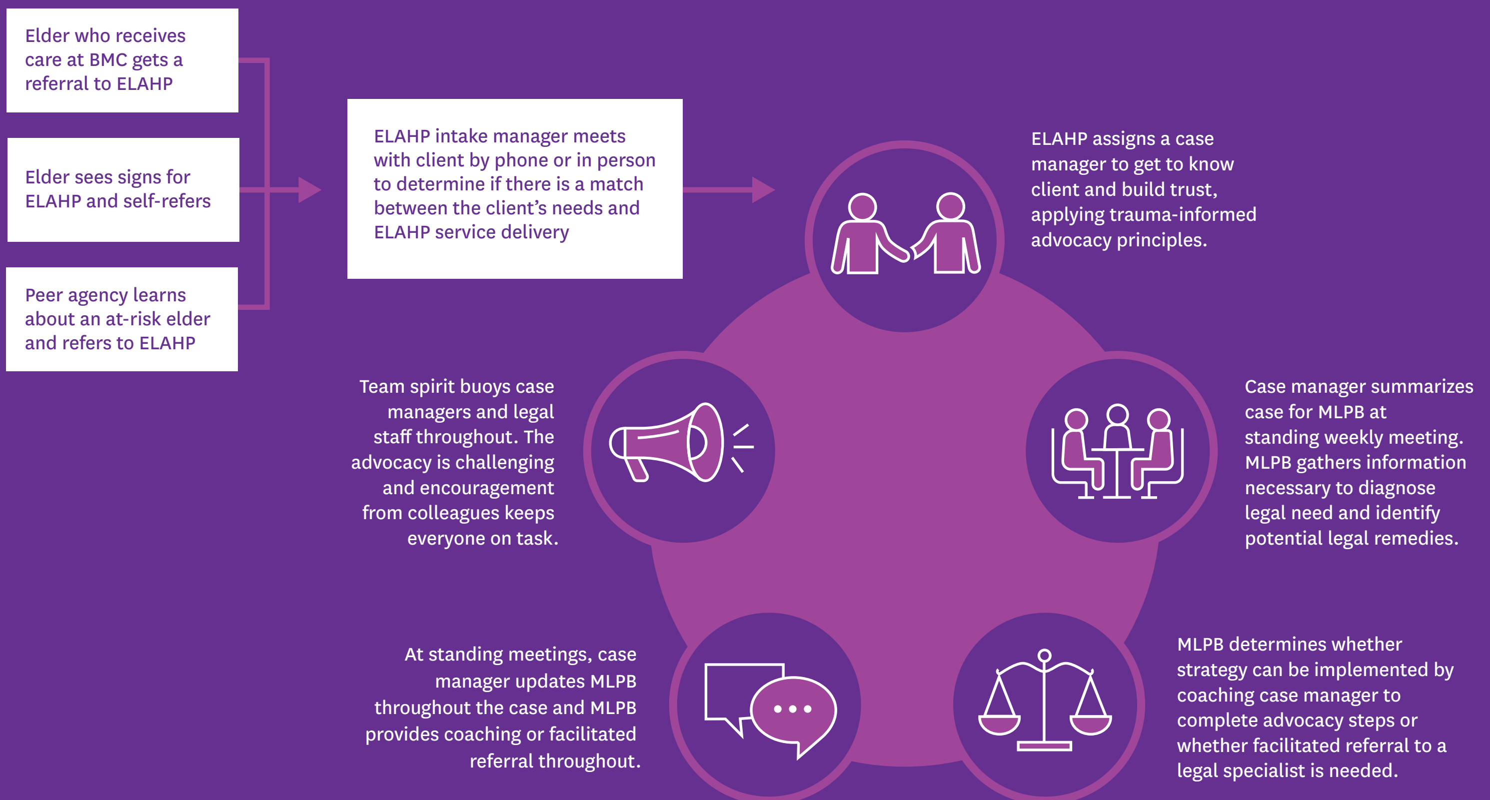
JoHanna Flacks
LEGAL DIRECTOR, MLPB

nip problems in the bud–opportunities that case managers can pursue independently equipped with salient legal information that boosts their problem-solving capacity.

Likewise, ARC case managers' expertise at building relationships with their clients enables the legal team member to engage in more thoughtful analysis about legal strategies, equipped with nuanced information about each individuals' life experience, clinical circumstances, and practical challenges. ELAHP intentionally creates an "open door" environment where its clients, many of whom are unbefriended and otherwise socially isolated, remain engaged for many years when in other contexts the client might be "lost to follow-up" in clinical parlance.

This combination of a "high dose" of specialized case management and a "low dose" of public interest legal advice allows the team to work more successfully in support of hard to reach older adults with complex needs. The ARC approach enables legal advisors to help see that rights are vindicated, frequently before older adults find themselves in court. Without taking on any level of direct representation, members of the legal team support case managers around stabilizing essential needs (e.g. housing reasonable accommodations or modifications, or maintaining or restoring income through public benefits programs), sometimes with a representative payee arranged to ensure that rent is paid on time.

Upstream "behind-the-scenes" legal advising of this nature comprises the majority of MLPB's work and impact in collaboration with the ARC team. MLPB also facilitates referrals to appropriately specialized lawyers in the subset of cases where downstream direct representation is required. At the policy level, MLPB works with ELAHP to advocate for expansion of emergency housing and subsidized housing that is accessible to and supportive of low-income older adults with complex challenges to housing security.



Source: Recreated from Flacks J, Langello K, Morton S, O'Brien E. Aging Right in the Community: How the Integration of Case Management and Legal Problem-Solving Prevents Older Adult Homelessness. November 2016. (Used with permission from the authors).

UF HEALTH SHANDS SENIOR MEDICAL-LEGAL PARTNERSHIP

In September 2018, the Florida Department of Elder Affairs contracted with Three Rivers Legal Services in Gainesville through a grant from the Administration for Community Living to provide legal services to older adults. Three Rivers decided to use this opportunity to pilot a medical-legal partnership in collaboration with Shands Hospital, serving low-income adults over age 60 residing in 17 counties. A part-time attorney in private practice and a part-time paralegal from Three Rivers work together with health care partners at both in-patient and outpatient clinics at Shands to identify patients who can benefit from legal assistance on a range of legal issues, such as housing, durable power of attorney, elder abuse, neglect and exploitation, and access to health care and long-term care services.

In the hospital setting, the MLP helps social workers and discharge planners to navigate complex long term care systems, particularly for patients on Medicaid, who may be difficult to place. But equally important is helping to identify long term care and in-home services and supports through Florida's Medicaid Long Term Care Waiver Program (LTC Waiver).

In its first year, the MLP trained 450 social workers and other health care and social service providers on options for older adults through the program, including through the LTC Waiver, which allows coverage for services needed to remain in the home. Nancy Wright, the lead MLP attorney, describes this workforce as the "Long Term Care Waiver Warriors." Trainings focus on rules around assessment, eligibility, and waitlist priorities.

The MLP has also helped to identify gaps and barriers in the system. Finding that the rules for assessment for home-based services were being misinterpreted to suggest that assessments could not be conducted while an older adult is hospitalized, the MLP team advocated for rule clarification with the Department of Elder Affairs, which then informed hospital staff that assessments may be conducted in-patient. Linking older adults and their family members with home and community-based services has also helped to address the burden on caregivers, preventing stress and reducing the likelihood of abuse and neglect.

Conclusion

Medical-legal partnerships have proven to be an effective way to better integrate problem-solving and service delivery for a range of socially vulnerable populations. As the U.S. population ages, MLP is a promising approach to support older adults and their families in navigating fragmented and confusing systems of care, optimize choice and self-determination, and protect and promote health and well-being. Several common goals have emerged for the effective integration of legal, social, and health care services for socially vulnerable older adults from the MLPs already working in this space:

01 **PROMOTE AUTONOMY AND SELF-DETERMINATION** through a person-centered approach to legal, social, and health care.

02 **FOCUS ON MEDICAL AGE, NOT LEGAL AGE** to support individuals according to their life experience, circumstance, level of functioning and unique needs, while helping them to access age-based government assistance programs and other services.

03 **SCREEN FOR UNMET SOCIAL AND LEGAL NEEDS EARLY,** especially with early signs of cognitive impairment, to facilitate planning and prevention and to optimize the patient/client's legal rights and care options.

04 **INCORPORATE A LEGAL HEALTH CHECKUP** that includes the common legal needs of older adults and that facilitates a holistic approach to health and well-being.

05 **RECOGNIZE FUNCTIONAL LIMITATIONS AND OTHER BARRIERS** that may make accessing services more difficult for older adults and bring assistance to them where they are (e.g. at home, in a nursing home, or at a medical visit).

06 **SUPPORT THE DEVELOPMENT OF AN ELDER CARE WORKFORCE** that is sensitive to the unique needs of older adults and is skilled at holistic problem-solving with the shared goals of promoting health, independence, and justice.

Endnotes

1 National Academy of Science. Health Literacy and Older Adults: Reshaping the Landscape: Proceedings of a Workshop. 2018; 1-2. Available at: https://www.nap.edu/catalog/25188/health-literacy-and-older-adults-reshaping-the-landscape-proceedings-of

2 The Commonwealth Fund, How High-Need Patients Experience Health Care in the United States. 2016. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2016/dec/how-high-need-patients-experience-health-care-united-states

3 The term "socially vulnerable" is used to describe older adults who are vulnerable based on poverty, health status, lack of access to resources and services, and/or social isolation.

4 Swartz K. "Medicare and Medicaid," in *Legacies of the War on Poverty,* edited by Martha J. Bailey and Sheldon Danziger (Russell Sage Foundation, 2013), 268-298.

5 Cubanski J, Koma W, Damico A, et al. How Many Seniors Live in Poverty. Kaiser Family Foundation, November 2018. Available at: https://www.kff.org/medicare/issue-brief/how-many-seniors-live-in-poverty/

6 Legal Services Corporation. Justice Gap Report: Measuring the Civil Legal Needs of Low-income Americans. 2017: 47. Available at https://www.lsc.gov/media-center/publications/2017-justice-gap-report

7 Cubanski J, Koma W, Damico A, et al. How Many Seniors Live in Poverty. Kaiser Family Foundation, November 2018. Available at: https://www.kff.org/medicare/issue-brief/how-many-seniors-live-in-poverty/ This statistic is based on the U.S. Census Bureau's calculation using the supplemental poverty measure: "The. U.S. Census Bureau reports two different measures of poverty: the official poverty measure and the Supplemental Poverty Measure (SPM). In 2017, the threshold for poverty under the official measure was $11,756 for an individual age 65 or older. Unlike the official measure, the SPM poverty thresholds vary by geographic area and homeownership status, and the SPM reflects financial resources and liabilities, including taxes, the value of in-kind benefits (e.g., food stamps), and out-of-pocket medical spending."

8 Kandasamy D, Platts-Mills TF, Shah MN, et al. Social Disconnection among Older Adults Receiving Care in the Emergency Department. Western Journal of Emergency Medicine. November 2018; 19(6): 919–925.

9 Regenstein M, Trott J, Williamson A, and Theiss J. Addressing Social Determinants of Health through Medical-legal Partnerships. Health Affairs. March 2018; 37(3): 378-85.

10 The State of the Medical-Legal Partnership Field: Findings from the 2016 National Center for Medical-Legal Partnership Surveys. 2017. Available at: https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf

11 Blaum CS, Rosen J, Naik AD, et al. Feasibility of Implementing Patient Priorities Care for Older Adults with Multiple Chronic Conditions. Journal of American Geriatric Society. Oct 2018; 66(10): 2009.

12 Rowe JW, Berkman L, Fried L, et al. Preparing for Better Health and Health Care for an Aging Population: A Vital Direction for Health and Health Care. National Academy of Medicine. September 19, 2016: 6.

13 Rowe JW, Berkman L, Fried L, et al. Preparing for Better Health and Health Care for an Aging Population: A Vital Direction for Health and Health Care. National Academy of Medicine. September 19, 2016: 2.

14 Centers for Medicare & Medicaid Medicare. Medicaid Coordination Office Services Fact Sheet. February 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

15 Burke G, Christ A. Updates on Managed Care for Dual Eligibles and Medicare Coordination Programs. National Center on Law and Elder Rights. September 2017. Available at: https://ncler.acl.gov/pdf/NCLER_PowerPoint_DualEligibles.pdf

16 Hooper S, Teitelbaum JB. A Missing Competency: Integrating Legal Advocacy into Care for Complex Older Adults (unpublished manuscript currently under development, on file with the authors).

17 42 U.S.C 35 §3026. See also, U.S. Department of Health and Human Services, Administration for Community Living. Older Americans Act. https://acl.gov/about-acl/authorizing-statutes/older-americans-act

18 National Association of Area Agencies on Aging. Older Americans Act. https://www.n4a.org/olderamericansact

19 42 USC. §3002(33) (2016).

20 U.S. Department of Health and Human Services, Administration for Community Living. Legal Services for the Elderly Program. https://acl.gov/programs/legal-help/legal-services-elderly-program

21 Medicaid.gov. Long Term Services and Supports. https://www.medicaid.gov/medicaid/ltss/index.html

22 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Long-Term Services and Supports for Older Americans: Risks and Financing. Revised February 2016. Available at: https://aspe.hhs.gov/system/files/pdf/106211/ElderLTCrb-rev.pdf

23 Freedman VA, Spillman BC. Disability and Care Needs among Older Americans. The Milbank Quarterly. 2014; 92(3): 509-541.

24 See Tyler DA, Gadbois EA, McHugh JP, Shield RR, et al. Patients Are Not Given Quality-Of-Care Data About Skilled Nursing Facilities When Discharged From Hospitals. 2017 Aug; Health Affairs 306(8): 1385-1391.

25 Administration on Community Living. Long Term Care Ombudsman Program. https://acl.gov/programs/protecting-rights-and-preventing-abuse/long-term-care-ombudsman-program

26 See Community First Choice Program (CFC) 1915 (k), https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html

27 Goldberg J, Carlson E. Legal Basics: Medicaid Long-Term Services and Supports, Chapter Summary. National Center on Law and Elder Rights. October 2017. Available at: https://ncler.acl.gov/pdf/Legal_Basics-Medicaid_LTSS_PowerPoint.pdf

28 Family Caregiver Alliance, The National Center on Caregiving. https://www.caregiver.org/caregiving

29 National Academies Press. Families Caring for an Aging America. 2016: 2-6. Available at: http://www.nationalacademies.org/hmd/Reports/2016/families-caring-for-an-aging-america.aspx

30 42 U.S.C. 35 §3030s-1.

31 Public Law 115–119 (Jan. 22, 2018).

32 Kean N, Lang K. Supporting Older Americans' Basic Needs: Health Care, Income, Housing and Food. Justice in Aging. April 2018. Available at: http://www.justiceinaging.org/wp-content/uploads/2018/04/Supporting-Older-Americans%E2%80%99-Basic-Needs_Health-Care-Income-Housing-and-Food.pdf

33 Kean N, Lang K. Supporting Older Americans' Basic Needs: Health Care, Income, Housing and Food. Justice in Aging. April 2018. Available at: http://www.justiceinaging.org/wp-content/uploads/2018/04/Supporting-Older-Americans%E2%80%99-Basic-Needs_Health-Care-Income-Housing-and-Food.pdf

34 Senior-Meals.Org. Government Food Programs for the Elderly. https://www.senior-meals.org/Senior-Food-Assistance-Programs

35 Kean N, Lang K. Supporting Older Americans' Basic Needs: Health Care, Income, Housing and Food. Justice in Aging. April 2018. Available at: http://www.justiceinaging.org/wp-content/uploads/2018/04/Supporting-Older-Americans%E2%80%99-Basic-Needs_Health-Care-Income-Housing-and-Food.pdf

36 Senior-Meals.Org. Government Food Programs for the Elderly. https://www.senior-meals.org/Senior-Food-Assistance-Programs.

37 Kean N, Lang K. Supporting Older Americans' Basic Needs: Health Care, Income, Housing and Food. Justice in Aging. April 2018. Available at: http://www.justiceinaging.org/wp-content/uploads/2018/04/Supporting-Older-Americans%E2%80%99-Basic-Needs_Health-Care-Income-Housing-and-Food.pdf

38 United States Department of Agriculture. Supplemental Nutrition Assistance Program. https://www.fns.usda.gov/snap/snap-special-rules-elderly-or-disabled

39 Kean N, Lang K. Supporting Older Americans' Basic Needs: Health Care, Income, Housing and Food. Justice in Aging. April 2018. Available at: http://www.justiceinaging.org/wp-content/uploads/2018/04/Supporting-Older-Americans%E2%80%99-Basic-Needs_Health-Care-Income-Housing-and-Food.pdf

40 U.S. Department of Housing and Urban Development, Resident Characteristic Report. Available at: https://pic.hud.gov/pic/RCRPublic/rcrmain.asp

41 Legal Services Corporation. Justice Gap Report: Measuring the Civil Legal Needs of Low-income Americans. 2017:47. Available at https://www.lsc.gov/media-center/publications/2017-justice-gap-report

42 42 USC. §3002 (2016).

43 American Bar Association/American Psychological Association Assessment of Capacity in Older Adults Project Working Group. Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists. 2008. Available at: https://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf

44 See for example, American Bar Association, Commission on Law and Aging. Practical Tool for Lawyers: Steps in Supporting Decision-Making. 2016. Available at https://www.americanbar.org/content/dam/aba/administrative/law_aging/PRACTICALGuide.pdf

45 See ABA Urges Supported Decision Making as Less-Restrictive Alternative to Guardianship. Jul-Aug 2017; Bifocal. 38(6): 95-97.

46 Sudore R, Schillinger D, Katen MT, et al. Engaging Diverse English- and Spanish-Speaking Older Adults in Advance Care Planning: The PREPARE Randomized Clinical Trial. JAMA Internal Medicine. December 2018; 178(12): 1616-1625.

47 U.S. Citizen and Immigration Services currently defines a person as a "public charge" if s/he "is likely to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense." https://www.uscis.gov/greencard/public-charge

48 Fremstad N. Trump's 'Public Charge' Rule Would Radically Change Legal Immigration. Center for American Progress. November 27, 2018. https://www.americanprogress.org/issues/poverty/reports/2018/11/27/461461/trumps-public-charge-rule-radically-change-legal-immigration/

49 National Academy of Science. Health Literacy and Older Adults: Reshaping the Landscape:Proceedings of a Workshop. 2018; 20. Available at: https://www.nap.edu/catalog/25188/health-literacy-and-older-adults-reshaping-the-landscape-proceedings-of

50 American Bar Association Commission on Law and Aging. Why am I left in the waiting room?: Understanding the Four C's of Elder Law Ethics. 2017. Available at: https://www.americanbar.org/products/inv/brochure/211008886/

51 National Academy of Elder Law Attorneys (NAELA). Preamble to the Aspirational Standards for the Practice of Elder Law and Special Needs Law, Second Edition. April 24, 2017.

52 Rao JK, Anderson LA, Lin FC, Laux J. Completion of Advance Directives Among U.S. Consumers. Am J Prev Med. 2014 Jan; 46(1): 65–70.

53 42 U.S.C. 1395cc(a).

54 42 CFR Part 405, 410, 411, 414, 425, 495 (2016).

55 American Bar Association Commission on Law and Aging. Advance Directives: Counseling Guide for Lawyers. 2018. Available at: https://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/ad-counseling-guide/

56 Barwise A, Juhn YJ, Wi CI, et al. An individual housing-based socioeconomic status measure predicts advance care planning and nursing home utilization. American Journal of Hospice and Palliative Medicine. Published on-line November 20, 2018. https://doi.org/10.1177/1049909118812431

57 Greenlee K. How Should We Address Elder Abuse? One State's Efforts. Health Affairs Blog. August 23, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180821.470098/full/

58 John A. Hartford Foundation. National Co-Laboratory to Address Elder Mistreatment. https://www.johnahartford.org/grants-strategy/national-co-laboratory-to-address-elder-mistreatment

59 Congressional Research Service. Older Americans Act: Overview and Funding. November 18, 2018. Available at: https://fas.org/sgp/crs/misc/R43414.pdf

60 The State of the Medical-Legal Partnership Field: Findings from the 2016 National Center for Medical-Legal Partnership Surveys. 2017. Available at: https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf

61 National Coalition for the Homeless. Homelessness among Elderly Persons. Factsheet, September 2009. Available at: http://www.nationalhomeless.org/factsheets/elderly.html.

62 Flacks J. Extreme Case Management with Legal Care: A Best Practice for Serving Elders at Homelessness Risk. Bifocal. 2015; 5. Available at: https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_36/issue_5_june2015/extreme-case-management/

63 Culhane DP, Metraux S, Byrne T, et al. The Age Structure of Contemporary Homelessness: Evidence and Implications for Public Policy. Analyses of Social Issues and Public Policy 2013; 13(1): 228—24.