Washington State
Institute for
Public Policy

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PUBLIC GUARDIANSHIP IN WASHINGTON STATE
COSTS AND BENEFITS

Summary

Guardians are court-appointed legal representatives who have the authority to make personal, medical, and financial decisions on behalf of incapacitated individuals. Washington State implemented a pilot program in 2007 to provide public (state-paid) guardianship services for individuals whose family members were unable to serve as a guardian, or the individual did not have financial resources to pay for a guardian.

This evaluation examines program outcomes and cost effectiveness for clients served by public guardians between 2008 and mid-2011. Our analysis over this period found the following:

- Average residential costs per client decreased by $8,131 over the 30-month study period. The average cost for providing a public guardian was $7,907 per client during that time.
- Personal care decreased by an average of 29 hours per month for public guardianship clients, compared with an increase in care hours for similar clients.
- One in five public guardianship clients showed improvements in self-sufficiency during the study.

This report discusses the characteristics and outcomes of public guardianship clients and presents related research on outcomes for public guardianship programs outside Washington State. While we found positive results for public guardianship clients in this evaluation, without a randomly assigned control group (that did not receive services), it is difficult to determine the extent to which public guardians may have contributed to these outcomes.

The Washington State Legislature passed Substitute Senate Bill 5320 in 2007, establishing an Office of Public Guardianship (OPG) within the Administrative Office of the Courts. The office is intended to "promote the availability of guardianship services for individuals who need them and for whom adequate services may otherwise be unavailable."[1] Guardians are court-appointed representatives who have the authority to make legal, medical, and financial decisions for an incapacitated individual. The court may establish limits on the extent of the guardian's decision-making authority (based on the nature of the incapacity) and can also limit the duration of guardianship. More information about the guardianship process and the establishment of Washington State's Office of Public Guardianship is provided in an earlier report.[2]

The Office of Public Guardianship was implemented as a pilot program which originally served clients in five counties (Clallam, Grays Harbor, Okanogan, Pierce, and Spokane). The program was expanded to serve five additional counties between 2009 and 2011.[3] To determine the effectiveness of this pilot program, the Legislature directed the Washington State Institute for Public Policy (Institute) to "analyze the costs and off-setting savings to the state from the delivery of public guardianship services."[4] This report includes information on the cost effectiveness of the program, as well as outcomes related to client health and functioning.

[1] RCW 2.72.005
[2] Burley, M. (2009). *Public guardianship services in Washington State: Pilot program implementation and review* (Document No. 09-08-3901). Olympia: Washington State Institute for Public Policy,
[3] These included King (2009), Snohomish (2010), Clark (2011), Kitsap (2011) and Thurston (2011).
[4] RCW 2.72.030(13)

Suggested citation: Mason Burley. (2011). *Public guardianship in Washington State: Costs and Benefits* (Document No. 11-12-3902). Olympia: Washington State Institute for Public Policy.

Section I: Guardianship Appointment and Eligibility

In Washington State, any interested individual may file a guardianship petition if they have concerns about the well-being of an allegedly incapacitated person (AIP). The Washington State Attorney General may also file a guardianship petition "in any case in which there is cause to believe that a guardianship is necessary and no private party is able and willing to petition."[5] At present, the Attorney General's office files for guardianship in selected cases on behalf of Adult Protective Services (for instances of abuse, neglect, or exploitation), or when the Division of Developmental Disabilities (DDD) requests a guardian for a client.

Prior to the court hearing (which usually occurs within 60 days of filing), the court appoints an independent investigator, called a *Guardian Ad Litem,* to evaluate the case and provide recommendations to the court. This evaluation must be provided to the allegedly incapacitated person, direct family members, and other persons involved in the case. As noted in Washington State law, the determination of incapacity involves a "significant risk of personal harm based upon a demonstrated inability to adequately provide for nutrition, health, housing, or physical safety."[6]

Case law in Washington State and elsewhere places great importance on preserving individual liberty and autonomy and notes that individual rights should be restricted "only to the minimum extent necessary to adequately provide for their own health or safety, or to adequately manage their financial affairs."[7] Upon hearing the guardian petition, the court may dismiss the case, or establish either a limited (partial) or full guardianship (covering all areas of decision-making). Once appointed, a guardian serves as the legal decision maker, and may be responsible for financial management, healthcare decision making, residential placements, service coordination, and status updates to the family and court.

There were 2,910 new guardianship petitions filed in Washington State in 2010,[8] and courts appointed a guardian in 1,951 of the cases.[9] In many cases, a family member or friend may be appointed to serve as a "lay" guardian advocate for the incapacitated individual. If a volunteer guardian is not available or willing to serve, the financial resources of the incapacitated individual may be used to hire a *certified professional guardian (CPG)*. According to the Certified Professional Guardian Board (which approves and oversees paid guardians), there were 242 individuals certified to serve as professional guardians in 2010.[10]

For low-income or indigent individuals requiring a guardian, there are few options available to help pay for these services. In Washington State, individuals that qualify for Medicaid may have their payment obligation ("participation") reduced by about $175/month to help pay for guardianship services. This income exemption, however, may not cover the full cost of guardianship services. Furthermore, incapacitated individuals could be unable to pay for a private guardian yet have income or assets that make them ineligible for Medicaid. In a companion to this report, we used several different methods to determine the unmet need for guardianship services among low-income individuals (under 200 percent of the federal poverty level). We estimated that between 4,000 and 5,000 adults in Washington State may require a guardian advocate, but may not have the financial resources to pay for these services.[11]

[5] RCW 11.88.030 (2)(a)
[6] RCW 11.88.010(1)(a)
[7] RCW 11.88.005

[8] http://www.courts.wa.gov/caseload/content/pdf/superior/Annual/prgfilyr.pdf
[9] http://www.courts.wa.gov/caseload/content/pdf/superior/Annual/prgresyr.pdf
[10] http://www.courts.wa.gov/content/publicUpload/cpg/2010%20Annual%20Report.pdf
[11] Burley, M. (2011). *Assessing the potential need for public guardianship services in Washington State*

A 2005 report by the Washington State Bar Association's Elder Law Division suggested that while there are costs associated with public guardianship services, there are also "significant opportunities to save public funds by providing timely and appropriate services to people in need of them; and experience elsewhere suggests that the savings should more than offset the costs."[12] The 2007 Washington State Legislature established the Office of Public Guardianship (OPG) based largely on the recommendations in this report.

The 2007 legislation set eligibility guidelines and requirements for the provision of public guardianship services. To be eligible for a public guardian, individuals (in the pilot program counties) must have incomes under 200 percent of the federal poverty level or be receiving long-term care services through the Department of Social and Health Services (DSHS). In addition, a public guardian can only be appointed when there is no one else qualified, willing, and able to serve.

As mentioned previously, the Office of Public Guardianship contracts with guardians in seven counties to provide services to eligible clients. Exhibit 1 shows the date when the first clients were assigned in each county, and the number of individuals represented. In 2011, the Office of Public Guardianship accepted cases for clients living in Clark, Kitsap, and Thurston Counties, but these cases could not be included in the study since data collection and matching for the analysis had already ended.

Exhibit 1
Public Guardianship Cases: 2008 to mid-2011

County	Date of First Assignment	Total Clients Served
Spokane	January 2008	21
Grays Harbor	July 2008	4
Pierce	September 2008	24
King	December 2008	29
Clallam	January 2009	4
Okanogan	January 2009	2
Snohomish	October 2010	3
Total		**87**

Public guardians have served 87 individuals who were referred to the program between 2008 and mid-2011. It should be noted that as a result of a reduction in state funding in the 2009–11 biennial budget, OPG reduced the number of accepted referrals starting in mid-2009.

The Office of Public Guardianship was created on the premise that a public guardian could improve the quality of life of low-income incapacitated persons. In addition to non-monetary benefits (like improved functioning and social connections), it was anticipated that the presence of a guardian would also reduce public costs over time. Previous studies have identified savings that occurred from lower health care costs, recovery of financial assets, and moves to less restrictive (and costly) residential settings. The next sections summarize this research and present outcomes for public guardianship clients in Washington State.

(Document No. 11-12-3901). Olympia: Washington State Institute for Public Policy.

[12] Washington State Bar Association. (2005, August 22). *Report of the Public Guardianship Task Force to the WSBA Elder Law Section Executive Committee*. Seattle, WA: Author, p. 7.

Section II: Previous Cost Benefit Studies

We identified three studies that examined cost-related outcomes for public guardianship clients. In each study, the results were based primarily on cost avoidance that occurred when a guardian was able to move the client to a less restrictive residential setting (such as from a nursing home to an adult family home). This section provides information and outcomes from these previous research efforts.

Virginia Public Guardian and Conservator Programs

A 2003 study conducted by the Center for Gerontology at Virginia Polytechnic Institute and State University looked at outcomes for 158 incapacitated persons served by public guardians.[13] The study period took place between 2001 and 2002. During this time, the average annual cost to provide services to incapacitated individuals was $2,995 per person.

In each period, the study reported on the following types of discharges:

- state psychiatric hospital to assisted living facility
- state psychiatric hospital to nursing home
- medical hospital to assisted living facility
- medical hospital to skilled nursing facility
- skilled nursing facility to assisted living facility

In total, 85 incapacitated persons moved to a less restrictive residential setting, resulting in a reported cost savings of $5.6 million. Nearly two-thirds of the reported cost savings were attributed to discharging incapacitated persons from psychiatric wards. The final evaluation report concluded that, "such a cost savings indicates that the programs not only pay for themselves, but they pay for themselves over three times their funding amount in a single fiscal year, and relatively early in the life of the programs."[14]

Florida Public Guardian Programs

The Florida Statewide Public Guardianship Office was established in 1999. A 2009 evaluation of this program,[15] used methodology similar to the study conducted in Virginia. The evaluation followed 2,208 incapacitated persons served by public guardians during 2008. During this period, 958 incapacitated persons were discharged to a less restrictive residential environment, resulting in a reported cost savings to the state of over $1.8 million. The cost savings were estimated after accounting for the annual average cost of $2,648 for guardianship services per client. These findings led the authors to conclude that the public guardian programs in Florida would recover public costs within a year.[16]

The Guardianship Project Demonstration

The Guardianship Project is a foundation-supported demonstration started in 2005 by the Vera Institute of Justice. The program provides guardianship services in New York City to elderly and disabled individuals. The program includes both clients with assets to pay for services and those without financial resources. The Project employs not only attorneys for legal representation, but also staff such as bookkeepers and social workers. This team works together with the goal of helping clients stay in their homes or retain as much autonomy and independence as possible.

[13] Teaster, P., & Roberto, K. (2003). *Virginia public guardian and conservator programs: Evaluation of program status and outcomes,* Blacksburg, VA: The Center for Gerontology, Virginia Polytechnic Institute and State University.

[14] Ibid., p. 67

[15] Teaster, P., Mendiondo, M., Schmidt, W., Marcum, J., & Wangmo, T. (2009). *The Florida public guardian programs: An evaluation of program status and outcomes.* Lexington: University of Kentucky Graduate Center for Gerontology.

[16] Ibid, p. 23.

Over 100 clients were served by the Guardianship Project in 2010; the program budget was $1.2 million. After calculating costs for both living and deceased clients, the program estimated that the annual average cost per living client was approximately $8,600. Researchers at the Vera Institute analyzed the cases of the 111 clients served during 2010, and examined cost savings in the following areas:[17]

- nursing home, hospital, and mental health facility avoidance among Medicaid clients;
- private-pay clients who avoided or delayed Medicaid receipt by staying in the community; and
- Medicaid liens paid by the Guardianship Project out of client assets.

Based on these cost areas, the project saved a reported $2.5 million in Medicaid costs for these clients in 2010.[18] Like the results from other studies mentioned, a substantial portion (over half) of the cost savings reported in the Vera study came from a reduction in the time clients spent in a mental health/psychiatric facility.

Limitations

Several key limitations should be noted about these results. For each study mentioned in this section, only favorable client outcomes are reported. Discharges from hospitals and nursing homes were presented, for example, but information about the number of clients with health declines or clients who moved to a *more* restrictive care setting are not reported. Given that this population frequently has some level of incapacity or disability, it seems important to report on the range of outcomes that may occur over time.

In addition, these studies focused primarily on short term impacts that took place over a one or two-year period. The greatest cost savings may occur in the initial period of guardianship, if a guardian can help move a client to a less restrictive setting. It is unclear, however, if the client may have been relocated eventually (if a guardian had not been appointed). Additionally, the cited studies do not provide any information about how the length of stay in each setting differed for guardianship clients compared to individuals with similar levels of incapacity and functioning.

The evaluation for the Washington State public guardianship program presented here addresses some of these shortcomings by examining a range of outcomes for both public guardianship clients and similarly acute clients receiving services from the DSHS Aging and Disability Services Administration (ADSA). In addition, we are able to follow clients for up to three years, providing a longer period in which to assess program costs and benefits. The next section (Section III) reports on the duration of guardianship appointments and includes baseline information on client characteristics, clinical acuity and functioning. After presenting this detail about program clients, we compare outcomes for public guardianship clients to two similar groups of individuals in the long-term care and developmental disability system (Section IV).

[17] Unpublished manuscript on file with the Vera Institute of Justice, Inc. Guardianship Project.
[18] www.vera.org/project/guardianship

Section III: Public Guardianship Clients

In 2008, the Office of Public Guardianship began accepting referrals for clients who potentially met the eligibility criteria for guardianship services. The Office of Public Guardianship cannot directly petition the court for guardianship cases. Instead, referrals come from a variety of sources, including court investigators (Guardian ad Litems), DSHS social workers, or the state's Attorney General Office (AGO). Exhibit 2 shows the number of accepted cases by year from 2008 to mid-2011. Of the 87 clients assigned to a guardian, 67 are still active; 20 cases were closed because the client died or the case was transferred.

Exhibit 2
Public Guardianship Cases Accepted by Year

Year	Total Clients Assigned	Closed Cases*	Length of Guardianship (Years)
2008	13	4	2.4
2009	30	6	2.2
2010	24	5	1.0
2011†	20	5	0.3
Total	**87**	**20**	

† As of October 1, 2011
* Of the 20 closed cases, 14 occurred with the death of the client and 6 occurred as a result of a case transfer or withdrawal.

While 87 clients were assigned a public guardian, the remainder of this report focuses primarily on outcomes for 49 of these clients who had comprehensive assessment data available (and were assigned a guardian prior to 2011). To include a comparison group in this analysis, we needed to identify a common data source by which to evaluate outcomes for similar clients. The data used in this report come from the Comprehensive Assessment Reporting Evaluation (CARE) tool, which is used by DSHS to "document a client's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care."[19]

[19] http://www.aasa.dshs.wa.gov/professional/care/

CARE Data

In 2003, the DSHS Aging and Disability Services Administration (ADSA) implemented the CARE assessment for clients receiving long-term care or disability services. The CARE assessment is completed at initial eligibility determination and every six to 12 months thereafter. The CARE tool measures an individual's cognitive performance, clinical complexity, moods and behaviors, ability to complete certain activities of daily living (ADL), and other factors necessary to assess the level of care required by the client and monitor changes over time.

These CARE assessment scores are used to place a client into one of 17 residential classification groups.[20] These classification groups help determine how much the state pays toward the cost of care in a residential facility or for community support services. The CARE assessment provides a reliable and valid measure of a client's need for care and services.[21] Since the assessment is also tied to payment rates, we can assess variations in the cost of care and changes in status for both the study group (public guardianship clients) and similar individuals.

Exhibit 3 shows the demographic characteristics for public guardianship clients with a CARE assessment. Incapacitated persons served by a public guardian include clients from the Division of Developmental Disabilities (DDD) as well as those from the Home and Community Services (HCS), which includes community, residential, and skilled nursing care. Since the circumstances and needs for these two groups differ, results for each population are reported separately throughout this report.

[20] WAC 388-106-0115
[21] Gillespie, J., & Mollica, R. L. (2005, June). *Streamlining access to home and community-based services: Lessons from Washington* (Issue Brief). Washington, DC: National Academy for State Health Policy.

Exhibit 3
Public Guardianship Study Cohort: Demographic Characteristics

Category	Developmental Disability	Home/Community Services and Long Term Care	Total
Gender			
Female	13 (45%)	10 (50%)	23 (47%)
Male	16 (55%)	10 (50%)	26 (53%)
Race			
American or Alaska Native	1 (3%)	0 (0%)	1 (2%)
Asian	2 (7%)	0 (0%)	2 (4%)
Black or African American	1 (3%)	1 (5%)	2 (4%)
Caucasian	25 (86%)	17 (85%)	42 (86%)
Native Hawaiian/Pacific Islander	0 (0%)	1 (5%)	1 (2%)
Unreported	0 (0%)	1 (5%)	1 (2%)
Age			
18-24	8 (28%)	3 (15%)	11 (22%)
25-34	7 (24%)	1 (5%)	8 (14%)
35-44	3 (10%)	1 (5%)	4 (10%)
45-54	1 (3%)	2 (10%)	3 (6%)
55-64	7 (24%)	3 (15%)	10 (20%)
65 and over	3 (10%)	10 (50%)	13 (27%)
Mean (years)	39.8	59.6	47.9
Marital Status			
Not Reported	0 (0%)	1 (5%)	1 (2%)
Divorced	0 (0%)	5 (25%)	5 (10%)
Married	1 (3%)	3 (15%)	4 (8%)
Never Married	28 (97%)	8 (40%)	36 (73%)
Widowed	0 (0%)	3 (15%)	3 (6%)
Ability to Provide Information to Caregiver or Guardian			
Can provide information	5 (17%)	13 (65%)	18 (37%)
Cannot speak	8 (28%)	2 (10%)	10 (20%)
Cannot understand questions	16 (55%)	3 (15%)	19 (39%)
Refuses to cooperate	0 (0%)	2 (10%)	2 (4%)
Total	**29**	**20**	**49**

As Exhibit 3 shows, the gender and ethnic background of public guardianship clients with developmental disabilities and those in the long-term care system do not differ significantly. In all other respects, however, these two populations have notably different needs and circumstances. Public guardianship clients with developmental disabilities span a much wider age range, with over half (52 percent) under 35 years old (mean age = 40). Clients in the community services and long-term care system, on the other hand, have an average age of 60 years old, with half being 65 or older.

A client's ability to provide information to a caregiver or guardian also varies between these two groups. Over 80 percent of clients with developmental disabilities are either unable to speak or answer questions from a public guardian. For clients receiving home and community or long-term care services, about 65 percent can directly provide some information to a public guardian.

A client's age, health status, cognitive ability, and level of functioning play a key role in the type of representation and assistance that a guardian advocate can provide. Before discussing the outcomes of public guardianship clients, more detail about the residential and service options based on these needs should be provided. While all individuals with a guardian require some level of assistance managing daily activities, support needs and residential settings differ widely among these incapacitated individuals. The next section lists some of the residential and support options available for guardianship clients.

Residential Situation of Guardianship Clients

The Home and Community Services (HCS) Division within DSHS "promotes, plans, develops and provides long-term care services" for Medicaid eligible adults.[22] Some programs supported by HCS help provide personal care within a client's own home. The Community Options Program Entry System (COPES), for example, provides care such as skilled nursing, home health aides, home delivered meals, transportation, or other supported living services that take place in a client's own home or within a boarding home or adult family home.[23]

The Residential Care Services (RCS) Division of DSHS works in conjunction with HCS to provide licensing and oversight for long-term care facilities. These include boarding homes, also called "assisted living' facilities, which allow residents to live in a community setting (such as a private apartment), while providing assistance with meals, laundry, medication administration, and personal care.[24] Adult family homes are neighborhood homes licensed and staffed to care for up to six full-time residents.[25] The level of staffing may depend on the need of residents, but includes household assistance (meals, laundry, personal care) as well as nursing and health care duties.

Nursing homes provide around-the-clock, facility-based care for residents requiring skilled nursing assistance.[26] Nursing homes also provide other residential services, such as rehabilitation therapy, nutrition management and consulting, social activities, and assistance with personal care. Finally, two state-owned psychiatric hospitals are run by the DSHS Division of

[22] http://www.adsa.dshs.wa.gov/professional/hcs.htm
[23] https://fortress.wa.gov/dshs/adsaapps/about/programs/Community%2Options%20Program%20Entry%20System.doc
[24] https://fortress.wa.gov/dshs/adsaapps/about/factsheets/Boarding%20Homes.doc
[25] https://fortress.wa.gov/dshs/adsaapps/about/factsheets/Adult%20Family%20Homes.doc
[26] https://fortress.wa.gov/dshs/adsaapps/about/factsheets/Nursing%20Homes.doc

Behavioral Health and Recovery (DBHR). These two hospitals, Western State Hospital (Lakewood) and Eastern State Hospital (Medical Lake) are institutions for adults with psychiatric disorders. Residents are referred to the hospital through the criminal justice or Regional Support Network (RSN) systems.

The Division of Developmental Disabilities (DDD) provides services to individuals meeting age and disability criteria as defined by Washington State law.[27] A range of services and supports are available to DDD clients. These include DDD supported living services,[28] which provide support and training for persons to live in their own homes within the community. Clients may receive intermittent assistance or 24-hour live-in support. DDD group homes may be licensed as a boarding home or adult family home, but specialize in providing care to DDD clients in a community residential setting.[29]

DDD Residential habilitation centers (RHC) are state-run facilities that provide 24-hour supervision and care services for adults with mental retardation or other disabilities that may require long-term nursing care.[30] The state currently operates four RHCs, serving about 900 residents.

Public guardians work to ensure that their clients are in stable and suitable living environments and that the incapacitated person receives appropriate engagement, care, and support. Care needs may be expected to increase over time for clients who are elderly or have deteriorating medical conditions. Other clients, however, may be able to stabilize and move toward independence after receiving necessary care and treatment. The cost of care can vary widely for these clients, ranging from $53 to over $600 dollars per day (Exhibit 4). Given these costs, it is important to examine if the presence of a guardian can result in changes that serve the best needs of the client and reduce public costs.

Exhibit 4
Average Daily Estimated Costs for Community and Residential Services

Setting/Service	Daily Cost/Rate
HCS/RCS	
COPES	$53 [a]
Boarding Home	$66–$79 [b]
Adult Family Home	$66 [b]
Nursing Home	$182 [c]
State Psychiatric Hospital	$584 [d]
DDD	
Supported Living	$216 [e]
Group Home	$201 [f]
Residential Habilitation Center	$537–$644 [f]

[a] Costs range by level of service received. Reported cost is the FY2010 average monthly cost per client ($1,600) divided by 30 ($53/day).
[b] State reimbursement rates for boarding homes and adult family homes are published at: www.aasa.dshs.wa.gov/professional/Rates/reports.
Rates vary according to CARE service classification (17 levels) and geography (King/metro/non-metro). Reported rates are for mid-tier clients in metro counties.
[c] Statewide weighted average rate (FY2011)
[d] State hospital routine inpatient charge rates (July 2011)
[e] Based on average monthly cost per client ($6,466) divided by 30 ($216).
[f] Reported reimbursement rates from DDD.

[27] WAC 388-823-0800
[28] https://fortress.wa.gov/dshs/adsaapps/about/programs/Supported%20Living%20DDD.doc
[29] https://fortress.wa.gov/dshs/adsaapps/about/factsheets/DDD%20Group%20Homes%20-%20Group%20Training%20Homes.doc
[30] https://fortress.wa.gov/dshs/adsaapps/about/factsheets/DDD%20Residential%20Habilitation%20Centers.doc

Case Studies: Residential Changes

The summary data presented in this report provide an overview of all clients served by public guardians and are necessary to evaluate program outcomes. The circumstances under which incapacitated persons come to be represented by a public guardian, however, differ in each case. Since this information cannot be conveyed effectively through tables or figures, we will highlight brief sample cases in relevant sections throughout this report. The client summaries are written by the public guardians and have been edited to protect client confidentiality.

Sample Case 1

We have an OPG client we received on *(omitted)* 2010. He was not expected to live because of a beating he received which caused a brain injury. He was a homeless man living on the streets of *(omitted)*, WA. We had no information on this client at all, no background, no family, nothing. He had no money to speak of, wasn't able to speak coherently, and had a hard time communicating. As time has gone on, he has been able to communicate through verbal boards in his room to learn to speak again. We received paperwork with his arrest record and military record and out-of-state address for his father. We mailed a letter to his father hoping to get a response, and received a message back from the brother three days later. The brother is the only living relative and they haven't seen each other since 2006. The brother came from *(omitted)* to be reunited in person; he is going to petition the court to become legal guardian and take _____ home.

Sample Case 2

This client, with Traumatic Brain Injury (TBI) had severe anger issues and had alienated friends and family. He was in the middle of a divorce at the time of his accident. The guardian, with the assistance of a pro-bono attorney, helped the client complete the divorce. The guardian worked with the client [on behavior modification/natural consequences] and doctor [on medication] and now the client is doing much better managing his anger. His family has re-established a relationship. The client has moved to a rental of his choice and is looking forward to taking a driving test to see if he can regain his driver's license.

These case studies illustrate some of the conditions under which individuals enter the program and the type of progress that may be achieved while they have representation and assistance from a guardian. The cases also demonstrate that two key factors must be considered when evaluating the effectiveness of the public guardianship program:

1) The expected results may differ according to a client's age, extent and type of incapacity, and previous background.
2) It is important to assess outcomes relative to what might have occurred to the client without the presence of a public guardian.

To address these issues, we were able to identify a relevant comparison group of clients with characteristics similar to individuals with public guardians. By comparing outcomes against like individuals, we can examine the extent to which public guardians are able to move a client to a stable and suitable living environment. Section IV discusses the methods used in this approach and presents our findings.

Section IV: Cost Benefit Results

For the purpose of this evaluation, we received unidentifiable CARE assessment records from 2004 to the present.[31] Authorized DSHS staff matched public guardianship records to both the CARE assessments and vital statistics/death records from the Department of Health. Following this match, all identifiable person information was removed and replaced with a study identifier.

Of the 87 persons assigned a public guardian since 2008, nine died within three months of a guardian assignment and another 17 had a guardian assignment in 2011, after the data matching for this study took place. We were unable to locate CARE assessment information for an additional 12 OPG clients. This left a total of 49 persons for analysis in our study group. This section describes the comparison group we created for this evaluation and the differences in outcomes and costs for each population.

Selecting Similar Clients

The goal of this analysis was to determine if vulnerable adults with incapacities were able to achieve a greater level of stability with the assistance of a public guardian. In order to consider the relative changes in stability for these clients, we identified two comparison groups. The first group includes DSHS clients from pilot counties (Clallam, Grays Harbor, King Okanogan, Pierce, Snohomish, Spokane) who had a CARE assessment prior to the implementation of the public guardianship program in 2008. The second (contemporary) comparison group includes clients from non-pilot counties with a CARE assessment that occurred from 2008 to present.

For clients in each group, we first identified those who required some level of decision-making assistance. Clients were retained in the analysis if they had an informal decision maker listed under reported contacts, or their assessment indicated they needed a payee, power of attorney, or had a pending guardianship.

The comparison group is intended to include clients with similar characteristics who may have required, but did not receive, formal guardianship assistance. Therefore, we excluded individuals with a reported guardian contact (near the time of assessment) or those who had "guardian present" listed under assessed financial strengths. We also excluded clients who were reported as having independent decision-making abilities regarding tasks of daily life and those who had certain assessed strengths, including the ability to budget or pay bills. Finally, clients with higher incomes (above $2,000 per month) were excluded from the analysis.

After these exclusions, we performed a series of matches to iteratively link the program/study group member with a similar client based on a number of factors, including:

- county of residence (for pre-program group)
- agency served by (DDD or long-term care)
- demographics (gender, age, marital status)
- cognitive status
- level of impairment
- housing status (own, rent, subsidized)
- Medicare coverage

We completed 14 different "passes" to identify the best possible match for each program group member. Up to three different comparison clients were selected for each client. A description of each group is presented in Exhibit 5.

[31] All study procedures and data analysis protocols were approved by the Washington State Institutional Review Board at the Washington State Department of Social and Health Services.

Exhibit 5
Public Guardianship Study and Comparison (Pre-Program and Contemporary) Groups

Category	Pre-Program Comparison Group	Contemporary (post-2008) Comparison Group	Program Group
Gender			
Female	55 (44%)	68 (48%)	23 (47%)
Male	69 (56%)	73 (52%)	26 (53%)
County			
Clallam	4 (3%)	n/a	3 (6%)
Grays Harbor	1 (1%)		1 (2%)
King	42 (34%)		9 (18%)
Okanogan	3 (2%)		2 (4%)
Pierce	31 (25%)		14 (29%)
Snohomish	19 (15%)		2 (4%)
Spokane	24 (19%)		18 (37%)
Age			
18-24	27 (22%)	26 (19%)	11 (22%)
25-34	22 (18%)	29 (21%)	7 (14%)
35-44	11 (9%)	13 (9%)	5 (10%)
45-54	18 (15%)	19 (13%)	3 (6%)
55-64	14 (11%)	20 (14%)	10 (20%)
65 and over	32 (26%)	34 (24%)	13 (27%)
Medicare Coverage			
	52 (42%)	71 (50%)	19 (39%)
Agency			
Developmental Disabilities (DDD)	59 (48%)	74 (52%)	29 (59%)
Long Term Care (LTC)	65 (52%)	67 (48%)	20 (41%)
Decision Making – Tasks of Daily Living			
Modified independence	41 (33%)	47 (33%)	17 (35%)
Moderately impaired	76 (61%)	86 (61%)	25 (51%)
Severely impaired	7 (6%)	8 (6%)	7 (14%)
In the last six months, number of times client admitted to…			
hospital with overnight stay			
No information (missing)	13 (10%)	8 (6%)	2 (4%)
None	96 (77%)	95 (67%)	37 (76%)
One	10 (8%)	26 (18%)	6 (12%)
Two or more	5 (4%)	12 (9%)	4 (8%)
emergency room without overnight stay			
No information (missing)	13 (10%)	8 (6%)	2 (4%)
None	91 (73%)	91 (65%)	35 (71%)
One	13 (10%)	24 (17%)	8 (16%)
Two or more	7 (6%)	18 (13%)	4 (8%)
Total	**124**	**141**	**49**

As Exhibit 5 shows, there were no statistically significant differences in demographic characteristics (gender, age) between the program and comparison groups. It should be noted that the first comparison group (pre-program, n=124) includes individuals from the same counties in care prior to the start of the program (pre-2008). The second comparison group (contemporary, n=141) includes members who did not live in the pilot counties, but received care during the same period (post-2008).

In terms of decision-making ability, about 65 percent of the program and comparison group members had moderate to severe impairment in making decisions regarding tasks of daily life. About 15 percent of the program group members were severely impaired, indicating that they never or rarely make decisions about daily activities. Moderate impairment is a sign of poor decision making or the need for supervision or reminders about daily routines.

An indication of the client's health and wellness comes from self-reported information on hospitalizations. According to the CARE assessment, between 15 and 30 percent of the program and comparison group members had at least one hospital admission or emergency room visit in the previous six months. Unfortunately, this self-reported data did not allow us to examine changes in the number of hospital stays over time. We were, however, able to investigate a number of other outcomes for the program and comparison groups. A change in residential setting is the primary outcome related to our cost-effectiveness analysis. These outcomes are presented in the next section.

Residential Changes: Settings

Previous research regarding public guardianship in other states has focused on the extent to which incapacitated persons have been able to move to a less restrictive living environment. For this analysis, we utilized a client residence report from the CARE assessment that provided information about changes in living environment. We created five categories based on the restrictiveness of the setting. These categories (from less restrictive to more) included:

- Community based (at home)
- Community support (supported living)
- Group home (community setting)
- Nursing care facility
- Institution

For each member in the program group, we identified the first reported residential setting after the assignment of a public guardian. When comparison group members were selected, we attempted to identify individuals who had matching characteristics and lived in a similar residential setting. As Exhibit 6 shows, the comparison group clients were more likely to be living at home (with parent, spouse, relative) at the start of the study period, while a higher percentage of clients in the program group were in a supported living arrangement. OPG clients were also more likely to be in a nursing home or institutional care setting.

It may not be surprising that public guardianship clients have living arrangements that are initially different from clients with similar characteristics. The goal of this research is to determine if clients can be moved to less restrictive (and less costly) residential settings after the assignment of a guardian. The next section examines this question in more detail.

Exhibit 6
Initial Residential Setting for Public Guardianship Study and Comparison (Pre-Program and Contemporary) Groups

Residential Setting	Pre-Program Comparison Group	Contemporary (post-2008) Comparison Group	Program Group
Homeless	1 (1%)	0 (0%)	1 (2%)
Community Based own home, relatives home, parents home	79 (64%)	80 (57%)	20 (41%)
Community Support own home (w/supported living), state operated living alternatives (SOLA)	12 (10%)	25 (18%)	19 (39%)
Group Home adult family home, boarding home, DDD group home	31 (25%)	25 (18%)	3 (6%)
Nursing Home nursing facility, intermediate care facility	0 (0%)	10 (7%)	4 (8%)
Intensive Care psychiatric hospital, residential habilitation center (RHC)	1 (1%)	1 (1%)	2 (4%)
Total	124	141	49

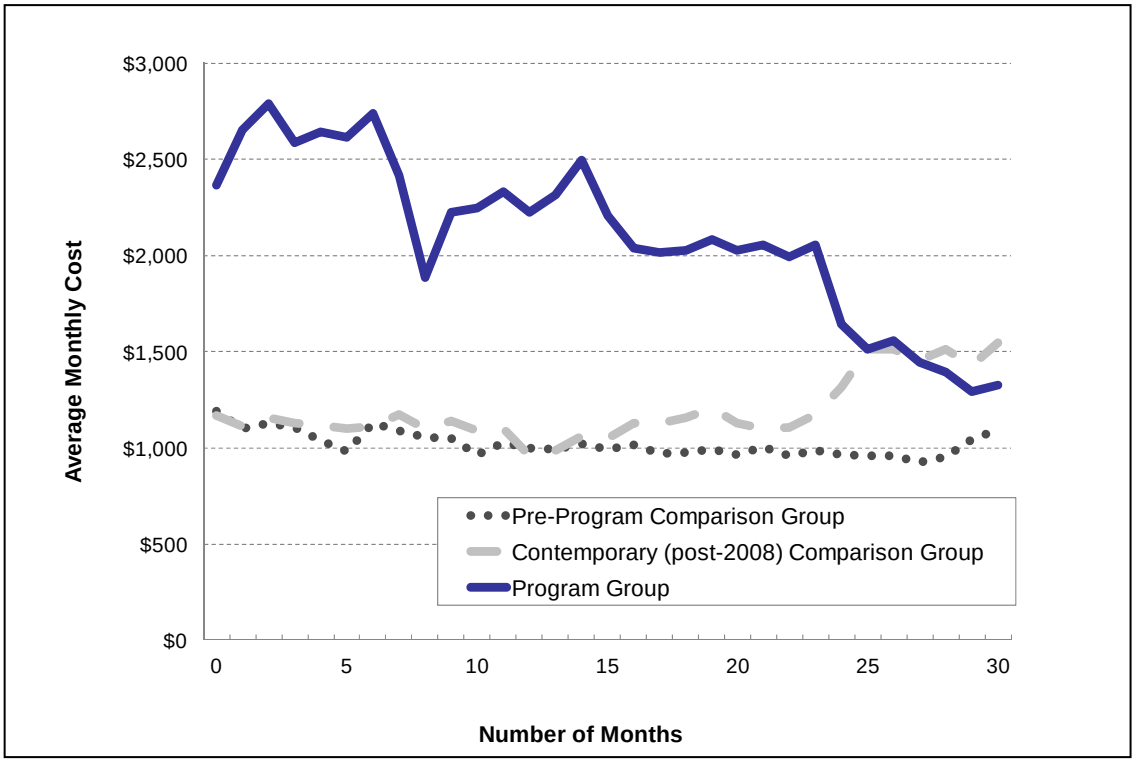
Residential Changes: Average Costs

The differences in residential settings and supports shown in Exhibit 6 only reflect a client's situation at a single point in time. To determine if these differences persisted, we followed changes in residential placements over a period of 30 months (2.5 years). For each day reported in a given setting, we were able to calculate a daily cost, based on the figures displayed in Exhibit 4. For long-term care clients (in boarding homes or adult family homes), we were able to calculate rate levels with even greater specificity. These residential reimbursement rates are based on a client's location (King County, metro, non-metro), and their service needs (as determined by the CARE assessment). Thus, even if a client remained in an adult family home, the reported cost would reflect increased or decreased service needs during this period.

Based on this information, we estimated an average cost for each client over the entire study period.[32] As Exhibit 7 shows, residential costs for OPG clients average about $2,400 per month at the time of a guardianship assignment. This was twice as much as the average monthly costs for each comparison group ($1,200 per month). Over the next 30 months, however, the average costs for clients with a public guardian declined steadily. By the end of the study period, average costs for program group members were about $1,300 per month, and consistent with average costs for both comparison groups.

[32] We did not have billing or claims data available for this study, so these results reflect the approximate, rather than actual cost of care.

Exhibit 7
Average Monthly Cost for OPG Program and Comparison Groups
(Over 30 Months in Program)



WSIPP, 2011

These results indicate that, over time, clients of public guardians move to a lower (and less costly) level of care that is consistent with similar clients. Exhibit 7 also shows that the average cost of care for program clients increases in the six months following the appointment of a public guardian. Based on interviews with public guardians and a review of cases, this increase is expected. In many cases, an incapacitated person is either homeless or experiencing an acute health crisis at the time a guardian is assigned to the case. In order to stabilize the client, he or she may be placed in a nursing home or other skilled care facility to address immediate needs. After a client's short-term situation stabilizes, the client can be transferred to a more appropriate long-term setting (see sample case, next page).

From a cost effectiveness perspective, we would like to compare these results with the costs that would have been incurred by the client *if a guardian had not been involved*. Without the presence of a randomly assigned control group, however, we cannot answer this question directly. That is, we cannot know for certain if average costs for these clients would have increased, stayed constant, or gone down over a longer time period.

It is clear, however, that costs for the program clients declined to the same level as those from both comparison groups within two and a half years after a guardianship assignment. The next section compares the program costs to this reduction in the cost of care to determine where the program may reach a "break-even" point.

Public Guardianship Costs and Benefits

Public guardians may be sole proprietors or work for a private agency that is licensed to provide guardianship services in the state of Washington. These guardians contract with the state at a rate of $50 per hour to provide representation and services for accepted OPG cases. Monthly payments to public guardians cannot exceed $525 for the first three months of a case and $325 for each month thereafter.

We compiled billing data that guardians provided for each case included in the analysis above. The average cost for these cases was slightly higher than $250 per month. Over the 30-month study period, the average cost per client totaled $7,907 (Exhibit 8). During this time, savings that resulted from moves to less restrictive environments led to an average decrease in residential costs of $8,131 per client.

As noted earlier, residential costs for program clients increased initially before declining in the second half of the study period. By the end of the study period, total savings had exceeded program costs. Since we did not have sufficient data beyond this period, we could not track how residential costs may have changed beyond this point.

Exhibit 8
Cost of Guardianship Compared With Estimated Savings (Months 1 to 30)

Cumulative Months	Total Program Costs (a)	Cumulative Residential Savings (b)	Total Savings Less Cost (a+b)
Months 1-12	- $ 3,069	- $ 1,110	- $ 4,179
Months 1-24	- $ 6,138	+ $ 1,744	- $ 4,394
Months 1-30	**- $ 7,907**	**+ $ 8,131**	**+ $ 224**

Sample Case 3

An elderly gentleman with *(omitted)* syndrome had been taken to the hospital by a friend who stated he had fallen hitting his head due to dizziness. No information was given as to his past. He came in with only the clothes on his back. At the time of his injury, he was living in a hotel and receiving no services and/or benefits other than his social security check. Information about the possibility of others exploiting him could not be substantiated, but is probable. Due to his severe cognitive disability and estrangement from family, there was no advocate available, and the hospital was unable to discharge him in his present state. I was appointed as guardian to act on his behalf. Currently, _____ is residing in an adult family home, and doing well. We are seeking a primary physician and additional socialization activities to meet his medical and social needs.

As mentioned earlier, without a randomly assigned control group, we cannot estimate the extent to which a public guardian contributed to the decrease in costs during the study. We do know that during the time guardians worked with these clients, average care costs steadily declined to expected levels. In addition, it should be noted that this analysis only captured cost savings attributed to residential care. Reductions in the cost of medical care (hospitalizations) and the recovery or preservation of assets are two other outcomes that may impact the cost-benefit equation. Non-monetary benefits are also important program outcomes, and are covered in Section V.

Guardianship Activity

This report has focused primarily on the impact of a guardian's assistance in helping to move a client to appropriate care settings. Relocation efforts represent only one of the many activities that guardians may undertake on behalf of the clients they represent. We conducted a short survey of public guardians to learn about the types of duties they performed for clients. The survey asked about individuals on a guardian's caseload between July 2010 and June 2011 (n=69). A summary of the activities completed for these clients is shown in Exhibit 9.

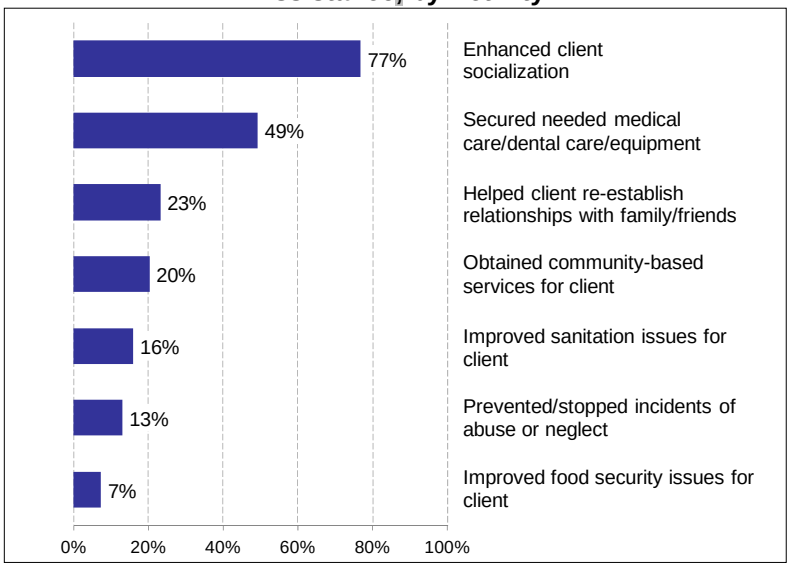
In a small percentage of cases, the guardian assisted with emergent issues such as preventing or stopping incidents of abuse or neglect (13 percent) or improving food security (7 percent) or sanitation (16 percent). In other cases, the guardian may have helped the client obtain needed medical treatment (49 percent) or other community-based services (20 percent). The benefit of some of these activities, such as enhancing socialization (77 percent), may be difficult to quantify, but are regarded as important to the well-being of the incapacitated person.

Guardians may also assist an incapacitated client in a number of other ways not shown in Exhibit 9. We discussed activities in the survey that may have a more direct economic benefit to the client, and found that guardians:

- helped a client apply for benefits in *20 percent* of cases;
- assisted with a supported employment/ training placement for *12 percent* of clients; and
- resolved or mitigated legal issues for *7 percent* of clients

Ensuring that the client has an appropriate living environment is an important responsibility for the guardian. However, the duties and obligations of a guardian extend beyond residential placements, as shown here. Decision making and client advocacy involve helping an incapacitated person continue to live with dignity and preserve individual autonomy to the greatest extent possible. These goals often rely on a client's ability to improve health and functioning. These outcomes are discussed in the final section of this paper.

Exhibit 9
Percentage of Guardianship Clients Receiving Assistance, by Activity



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Health and Functioning Outcomes

The CARE assessment includes reports about a client's medical diagnosis, pain levels and other symptoms, and active treatments. Given the small sample size of this study and number of assessments completed, we could not make a detailed determination about improvements in a client's health condition. The assessment, however, does ask a client to rate their health in general terms (excellent, good, fair, poor). We looked at the initial health rating for both study and comparison group members (time one) and compared this rating with the latest assessment available (time two). The results for both time periods are presented in Exhibit 10.

Not all study and comparison group members had a health self-assessment in both time periods. For those with assessments, there were no significantly different changes in health status for either the program (OPG) or comparison groups. These questions, however, may have been too broad of a measure to gauge changes in a client's health. Between 70 and 80 percent of all individuals, for example, reported that their health was either good or fair. A scale that includes more detailed ratings would be necessary to make a valid determination about whether the incapacitated person's health improved or declined during this period.

Since the medical needs and diagnoses of clients in this study may vary considerably, we also examined the "personal-care hours" approved for clients in the study. The CARE assessment includes several different scales that are used to determine the number of caregiver hours reimbursed by the state each month. The criteria[33] are based on clinical complexity, mood and behavior problems, cognitive performance, and ability to perform "activities of daily living." Exhibit 11 shows the change in mean caregiver hours between the first and last assessments recorded for both study groups.

Exhibit 10
Changes in Health Rating for OPG Program and Comparison Groups

	Pre-Program Comparison Group		Contemporary (post-2008) Comparison Group		Program Group	
Health Rating	**Time One**	**Time Two**	**Time One**	**Time Two**	**Time One**	**Time Two**
Excellent	10 (9%)	10 (9%)	5 (4%)	5 (4%)	3 (10%)	2 (7%)
Good	50 (43%)	49 (43%)	53 (43%)	51 (43%)	12 (40%)	9 (32%)
Fair	36 (31%)	36 (31%)	31 (25%)	36 (30%)	10 (33%)	13 (46%)
Poor	17 (15%)	18 (16%)	21 (17%)	20 (17%)	4 (13%)	3 (11%)
Unable to Respond	4 (3%)	2 (2%)	12 (10%)	8 (7%)	1 (3%)	1 (4%)
Total	**117**	**115**	**122**	**120**	**30**	**28**

[33] Listed in WAC 388-106-0130

Exhibit 11
Average Approved Monthly Personal Care Hours for Program and Comparison Group Members

Study Group	First Assessment	Last Assessment	Difference
Pre-Program Comparison Group	116 (n=97)	133 (n=86)	**+17**
Contemporary (post-2008) Comparison Group	115 (n=105)	119 (n=95)	**+4**
Program Group	140 (n=17)	111 (n=12)	**-29**

Clients in the pre-period comparison group had an increase of 17 hours in the number of monthly personal care hours approved between the beginning and end of the study period. Clients in the contemporary (post-2008) study group had an increase of four hours between the first and last reported assessment. Clients with a public guardian, on the other hand, had a *decrease* of 29 hours in personal care hours needed each month.

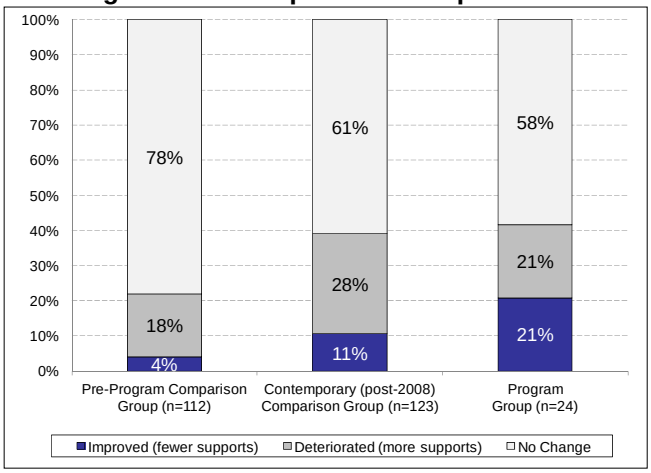
Medicaid Personal Care (MPC) services are only available to persons who are in a non-institutional setting (private home, adult family home, or boarding home), and have unmet needs in three or more activities of daily living.[34] An approved client may receive up to 420 hours of personal and nursing care per month under this program. The results presented in Exhibit 11 only apply to those individuals who met eligibility guidelines *and* had two or more assessments during the study period. The change in personal care hours provides some indication of a client's decreasing dependence on a personal caregiver or nurse (see Sample Case 4).

Sample Case 4

Prior to the guardianship, my client was moved from one family member to another as the parents had each abandoned my client and her siblings. My client was sullen and withdrawn with poor social skills. After living with her caregiver for a year, she has become happy and outgoing. The caregiver has taught and continues to teach appropriate social skills. The client will answer the door and invite me in instead of hiding in the back of the house. When eating, she will allow others to share the table. She helps with the housework and takes great pride in cleaning her own room. She tries to engage in conversation, when before she wouldn't talk at all. She is very stable and healthy because she has a safe environment.

The CARE assessment also includes a question related to functional capacity that asks if "overall self-sufficiency has changed significantly as compared to status of 90 days ago (or last assessment)." Exhibit 12 reports the responses to this question for the most recent assessment of program and comparison group members.

Exhibit 12
Change in Self-Sufficiency (past 90 days) for Program and Comparison Group Members



WSIPP, 2011

[34] WAC 388-106-0210

According to these responses, 21 percent of clients with a public guardian had a reported improvement in self-sufficiency in the previous 90 days. In contrast, only 4 to 11 percent of the comparison group members had a recent improvement in self-sufficiency. The pre-program comparison group had the smallest percentage of persons requiring more support, but over 70 percent of this group had no change in self-sufficiency.

Based on a range of measures—including cost of community and residential care, personal care hours, and reported self-sufficiency—we find a steady improvement in the outcomes of public guardianship clients. Matched comparison groups (from two different time periods) had either no change or declining outcomes when measured against the same indicators.

Conclusion

This evaluation of Washington State's public guardianship pilot program has provided an analysis of how the potential cost savings for program participants compare with the recorded costs. We found that based on one outcome (change in residential settings), the decrease in average costs exceeds the cost of providing a guardian within 30 months. Other outcomes not included in this cost calculation were also positive for OPG clients, including a reduction in personal care hours and reported improvements in self-sufficiency.

The sample cases presented throughout this report also illustrate that a cost-effectiveness analysis is only one way to evaluate the results the program may be achieving. When a court determines that an individual can no longer fully act in his or her own best interests, a guardian takes on this personal decision-making role. Based on this surrogate relationship, the guardian assumes responsibility for the health, safety, financial and social well-being of the incapacitated client. The role of a guardian should be evaluated in terms of the cost-effectiveness of this service and the degree to which the lives of incapacitated persons are improved by having an advocate.

As of 2007, 49 states had some form of public guardianship available.[35] While the program in Washington State only serves individuals from ten (of 39 counties), we found encouraging results for this pilot program over a three-year study period. These findings are consistent with research conducted in other states, as well. This research should be considered in future decisions regarding the role of the public guardian in Washington State and throughout the country.

[35] Teaster, P. B. (2010). *Public guardianship: In the best interests of incapacitated people?* Santa Barbara, CA: Praeger.

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