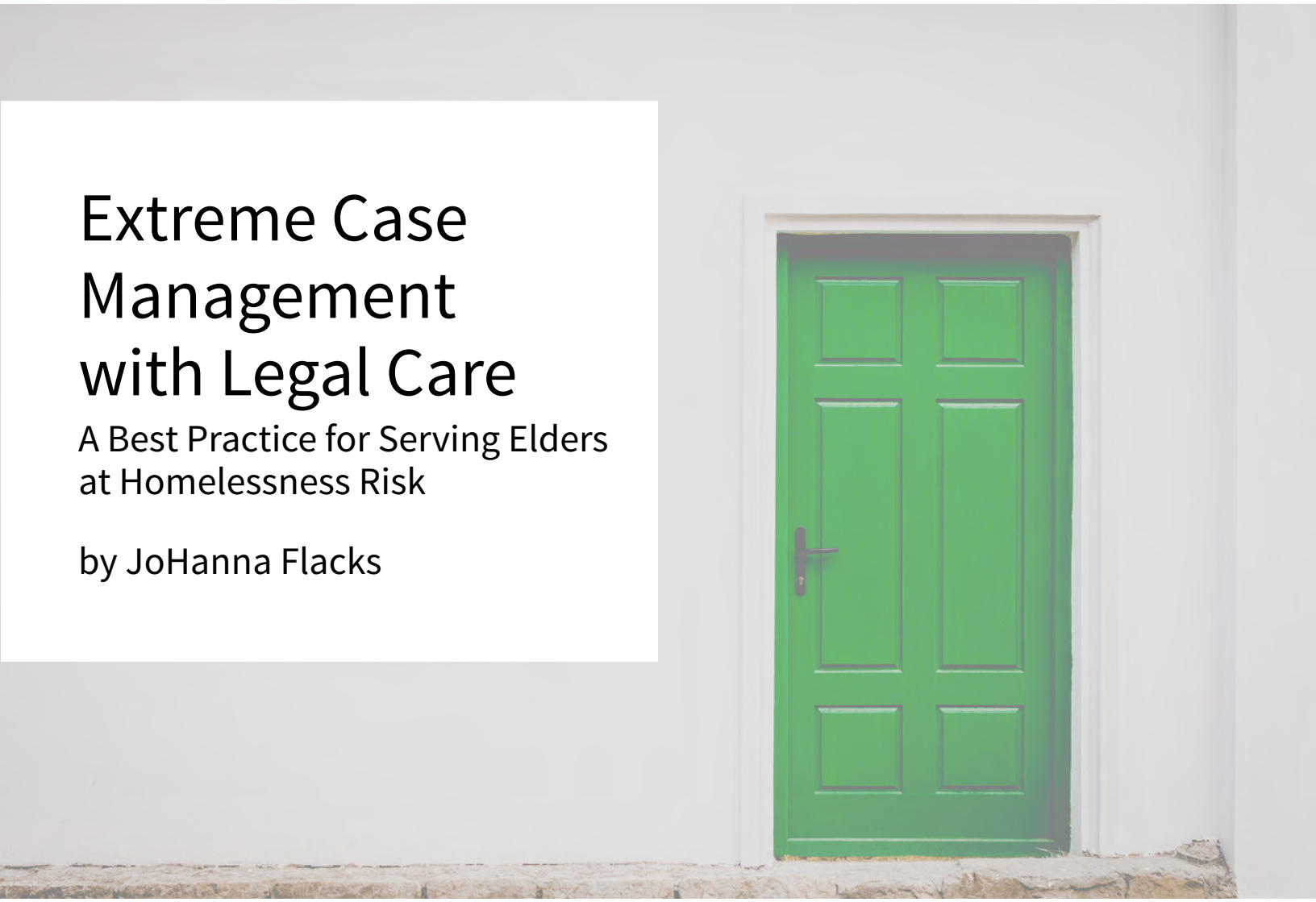
Extreme Case Management with Legal Care

A Best Practice for Serving Elders at Homelessness Risk

by JoHanna Flacks



Aging in Boston

Boston, Massachusetts, and its surrounding inner-urban areas are home to a diverse group of elders. Some of its neighborhoods are described as NORCs (Naturally Occurring Retirement Communities) because so many Bostonians have roots going back generations, and have chosen to grow old in the same homes in which their grandparents were born. Some of these homes are the ubiquitous triple-deckers that have housed multi-generational families in Boston since the 19th century, while others are public housing apartments that generations of very low-income families have also called home.

This article focuses on the population of Boston elders whose life story leads them to enter old age un-befriended, under-resourced, and at risk of homelessness—either because they have been homeless before and are at greater risk due to aging challenges, or because aging challenges like dementia have worn away their last buffers against homelessness.

Extreme Case Management (ECM)

Elders at risk of homelessness stand to benefit from models recently discussed in this publication, such as a dementia-ready community.[1] However, they often require a level of service that exceeds these empowering supports. In other words, what works for Ms. Smith who owns her home and has developed dementia without a backdrop of other vulnerabilities, may not work for an elder whose dementia is layered atop other defeating life experiences. This is where

[1] http://www.americanbar.org/publications/bifocal/vol_36/issue_3_february2015/dementia_friendly.html

Extreme Case Management (ECM) can help reach some of a community's most isolated older adults—those who have aged on the margins of society due to poverty, trauma history, mental illness, and addiction, among other risk factors.

ECM—an approach to elder homelessness prevention and advocacy developed by the Elders Living at Home Program (ELAHP)[2] based at Boston Medical Center (BMC)[3]—describes a "high-touch" method of case management. It emphasizes not only meeting clients where they are in the figurative sense, but in the literal sense, by visiting them where they live and engaging with them actively in the process of averting threats to their housing stability. This may mean, for example,

- Knocking on the door for a full 30 minutes because it will take Mr. Anwar that long to muster the focus to work with his ELAHP case manager;
- Scheduling to visit Senora Lopez at midnight for a hoarding intervention because that is when she returns home on rubbish collection nights in her neighborhood;
- Visiting Mr. Andre with barber shears in hand, so he has the dignity and advantage of a neat appearance on status conference days in housing court; or
- Arranging for a male lawyer to visit Mr. Jones at his home to discuss hygiene/housekeeping challenges threatening his tenancy.

Thanks to funding from the London-based Oak Foundation[4] and other generous funders, Medical-Legal Partnership | Boston (MLP | Boston)[5] has had the privilege of partnering with ELAHP and its extreme case managers for the past 24 months on a project called *Aging Right in the Community*. This pilot project integrates a legal advocate into ELAHP's case management team so that social services and legal services can be planned and delivered in a highly coordinated fashion. This experience has taught the MLP | Boston team a great deal as lawyers and as human beings committed to the program's mission: to equip healthcare, public health, and human services teams with legal problem-solving strategies that promote health equity for vulnerable people. Since undertaking this collaboration with ELAHP, it is difficult to imagine attempting legal advocacy for this complex population without partners who practice ECM.

ECM's Role in Elder Homelessness Prevention

From a housing advocacy perspective, ECM provides advantages for older tenants negotiating with landlords at their wits' end. It makes it possible to break the problem down into approachable pieces, including (1) arranging home-based health care, (2) engaging housekeeping services, and (3) assuring that the tenants are not alone in their struggle to remain housed, frequently in the only community they have ever known.

Exercising patience and persistence until a client answers the door is sometimes the first step in the process of tackling the herd of elephants in the room: including, for example, elephant-sized piles of miscellany that completely filled Senora Lopez's bathroom floor to ceiling. Other elephant-sized health conditions, like PTSD, alcoholism, and progressive dementia often underlie the symptom of hoarding, and can interfere, tragically, with otherwise avoidable institutionalization.

Many ELAHP clients seem more aged than their years. This is not surprising when at least one research study cited by the CDC estimates the average life expectancy for homeless people is 45.[6] ELAHP clients with a history of homelessness who reach eligibility age (ELAHP serves people over 50) very often need intensive help both to get housing and to keep it.

Protecting existing tenancies is a core ECM focus side-by-side with ELAHP's policy advocacy to increase appropriate emergency shelter options and permanent, deeply subsidized housing stock that meets elders' needs. While there is encouraging movement toward a right to housing, (See the D.C. Right to Housing Initiative[7] and the National Law Center on Homelessness and Poverty's[8] work), currently the existing stock of deeply subsidized housing meets at best only half the need for it. And, the statistics

[2] http://www.bmc.org/eldersathome.htm

[3] http://www.bmc.org/

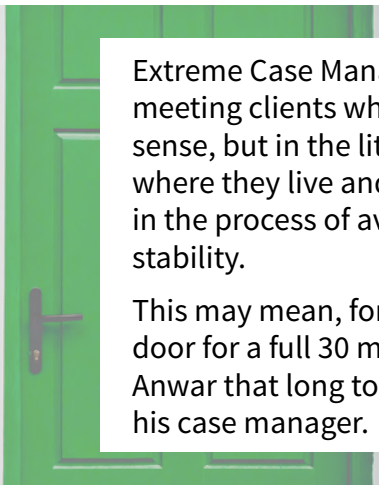
[4] http://www.oakfnd.org/

[5] http://www.mlpboston.org/

[6] http://www.cdc.gov/features/homelessness/

[7] http://www.legalclinic.org/dc-right-to-housing-initiative/

[8] http://www.americanbar.org/content/dam/aba/events/homelessness_poverty/2013_Midyear_Meeting_Right_To_Housing/housing_as_a_right_fact_sheet.pdf



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are worse for people with disabilities that require accessibility features. This is an urgent health equity issue. Against this backdrop, helping tenants hold tight to the affordable housing they have is critical. Often, Extreme Case Management just begins with the dismissal of an eviction action. The door to the office shared by ELAHP's Case Managers and stabilization workers is always open. When new and long-time ELAHP clients are worried about something (usually directly or indirectly related to their housing), they easily can (and often do) visit ELAHP's modest offices tucked in the back of BMC's Massachusetts Avenue overpass. From the East-facing windows, you can see the line queue up outside the Woods Mullen shelter in the afternoon—a line in which many ELAHP clients have a history of waiting, a fear of waiting again, and a high risk of yet again waiting were it not for their relationship with ELAHP.

A Supports-Based Approach

Notably, ELAHP's ECM practice does not adhere strictly to a strengths-based empowerment approach, through which an advocate typically focuses on helping a client identify her strengths and address her own needs with the ultimate goal of self-advocacy and independence. That approach squares with an important point often emphasized by Elmer Freeman,[9] MSW, Director of the Office of Urban Health Programs and Policy at Northeastern University's Bouvé College of Health Sciences: most of the problems confronted by disempowered people are not "in their heads." Instead, most of the time the problems disempowered people confront have a logical public policy solution: a unit of subsidized housing, for example, for a family living on minimum wage in a high-rent district or an elder living on a similarly insufficient fixed income for the housing market where she lives. Empowering these renters to identify, apply for, and navigate the subsidized housing bureaucracy (however limited we know it to be) may be the beginning and the end of these renters' advocacy needs.

At the same time, ELAHP serves particularly vulnerable older adults who need hands-on support and who likely are on a trajectory to need more support, not less. While an empowerment model in a vacuum will not work for most ELAHP clients, this does not necessarily mean the client is incapable of active engagement with advocacy; and elders are not the only members of the community who may benefit from the foundation established by an ECM approach prior to an empowerment approach.

For example, evidence shows that younger adults and parents with clinical depression often get stuck in a cycle of needing public benefits in order to engage with clinical care, and needing clinical care in order to access public benefits—and getting neither because what they really may need as a condition precedent to a strengths-based empowerment approach is the active support of an Extreme Case Manager knocking at their door, and knocking again. Once that person is enrolled in a health insurance program, has applied for Supplemental Security Income (SSI) with the benefit of well-developed medical evidence, and has learned to manage his depression, an empowerment approach to advocacy may succeed.

In this way, ECM 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 (>90% rate

[9] http://www.northeastern.edu/bouve/directory/elmer-freeman/

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. This is because homelessness is not only costly in its own right but also is associated with increased healthcare utilization that can be prevented by stable housing—a true win-win.

The Future

Based in no small part on our collaboration with ELAHP and exposure to ECM, Medical-Legal Partnership | Boston increasingly seeks to include ECM principles in our approach to legal advocacy for people at high risk of homelessness for complex reasons—elders and younger families alike.

For MLP | Boston, ECM is embodied in the quietly heroic work of ELAHP's case managers who stabilize tenancies for older adults with multiple complicated health conditions, day in and day out. In other communities throughout the country, ECM may be practiced by case managers, care coordinators, resource social workers, navigators, or community health workers. By whatever name, ECM practitioners armed with support from legal advocates will be important people in the neighborhood if a community is to welcome and support all older adults.

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Centers for Medicare and Medicaid Services May Finally Pay for Advance Care Planning

On July 8, 2015, Centers for Medicare and Medicaid Services (CMS) announced its proposed physician fee schedule for next year. Two new Advance Care Planning codes that had been recommended by the American Medical Association are included and are funded. Both codes apply to a physician or other qualified health professional providing advance care planning services. If included in the final rule, this will be the first time advance care planning counseling will be expressly reimbursable by Medicare (other than as part of the Welcome to Medicare exam).

The comment period on the rule runs till September 8, 2015. When coverage of advance care planning was proposed as part of the Affordable Care Act, it triggered a hyperbolic "death panel" backlash. The proposed rule will need overwhelming support to survive, so supportive comments from as many groups as possible is extremely important.

The pre-publication copy of the rule is at: https://federalregister.gov/a/2015-16875. Instructions on filing comments are included. The advance care planning language in the rule is on pp. 246-247.

The ABA has strong policy in favor of advance care planning. Health care providers can't know and honor patient's values and wishes unless these care

planning conversations take place. All the incentives in Medicare right now work against focusing time on meaningful care planning discussions. These proposed codes are long overdue and will have the effect of acknowledging the importance of those conversations and providing at least a modicum of incentive to engage in them.

Related Commission-supported policy is online at: http://www.americanbar.org/groups/law_aging/policy.html

Advanced Care, February 2015, 100
Urges federal, state, local, territorial, and tribal governments to enact legislation and regulation that will promote six enumerated components in the provision of care to persons with advanced illness.

Medical Decision-Making, August 2012, 106A
Amendments to the Patient Self Determination Act, calling for strengthening advance care planning rights and procedures for health care decisions. ■