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**Nebraska public guardianship of unbefriended patients: a preliminary
review of health outcomes and cost savings**

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Abstract

Unbefriended patients often experience an extended length of stay in the hospital while their medical providers await legal appointment of a public guardian to make their medical decisions. The medically unnecessary days the unbefriended patient spends in the hospital equates to high costs for the hospital, but more importantly, negative health outcomes for the patient. The purpose of this study is to provide literature and data to support recommendations for possible changes in Nebraska's public guardianship appointment process. A literature review seeks to answer: (1) What is the median hospital length of stay for an unbefriended patient without a guardian compared to the unbefriended patient with a guardian? (2) What are the health outcomes for unbefriended patients without a guardian compared to those with a guardian? (3) What are the cost savings for a hospital when an unbefriended patient receives a public guardian? The literature review findings will also inform an outline for a future cost savings study of the unbefriended patient population in a Nebraska hospital.

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Chapter 1 – Introduction

Background

The Unbefriended Patient

When hospitalized adults are unable to make medical decisions due to cognitive impairments and they do not have an advanced directive, clinicians usually turn to the patients' close friends and family. However, some incapacitated patients are “unbefriended,” or more prosaically, unrepresented. They have no legally authorized surrogate, family member, or friend willing or able to make medical decisions on their behalf (Chamberlain et al., 2018; Farrell et al., 2017) . The American Bar Association uses “unbefriended” to refer to adults who lack decision-making capacity, a surrogate, and an advance directive (Karp & Wood, 2003). In the rest of this research paper, the author will use the term “unbefriended” when referring to this patient population.

Literature on the unbefriended patient population often quotes Nancy Dubler, Bioethicist and Professor Emerita at Montefiore Medical Center in Bronx, NY. She wrote:

The single greatest category of problems we encounter are those that address the care of decisionally incapable patients who have been transferred for care from nursing homes and who have no living relative or friend who can be involved in the decision-making process. These are the most vulnerable patients because no one cares deeply if they live or die. That is not to say that staff are not concerned to do what is right and in the best interest of the patient, but no one's life will be fundamentally changed by the death of the patient. We owe these patients the highest level of ethical and medical scrutiny; we owe it to them to protect them from over-treatment and from under-treatment; we owe it to them

to be certain that they are not a statistic in a study that demonstrates that over 50 percent of patients who die do so in moderate to severe pain; we owe it to them to help them to live better or to die in comfort and not alone (Karp & Wood, 2003).

Incapacitation may be a result of developmental disabilities, chronic mental illness, traumatic brain injuries, progressive cognitive loss and other illnesses and medical conditions. The most common causes include neurological diseases, such as dementia, stroke, traumatic brain injury, Parkinson's disease, multiple sclerosis, and mental illnesses such as depression, schizophrenia, and bipolar disorder (Mental Illness Policy Org., 2017). The state of Nebraska defines an incapacitated individual as, "any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning himself or herself" (Public Guardianship Act, 2014). A clinician may diagnose a patient as incapacitated, but evidence must be presented to a court for the patient to be deemed *legally* incapacitated.

Capacity determination is a debated ethical issue. Most clinicians agree that a person with end-stage dementia who is nonverbal would not be able to (currently) express a choice in his or her care needs. However, a person with a severe and persistent mental health disorder, such as schizophrenia, may have periods of decisional capacity or incapacity depending on the severity and state of the illness. Alternatively, a person with a stable but significant intellectual disability may present a different clinical picture and surrogate need. Legal scholars, clinicians, ethicists, and advocates continue to debate these complex issues related to capacity and decision-making

(Moye et al., 2016). Individuals who are most at-risk of being incapacitated and also unbefriended include: those who are homeless, the mentally ill, those who by “choice or life history” do not have family or friends who could act as a surrogate, those who do not have the financial resources for a friend or family member to serve as a guardian (Muerrens & Daywitt, 2013), and those who are elderly and have outlived their family and friends (Courtwright & Rubin, 2016).

Unbefriended patients are typically white, male, age 65 or older, have multiple chronic conditions and are institutionalized in a long-term care facility or mental hospital (Chamberlain et al., 2018; Moye et al., 2017; Kim & Song, 2018). A large national survey about unbefriended patient care conducted in 2004 as a follow-up to its original implementation in 1981 found that today, unbefriended patients are younger individuals with more complex needs than 25 years ago. Individuals aged 65 or older represent between 37% and 57% of unbefriended patients, while those age 18-64 represent between 43% and 62% of the total (Teaster et al., 2007).

In 2017, it was estimated that there were more than 70,000 unbefriended patients and that they represent about 3 to 10% of the United States' patient population (Pope, 2017; Moye et al, 2017). A 2006 study by White et al. found that 16% of patients admitted to an intensive care unit (ICU) were unbefriended patients (White et al., 2006). A 2007 multicenter study added that unbefriended patients represented 5.5% of deaths in ICUs (White et al., 2007). In 2016, The American Bar Association, the Society of Critical Care Medicine, and the Society of Hospital Medicine surveyed 45,000 physicians; nearly 50 percent of respondents reported seeing at least one unbefriended patient per month (Pope, 2017). Researchers predict that the number of

unbefriended patients will rise dramatically between 2010 and 2030 due to the aging Baby Boomer generation, the expanding population of seniors with dementia and the growing number of seniors who live on their own and are childless (Schweikart, 2019).

The 2006 study by White et al. also found that the median ICU length of stay for the unbefriended patient was twice that of all other ICU patients. Unbefriended patients often have a longer length of hospital stay due to medically unnecessary days (MUDs). MUDs are days when the unbefriended patient was in the hospital, but not receiving medical treatments or procedures. MUDs equate to an increased risk of nosocomial infections, falls, antibiotic-resistant infections, urinary tract infections, and medication errors (Moye et al., 2017). One explanation for this medically unnecessary increased length of stay is that in the absence of information about an unbefriended patient's wishes, clinicians tend to administer longer treatment or delay treatment all together as a means of avoiding decisions on more short-term high-risk treatments. A clinician interviewed in a 2003 study by the American Bar Association Commission on Law and Aging stated that, "one main approach for decision-making for the unbefriended is to wait until the need for treatment becomes an emergency and consent is no longer necessary" (Pope, 2017). A second explanation is that unbefriended patients cannot be transferred to an appropriate outpatient facility such as a skilled nursing facility without someone legally consenting to their discharge. Additionally, most skilled nursing facilities, looking to avoid high-risk liabilities, will not accept patients who do not have a representative to make decisions (Moye et al., 2017). In 2010, Bandy et al. reported that according to the legal files, for 63 (88.7%) of 71 unbefriended patients in their study, the primary reason the unbefriended patient required guardianship was for transfer to an outpatient facility (Bandy et al., 2010).

While some clinicians avoid making decisions for the unbefriended patients, the 2003 American Bar Association study found that others prefer to err on the side of over-treatment. Clinicians do this for various reasons, including a fear of civil liability for failure to treat, economic incentives to treat, and the medical ethics emphasis on taking all actions necessary to preserve life (Pope, 2017). 80% of decisions about life support for unbefriended patients are made by physicians with no institutional or judicial review (Moye et al., 2017). Compared to those with a surrogate, adults without a surrogate tend to have lower quality of end-of-life care, characterized by fewer palliative care consults, chaplain visits, and do-not-resuscitate orders. Due to the limited oversight in their health decisions and their MUDs, unbefriended patients are highly prone to negative health outcomes—they are the most vulnerable, voiceless population in healthcare (Pope, 2017).

Public Guardianship

Finding solutions for the care of these patients is an issue that spans healthcare, law, and ethics. One approach is public guardianship. Public guardianship programs vary by state. Some states have created an Office of the Public Guardian, while other states organize public guardianship through the courts, county, or a state agency (Moye et al., 2017). Public guardianship is an action in which a court, upon determination of incapacitation, can give a trained employee from the public guardian program (the guardian and conservator) the duty and power to make personal and/or property decisions on behalf of the unbefriended patient (the ward) including those related to: housing, medical decisions, consent and approval, arranging for services, education, protecting personal effects, applying for private or government benefits, and managing

contractual agreements and finances. (Teaster et al., 2010) (State of Nebraska Judicial Branch, n.d.). The medical decisions can range from those about routine appointments to serious surgical procedures and end-of-life. Most states require court approval for public guardian decisions related to placing an individual in a mental health or residential facility, consenting to invasive or experimental procedures, and withholding life-sustaining treatment (Dayton, 2012). When clinicians do not wish to make healthcare decisions on behalf of the unbefriended patient, hospitals may request appointment of a public guardianship. A probate court makes the public guardian appointment on the basis of the totality of the evidence provided by the health care team. The guardian appointment is indefinite, terminating only after the ward dies or regains capacity or a court terminates the guardianship (Public Guardianship Act, 2014).

Nebraska Public Guardianship

While some states enacted a public guardianship program as early as the late 1970s, the Nebraska State Legislature did not enact a program until 2014 when it established the Office of Public Guardian (OPG) (Teaster et al., 2006; Public Guardianship Act, 2014). Nebraska was the last state to establish a public guardianship program. The OPG operates within the judicial branch of the Nebraska state government and is funded by state appropriations, Medicaid funds, and county funds. The OPG charges its wards with over \$5,000 in liquid assets a monthly fee. It seeks approval for these fees on an annual basis, in conjunction with the ward's annual report, from the court (State of Nebraska Judicial Branch, n.d.).

The OPG is led by the public guardian, an attorney who is licensed to practice law in Nebraska. The public guardian leads a group of associate public guardians who are professionals trained in

law, health care, social work, education, business, accounting, administration, geriatrics, psychology, and other specialties with experience working with individuals with dementia, developmental disabilities, chronic and acute medical needs, mental health issues, substance abuse, or other conditions that are served by the OPG. The associate public guardians act on the public guardian's behalf in caring for all wards (Nebraska Revised Statute 30-4104, 2016). At its inception, the OPG employed 12 associate public guardians. Today it employs 17—six in Omaha, four in Lincoln, two in Norfolk, one in Hastings, one in Grand Island, one in Kearney, one in North Platte and one in Scottsbluff/Gering. Each represents wards in their respective geographic area. Nebraska associate public guardians have a maximum caseload of 20 wards, making for a current potential maximum of 340 wards served by the Nebraska OPG. The OPG trains volunteer successor guardians so that they may assume guardianship cases from the OPG and allow associates the capacity to take on more emergency cases. When all associate public guardians in a geographic area have reached their maximum caseload, the OPG cannot accept further public guardian appointments. The OPG may place unbefriended patients on a guardianship appointment waitlist for a maximum of 90 days. This 90-day wait can be extended indefinitely pending continuous review of the case and confirmation that guardianship services are still necessary (State of Nebraska Judicial Branch, n.d.).

The Nebraska public guardian appointment process is detailed in Appendix A. The petition for a Nebraska public guardianship appointment, paperwork that the hospital legal team will complete, is presented in Appendix B. The OPG also approves temporary guardianships for emergency situations such as when the unbefriended patient is awaiting medical services. Temporary guardianship requests receive an expedited hearing—a court hearing within ten days of the

request. Courts generally limit temporary guardianship powers and duties to those necessary to address the emergency. Temporary appointments are 90 days and can be extended (State of Nebraska Office of Public Guardian, 2020).

The OPG began accepting nominations (requests for a public guardian appointment) in December 2015. As of October 31, 2020, the OPG had been nominated 705 times.

Hospital/physician nominations outweigh all other nomination sources as seen in Figure 1.

Emergency cases accounted for 67 of those nominations. According to the Nebraska OPG's 2020 annual report, it received 111 nominations between November 1, 2019 and October 31, 2020.

The OPG did not initially accept 86 of the 111 nominations for several reasons, 1) the proposed ward passed away before the OPG could serve them, 2) the OPG had no capacity to serve, and the individual was referred to the waiting list, 3) the proposed ward regained capacity, and 4) an alternative to the OPG was identified and appointed as guardian and/or conservator. Ultimately the OPG referred 66 cases to the waitlist and accepted 11. Including those who were not nominated, the OPG served a total of 310 wards between November 1, 2019 and October 31, 2020. Of the 310 wards, 226 had medical conditions, 83 had developmental disabilities, 251 had a mental health diagnosis, 92 had substance abuse issues and 87 had a history of criminal involvement (State of Nebraska Office of Public Guardian, 2020).

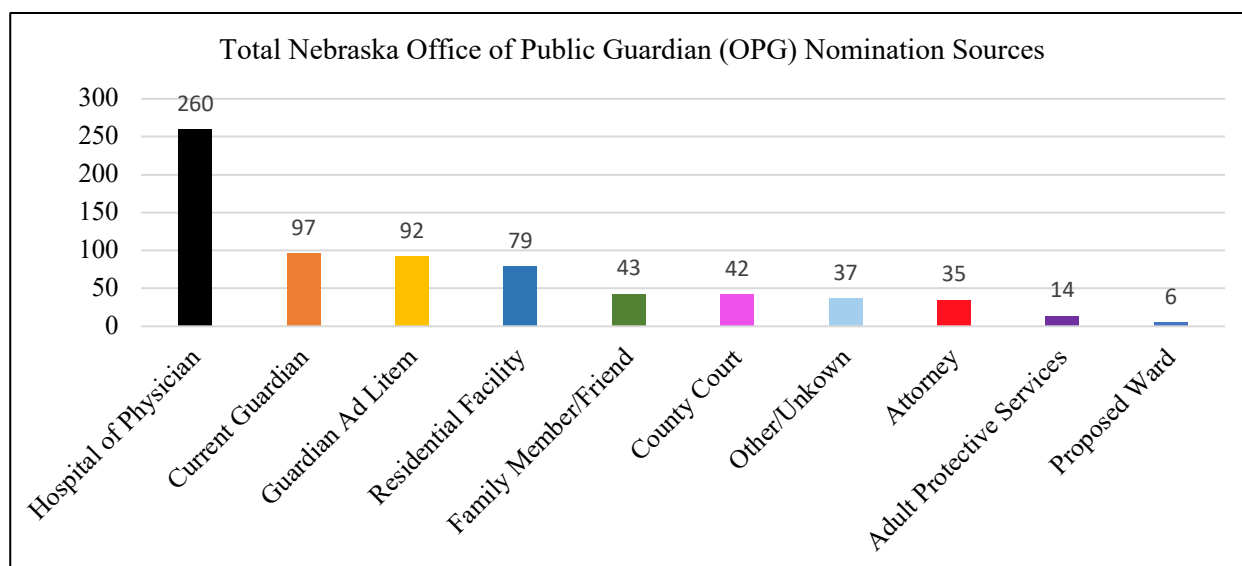


Figure 1. Total Nebraska OPG nomination sources (December 2015-October 2020)

Guardianship of Last Resort

Existing literature and legal writings often refer to public guardianship as “guardianship of last resort.” It is important to note that public guardianship is indeed the last resort for caring for unbefriended patients. Those considering petitioning for public guardianship should first make every effort to contact family members and friends to determine if they are willing to serve as guardian. Public guardianship *is not* an alternative if a qualified relative or friend is willing and able to assume guardianship. Other solutions or a combination of solutions that should be attempted before public guardianship include: a representative or substitute payee, case/care management, health care surrogacy, trusts, durable powers of attorney, living wills, community advocacy systems, joint checking accounts, community agencies/services, and supported decision-making networks (National Academy of Elder Law Attorneys, 2018).

Public guardianship protects unbefriended patients and provides for their decisional needs, but it also simultaneously removes their fundamental rights. This paradox is described by author Mary Joy Quinn in her book, *Guardianships of Adults Achieving Justice, Autonomy, and Safety*. Ms. Quinn wrote:

A key to understanding guardianship and its history is to recognize that it is based on an inherent tension. Guardianship has always had two faces—it is protective yet oppressive, an instrument of beneficence that can at the same time bring a dire loss of rights.

Guardianship can be an accommodation, an enabler helping to provide for basic needs and offer essential protections. Without guardianship, vulnerable individuals may languish unnecessarily in situations, suffer from lack of appropriate health care, or be subject to abuse and exploitation. Yet the very same institution of guardianship removes fundamental rights, restricting self-determination, freedom to choose, freedom to risk. It has been said to ‘unperson’ an individual, reducing her to the status of a child. Thus, guardianship can “empower” and it can ‘unpower’ (Chaffee, 2015).

Guardianship in the United States has drawn criticism since at least the 1970s for insufficient protections for the person under guardianship; specifically, there have been concerns regarding limited due process, lack of protection of rights, poor interface between medical providers and the court, overly intrusive interventions leading to the loss of all decision-making rights, and the potential for guardianship to hasten institutionalization. An explosion of statutory reforms over the past 20 years have sought to improve components of guardianship processes and to employ safeguards for the health and safety of the wards (Moye et al., 2016). Nebraska state law forbids

guardians from paying themselves more than \$500 or paying an attorney more than \$1,000 each year without the court's approval. Public guardians must also petition the court in order to move the ward outside of the state (State of Nebraska Judicial Branch, n.d.).

Nebraska statutes require that each guardianship relationship involve at least one "interested person." This interested person can be a child, spouse, future heir, trustee, devisee in the most recent will of the ward, or a government agency who pays benefits to the ward. They are not required to be active in the guardianship. The statute aims to identify an interested person so that it is documented that someone is vested in the ward and the outcomes of their guardianship. It is another safeguard mechanism. When an interested person cannot be identified, the court will assign a guardian ad litem (an attorney) to follow the guardianship relationship and to represent the interests of the ward (State of Nebraska Judicial Branch, n.d.).

Once guardianship is assigned, the guardian has full power to make most, if not all, decisions for the patient. The primary goal of effective guardianship is to eventually restore the capacity of the unbefriended patient and to end the guardianship. The courts require an annual review to assess the argument for maintaining or terminating a guardianship. Unfortunately, in many instances, once a guardianship has been initiated by a court, it is in place until the unbefriended patient dies (National Guardianship Association, n.d.).

Defining the Issue – A cumbersome appointment process

The legal process of securing public guardians for unbefriended patients is a hidden source of stress at many U.S. hospitals. The process is slow, costly and public guardians are often

unavailable. To appoint a public guardian, a hospital's legal team must assemble and complete all the paperwork for the petition, wait days to weeks for the paperwork to be processed and for the court hearing to be arranged, and then they spend half a day or more in probate court. The hospital must pay medical experts to assess the patient's capacity, and must pay an attorney to prepare and argue the petition. It also must often pay for a guardian ad litem to serve as the interested party and pay for filing fees and other court costs. All these expenses can total \$5,000 to \$8,000 (Pope, 2017). The expensive and cumbersome process regularly takes at least six to eight weeks, and it frequently takes much longer than that—a length of time that is not compatible with urgent needs for health care decisions (Moye et al., 2016).

The wait for a public guardianship appointment is a large contributor to the unbefriended patient's higher number of MUDs. In a 2017 study by Moye et al., a clinician told the researchers in an interview, "I've gotten on the phone and begged someone to take someone. We had a 19-year-old with a head injury after a motor vehicle accident. Every day they stay here they are losing their rehab ability. And really it is because they don't have a legal guardian, not because [of] insurance. Really awful" (Moye et al., 2017). Hospitals are legally bound in how and on what grounds they can petition for guardianship. In 2013, St. Joseph's/Candler Health System in Georgia petitioned for an emergency guardian to authorize the discharge of a patient who was deemed unbefriended and incapacitated due to Parkinson's disease and a variety of comorbidities. The hospital believed that the patient would be better served in a skilled nursing facility. The court denied the request on the basis that there was no "emergency," no "immediate and substantial risk of death or serious physical injury, illness, or disease" that required the patient's transfer (Pope, 2017) (Georgia Court of Appeals, 2013).

In 2018, attorneys in the general counsel's office at Boston Medical Center (BMC), a 387-bed tertiary care academic hospital, began investigating public guardianship process issues at their hospital. They discovered that at any given time, 10 to 15 unbefriended patients were stalled at the hospital waiting for a public guardianship appointment to be completed. Those patients experienced significantly longer length-of-stays, about 100 days, compared to the 5-day length-of-stay that their counterparts experienced. In extreme cases, unbefriended patients awaiting an appointment stayed at BMC for more than a year after they were ready for discharge (Ortiz Langlois, 2019).

A 2019 survey of clinicians revealed that the most commonly reported negative outcomes of the public guardian appointment process were a prolonged length of hospital admission (66%) and the clinician's own personal distress (68%) related to assuming decision-making responsibilities. This study also found that when clinicians perceived public guardians as unhelpful, it was not necessarily because they were actually unhelpful, but because there were issues related to their legal authority and/or the length of time it took to complete the legal paperwork and obtain a court hearing date for the guardianship appointment (Catlin et al., 2019).

As of April 2021, the Nebraska OPG stated that, "currently, the maximum case load and distribution capacity limit has been attained by some associate public guardians within the Eastern and Southeastern OPG service areas. Accordingly, courts have begun to request cases be placed on an OPG Waiting List for future assignment of a public guardian/conservator when an opening occurs." It also stated, "the limited resources of the OPG do not allow for full compliance with the duties listed for all cases and the OPG cannot meet all requests for public

guardians and public conservators” (State of Nebraska Judicial Branch, n.d.). The OPG’s staffing, funding, and general resources, greatly inhibit the public guardianship appointment process and consequentially, the unbefriended patient’s medical care.

Research Question and Objectives

The purpose of this study is to provide literature and data to support recommendations for possible changes in Nebraska’s public guardianship appointment process. The literature review seeks to answer: (1) What is the median hospital length of stay for an unbefriended patient without a guardian compared to the unbefriended patient with a guardian? (2) What are the health outcomes for unbefriended patients without a guardian compared to those with a guardian? (3) What are the cost savings for a hospital when an unbefriended patient receives a public guardian?

The literature review adds to only one other review of studies of unbefriended adults that has been conducted in the past 15 years (2006 and after) (Kim & Song, 2018). Overall, there are limited writings and research about the unbefriended patient population. The researcher will use the literature review findings to outline a future cost savings study of the unbefriended patient population in an urban Nebraska hospital. Only one other study conducted in Massachusetts between 2011 and 2013 included a cost savings analysis (Chen et al., 2014). This research is a collaborative project between the researcher, Legal Aid of Nebraska and its Health Education and Law Project (HELP), and a Nebraska hospital.

Literature Review Search Strategy

A two-tiered literature review was conducted. First, a PubMed search yielded articles that were screened for the inclusion and exclusion criteria outlined in Table 1. The bibliographies of the articles that met the inclusion and exclusion criteria after the full text review were then also reviewed. Articles cited in the bibliography that met the inclusion criteria and exclusion criteria were also kept for the final analysis

The initial PubMed search was conducted on November 14, 2020. A preliminary search of other databases yielded little to no results. The search terms included: “unbefriended,” “unrepresented patients,” and “public guardian.” A MeSH search did not produce relevant MeSH terms, so the search was conducted without MeSH. To meet inclusion criteria, the following search filters were applied: publication date from 2006/01/01, English, Adult: 19+ years. Citations from each search were downloaded and compiled in an Excel spreadsheet. Duplicate entries were deleted. Titles and abstracts were screened for the inclusion and exclusion criteria outlined in Table 1. Then, the remaining full texts were screened according to the inclusion and exclusion criteria. Studies must have met all of the inclusion criteria and no exclusion criteria to be eligible for final inclusion.

Selected articles had to report quantitative or qualitative assessments of the unbefriended patient population and the public guardianship process. Legal professionals and other invested parties have written many case studies, legal briefs, and editorials about the unbefriended patient population and the public guardianship process, but their writings do not provide data. Although some long-term care facilities and other entities petition for public guardianship, according to the

Nebraska OPG’s 2020 report, hospitals by far submit the most petitions for public guardianship (State of Nebraska Office of Public Guardian, 2020). For this reason, the search focused on research studies of adult unbefriended patients in the hospital setting in the United States. Many studies evaluate public guardianship alternatives; these were excluded as they then do not assess the public guardianship process. To review the most recent sources, the search was limited to publications from 2006 to 2020. Evaluating recent articles was especially critical because public guardianship is tied to legal statutes, many of which have changed in recent years.

Table 1. Literature review inclusion and exclusion criteria

	Inclusion Criteria	Exclusion Criteria
Type of Publication	Research studies	<ul style="list-style-type: none"> • Case Studies • Legal Briefs • Editorials
Setting	Hospital	Not in the hospital
Population	Unbefriended patients	<ul style="list-style-type: none"> • Included participants under age 19 • Focused on one group e.g. older unbefriended patients
Geographic Location	United States	Not in the United States
Intervention/Comparator	Public guardianship	No discussion of public guardianship as an intervention
Reported Outcomes	<ul style="list-style-type: none"> • Estimates/Description of the hospitalized unbefriended incapacitated patient population AND <ul style="list-style-type: none"> • Analysis or mention of the public guardianship appointment process 	N/A
Language	English	Non-English
Published Date	2006-Present	Published 2005 or earlier

Literature Review Data Extraction

After the included studies were determined, the following characteristics were extracted and compiled in an Excel spreadsheet: study purpose, data sources, sample size, key results, and relevant descriptive data or recommendations. Data were synthesized qualitatively for analysis.

Chapter 4 – Results

Literature Search Results and Selection Process

The “unbefriended” search yielded 30 articles, the “unrepresented patient” search yielded 13 articles, and the “public guardian” search yielded 20 articles. After duplicates were removed, the searches yielded a total of 54 articles. 50 were excluded because they did not meet inclusion criteria and/or they met exclusion criteria. The bibliographies of the four remaining studies then led to identification of four more studies that met inclusion criteria. In total, eight studies were selected for analysis. The selection process is outlined in Figure 2 below.

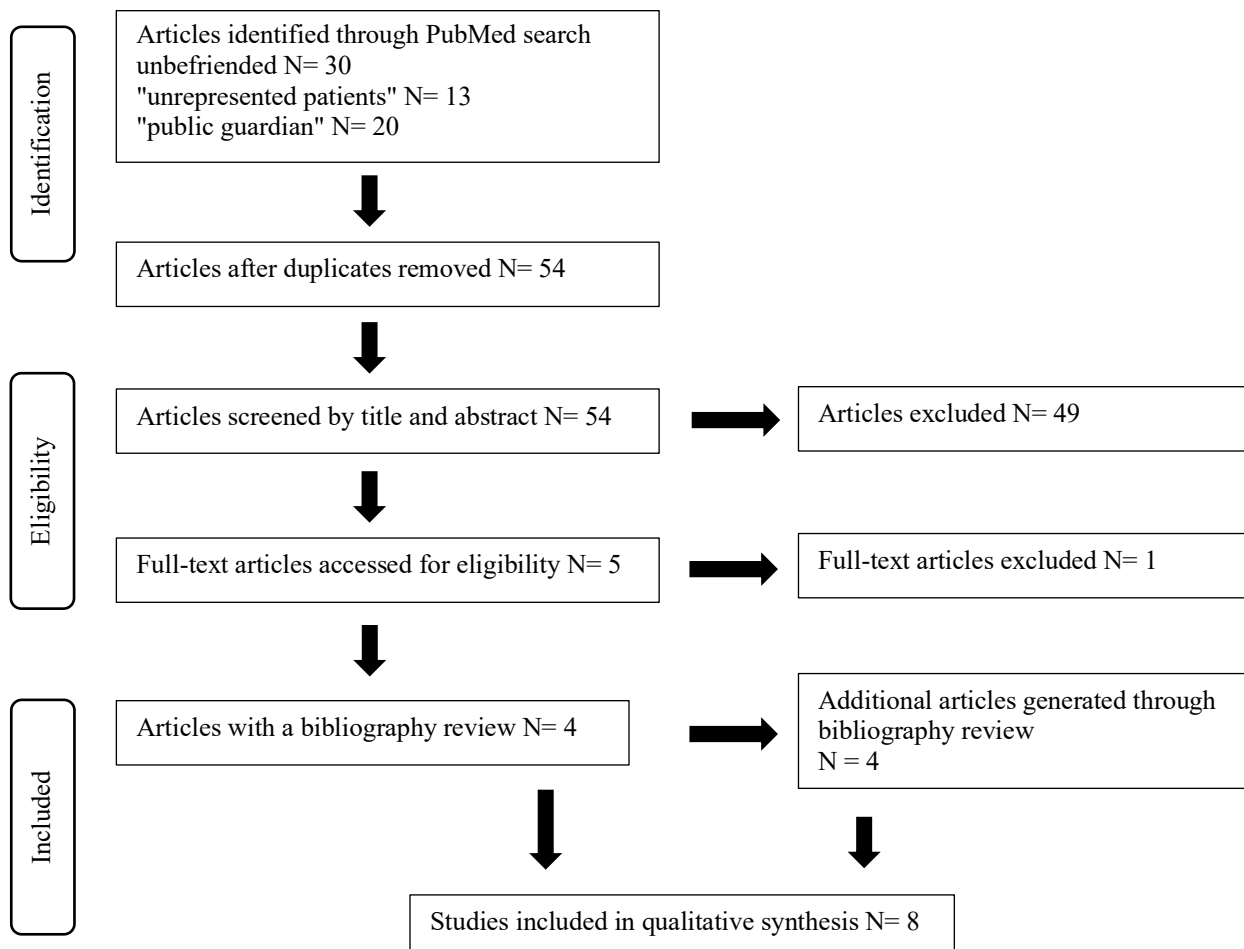


Figure 2. PRISMA diagram showing literature review study attrition

Description of Studies

An overview of the eight studies included can be found in Table 2 below. Full data extraction is available in Appendix C. Most (three) were cohort studies that sought to evaluate the unbefriended patient's length-of-stay and the medical decision-making process while waiting for a guardian appointment. Two were retrospective and one was prospective. In the prospective study, the researchers contacted the attending physician of the ICU every day to see if an incapacitated patient without a surrogate decision-maker had been admitted. Other study designs included interviews (two), surveys (one), a controlled intervention (one), and a literature review (one). All of the study purposes included the objective to understand medical decision-making for unbefriended patients who do not yet have a public guardian or other surrogate. The majority of the studies were completed in the East coast region, specifically, Massachusetts (three) and New Hampshire. Sample sizes of unbefriended patients ranged from 26 to 79. The recruitment period for these samples varied greatly—from seven months to three years. The sample sizes of stakeholders interviewed and surveyed ranged from 20 to 104.

Table 2. Overview of included studies

Citation	Data Type, Study Design	Study Purpose	Setting	Sample Size
Bandy et al., 2010	Quantitative, Retrospective cohort	To describe the process of medical decision-making for incapacitated, hospitalized adults for whom court-appointed guardians are requested	<ul style="list-style-type: none"> Large public hospital Indianapolis, IN 	79 unbefriended patients (three yrs)
Catlin et al., 2019	Qualitative, Survey	To describe clinical outcomes for unrepresented adults as described by clinicians	Massachusetts	81 clinicians and 23 attorneys/guardians
Chen et al., 2014	Quantitative, Controlled intervention	To create and assess the effectiveness of a clinical pathway for guardianship	<ul style="list-style-type: none"> 387-bed tertiary care academic hospital and Level I trauma unit Lebanon, NH 	26 unbefriended patients (two yrs)
Chen et al., 2016	Quantitative, Retrospective cohort	To assess nonclinical factors delaying hospital discharge of guardianship patients + examine demographics, medically unnecessary days (MUD) of hospital stay, and specific delay codes of guardianship patients	<ul style="list-style-type: none"> 387-bed tertiary care academic hospital and Level I trauma unit Lebanon, NH 	48 patients (three years)
Kim & Song, 2018	Quantitative & Qualitative, Literature review	To examine what is known about adults who lack decision-making capacity and a surrogate and identify gaps in the literature	N/A	10 articles
Moye et al., 2016	Qualitative, Interviews	To describe what happens when individuals need a guardian, do not have family or friends to serve, and do not have means to pay	Massachusetts	20 stakeholders (twelve clinical, four agencies, four courts)
Moye et al., 2017	Qualitative, Interviews	To describe the results of qualitative interviews with relevant stakeholders with experience in working with adults who are incapacitated and alone within hospital and long term care settings	Massachusetts	20 stakeholders (four state agency officials, four probate court personnel, 12 clinicians/hospital counsel)
White et al. 2006	Quantitative, Prospective cohort	To determine how unbefriended patients are admitted to the ICU of a metropolitan hospital and how end-of-life decisions are made for them	Metropolitan West Coast hospital	72 unbefriended patients (seven months)

Summary of Findings

Unbefriended Patient Demographics

The three studies that collected demographic information of unbefriended patients reported that unbefriended patients are generally male, age 65 and older, and incapacitated due to dementia (Bandy et al., 2010) (White et al., 2006) (Chen et al., 2016). Some studies found that over half were African American patients (Bandy et al., 2010), while others reported a majority were White. (White et al., 2006). Unbefriended patients often have Medicare/Medicaid as their primary payer (Bandy et al., 2010). Although it is possible that they may at some point regain capacity, most unbefriended patients do not. White et al. found that 17 of the 71 unbefriended patients in their study regained decision-making capacity before a surrogate decision-maker could be located. The remaining 69% (49 of 71) did not regain decision-making capacity (White et al., 2006). The medical conditions that most often led to hospitalization were respiratory failure (White et al., 2006) (White et al., 2007) and psychiatric disorders (Bandy et al., 2010). The destination or intended destination after discharge from the hospital for most unbefriended patients is a skilled nursing facility (Bandy et al., 2010).

Length of Stay and Medically Unnecessary Days

Clinicians identify incapacitation relatively quickly, but this does not correlate to a swift petition for guardianship. Bandy et al. found that the median time between patients' admission and the date of documented incapacitation was one day. However, the median time between documented incapacitation and guardianship request was 14 days (ranging two to 90 days). The mean number of medically unnecessary days of length-of-stay reported by the studies ranged from 19.5 (Chen et al., 2014) to 63 days (Chen et al., 2016). Daily costs for the hospital per medically unnecessary

day of the unbefriended patient's length-of-stay can range from \$4,700 (Chen et al., 2014) to \$5,000 per day (Chen et al., 2016).

Clinical Outcomes

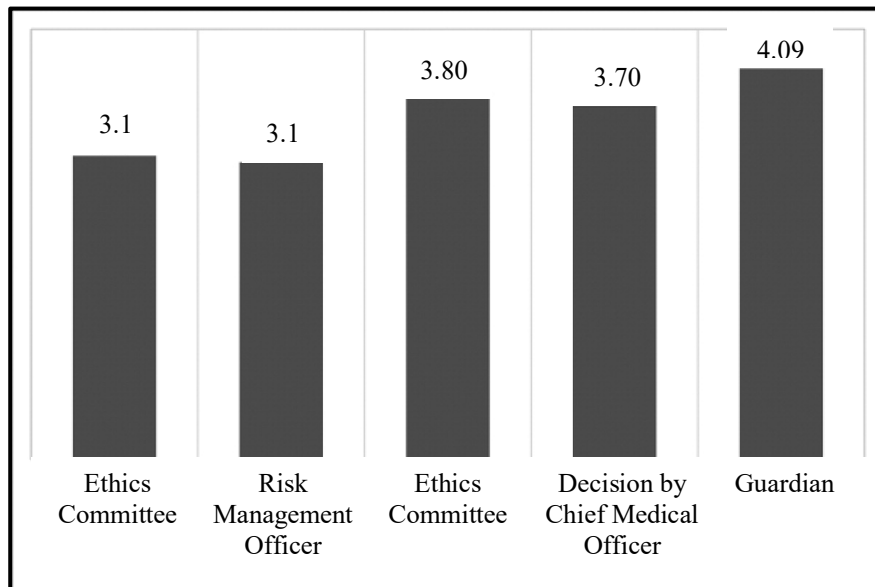
While unbefriended patients and their medical providers await a guardianship appointment, a need for important medical decisions often arose. The Bandy et al. review of medical records found that of the 81 documented invasive procedures identified for their study sample during the study period, 63 were performed prior to a guardianship appointment (Bandy et al., 2010). Some of the required decisions were related to end-of-life and do not resuscitate DNR. In the White et al., 2006 study, physicians considered withdrawing life support from 15 of their unbefriended patients (White et al., 2006). In interviews for the Catlin et al. study, clinicians felt that the most common negative outcomes for unrepresented patients were a prolonged length of hospital admission (66%) and the clinician's own personal distress (68%). About half of the participants reported delays in transitioning to end of life care, postponements in surgery, inability to improve quality of life, and mismanagement of patient pain (Catlin et al., 2019).

Stakeholder Insights

The survey and interview studies revealed that clinicians view guardianship as helpful contingent on a swift appointment and a competent and involved guardian. When asked about the qualities of a "good guardian," one respondent in Moye et al., 2017 replied with a remarkably low standard: "someone who answers the phone and visits once per quarter" (Moye et al., 2017). An interviewee in Moye et al., 2016 posited that, "some guardians are completely invested, and they are such a pleasure to work with, they are really looking out for and trying to understand this

person. With others, they are spread so thin and their time is so limited, it's a struggle to reach out to them" (Moye et al., 2016). When describing their overall experiences with guardians, about one-half (56%) of clinician respondents in Catlin et al., 2019 said their experiences varied, and about one-third (37%) said it was usually or always good. Only 6% said their experiences with guardians were usually or always poor. Clinicians working in hospital settings rated their experiences with guardians more negatively than those working in skilled nursing facilities. Their specific comments suggested that it may not be the guardian themselves who is not helpful, but rather the length of time it takes for an appointment (Catlin et al., 2019). Despite varied experiences with guardians, clinicians rated guardianship as the most helpful mechanism when a decision is needed for an individual who does not have family or friends able to make such decisions (Figure 3) (Catlin et al., 2019).

Table 3. Clinician perception of the helpfulness of a mechanism when "you need a serious medical decision made for an incapacitated adult without a surrogate" (1= not helpful to 5 = very helpful) (Catlin et al., 2019).



Guardianship Appointment Process Improvements

To address the problems that they observed, the attorneys involved in the 2014 Chen et al. study formed a multi-disciplinary consultation group consisting of stakeholders from the hospital's legal affairs, business strategy, social work, case management, psychiatry, and hospital services departments. The group met weekly to review guardianship needs and current length of stay for those waiting for a guardianship appointment. They also worked with executive leadership to identify, plan, and execute interventions to streamline the guardianship and conservatorship processes. Their final intervention included an expedited legal process and centralized guardianship oversight. They achieved an expedited legal process by retaining two outside firms to petition for the would-be guardian on behalf of the hospital and by creating a more streamlined process between the legal department, outside counsel and clinical care team to more quickly identify patients who need a public guardian and begin the appointment process (Chen et al., 2014).

Within a year of implementing their intervention, the attorneys observed a 75% reduction in the average length of stay for hospital patients who required public guardianship. The average length of stay dropped from 150 days to 39 days and the median length of stay dropped from about 100 days to 34 days. They estimated that the intervention freed up an average of 5 to 10 hospital beds per day. The legal team also found that it relieved workload for the social work team. 85% of social workers who responded to an intervention assessment survey indicated that they experienced a decrease in guardianship workload following the process changes. (Chen et al., 2014).

Chapter 5 – Discussion

Summary

Despite evolving legislation, the unbefriended patient population and public guardianship is a relatively unstudied population and intervention (Meurrens & Daywitt, 2013). A 2005 landmark study for the American Bar Association reviewed the state of public guardianship across the United States Teaster et al reported that a significant number of the states could not respond to the questions on their assessment survey and that no state had standardized data collection and reporting systems related to public guardianship outcomes. (Teaster et al., 2007). This literature review study looked at articles published between 2006 and 2020 to assess the changes in data collection, if any, that followed the 2005 landmark study.

The literature review findings demonstrate that recent empirical studies of the unbefriended patient population and public guardianship, although they are limited, have produced a variety of data that provide a helpful beginning overview of unbefriended patients and the public guardianship process. They've provided quantitative estimates of the demographics of the unbefriended population, quantitative measurements of the medically unnecessary length of stay days, quantitative estimates of the unbefriended patient's cost to the hospital, qualitative assessments of clinicians, and legal counsel opinion of public guardianship and the appointment process, and examples of public guardianship appointment process improvement. This data will be crucial to building future studies and policy change. None of the studies directly addressed this literature review's research questions. The driving questions of this literature review sought to compare between cohorts of unbefriended patients who receive a guardian and those who don't. The reviewed studies did not offer comparison. They only offered descriptive statistics,

which suggests that research studies are still exploring the scope of the issues related to unbefriended patients and public guardianship.

This literature search yielded one other literature review that was completed by Kim & Song in 2018. Their search was not restricted by time and included articles that (a) reported empirical data and (b) focused on adults who lack decision-making capacity and a surrogate. Their search yielded ten articles, some of which were also included in this literature review study. Not all of the articles crossed over into this study because some were published before 2006, and some focused on the unbefriended patient population, but did not include discussion of public guardianship. This study's literature review required that the study discuss the unbefriended patient population *and* public guardianship. Despite these inclusion criteria differences, it is interesting to note that both this literature review search and the Kim & Song search yielded a similar number of data-based studies. Their search yielded 10 articles while this study's search yielded eight. This further confirms the conclusion that empirical studies of the unbefriended patient population and guardianship are limited, and it suggests that data-based studies of these topics were not conducted until the 2000s (Kim & Song, 2018).

Gaps in Evidence

There are a few methodology trends in the recent studies assessed in this literature review that greatly limit their generalizability and demonstrate continued gaps in the literature. The studies were conducted in the same geographic areas: Massachusetts, New Hampshire and a select few states on the west coast and southwest United States. Massachusetts has a Center for Guardianship Excellence supported by the Guardian Community Trust nonprofit. The Center for

Guardianship Excellence carries out basic and applied social and economic research on guardianship and alternative decision-making that is funded by the community trust. This organizational support of research related to unbefriended patient populations and public guardianship drives the disproportionate number of studies conducted in Massachusetts. Furthermore, many of the same researchers conduct and publish studies on the unbefriended patient and public guardianship issues—names like White, Moye, Chen, Pope, Bandy, are repeatedly referenced in public guardian research. These researchers are physicians and legal counsel with large hospitals. Because unbefriended populations are a stress both financially and ethically to health systems, it is not surprising that researchers with these particular backgrounds are the individuals with a demonstrated vested interest in unbefriended patient and public guardianship issues.

All of the reviewed studies were conducted with large urban hospital or statewide guardian program populations. Existing literature does not address the unbefriended patient population in rural health care settings and it has not assessed public guardianship operations at a more local level such as at the county level. Although recent research provides demographic information about the unbefriended patient population, it fails to compare unbefriended patient outcomes by incapacitation type. For example, it may be valuable to compare patient outcomes between those who are incapacitated due to developmental disabilities and those who are incapacitated due to dementia because demographically, these patients can be very different. Knowledge of the differences between these unbefriended patient populations may be useful in creating policy to change the public guardianship process and in preventing the need for public guardianship.

Public Health Implications

Although issues pertaining to unbefriended patients and public guardianship most commonly present in the healthcare system, unbefriended patient issues are inherently public health issues. Unbefriended patients are an extremely vulnerable growing population, who, for various reasons, are unable to access the social determinants of health on their own. Public health is highly involved in the prevention of incapacitation and public guardianship through preventative health activities. Although not all incapacitation is avoidable, access to health care and healthy lifestyles can prevent many chronic illnesses that could ultimately lead to incapacitation. Public health has the opportunity to be involved in advocacy for policies that will improve the public guardianship appointment process and ultimately guardianship as a whole. The argument for the stake of public health in this advocacy is clear: a good guardianship will protect the unbefriended patient and create pathways for the patient to meet all of their social determinants of health needs.

Guardianship Process Improvement Recommendations

OPG Recommendations

Much of the data related to public guardianship is not currently maintained in an accessible reporting system. The public guardianship legal proceedings require extensive documentation, so the data is available, just not in an accessible congregate form. Data collection should include the annual number of guardianship and conservatorship cases for which the public guardian program was appointed as guardian or conservator, the total number of open cases, the number of cases terminated and their disposition, referral sources, cost per case, actions taken by guardians, the

age and condition of clients, and the number institutionalized. Other data elements, such as the number of limited guardianships, size of the estates, paid professional staff time spent on each ward, referral sources, and more, should also be standardly reported. Regular internal and external program evaluation requires the consistent collection and aggregation of data. This may be achieved through the establishment of external agencies such as Massachusetts's Center for Guardianship Excellence or Alaska's Working Interdisciplinary Network of Guardianship Stakeholder (WINGS) (Wawrzonek and Marz, 2019). These agencies have the capacity and an overall mission to research and improve the guardianship process.

The 2005 landmark study by Teaster et al. confirmed recommendations that the most appropriate ratio between public guardians and wards is 1:20. When possible, states should conduct process evaluations through pilot programs to evaluate the client outcomes achieved through new ratios and the costs saved in terms of timely interventions that prevent crises. Staffing ratios must be supported by appropriate funding.

In addition to coordinating public guardianship services, the Nebraska OPG aims to provide education and support to individuals who may volunteer to serve as guardians. As of April 2021, the office offered an educational course to train guardians in both an online format and a phone format. The online format costs \$20 and is self-paced. When completed in one sitting, the online course takes about two hours. It is offered in English and Spanish. The phone course is \$35 and taught by a live instructor. It is offered once a month on a weekday from 1 pm-4 pm Central Time. Prior to the COVID-19 pandemic, the OPG offered an in-person course instead of the phone course. The course is required for all newly appointed guardians and conservators, unless

specifically waived by the court. The course description states that the “content, approved by the Nebraska Supreme Court, provides detailed information for those serving as guardian or conservator.” The OPG should expand outreach and promotion of this course so that the public guardianship caseload can be shared with trained volunteer public guardians. The course, however, must remain up-to-date, provide a manageable amount of information, and be complimented by person-to-person support between the OPG and the volunteer guardian. The current course displays outdated documents and provides a large quantity of information in one sitting. Furthermore, those who complete the training do not receive follow-up from the OPG, unless they request it. This disconnect between online training and the OPG does not support retention of those who complete the training and who would be eligible for volunteer guardianship.

Hospital Recommendations

Hospitals should form a multidisciplinary stakeholder team that includes physicians, psychiatrists, nurses, social workers, legal counsel, and other parties who may be involved with an unbefriended patient to form an advisory group that frequently, at least every two weeks, reviews unbefriended patient cases to plan action, or if action has already occurred, to perform process evaluation. Additionally, this group can review cases of patients who are at-risk of becoming incapacitated to ensure that they have a surrogate guardian named. If the patient does not, the hospital can assist in identifying a surrogate decision maker or outlining an advanced directive so as to avoid the need for public guardianship upon incapacitation. If it is established that guardianship is needed, the hospital should have a standardized operating procedure in place for the petitioning process. It should be clearly outlined in a written procedure who is responsible

for identifying capacity and declaring the need for guardianship, who is responsible for completing the petition, and the mandated turnaround time for this process (ideally as quickly as possible). The 2014 study by Chen et al. offers an excellent overview of the implementation of these suggestions in a hospital setting. It should be noted that multiple large, urban hospitals in Nebraska have established these multidisciplinary guardianship stakeholder teams to provide such oversight. This suggests that while delays in public guardianship can occur in all steps of the process, hospitals have begun efforts to improve the process; future efforts, perhaps, should center around the OPG in Nebraska or, for other states, around the organization that oversees public guardianship.

Strengths and Limitations

This literature review is one of few that synthesize recent studies related to unbefriended patients and public guardianship. The findings included a wide range of data based on an equally wide range of empirical evidence from retrospective and prospective cohort studies, interviews, surveys, and interventions. This literature review does have a few limitations. It was limited to one electronic database using three different search terms, and it included published studies only. Quality assessments were not completed due to the small number of articles reporting empirical data and due to the various study designs. Additionally, only one researcher performed the search and assessed eligibility based on the inclusion and exclusion criteria. The inclusion and exclusion criteria was highly selective. This literature review is subject to selection bias. Findings from the selected studies were synthesized rather than compared to one another due to the wide range of study types and reported outcomes.

Next Steps

The researcher conducted this literature review in preparation for a cost savings study of unbefriended patients in an urban Nebraska hospital. The researcher completed a confidentiality agreement, presented the study to the hospital's research review board, and received approval to complete the study. The study will be completed upon the researcher's receipt of the requested deidentified data. The researcher requested deidentified data with information on the patient's gender, race, hospital location (for admittance), hospital admittance and discharge dates, reason for admittance to the hospital/diagnosis at admittance, major medical procedures completed during the length of stay, health status at discharge, date declared incapacitated, medically unnecessary days, total charges, and the type and total payments that the hospital received.

Study Overview

The study is a retrospective statistical analysis of data collected from a convenience sample of one year (January 1, 2019-December 31, 2019) of medical records from an urban Nebraska hospital. Its purpose is to assess health outcomes of the unbefriended, incapacitated patient and to assess the cost savings for the health system ensuing a Nebraska public guardianship appointment. The study will seek to answer the following research questions: (1) What is the average number of days that an unbefriended patient remains in a Nebraska hospital? (2) Is the average length of stay of unbefriended patients who remain hospitalized for an extended period of time without receiving a guardian different compared to unbefriended patients who receive a guardian? (3) What are the cost savings for a Nebraska hospital when an unbefriended patient receives a public guardian and approval for a transfer to an outpatient facility?

In 2019, the hospital had 102 cases of unbefriended patients who the hospital referred to Legal aid consultants to petition for a public guardian. These patients were referred if they were deemed “nondecisional” by a licensed clinical psychologist. The youngest unbefriended patient during 2019 was 21 and the oldest was 98. The average age of these patients was 64. The Director of Health Information Management will review these patients’ records and pull the researcher’s requested data. A medical record will be included in analysis if it meets all of the following characteristics: the patient is age 19+, the patient had a one day or greater length of stay, the medical record includes documentation of patient incapacitation (e.g. documentation of delirium, unresponsiveness, sedation, statements that the patient was unable to participate in decisions, or signature of someone other than patient on a written informed consent document), the medical record includes documentation of a public guardianship request through the OPG and the date at which guardianship was appointed, and the medical record has an associated billing record.

Data analysis will involve three statistical analyses, each exploring a research question.

- (1) The researcher will calculate the average length of stay in the hospital for the patients included in the study using the Excel average and mean functions. This is a descriptive analysis to answer, “what is the average number of days that an unbefriended patient remains in a Nebraska hospital?”
- (2) The researcher will complete an independent T test using the SAS 9.4 software. They will divide the patients into two cohorts—those who received a public guardian while in the hospital and those who did not. The intended SAS code is presented in Appendix D. This

is an inferential analysis to answer, “is the average length of stay of unbefriended patients who remain hospitalized for an extended period of time without receiving a guardian different compared to unbefriended patients who receive a guardian?”

- (3) The researcher will complete a cost savings analysis using Excel. They will follow the analysis procedure validated by the Florida Department of Elder Affairs Statewide Public Guardianship Office 2009 evaluation of their public guardians program (see Appendix E). Cost savings will be calculated on reported national and Nebraska-specific estimates. The average cost of nursing homes and assisted living facilities in Nebraska will be calculated based upon the 2016 MetLife Mature Market Institute National Survey of Nursing Home and Assisted Living Costs. The United States Department of Health & Human Service’s mean cost for all hospital stays in the nation for 2016 will be used to estimate the daily cost and median stay at an acute hospital. Finally, the Nebraska state hospital cost will be estimated based on the average daily cost of the study hospital. This is an inferential analysis to answer, “what are the cost savings for a Nebraska hospital when an unbefriended patient receives a public guardian and approval for a transfer to an outpatient facility?”

Conclusions

Studies demonstrate that unbefriended patients and the public guardianship process create various financial and ethical issues for hospitals. Researchers have only recently begun measuring these issues empirically. Preliminary findings suggest that the unbefriended patient population is large, that this patient population experiences a longer than average length of stay

and medically unnecessary days in the hospital, that the greater length of stay can result in numerous negative health outcomes, and that public guardianship is a viable solution, but the appointment process is generally too slow and cumbersome. Researchers must continue to collect data on the unbefriended patient population and public guardianship process to inform policy and overall process improvement. Future research should explore the reasons why some friends and family members are unable to serve as guardians. Some barriers, such as difficulty paying attorney or court fees, may be remediable and preferred. Although public guardianship is a viable intervention for decision-making for unbefriended patients, it should always remain the last resort.

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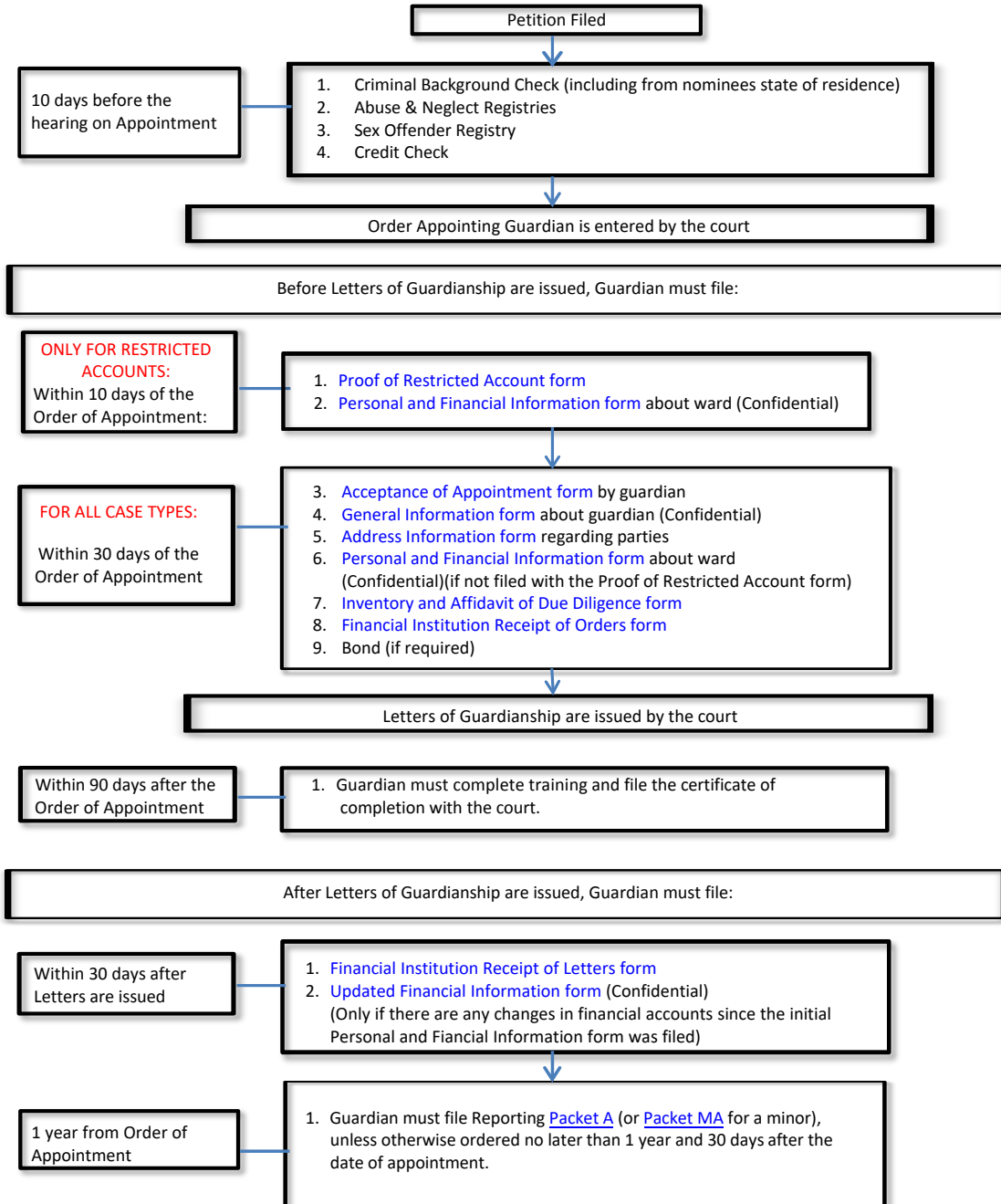
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Appendix A: Nebraska Public Guardianship Appointment Process Overview

NEBRASKA GUARDIANSHIP FLOWCHART



Appendix B: Order Appointing Public Guardian as Guardian and Conservator

Nebraska State Court Form
REQUIRED
 CC 16:2.115 Rev. 04/2020
 Neb. Rev. Stat. §§ 30-2633, 30-2619,
 30-2639, 30-2627(a), 30-4112,
 30-2627(e), Neb. Ct. Rule § 6-1433.02(D)

ORDER APPOINTING PUBLIC GUARDIAN AS GUARDIAN AND CONSERVATOR

Choose the county

IN THE COUNTY COURT OF _____ COUNTY, NEBRASKA

Case No. _____

IN THE MATTER OF

 Ward/Protected Person.

ORDER APPOINTING PUBLIC GUARDIAN AS GUARDIAN AND CONSERVATOR

The Petition for Appointment of Guardian and Conservator having come before the court, the court finds as follows:

1. Petitioner(s) is/are entitled to file the Petition pursuant to [Neb. Rev. Stat. §§ 30-2633 and 30-2619](#).
2. Notice has been given or waived as required by law.
3. Venue in this county is proper.
4. Upon clear and convincing evidence presented to the court, there is a sufficient basis for the appointment of the guardian for _____
 - an incapacitated person, pursuant to lawful proceedings of record in this court or
 - an incapacitated person, pursuant to the provisions of the Last Will and Testament of _____, parent or spouse of said incapacitated person, which Will was admitted to probate in this court and there are no less restrictive alternatives than the appointment of a guardian for the above-named incapacitated person.
5. Upon clear and convincing evidence presented to the court, there is a sufficient basis for the appointment of the conservator for _____ and there are no less restrictive alternatives than the appointment of a conservator for the above-named protected person.

Lines Remove Lines
6. Appointment of a guardian and conservator is necessary because:

7. Proper notice has been given to the Office of Public Guardian.

8. The petitioner has acted in good faith and due diligence to identify a guardian and/or conservator who would serve in the best interest of the ward/protected person.
9. The appointment of the Office of Public Guardian is necessary and does not exceed the caseload limitations as set forth by statute.
10. The Court Visitor or Guardian ad Litem report has provided supporting evidence that no person is available for appointment as guardian and/or conservator, all options available to support the individual in the least restrictive manner possible have been explored, and guardianship and/or conservatorship is a last resort.
11. There is no other alternative than to appoint the Office of Public Guardian.

The court finds clear and convincing evidence that a full guardianship is necessary and is the least restrictive alternative. **The Public Guardian is granted all powers conferred upon guardians by law which are listed below:**

- i. Selecting the ward's place of abode within this state or with court permission, outside of this state;
- ii. Arranging for medical care for the ward;
- iii. Protecting the personal effects of the ward;
- iv. Giving necessary consent, approval, or releases on behalf of the ward;
- v. Arranging for training, education, or other habilitating services appropriate for the ward;
- vi. Applying for private or governmental benefits to which the ward may be entitled;
- vii. Instituting proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform such duty, if no conservator has been appointed;
- viii. Entering into contractual arrangements on behalf of the ward, if no conservator has been appointed; and
- ix. Receiving money and tangible property deliverable to the ward and applying such money and property to the ward's expenses for room and board, medical care, personal effects, training, education, and habilitating services, if no conservator has been appointed, or requesting the conservator to expend the ward's estate by payment to third persons to meet such expenses.

- This is a limited guardianship. The Public Guardian, as guardian, shall have the following authorities and responsibilities (acting together with the ward or singly):
 - Selecting the ward's place of abode within this state, or with court permission, outside of this state;
 - Arranging for medical care for the ward;
 - Protecting the personal effects of the ward;
 - Giving necessary consent, approval, or releases on behalf of the ward;
 - Arranging for training, education, or other habilitating services appropriate for the ward;
 - Applying for private or governmental benefits to which the ward may be entitled;
 - Instituting proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform such duty, if no conservator has been appointed;
 - Entering into contractual arrangements on behalf of the ward, if no conservator has been appointed;
 - Receiving money and tangible property deliverable to the ward and applying such money and property to the ward's expenses for room and board, medical care, personal effects, training, education, and habilitating services, if no conservator has been appointed, or requesting the conservator to expend the ward's estate by payment to third persons to meet such expenses.
 - Other:

12. The Public Guardian is entitled to appointment pursuant to [Neb. Rev. Stat. §§ 30-2639, 30-2627, and 30-4112](#) and should be appointed as guardian and conservator. The Public Guardian is authorized and ordered to obtain a Financial Institution [Receipt of Orders](#) form completed by each financial institution holding any assets or accounts titled in any manner in the name of the protected person along with a printout of all assets and account numbers in each financial institution, which shall be filed in these proceedings.
13. If any funds are ordered restricted, the Public Guardian is further authorized and ordered to open an account at a financial institution with the restriction that **no withdrawals can be made without a**

court order. To show the court that they complied with this restriction, the Public Guardian shall file with the court a Proof of Restricted Account form within 10 days of this order.

14. Bond is not required per [Neb. Rev. Stat. § 30-2627\(e\)](#).
15. Training: For good cause shown training is waived. The Public Guardian and the Associate Public Guardians have already taken the training.
16. The Public Guardian shall file the Notice of Designation of Deputy Public Guardian and Associate Public Guardians form (CC 16:2.96) with the court indicating who the designated Associate Public Guardian is for this case. If the Associate Public Guardian changes, the Public Guardian shall file an updated Notice of Designation of Deputy Public Guardian and Associate Public Guardians form (CC 16:2.96) with the court indicating who the new designated Associate Public Guardian is for this case.

IT IS THEREFORE ORDERED that the Public Guardian is appointed guardian and conservator of the estate of _____ and Letters of Guardianship and Conservatorship shall be issued to the Public Guardian upon the filing of the following documents:

1. Acceptance of Appointment;
2. General Information Form.
3. Address Information Form;
4. Financial Institution Receipt of Orders form with a printout of all assets in each financial institution;
5. Proof of restricted funds form for any assets the court has ordered to be held in a restricted account;
6. Inventory, Affidavit of Due Diligence, and Certificate of Mailing form;
7. Budget that pursuant to [Neb. Ct. Rule § 6-1433.02\(D\)](#) is for informational purposes only;
8. Personal and Financial Information for Guardianships and Conservatorships form.

After Letters are issued, the Public Guardian shall deliver to each financial institution where the ward/protected person has accounts/assets a copy of the Letters of Guardianship and Conservatorship and file with the court a Financial Institution Receipt of Letters form acknowledging that they received the Letters, along with a printout of all assets and account numbers in each financial institution. The Public Guardian shall thereafter be entitled to deal with such assets. This form shall be filed within 30 days. Failure to file this form will result in a suspension of your authority.

As a guardian and conservator the Public Guardian is ordered to comply with the following restrictions:

- 1. The Public Guardian shall not pay compensation to themselves from assets or income of the ward/protected person, nor sell real property of the estate without first giving notice to interested persons and obtaining an order of the court. To obtain an Order, the Public Guardian must first file an application, give notice to interested persons, then have a hearing date scheduled. The order may be entered without a hearing if all interested persons have waived notice of hearing or have executed their written consent to such compensation or sale or any other restrictions as determined to be appropriate by the court.**
- 2. The Office of Public Guardian is prohibited from making **cash** withdrawals or receiving cash back.**
- 3. If any funds have been restricted by the court, the Public Guardian shall not make any withdrawals from the restricted account without a court order.**
- 4. Other:**

DATED: _____.

BY THE COURT:

County Judge

PREPARED AND SUBMITTED BY:

Appendix C: Full Data Extraction



Appendix D: SAS Code for the Cost Savings Study Statistical Analysis 2

```
PROC FORMAT;
  value GUARDIANSHIPfmt 1= 'Guardianship' 2= 'No Guardianship';
RUN;

PROC IMPORT DATAFILE='/home/u53381117/GuardStudy/DataRequest.xlsx'
  OUT=Guardianships
  DBMS=XLSX
  REPLACE;
RUN;

DATA Guardianships;
  LOS= DischargeDate-AdmittanceDate;
RUN;

PROC TTEST Data=Guardianship;
  Class Guardianship;
  VAR LOS;
  FORMAT GUARDIANSHIP GUARDIANSHIPfmt.;
RUN;
```

Appendix E: Florida Department of Elder Affairs Statewide Public Guardianship Office Evaluation Cost Savings Calculation Explanation (2009)

Action	Calculation	Cost
From SH to ALF	$(SH) \$233/day - (ALF) \$89/day = \$144 \times 30 \text{ days}$	\$4,320
From SH to NH	$(SH) \$233/day - (NH) \$191/day = \$42 \times 30 \text{ days}$	\$1,260
From AH to ALF	$(AH) \$1817/day - (ALF) \$89/day = \$1728 \times 3 \text{ days}$	\$5,184
From AH to NH	$(AH) \$1817/day - (SH) \$191/day = \$1626 \times 3 \text{ days}$	\$4878
Secure community-based services	\$100	\$100 1-Time

Assumptions:

1. Nursing home (NH) day = \$191
2. Assisted living facility (ALF) day= \$89
3. Acute hospital day (AH)= \$1,817
4. State hospital (SH) day = \$233 (This includes Psychiatric Hospitals)
5. Pre-paid funeral = \$6,000
6. \$100 one-time per client for securing community-based service to prevent moving to more restrictive environment
7. Patient would have stayed in state hospital for 30 days if not otherwise moved
8. Patient would have stayed in acute hospital for 3 days if not otherwise moved

Biography

Emily Berzonsky is a May 2021 Master of Public Health (MPH) candidate at the University of Nebraska Medical Center (UNMC). She is pursuing her MPH with an emphasis in health promotion. She comes to the UNMC College of Public Health after completing her Bachelor's degree in Community & Public Health at South Dakota State University and after completing the CDC's Research Initiatives in Student Enhancement- Undergraduate Program (RISE-UP) summer leadership program. Emily's public health interests include intervention planning, implementation and evaluation, chronic disease prevention, food insecurity, and interventions that target older adult populations.

While completing her MPH, Emily assisted as a student worker to Dr. Kendra Ratnapradipa on her research project to evaluate a cancer distress screening tool and later to Dr. Fabio Almeida in his implementation of DiaBEAT-IT, a telehealth diabetes intervention. She served as the 2020-2021 Vice President of UNMC's College of Public Health Student Association. Emily was one of five students to be awarded funded support for her Applied Practice Experience (APEX) from the Midwestern Public Health Training Center. She completed her APEX with North Central District Health Department in O'Neill, NE. Emily was also one of 25 public health students nationwide to be awarded funded conference attendance to the American Public Health Association 2020 Virtual Annual Meeting. Emily was part of the 2020-2021 cohort of the Leadership Education in Neurodevelopmental Disabilities (LEND) Fellowship through the Munroe Meyer Institute. She completed this capstone project in collaboration with her LEND community leadership and learning project agency, Legal Aid of Nebraska.

Curriculum Vitae

Emily Berzonsky

Omaha, NE

emily.berzonsky@unmc.edu

EDUCATION

- 2021 MPH University of Nebraska Medical Center (UNMC), Health Promotion
Omaha, NE
Capstone: *Nebraska public guardianship of unbefriended patients: a preliminary statistical analysis of health outcomes and cost savings*
Committee: Ann Mangiameli, Hongmei Wang, Brandon Grimm (Chair)
- 2019 BS South Dakota State University, Community & Public Health
Honors Thesis: *Causal Analysis of the Deficiencies of the Veteran HealthCare System.*
Thesis Advisor: Dave Graves

PROFESSIONAL EXPERIENCE

- 2020-2021 Leadership Education in Neurodevelopmental Disabilities (LEND) Fellow,
Munroe Meyer Institute, Omaha, NE
- 2020-2021 Student Association Vice President, UNMC College of Public Health, Omaha,
NE
- 2020-2021 Student Response Team Member, UNMC College of Public Health, Omaha, NE
- 2019 CDC Maternal Child Health Careers/Research Initiatives for Student
Enhancement – Undergraduate Program (MCHC/RISE-UP) Scholar, Sioux Falls,
SD

RESEARCH EXPERIENCE

- 2020-2021 Research Assistant to Dr. Fabio Almeida, Implementing the DiaBEAT-IT
telehealth diabetes prevention intervention
- 2019-2020 Research Assistant to Dr. Kendra Ratnapradipa, researching the cancer treatment
“distress thermometer” distress screening instrument
- 2017-2018 Research Assistant to the Fruit and Vegetable Education (FRUVED), a USDA
grant-funded research project implementing a community-based research
approach to help college and high school students manage their weight and live
healthier by focusing on improving dietary intake, increasing physical activity,
and improving overall stress management skills

HONORS / AWARDS

- 2020 American Public Health Association 2020 Virtual Annual Meeting Scholarship
- 2020 Midwestern Public Health Training Center's Field Placement Scholarship
- 2019 Omaha GenderWorks Transgender Healthcare Conference scholarship
- 2019 Schultz-Werth Award for Scholarly Research
- 2019 Hilton M. Briggs Library Research Poster Award

MEMBERSHIPS / AFFILIATIONS

American Public Health Association