Study and Report on the Need and Feasibility of Qualified Professional Guardians

Final

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Glossary

Advance Directive –An advance directive is a broad term used to describe documents completed in advance that outline an individual's preferences for medical care in the event they become unable to make or communicate decisions. This may include a Healthcare Proxy or a Living Will (personal directive). While these documents provide important guidance to health care providers and family members, Massachusetts law recognizes only the Healthcare Proxy as having binding legal authority.[1]

Default Surrogate Statute - A default surrogate statute allows a person, typically a close family member or friend, to assume healthcare decisional authority for an incapacitated individual without requiring formal appointment through the judicial system. These statutes usually establish a prioritized list or "surrogacy ladder" of individuals (e.g., spouse, adult child, parent, sibling) who may act as a health care decision-maker when no advance directive or Healthcare Proxy is in place.[2] A growing number of states also authorize a close friend to act as default surrogate.[3] The structure and scope of these statutes vary by state, but they can be utilized to help reduce reliance on court-appointed guardianship.[4]

Guardian - A guardian is a court-appointed individual authorized to make personal, medical, and/or financial decisions on behalf of an incapacitated person. Guardianship is based on a person's functional inability to make informed decisions, often due to conditions such as dementia, mental illness, developmental disability, or brain injury. In some states, including Massachusetts, separate terms are used – such as guardian for personal/medical decisions and conservator for financial decisions. The term guardian is commonly applied broadly.[5,6]

Healthcare Proxy (HCP) - A healthcare proxy is a legal document that allows an individual to designate another person to make medical decisions on their behalf if they become unable to do

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[1] Massachusetts Executive Office of Health and Human Services. (2025). *Massachusetts law about health care proxies and living wills.* Retrieved from: https://www.mass.gov/info-details/massachusetts-law-about-health-care-proxies-and-living-wills

[2] DeMartino et al. (2017) Who Decides When a Patient Can't? Statutes on Alternate Decision Makers. The New England Journal of Medicine, 376(15), 1478-1482. https://doi.org/10.1056/NEJMms1611497

[3] Arias, J.M. (2023). Default Surrogate Statutes. Bifocal, 44(3), 54-57. Journal of the American Bar Association Commission on Law and Aging. https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bifocal-vol-44-issue3/recent-updates-to-default-surrogate-statutes/

[4] Arias, J.M. (2023).

[5] Moye, J., et al. (2016). Examining the need for a public guardian in Massachusetts: Phase 1. Guardian Community Trust https://guardianship.institute/wp-content/uploads/2019/02/1-Examining-the-Need-for-a-Public-Guardian-in-Massachusetts-PROOF-for-PRINTING-2d-Printing.pdf

[6] Moye, J. et al. (2018). Guardianship for adults without surrogates in Massachusetts (*Guardianship Community Trust [report]*) https://guardianship.institute/wp-content/uploads/2019/02/1.-Guardianship-for-Adults-without-Surrogates-in-Massachusetts-April-11-2018.pdf

so. The healthcare proxy only becomes active when a physician determines that the individual lacks capacity to make or communicate healthcare decisions.[7]

Living Will (Personal Directive) – A living will, also called a personal directive, is a written statement of an individual's preferences regarding specific medical treatments. Unlike a healthcare proxy, a living will does not have legal standing in Massachusetts.[1] However, it can serve as guidance for the appointed agent and healthcare professionals when making decisions on behalf of an incapacitated agent.[8]

Post-Acute Care – Post-Acute care is care provided after an acute care stay, either at home or in an institutional setting such as a nursing home, skilled nursing facility, long-term acute care hospital, or inpatient rehabilitation facility.[9]

Public Guardianship - Public guardian refers to guardianship programs established and funded by state or local governments to serve individuals who lack the capacity to make personal, medical, or financial decisions, and who have no family, friends, or other suitable persons willing or able to act on their behalf.[10] While these programs vary widely in structure, funding, and administration across jurisdictions, they share a common purpose of supporting the most indigent and vulnerable members of society.[11] There are four models within the public guardianship sphere: 1) the "government as a guardian" model, in which a state agency or office directly serves as the court-appointed guardian, 2) the "privatized public guardian" model in which guardianship services are provided by private nonprofit or for-profit entities under contract with the state, 3) the "private appointment originated by a public agency" model where a public agency identifies the need for guardianship and then petitions the court for a guardian, in this case a private individual, to be appointed, and 4) the "privately funded public guardian" model which include guardianship programs that serve public functions (i.e., guardians of last resort for indigent individuals) but are primarily financed through private or philanthropic sources rather than government funding.[11,12]

Qualified Professional Guardian - A Qualified Professional Guardian is a court-appointed individual authorized to make personal, medical, and/or financial decisions on behalf of an incapacitated person.[13] However, unlike lay or family guardians, professional guardians are compensated for their services and must meet formal requirements, which typically include

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[7] https://masshealthdecisions.org/health-care-proxy/

[8] Massachusetts Medical Society. *Important differences between healthcare proxies and living wills.* Retrieved from: https://www.massmed.org/Patient-Care/Health-Topics/Health-Care-Proxies-and-End-of-Life-Care/Important-Differences-Between-Health-Care-Proxies-and-Living-Wills/

[9] https://www.medpac.gov/research_area/post-acute-care/

[10] Moye, J. et al. (2018). Guardianship for adults without surrogates in Massachusetts (*Guardianship Community Trust [report]*) https://guardianship.institute/wp-content/uploads/2019/02/1.-Guardianship-for-Adults-without-Surrogates-in-Massachusetts-April-11-2018.pdf

[11] Massachusetts Guardianship Policy Institute (2023). The first ten years: Review and recommendations [unpublished report]

[12] MGPI, *The first ten years,* 2023.

[13] Cohen, A. et al. (2019) End-of-life Decision-Making and Treatment for Patients with Professional Guardians. *Journal of the American Geriatrics Society, 67(10*), 2161-2166. DOI: 10.1111/jgs.16072

completing training, passing a criminal background check, and adhering to ethical standards, and may include ongoing oversight.[14]

Rogers Guardianship: A type of guardianship where there is a court order that authorizes the guardian to agree to extraordinary treatment, with the appointed individual as a Rogers monitor who is responsible for monitoring whether treatments are within the scope of the court order. Named after the *Rogers v. Commissioner of the Department of Mental Health 1983* decision, Rogers guardianships are typically used in psychiatric settings and are distinct from other guardianship types

Unrepresented Individuals - An unrepresented individual lacks the capacity to make medical decisions and has no surrogate, guardian, or advance directive. They are usually facing an important medical decision while incapable of autonomous decision-making, with little chance of regaining capacity in time, and no identifiable substitute decision-maker or clear past statements or evidence of preferences. Unrepresented individuals are at high risk for inappropriate medical care, including overtreatment, undertreatment, and delayed discharges from hospital facilities. Unrepresented Individuals generally fall into three categories, including individuals who: 1) may be experiencing homelessness or serious mental illness, 2) lack a willing or appropriate health care surrogate by circumstance or personal choice, and 3) have outlived their family and close social supports.[15]

[14] https://guardianshipcert.org/certification-requirements

[15] Schweikart, S. J. (2019). Who makes decisions for incapacitated patients who have no surrogate or advance directive? *AMA Journal of Ethics, 21*(7), E587–593. https://doi.org/10.1001/amajethics.2019.587

Executive Summary

The Massachusetts Department of Public Health's (DPH) Bureau of Health Care Safety and Quality contracted with Eastern Research Group, Inc. (ERG) to conduct a study to evaluate the need for and feasibility of establishing access to Qualified Professional Guardians[16] within the Commonwealth. This Executive Summary provides a high-level overview of issues and findings of the research conducted under this project, with details provided in the body of this Study and Report on the Need and Feasibility of Qualified Professional Guardians ("The Report").

In the context of this Report, Unrepresented Individuals are those who lack the capacity to make their own medical decisions but do not have a surrogate decision maker.[17] These Unrepresented Individuals were either admitted to an acute care hospital without a surrogate decision maker (e.g., because of a medical emergency) or lost their surrogate decision maker while in the hospital (e.g., the family member acting as surrogate decision maker died). When an Unrepresented Individual no longer needs to be in an acute care hospital setting to receive appropriate care, they cannot be discharged from the acute care hospital to a more appropriate healthcare setting until a surrogate decision maker, such as a family member or friend, is found to consent. In the absence of an appropriate surrogate decision maker, the Unrepresented Individual cannot be discharged until a Guardian is appointed by the court to consent.

Research in the Commonwealth of Massachusetts ("Massachusetts" or "Commonwealth") and other states suggest that the shortage of Guardians available to take on Unrepresented Individuals can lead to discharge delays resulting in significant burdens on Unrepresented Individuals as well as healthcare systems and stakeholders.[18]

Key Findings

The legislation that necessitated this study and report directed DPH to "study and report on the need and feasibility of qualified professional guardians to give informed medical consent for indigent persons and whether such guardians would reduce hospital discharge issues and increase access to long-term care and preventive care" and specifically required DPH to include five key elements in the report: (i) The need for qualified professional guardians to assist indigent persons with accessing appropriate medical care, including preventive care; (ii) data on the current

[16] For purposes of this report, we are defining Qualified Professional Guardian as an individual or organization formally appointed by a court to make personal, medical, and/or financial decisions on behalf of an incapacitated person. Professional Guardians are compensated for their services and must meet formal requirements, which typically include completing training, passing a criminal background check, completing certification, and adhering to ethical standards. Their duties may be subject to ongoing oversight and monitoring by the state and/or professional organizations.

[17] A surrogate decision maker is an individual authorized to make medical decisions for another person who lacks the capacity to make or communicate those decisions themselves. Source: https://www.merckmanuals.com/home/fundamentals/legal-and-ethical-issues/default-surrogate-decision-making

[18] Ricotta et al. (2018). The burden of guardianship: A matched cohort study. *J Hosp Meds. 13*(9):595-601 DOI: 10.12788/jhm.2946

number of Rogers guardians and similar guardians and the financial impact of reimbursing such guardians; (iii) the fiscal impact of establishing MassHealth fee-for-service guardians; (iv) consideration of the benefits to an individual and cost to the Commonwealth of deducting from an applicant for MassHealth or a MassHealth member's income for guardianship fees and related expenses when the appointment of a guardian is essential to enable an applicant or member to gain access or consent to medical treatment and an estimation of reasonable costs for such a deduction; and (v) other recommendations deemed necessary by the department.

As a result of the study, DPH finds there is a significant need for qualified professional guardians to give informed medical consent for persons who are unable to afford these services otherwise and that increasing payment to Qualified Professional Guardians, coupled with other recommended legislative changes, could substantially reduce delays in hospital discharges and expedite access to long-term and preventative care. With respect to the five requirements set forth in the legislation for this study and report, key takeaways include:

(i) The need for qualified professional guardians to assist indigent persons with accessing appropriate medical care, including preventive care. Multiple interviewees representing patients, acute-care hospitals, and the legal system indicated that they believe Massachusetts relies on a limited and shrinking pool of professional or pro bono Guardians, usually attorneys or retired attorneys, to fill this gap. We were not able to identify an independent data source to confirm this assertion. However, respondents report that acute-care hospitals often struggle to identify a suitable Guardian in a timely manner. According to several interviewees, attorneys seeking a pro bono Guardian on behalf of acute-care hospitals for indigent Unrepresented Individuals might contact anywhere from four to thirteen Guardians before finding one willing to accept the case. The consensus from interviewees and literature is that a primary factor impacting the lack of availability of qualified Guardians for Unrepresented Individuals is inadequate compensation. There are insufficient individuals willing to provide guardianship services. Providing compensation to Guardians may potentially increase the number of qualified Guardians.

(ii) Data on the current number of Rogers guardianships and similar guardianships and the financial impact of reimbursing such guardianships. We are not able to provide an estimate of the number of Rogers guardianships or similar guardianships with currently available data. Available data does not distinguish the circumstances under which Guardianship is appointed, and therefore the number of Rogers guardianships cannot be estimated. Guardianship in Massachusetts operates through a combination of limited state-funded services and an informal network of unpaid or pro bono Guardians rather than a centralized or Public Guardians program. Massachusetts court records show that since 2017, a total of 3,500 to 4,000 guardianship petitions have been filed each year for incapacitated individuals. These court records do not provide data on reimbursement to Guardians. Summary data of the annual petitions filed are available through the Massachusetts Trial Court, Department of Research and Planning. There is no way to summarize the demographic characteristics of the guardians assigned to these individuals or determine how many of these are Rogers guardianships.

(iii) The fiscal impact of establishing MassHealth fee-for-service guardians. There is no pathway to federal approval to provide MassHealth fee-for-service reimbursement for Public

Guardianship services, therefore, no federal revenue would be available to support these costs. All guardianship services would need to be paid for at the cost of the state.

(iv) Consideration of the benefits to an individual and cost to the Commonwealth of deducting from an applicant for MassHealth or a MassHealth member's income for guardianship fees and related expenses when the appointment of a guardian is essential to enable an applicant or member to gain access or consent to medical treatment and an estimation of reasonable costs for such a deduction.

The Massachusetts statute on MassHealth eligibility includes certain long-term care general income deductions. These include a personal-needs allowance, spousal-maintenance-needs-deduction, family-maintenance needs, maintenance of a former home, and health-care coverage and other incurred expenses. The deductions for health-care coverage and other incurred expenses contain guardianship expenses that are allowable with the specified maximum amounts. There is no pathway currently available to increase the number of allowable deductions from a MassHealth member's income. To increase the number of allowable deductions would require statutory changes at the state level as well as federal approval.

(v) Other recommendations deemed necessary by the Department. The following actions are recommended: enhance the pool of qualified Guardians to reduce acute-care hospital discharge delays by providing sufficient compensation and reduce the need for guardianship by enacting a default surrogate statute and promoting programs that increase completion of Health Care Proxies.

Introduction

Section 30 of Chapter 197 of the Acts of 2024 (the Act) required DPH to:

> "[S]tudy and report on the need and feasibility of qualified professional guardians to give informed medical consent for indigent persons and whether such guardians would reduce hospital discharge issues and increase access to long-term care and preventive care: provided, however, that the report shall include: (i) the need for qualified professional guardians to assist indigent persons with accessing appropriate medical care, including preventive care; (ii) data on the current number of Rogers guardianships and similar guardians and the financial impact of reimbursing such guardians; (iii) the fiscal impact of establishing MassHealth fee-for-service guardians; (iv) consideration of the benefits to an individual and cost to the commonwealth of deducting from an applicant for MassHealth or a MassHealth member's income for guardianship fees and related expenses when the appointment of a guardian is essential to enable an applicant or member to gain access or consent to medical treatment and an estimation of reasonable costs for such a deduction; and (v) other recommendations deemed necessary by the department." [19]

In response to the requirements in the Act, the DPH Bureau of Health Care Safety and Quality contracted with Eastern Research Group, Inc. (ERG) to conduct a study to evaluate the need for and feasibility of establishing access to Qualified Professional Guardians[20] within the Commonwealth, with input from subject matter experts at the Center for Guardianship Excellence (CGE), and issue the Report.

The Report must be submitted by DPH, along with any proposed legislation necessary to carry out DPH's recommendations to the clerks of the Senate and House of Representatives, the Senate and House Committees on Ways and Means, and the Joint Committee on Elder Affairs.

Pursuant to the Act, this Report reviews the role of Qualified Professional Guardians in assisting Unrepresented Individuals to access appropriate medical care and reducing hospital discharge delays. Massachusetts acute-care hospitals are experiencing delays in discharging due, in part, to the inability to safely discharge Unrepresented Individuals who often remain hospitalized for extended periods in part due to the absence of legal Guardians authorized to make decisions on their behalf. The delay in acute-care hospital discharge of Unrepresented Individuals constrains patient beds and impacts hospital throughput. Guardianship Appointments often require prolonged legal processes to secure, which may lead to medically unnecessary and costly acute-

[19] An Act to Improve Quality and Oversight of Long-Term Care - Chapter 197 of the Acts of 2024. Accessible at: https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter197

[20] For purposes of this report, we are defining Qualified Professional Guardian as an individual or organization formally appointed by a court to make personal, medical, and/or financial decisions on behalf of an incapacitated person. Professional Guardians are compensated for their services and must meet formal requirements, which typically include completing training, passing a criminal background check, completing certification, and adhering to ethical standards. Their duties may be subject to ongoing oversight and monitoring by the state and/or professional organizations.

care hospital stays for Unrepresented Individuals. These delays may impact the well-being of Unrepresented Individuals and contribute to backlogs within acute care settings, limiting acute-care hospital throughput and straining resources within the broader healthcare system.

Additionally, to meet the requirements of the Act, this Report seeks to establish the following:

- A definition of "Qualified Professional Guardian"
- A baseline of the use of Guardians in Massachusetts
- Guardian usage and practices in other key states
- Guardian usage and practices in hospitals, including why delayed hospital discharge of Unrepresented Individuals requiring guardianship occurs
- The cost of delayed hospital discharge for Unrepresented Individuals
- How delayed hospital discharges for Unrepresented Individuals can be reduced
- The impact of Qualified Professional Guardian use on timely hospital discharge, placement in long-term care facilities, and access to medical and preventive care in the community.

Research to help answer these questions included a review of relevant literature, interviews with practitioners and experts in guardianship within and outside of Massachusetts, and an analysis of data pertaining to guardianship filings and acute-care hospital discharges within the Commonwealth.

The primary objective of this Report is to develop insights and recommendations to inform policy regarding professional guardianship services, particularly as they relate to decreasing acute-care hospital discharge delays.

Research Methods

This section describes the methods and data used to help inform the key research topics and methods. The findings from this collective research are used to inform the subsequent sections of this Report.

Literature Review

A literature review was conducted to identify key research and policy documents related to guardianship in Massachusetts and across the United States. The review began with a broad internet search of publicly available information using the keyword "guardianship" in Google Scholar. The search was limited to U.S.-based publications from the year 2016 onward. The search was then extended using the additional terms: "unrepresented", "unbefriended", "public guardianship", "guardianship hospital discharge", "incapacitated adults", "adults without advocates", and "guardianship alternatives". These searches yielded a range of research articles and policy or legal reviews. In addition, further relevant literature was provided by DPH, the subject matter experts from CGE, and several interview participants. In total, the review identified 81 articles and publications that met the criteria of interest. These sources fall into seven main categories of focus: Guardianship Best Practices (5), Hospital Discharge Delays (19), Alternatives to Guardianship (13), Public Guardianship (12), Guardianship Policy (10), the Unrepresented Population (17), and Other (5). [21] A bibliography of literature reviewed is included in Appendix A.

Interviews

Twenty semi-structured interviews were conducted with a range of stakeholders associated with the guardianship process. These interviews aimed to gather stakeholder input on key research questions (described further below) based on the individual's relevant expertise and experience. Table 1 provides an overview of the number of interviews conducted by area of expertise. Interviewees have been categorized based on their primary affiliation and interview discussion topic(s).[22]

Interviewee Selection

Interviewees were selected through several avenues. DPH provided an initial set of interviewee suggestions for individuals with expertise with various aspects of the guardianship process in Massachusetts. State programs outside of Massachusetts were identified by subject matter experts and teaming partners from CGE based on the structure and elements of their program,

[21] This categorization framework is imperfect due to the inherent overlap between topics. For example, articles on Unrepresented Individual populations often touch on Public Guardianship or policy reform. As such, the "other" category of five references serves as a catch-all for sources that do not align neatly with a single theme or address adjacent issues.

[22] The categorization reflected in the table does not account for individuals who provided information on multiple focal areas or topics within the guardianship process. For example, while only one interview is denoted for an LTC trade association, there were several interviewees with other areas of primary expertise (e.g., advocacy, hospitals, state agencies) who engaged on topics related to the LTC setting, as it is enmeshed with the individual's work and patient populations served.

along with several hospital and advocacy programs. The remainder of interviewees were identified during other interviews, as the project team asked for recommendations for key individuals who might offer perspectives and insight to fill information gaps that were identified throughout the data collection process.

Table 1: Summary of Interviews Conducted by Area of Expertise

Area of Expertise [a]	Number of Interviews Conducted
Inside Massachusetts	
State Agencies	5
Guardianship Programs	1
Hospitals	3
Courts/Judicial System	1
Long-Term Care Trade Association	1
Advocacy	2
Guardianship Financing	2
Outside Massachusetts	
Other State Guardianship Programs [a]	4
National (multi-state) Guardianship Expert	1
Total Interviews	**20**

* The categorization of interviewees into expert areas reflects their primary affiliation and interview discussion topic(s). Many interviewees had expertise and experience across multiple topic areas.
[a] An additional three states provided email responses to written interview guide questions.

Interview Topics and Questions

Several core interview scripts were developed that could be adapted for use in the semi-structured interviews. For example, a general interview guide was developed for use in state interviews, as was one for hospitals and state agencies and then tailored for specific interviews. Interviews having an expert with a unique perspective were developed individually, often pulling foundational questions from the core interview scripts and then tailoring the other questions to the individual's expertise or focal area. Across these interviews, the questions focus on the main topics of:

- Guardianship processes, such as identifying and appointing Guardians
- Current challenges in the guardianship process
- Factors that contribute to the delay in hospital discharge and access to appropriate medical care for Unrepresented Individuals
- Suggested alternatives or changes to the current guardianship processes, including those that could reduce hospital discharge delays
- Guardianship best practices
- The cost and financial aspects of guardianship, including program costs, Guardian pay, and cost of guardianship per patient.

Data Sources

Data on the Number of Individuals Needing Guardianship

Due to the legal requirements for appointing a Guardian, the Massachusetts Court System is the definitive source for data on guardianship cases.[23] Therefore, to determine the number of guardianship petitions filed by year and by county, this Report relied on the following resources:

- The "Court Data, Metrics & Reports" website[24] provides relevant information such as prepared reports on trial court case flow metrics by year.
- The "Massachusetts Trial Court, Civil Case Filings" contains civil court case filings from FY2017 to FY2024 and can be broken down by Trial Court department, case type, and county.

Data on Acute-Care Hospital Discharge Delays

To estimate the magnitude of acute-care hospital discharge delays, two primary data sources were used: the Massachusetts Health & Hospital Association's (MHA) Monthly Throughput Survey Reports[25] and the Center for Health Information and Analysis (CHIA) Case Mix Data Hospital Inpatient Discharge Database.[26] Both datasets were analyzed to generate estimates of the number and magnitude of acute care hospital discharge delays. However, neither dataset includes the information needed to identify certain sub-populations of interest, such as Unrepresented Individuals.

MHA Throughput Survey Reports

MHA Throughput Survey Reports summarize the results of monthly survey responses from case management directors regarding their member acute and Post-Acute Care hospitals. The focus of the MHA Survey Report is to obtain information about the number of patients awaiting discharge to Post-Acute Care settings including details such as the types of post-acute settings, types of patient issues, and length of wait. Data are reported voluntarily by hospitals, with the survey instrument and information about the representativeness of the sample being unavailable.[27] In the absence of this information, assumptions were developed to estimate the number of patients experiencing hospital discharge delays and the subset of those patients who were awaiting a Guardian.

CHIA Case Mix Data

CHIA, an independent state agency responsible for producing healthcare statistics for Massachusetts, provided a Limited Data Set version to DPH. CHIA collects detailed financial and patient-level data from Massachusetts payers and providers. The Hospital Inpatient Discharge Database is a collection of acute care hospital inpatient discharge data provided by Massachusetts facilities. The main data field of interest for this study is the "Total Administratively Necessary Days" which is described as "The number of days which were deemed clinically

[23] Only certain aggregate numbers are available. Access to the underlying data was requested, but case-level data were unavailable.

[24] https://www.mass.gov/court-data-metrics-reports

[25] Available at https://www.mhalink.org/throughputreports/

[26] Documentation available at https://www.chiamass.gov/case-mix-data

[27] Tabulations other than those published in the MHA Survey Reports could not be obtained.

unnecessary in accordance with review by the Division of Medical Assistance."[28] The data also include information about the demographics of the patient, details about the acute-care hospital inpatient stay, and information about where the patient was discharged. Some of these variables were used to restrict the observations to approximate the population of interest. One limitation of the CHIA data is that they do not include any information related to a patient's need for a Guardian or any other reason for a delayed discharge.

[28] See the Case Mix Documentation: Hospital Inpatient Discharge Database (HIDD) FY24 Documentation Manual, available at https://www.chiamass.gov/case-mix-data

Decision Making Support and Guardianship in Massachusetts

Massachusetts law (G.L. c. 190B, § 5-306) sets the conditions and requirements for appointing a Guardian for an incapacitated individual. The law requires that less restrictive options to guardianship are explored and ruled out prior to appointing a Guardian.[29] In Massachusetts, less restrictive options include:

- The designation of a Healthcare Proxy (HCP) or an Advance Directive to make medical and treatment decisions on behalf of the patient. These options require the individual to make decisions and complete documentation prior to complete incapacitation of the individual.
- Supported Decision-Making (SDM), which uses the help of an individual's trusted supporters to help the individual preserve autonomy in decision-making.[30] SDM is not suitable for an incapacitated individual who lacks the appropriate support network.

Once a patient is deemed to lack capacity and does not have a HCP in place, a Guardian is required to make decisions for the patient, as Massachusetts does not have a Default Surrogate Statute (one of only four states in the U.S).[31] A surrogate consent law allows another individual, generally a close family member, to be the healthcare decision-maker for an incapacitated individual who has not designated an HCP or been appointed a Guardian.

Guardianship in Massachusetts operates through a combination of limited state-funded services and an informal network of unpaid or pro bono Guardians rather than a centralized or Public Guardians program. Massachusetts has four types of guardianship:

- **Limited Guardianship:** The Guardian decisions are limited to a subset of court-defined **specified** decisions. This allows the individual under guardianship to retain autonomy in areas where they are still capable.
- **Plenary or Complete Guardianship:** The Guardian has broad, comprehensive authority over nearly all personal decisions for an individual, often due to advanced cognitive impairment or severe mental illness. While necessary in some cases, plenary guardianships result in a near-total loss of personal autonomy and are considered the most restrictive form of guardianship.[32]
- **Rogers Guardianship:** A type of guardianship where there is a court order that authorizes the guardian to agree to extraordinary treatment, with the appointed individual as a Rogers

[29] https://malegislature.gov/Laws/GeneralLaws/PartII/TitleII/Chapter190B/ArticleV/Section5-306

[30] Carlson, K et al. (2021) Best Practices in Support Decision Making: How to Be an Effective Supporter. *Center for Excellence in Supported Decision Making.* Retrieved from https://www.voamnwi.org/center-excellence-supported-decision-making

[31] The other three states are Minnesota, Missouri, and Rhode Island. See https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bifocal-vol-44-issue3/recent-updates-to-default-surrogate-statutes/.

[32] Catlin et al. (2022). Unrepresented Adults Face Adverse Healthcare Consequences: The Role of Guardians, Public Guardianship Reform, and Alternative Policy Solutions. *J Aging Soc Policy.* 2022 May 04; 34(3): 418–437. doi:10.1080/08959420.2020.1851433.

monitor who is responsible for monitoring whether treatments are within the scope of the court order. Named after the Rogers v. Commissioner of the Department of Mental Health 1983 decision, Rogers guardianships are typically used in psychiatric settings and are distinct from other guardianship types

- **Temporary Guardianship**: A temporary guardianship for an individual may be appointed in emergency situations until a permanent guardian is appointed. The temporary guardianship generally lasts for a maximum of 90 days and requires "immediate and substantial harm to the incapacitated person's health, safety, or welfare."[33] Some hospitals frequently file this type of guardianship petition for Unrepresented Individuals.

Jurisdiction for Guardianship issues is with the Massachusetts Probate and Family Court Department, which operates through a number of local district courts. In early 2025, the Office of Adult Guardianship and Conservatorship Oversight (OAGCO) was implemented as part of the Massachusetts Probate and Family Court Department by a federal grant funded by the Administration for Community Living (ACL) and the U.S. Department of Health and Human Services (HHS).[34] The office is responsible for monitoring the reports that Guardians and conservators are required to file annually, collecting and reporting data on adults under guardianships and conservatorships, coordinating with other state agencies and private organizations on guardianship matters, and providing education to the public about guardianship and conservatorship issues.[35][36]

Guardians

Although demographic information about individuals serving as Guardians is not publicly available, most Guardians are believed to be family members. Other than family petitioners, the Department of Mental Health (DMH), the Department of Developmental Services (DDS), and the Executive Office of Aging & Independence (AGE) assist qualifying individuals in their client populations to access guardianship services. While DDS and DMH assist its clients in obtaining guardianships through their service plan on an as-needed basis (DDS assists approximately 1,000 clients per year), AGE helps place eligible individuals in a limited number of predetermined guardianship slots. 153 slots are available within AGE's Adult Protective Services for individuals over the age of 65 with no financial capability and where family or friends cannot serve as guardians. Services are provided via contracts with community organizations. [37] [38] For Unrepresented Individuals who do not

[33] https://malegislature.gov/Laws/GeneralLaws/PartII/TitleII/Chapter190B/ArticleV/Section5-308

[34] https://www.mass.gov/office-of-adult-guardianship-and-conservatorship-oversight-oagco

[35] Guardians are appointed for incapacitated persons, and conservators are appointed for persons to be protected. (https://www.mass.gov/info-details/general-information-regarding-guardianships-and-conservatorships-mpc-190)

[36] https://www.mass.gov/news/massachusetts-trial-court-announces-the-implementation-of-the-office-of-adult-guardianship-and-conservatorship-oversight

[37] Massachusetts Guardianship Policy Institute. 2025. "Report on Public Guardianship: Ten Year Review & Recommendations." Available at https://guardianship.institute/report-on-public-guardianship/

[38] Eligibility for guardianship through AGE: Individuals 60+ that have gone through an investigation that shows they need protective services as evidenced by some level abuse or self-neglect. (https://www.mass.gov/protecting-older-adults-from-abuse)

qualify for one of the state agency Guardian appointment programs, guardianship is fulfilled on a pro bono basis by volunteers, such as attorneys, retired attorneys, or retired social workers.

Qualifications and Training

Qualifications and training vary by the type of Guardian in Massachusetts. At minimum, all Guardians are required to be at least 18 years of age, pass a criminal background check, and be determined competent by the court. Optional training is provided through several programs that help Guardians better understand various aspects of guardianship, such as Guardian responsibilities, the legal process, and ethical decision-making. In addition, some agencies and organizations require additional training or certification. For example, Guardians for DDS patients are required to demonstrate experience working with their client population and are required to meet a set of criteria determined by their office. Guardian programs contracted by the Commonwealth often have staff with social work or other relevant education and/or background experience.

Funding and Payment

Qualified Professional Guardians in Massachusetts are paid either by the incapacitated individual's estate or through an agency. For funding by the Commonwealth, the largest amount of public payment for Guardian services is a total payment of $892.78 per month ($10,713 per year) per client for the slots paid through AGE's Adult Protective Services. This amount is used to cover wages, benefits, and overhead (i.e., the full wage amount does not go directly to the Guardian).[39] DDS pays an average of $50 per hour for up to 20 hours per patient per year for guardianship services. DMH pays up to $60 per hour for up to 20 hours per year, plus up to $300 for reimbursable expenses, and $150 for travel. Rudow payments are available for Guardians of nursing facility residents with MassHealth but the payments are a maximum of $100 per month ($50 per hour for a maximum of 2 hours per month).[40] For patients needing Rogers Guardianships, the Guardians are eligible for payment by the Massachusetts Probate and Family Court Department for up to 2 hours per month at a rate of $50 per hour.[41,42]

Eligibility for guardianship through DDS: Individuals 22 years of age or older with an intellectual or developmental disability as defined in 115 CMR 2.01 (https://www.mass.gov/doc/115-cmr-2-definitions/download)
Eligibility for guardianship through DMH: Individuals 18 years of age or older with a serious and persistent mental illness as specified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (https://www.mass.gov/doc/104-cmr-29-application-for-dmh-services-referral-service-planning-and-appeals/download)

[39] https://www.mass.gov/doc/rates-for-certain-elder-care-services-effective-january-1-2025-0/download

[40] These reimbursements are available due to the Massachusetts Supreme Court case Rudow v. Commissioner of the Division of Medical Assistance, 429 Mass. 218 (1999). Guardianship fees can be deducted from the personal income allowed for an individual receiving long-term care under MassHealth.

[41] A Rogers guardianship is a specialized form of guardianship in Massachusetts thatI s a court order that authorizes extraordinary treatment, with the appointed individual as a Rogers monitor who is responsible for monitoring whether treatments are within the scope of the court order. . Named after the *Rogers v. Commissioner of the Department of Mental Health 1983* decision.

[42] Massachusetts Guardianship Policy Institute. 2025. "Report on Public Guardianship: Ten Year Review & Recommendations." Available at https://guardianship.institute/report-on-public-guardianship/.

Baseline Guardian Use

Although OAGCO is in the process of collecting and reporting data about adults who have Guardians, these data have not yet been made publicly available. Summary data of the annual petitions filed are available through the Massachusetts Trial Court, Department of Research and

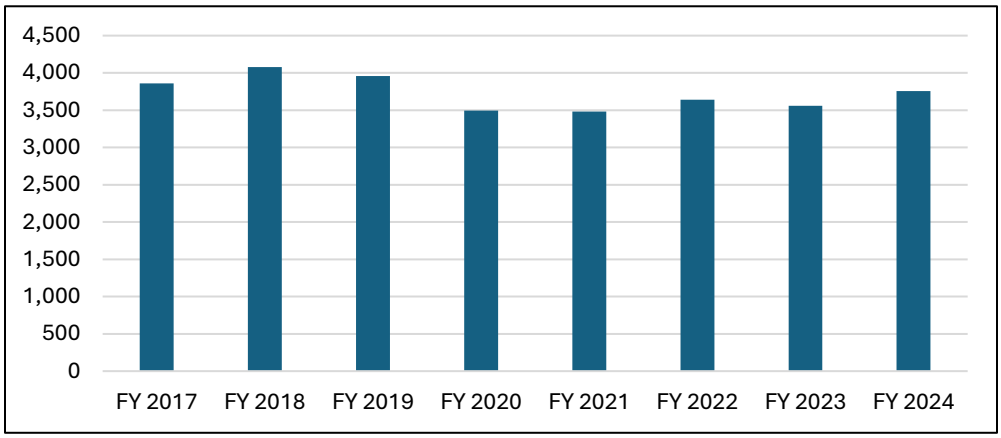

Figure 1: MA Guardianship Petitions for Incapacitated Individuals FY2017-2024

Planning.**Error! Reference source not found.** Figure 1 shows the number of guardianship petitions filed in the Massachusetts Family and Probate Court for incapacitated patients in the Commonwealth from Fiscal Year (FY) 2017 to FY 2024. No other characteristics are available. For example, the trial court data do not provide information on how many of these Guardianships are for incapacitated patients that are Unrepresented Individuals.[43]

For this report, the current need for guardianship services was estimated using data from the MHA Monthly Throughput Survey Reports and the CHIA Case-Mix Hospital Inpatient Discharge Database (HIDD). The values calculated from the data in the MHA Monthly Throughput Survey Reports for March 2024 through February 2025 are shown in Table 2. Using monthly data, the first step of the calculation was to estimate the statewide number of acute-care hospital patients awaiting discharge to skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs), inpatient rehabilitation facilities (IRFs), or home with home health care (HH) by dividing the number of patients awaiting discharge in the respondent hospitals by the percent of statewide staffed inpatient beds represented by respondents in acute care. The next step was to calculate the weighted average length of stay (LOS) based on the data reported for the number of patients by categories of length of time patients are awaiting discharge.[44] The estimated number of new cases from each month's data was calculated as the statewide number of patients awaiting acute-care hospital discharge divided by the average length of stay in months. Finally, the estimated new

[43] Massachusetts Trial Court, Department of Research and Planning: https://public.tableau.com/app/profile/drap4687/viz/MassachusettsTrialCourtCivilCaseFilings/AboutthisDashboard

[44] The categories are: 7 to 13 days, 14 to 29 days, 30 days to 6 months, and more than 6 months. The midpoint was used for the bounded categories. The average days of delay assumed for discharges with more than 6 months of delay was based on the CHIA Hospital Inpatient Discharge Database for FY 2023 (252 days).

cases each month were summed to calculate an estimated annual number of new cases of inpatient acute care hospital stays with delayed discharges.

Table 2: Estimated Annual Patients with Hospital Discharge Delays

Source	Time Period	Patients Awaiting Discharge/ Discharged to SNF, LTACH, IRF, HH*		Patients Requiring Appointment of a New/Initial Guardian with Delayed Discharge to SNF, LTACH, IRF, or HH*
		Annual Cases	Average LOS (Days)	Annual Cases
MHA Throughput Survey	March 2024-February 2025	18,346 [a]	54.1 [c]	3,313 [d]
CHIA HIDD	FY2023	21,798 [b]	15.7	3,027 [d]

*Acronyms are defined as follows: skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs), inpatient rehabilitation facilities (IRFs), home with home health care (HH)

[a] For each month, the number of statewide total patients in acute care hospitals awaiting discharge was estimated by dividing the reported number of delayed discharges by the percentage of staffed inpatient beds accounted for by the reporting hospitals in that month (e,g.,1,527 delayed discharges were reported by hospitals accounting for 73 percent of staffed inpatient beds in March 2024). Because each patient stay may appear in more than one month's data, that value was divided by the average LOS measured in months (59 days/(365 days/12 months) in March 2024) to estimate the numbers of new cases in that month. Finally, the monthly estimates of new cases were summed to calculate an estimate of the annual number of cases of delayed discharges from acute care hospitals.

[b] Number of adult observations whose inpatient admission began in the hospital's emergency department, were discharged to a SNF, LTACH, IRF, or HH, and had at least 7 administratively necessary days (for consistency with how the MHA reports the number of patients with delayed discharge from acute care hospitals).

[c] Calculated as a weighted average of the length of time for patients awaiting discharge to SNFs using the midpoint of bracketed categories in the MHA reports. For those waiting more than 6 months, an assumed average of 252 days was estimated from observations with at least 6 months of administratively necessary days in the FY2023 CHIA data.

[d] Based on applying the average percentage of patients with hospital discharge delays who were awaiting a Guardian in the MHA Monthly Throughput Survey Reports for May 2024-April 2025 (a March 2025 report is not available).

The calculations of the number of unique cases of acute care hospital visits with delayed discharge using the data reported in the MHA Monthly Throughput Surveys contain two implicit assumptions. First, the calculations assume that patterns of delayed discharge for hospitals not reporting are similar to those of hospitals that do report. A second implicit assumption is that the characteristics of delayed discharge for patients awaiting guardianship to be discharged to an LTC facility are similar to those awaiting guardianship to be discharged to other Post-Acute Care settings.

Similar to the estimate of the number of new cases of delayed discharge from acute care hospitals that involve patients waiting for Guardians using the MHA reported numbers of delayed discharges, the CHIA HIDD calculation implicitly assumes that the patterns of delayed discharge for patients awaiting guardianship to be discharged to a LTC facility as reported in the MHA Throughput Survey Reports are similar to those awaiting guardianship to be discharged to other Post-Acute Care settings.

Sensitivity Analysis

The results about the current need for Guardians are sensitive to changes in the estimated LOS for patients awaiting guardianship for discharge. The analysis also approximated how acute-care hospital occupancy might change under different assumptions about the LOS for patients awaiting guardianship for discharge. CHIA data for the one-year period from April 2023 through March 2024 showed 759,000 hospital discharges with a total 4.22 million bed days (average LOS of 5.6 days).[45] The approximation shows that the estimated 12,900 patients with delayed discharges for reasons other than guardianship accounted for 591,000 of those bed days (13.4 percent of the total).

If the average excess LOS for patients awaiting guardianship for discharge is 41 days, the 3,300 patients whose discharge is delayed due to guardianship issues account for approximately 0.4 percent of patients and 156,200 occupied bed days (3.6 percent). If acute-care hospitals were able to reduce the excess LOS for these patients by 50 percent (about 20 days), this would make available an additional 68,000 bed days per year (1.5 percent).

However, if the average LOS for patients awaiting guardianship for discharge is 12 days (Ricotta, et al., 2018), then those same 3,300 patients account for 63,100 of occupied bed days in a year (1.5 percent). If acute-care hospitals were able to reduce their excess LOS by 50 percent (about 6 days), this would make available an additional 19,400 bed days in a year (0.5 percent).

The Role of Guardianship in Delayed Hospital Discharge and Access to Appropriate Medical Care

According to a 2023 report from the Massachusetts Health and Hospital Association (MHA), for approximately 1,200 of the patients (about 2 percent of patients) statewide who are medically stable, discharge is delayed due to systemic barriers, such as workforce shortages in Post-Acute Care settings, limited availability of specialized care settings for those with complex care needs, transportation issues for patients requiring ongoing outpatient services such as dialysis, and rules regarding minimum inpatient stay before eligibility for SNF admission. Because this extends their LOS, these 2 percent of medically stable patients account for approximately 15 percent of the Commonwealth's occupied medical-surgical bed days annually.[46]

The MHA Throughput Survey Reports estimate that approximately 14 percent of the 1,200 patients who are medically stable but have a delayed discharge is attributable to guardianship issues. While many other challenges cause delay, as noted above[47] the guardianship appointment process can be a factor that further delays discharge.[48]

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[45] Massachusetts Acute Care Hospital Inpatient Discharge Data. October 2018 through March 2024 (Preliminary). August 2024. CMSR-HIDD-Quarterly-Databook-10-01-2018-to-03-31-2024.xlsx. https://www.chiamass.gov/massachusetts-acute-care-hospital-inpatient-discharge-reporting. Downloaded June 4, 2025.

[46] Massachusetts Health & Hospital Association. (2023). *A clogged system: Keeping patients moving through their care journey*. https://www.mhalink.org/reportsresources/acloggedsystem/

[48] MHA, *A clogged system,* 2023.

- Interviews and literature reviewed confirmed that the role of guardianship in the acute-care hospital discharge process is a critical factor contributing to delays, particularly for individuals with complex medical, cognitive, or behavioral health needs. When a patient is deemed medically ready for discharge but lacks the capacity to make decisions and has no available surrogate decision maker, guardianship is required to facilitate discharge planning and access to a more appropriate care setting

Challenges

According to interviewees, professional Guardians are available for Unrepresented Individuals who have sufficient funds to pay for them. Massachusetts has a shortage of Guardians willing and able to serve incapacitated individuals who do not have the funds to hire a professional Guardian. Interviewees report that Massachusetts relies on a limited and shrinking pool of professional or pro bono Guardians, usually attorneys or retired attorneys, to fill this gap. As a result, acute-care hospitals often struggle to identify a suitable Guardian in a timely manner. The consensus from interviewees and literature is that the main factor that impacts the lack of availability of qualified Guardians for Unrepresented Individuals is inadequate or nonexistent compensation. According to interviewees with knowledge of the process of obtaining a Guardian for Unrepresented Individuals, professional Guardians are unlikely to accept cases involving indigent patients when the limited funding available is insufficient. Existing stipends in Massachusetts were set more than 20 years ago. For example, the Rudow payments available for Guardians of nursing facility residents with MassHealth were established in 1999 and are $50 per hour and capped at $1,200 annually. Adjusted for inflation, the Rudow payments available for Guardians of nursing facility residents with MassHealth would need to be increased to $94 per hour and $2256 per year to maintain the same purchasing power.[49] Many interviewees noted that these Rudow payments are administratively complex to apply for. According to many interviewees, Guardians often do not even seek to claim these payments. Cases involving the indigent population are often complex and require a considerable investment of time on the Guardian's behalf to be executed appropriately and ethically, a fact that further discourages Guardians from taking on these cases. According to several interviewees, attorneys seeking a volunteer Guardian on behalf of acute-care hospitals might contact anywhere from four to thirteen individuals before finding one willing to accept the case.

As previously noted, admission from an acute-care hospital into an appropriate LTC facility can be significantly delayed due to the time required to complete the guardianship process. In Massachusetts, most LTC facilities will not screen or accept residents for admission unless a legally authorized individual is available to provide consent and complete the necessary paperwork.

[49] Federal Reserve Bank of Minneapolis. Inflation Calculator. Available at https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator. Accessed on August 18, 2025.

Comparing State Guardianship Programs

To better understand guardianship programs and approaches utilized in other states and how they compare to those in Massachusetts, interviews were conducted with guardianship experts from four states (Oregon, Pennsylvania, Minnesota, Tennessee) with three additional states (Idaho, North Dakota, Washington) providing limited information via email communications. Prior to these communications, an interview was held with a guardianship expert who offered a national perspective on the key guardianship issues as they relate to acute-care hospital discharge to gather a foundational understanding of key elements. In addition, an online internet search for publicly available information was conducted to glean information about core guardianship program elements in New York, California, and Colorado to inform guardianship best practices across states. Table 3 below provides an overview of the key program elements in Massachusetts compared to the other states that provided input on their guardianship programs.

Table 3: Summary of State Guardianship Program Elements

State	Program Structure/ Feature	Guardians Paid*	Training Required	Certification Required**	Non-Estate Program Funding Source(s)					
					County	State	Federal	Organization	Hospital	Not Specified
MA	Patchwork	✓ *				✓	✓	✓		
California [a]	Public	✓	✓	CGE/State	✓					
Colorado [a]	Public	✓	✓	CGE		✓				
Idaho [b]	NA	Not specified	✓	Not specified						✓
Oregon	Public	✓	✓	CGE		✓				
Minnesota	Patchwork	✓ *		-	✓					
New York [a]	Patchwork	✓ *		-		✓	✓	✓		
North Dakota [b]	Patchwork	✓	✓	CGE		✓				
Pennsylvania	Patchwork/ Statewide Tracking	Not specified	✓	CGE	✓		✓			
Tennessee	Patchwork/ Expedited Legal Assistance	✓ *		-			✓		✓	
Washington[b]	Public	✓ *	✓	State		✓				

* Indicates at least some professional Guardians that receive payment; however, this may not include all Guardian types.

** CGE stands for certification through the Center for Guardianship Certification

[a] Information based on internet search of public information.

[b] Indicates information provide via email responses to interview questions.

As Table 3 shows, of the state programs researched most do not have a centralized guardianship program or structure, but rather they implement a “patchwork” system, where the state pieces

together guardianship services by relying upon an array of entities (e.g., non-profit organizations, state agencies) and funding sources.

Highlighted below are some Guardian program types, approaches, and elements gleaned from the research that could inform possible changes to Massachusetts' current system.

Three researched states (Colorado, Oregon, Washington) operate state Public Guardianship programs that provide last resort guardianship services where the individual is incapacitated, does not meet criteria for coverage by other state agency programs, and/or does not have sufficient resources to obtain their own Guardian. These programs are funded through state appropriations with fully expanded programs costing somewhere from $686,000 (Washington) upward to nearly $8 million (Oregon). These state programs vary in the number of cases that they support (81 to 420), the number of total program staff, and the number of qualified Guardians that they can access (4 to 100+). Each program requires their professional Guardians to be certified and provides compensation ranges from $60,000 to over $100,000 per year, depending on the state and the number of clients they assist.

In contrast to the other states with Public Guardianship programs, California's program is funded and implemented at the county level, with costs and staffing varying by county. Each county is required to provide some type of public Guardian and/or conservatorship, but what that looks like varies by county. According to the California State Association of Counties, "The role may be executed through a separate department, an elected official, or be incorporated into a larger county department, such as health or human services."[50] "In some counties, the Public Guardian, Public Conservator, and Public Administrator may operate as distinct entities, but their functions can also be consolidated within a single department."[50]

Table 4 provides a summary of program staffing, caseload, and costs for each state with Public Guardianship programs.

[50] https://www.counties.org/counties/role-of-counties/

Table 4: Summary of Public Guardian Program Staffing, Caseload, and Costs in Colorado, Oregon, and Washington.

State	Number Employees	Number Guardians	Number of Active Cases	Caseload	Average Annual Program Per Client Cost	Annual Guardian Pay ($thousands)	Annual Program Cost ($thousands)
Colorado [a]	10[b]	4 [b]	81	Not specified	Not specified	$25-$62[c]	$263[d]
Oregon [e]	18	13	270	20-22	$12,000	$60 -$100	$7,900[f]
Washington	Not specified	250[g]	420	30 [h]	$7,688 [I]	$6.3 - $9 *per client* [j]	$686 [i]

[a] Figures based on FY25-26; however, program is undergoing expansion and number increase for FY26-27. Anticipated shifts across this timeframe are outlined here: https://colorado-opg.org/wp-content/uploads/2024/11/COPG-FY2025-26-Budget-Request.pdf

[b] Number of anticipated full-time employees is 10 for 2025-2026 and 28 by the end of program expansion in 2030.

[c] Likely an underestimate, as values are for FY22-23: https://colorado-opg.org/wp-content/uploads/2023/11/FINAL-Office-of-Public-Guardianship-FY2024-25-Budget-Request.pdf

[d] Based on FY2025-2026 budget request. Budget request for expanded program in FY 2026-27 is $1,196,542.

[e] Information from interview with Oregon Public Guardian & Conservator

[f] https://www.oregon.gov/das/financial/documents/2025-27_gb.pdf

[g] Estimated number of certified Guardians in WA state, but not all are contracted with OPG. Certified Guardian contracted with the OPG can, and do, serve the general public (i.e. they have other clients that are not OPG cases).

[h] Average caseload for OPG's Public Guardians per contractor.

[i]https://www.courts.wa.gov/content/Financial%20Services/documents/2023_2025/Combined%20Branch%20PDF/53%20S6%20Increase%20Public%20Guardianship%20Services%20FINAL.pdf

[j]https://www.courts.wa.gov/content/publicUpload/Office%20of%20Public%20Guardianship/Office%20of%20Public%20Guardianship%20-%20FAQs.pdf

Tennessee has addressed the issue of delayed hospital discharge for Unrepresented Individuals through an Expedited Limited Healthcare Fiduciary (ELHF) process. A solution spurred by hospitals to address delayed hospital discharge, the ELHF process allows a court to quickly appoint a temporary decision-maker within a time period of 40 hours to one week from when it is determined that a surrogate decision maker is needed for hospital discharge and continued care. An attorney acting as the ELHF is paid by the hospital for a temporary appointment of 60 days to assist their client in getting discharged from the hospital and accessing appropriate medical care access thereafter. During this time, the ELHF also attempts to identify other family or friends who can transition to the role of permanent Guardian after the initial 60-day period. After 60 days, the ELHF is either terminated with the role reassigned to a family member, or the role is maintained by the same individual that was executing the ELHF and is converted into a conservatorship. A conservatorship grants the surrogate decision-maker broader authority than an ELHF appointment and is financed by the Unrepresented Individual's assets. If the Unrepresented Individual does not have sufficient assets to pay the ELHF, the ELHF remains the Guardian on a pro-bono basis. The ELHF program is regularly utilized by hospitals, with at least 300 requests per year in Davidson County alone.

Guardianship in New York is a patchwork of entities serving as Guardians and funding coming from multiple sources. To help address guardianship issues in New York, a pilot program-turned non-profit, named Project Guardianship is changing the way guardianship is approached in the state by implementing a person-centered approach that considers the continuum of patient care and aims to return individuals to their community homes, when possible. This model presents considerations for the Commonwealth in the manner of how guardianship is approached along with the potential cost savings.

Project Guardianship's approach to guardianship integrates a full range of services for individuals that helps address the spectrum of needs they have from daily living through end-of-life. Individuals are supported by an interdisciplinary staff that includes "attorneys, case managers, housing and benefits coordinators, and finance managers".[51] In their 2025 report on the cost and savings of person-centered guardianship[52,] Project Guardianship indicated that this approach to guardianship helps create cost-saving to the state by:[53]

- Reducing the number and length of hospitalizations
- Decreased nursing home care and increasing home care
- Delaying spend-down of assets to meet Medicaid eligibility requirements
- Recovery of Medicaid liens
- Reduced homelessness

Over their nine-and-a-half-year study period of 236 patients, they estimate savings of approximately $67,000 per patient per year, with a total between $155 and $166 million in savings. Table 5 shows the estimated savings by cost type.

Table 5: Project Guardianship Costs Savings by Category

Cost Category	Estimated Savings
Avoiding nursing home placements	$26.9M–$72.6M
Reducing hospitalizations and lengths of stay	$1.2M–$17.4M net savings
Recovering Medicaid liens	$373,524
Homeless shelter avoidance	$6.5M–$17.6M

Source: https://projectguardianship.org/news-and-views/blog/cost-benefit-analysis-report

While Pennsylvania also faces hospital delayed discharge and does not have a public Guardian of last resort program, it has established a statewide Guardianship Tracking System (GTS) that is helping streamline case tracking, monitoring, and Guardian document submissions. It currently tracks information such as the number of active cases, the type of each active guardianship (e.g., limited, plenary), statistics on how often the proposed Guardian is appointed Guardian, how often the adjudication is different than what is requested, why cases are closed, and whether reports are

51 Project Guardianship, 2025, pg. 3: https://projectguardianship.org/news-and-views/blog/cost-benefit-analysis-report

52 https://projectguardianship.org/news-and-views/blog/cost-benefit-analysis-report

53 [sic]

being filed. These data allow the state to better understand guardianship issues and needs, and serve a critical role in the monitoring of guardianships in the state.

GTS also allows people serving as Guardians to more easily upload and access information and helps decrease issues surrounding documentation and reporting. GTS sends Guardians electronic notifications when a report is due or overdue to help increase compliance with reporting requirements, provides guidance for completing reports, and allows individuals to file reports at any time throughout the day or year.[54] The standardized system also helps eliminate arithmetic errors in information submitted and allows Guardians to view previously filed reports.[54]

Fiscal Impact on MassHealth

Section 30 of Chapter 197 of the Acts of 2024 requires the Massachusetts Department of Public Health (DPH) to study and report on the fiscal impact of providing fee-for-service reimbursement for Public Guardianship services. The Executive Office of Health and Human Services (EOHHS) is the single state agency responsible for the administration of the Medicaid Program and the State's Children's Health insurance Program within Massachusetts (collectively, MassHealth) as well as other health and human services programs designed to pay for medical services for eligible individuals pursuant to M.G.L. c. 118E, Title XIX of the Social Security Act (42 U.S.C. sec. 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. sec. 1397aa et seq.), and other applicable laws and waivers. As a threshold issue, fee-for-service reimbursement for any service is subject to federal approval by the Centers for Medicare and Medicaid Services (CMS) to qualify for federal revenue for such services. There is no pathway to federal approval to provide MassHealth fee-for-service reimbursement for Public Guardianship services, therefore, no federal revenue would be available to support these costs. Therefore, the estimates provided assume reimbursement of Public Guardianship services at all state cost.

Estimating the Number of Unrepresented Individuals Needing Guardianship Support

Based on the research presented in Section 0, an estimated 3,100 to 4,950 Unrepresented Individuals per year could require Public Guardianship services. Although not all Unrepresented Individuals are or will be eligible for MassHealth, in the absence of exact payor data,[55] the calculations included the entire Unrepresented Population in determining the fiscal impact of providing fee-for-service reimbursement for Public Guardianship Services through MassHealth.

Estimating the Fiscal Impact to MassHealth of Guardianship Services

Through interviews with stakeholders with expertise in providing professional guardianship services, the average cost to cover guardianship services is approximately $10,000 to $11,000 per client per year. This is consistent with what AGE pays contractors to provide guardianship services (the amount is currently $892.78 per month which equals $10,713 per year). Thus, during the

[54] https://ujsportal.pacourts.us/Guardianship/Overview

[55] Although the MHA Monthly Throughput Survey publishes the percentage of patients awaiting discharge to SNFs by insurance provider, Unrepresented Individuals awaiting discharge due to guardianship issues are only a subset of these patients and the percentage of Unrepresented Individuals by provider may differ for the overall percentage.

Unrepresented Individual's discharge year funding guardianship services at $11,000 provides an estimated net benefit ranging from $300 to $55,000.

Utilizing the estimated 3,100 to 4,950 Unrepresented Individuals per year who may require Public Guardianship service and assuming MassHealth fee-for-service reimbursement will assume all state cost for all Unrepresented Individuals, and that the reimbursement is approximately $10,000 to $11,000 per year results in a potential Fiscal Impact of range of $31,000,000 to $54,450,000. This number cannot be further refined due to the limitations on data as described above.

Potential Cost Savings Associated With the Provision of Public Guardianship Services

Implementation of MassHealth fee-for-service Public Guardian services and the resulting throughput shortening unnecessary stays in acute care hospital settings to more appropriate Post-Acute care settings is estimated to lower the cost of medical care for each individual between $945 to $2,500 per patient per day.[56] For example, KFF estimated the hospital expenses per adjusted inpatient day exceeded $3,600 for Massachusetts community hospitals in 2023.[57] Thus, if Public Guardianship prevents or shortens a single hospital admission for a patient, the cost savings might be significant. In addition, full-time professional Guardians have been shown to improve patient care through attention to appropriate outpatient care that may result in avoided health care costs such as emergency department visits or acute illness.

Furthermore, researchers have estimated that larger cost savings from providing professional guardianship services to Unrepresented Individuals accrue in the years following discharge than the immediate costs savings from more prompt discharge from acute care hospitals [58] This research indicates the potential for guardianship services to result in cost savings to offset implementation of MassHealth fee-for-service reimbursement for Public Guardianship services at all state cost. However, the existing research is not sufficient for estimating these cost savings systemwide.

In addition to the issues described in the previous section, cost savings might accrue to different stakeholders depending on the timing and other circumstances of those savings, inherently limiting the ability to estimate the full scope of cost-savings across the system. The costs of providing guardianship services are relatively straightforward to identify and estimate, the cost savings and

[56] Estimate based on the assumptions that a reasonable range of the cost of a medically unnecessary hospital day is $1,420 to $2,976 (based on values inflated to 2024 dollars from https://www.sciencedirect.com/science/article/pii/S2667296021000768 and https://journals.sagepub.com/doi/10.1177/00469580221086912) and that the cost of a day of stay in Massachusetts at a long terms facility is $475. Source: https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf.

[58] Levine et al. 2019 estimated cost savings per individual in the first year of guardianship only. Boswell et al. 2025 estimated cost savings per individual per year over 9.5 years. Both study cohorts include patients with mental health challenges who might not be representative of the delayed discharge patient cohort in the Commonwealth (e.g., these patients might be covered by the DMH—DMH has no less, and arguably more, difficulty finding guardians for its clients than the general case.). In addition, the Boswell study is based on a small sample size.

benefits that might accrue as a result of those services are more difficult to quantify and are more likely to be dispersed across multiple stakeholders.

Deduction from Individual Income of MassHealth Members

As previously noted, Section 30 of Chapter 197 of the Acts of 2024 requires "consideration of the benefits to an individual and cost to the Commonwealth of deducting from an applicant for MassHealth or a MassHealth member's income for guardianship fees and related expenses." The Massachusetts statute on MassHealth eligibility includes certain long-term care general income deductions.[59] These include a personal-needs allowance, spousal-maintenance-needs-deduction, family-maintenance needs, maintenance of a former home, and health-care coverage and other incurred expenses. The deductions for health-care coverage and other incurred expenses contain guardianship expenses that are allowable with the specified maximum amounts. Expenses related to guardianship may exceed these specified maximum amounts. However, there is no pathway available to increase the amount of allowable deductions from a MassHealth member's income without statutory change at the state level and CMS approval at the federal level.

[59] See 520.026: Long-term-care General Income Deductions. https://www.mass.gov/doc/130-cmr-520000-masshealth-financial-eligibility-0/download

Recommendations

The following proposed recommendations are grounded in available literature, interviews, and policy analysis. As described in the preceding sections, many factors contribute to delayed acute-care hospital discharge, and multiple initiatives are likely necessary to reduce delays but it is clear from the study that there is a significant need for qualified professional guardians to give informed medical consent for persons who are unable to afford these services otherwise. Increasing the number of Qualified Professional Guardians, coupled with the additional recommendations below, could substantially reduce delays in hospital discharges and expedite access to long-term and preventative care. Given the complexity of guardianship and the wide range of invested parties, further research and stakeholder engagement will be important to refine any significant decisions.

1. Increase the Number and Quality of Guardians Through Payment. Based on the research performed for this study, the single most important policy recommendation is to increase the availability of Guardians by paying them an adequate amount consistent with inflation and indicative of the time necessary for Guardians to effectively perform their required duties. The optimal solution for reducing acute-care hospital discharge delays is to increase the pool of qualified Guardians, and to do this, interviewees and literature indicate that it will be necessary to pay them. With the exception of one individual, those interviewed all described a lack of pay as the single largest barrier to having sufficient Guardians available. The single exception worked in a state where Guardians are paid, and the interviewee stated that they receive well-qualified applicants every time they advertise an opening.

2. Enact a Default Surrogate Statute. Massachusetts is one of four states that does not have a Default Surrogate Statute. Enacting this statute would allow a close family member or friend to assume healthcare decisional authority for an incapacitated individual without requiring formal appointment through the judicial system. By enacting a Default Surrogate Statute, the Commonwealth may reduce the need for guardianship among acute-care hospital patients with friends or family willing to step into this role, thereby freeing court time for Unrepresented Individual guardianship cases. One expert suggested that this would reduce the backlog of guardianship cases by about 50 percent. The majority of interviewees expressed support for enacting a Default Surrogate Statute.

There are limitations to default surrogate statutes that must be considered when contemplating enactment. Some states place restrictions on default surrogates making certain decisions, such as withholding life-sustaining treatment and some require a strict hierarchy for the designated surrogate, usually starting with an individual's spouse, which may ignore personal dynamics and relationships. Additionally, there are differences among states with default surrogate statutes about if consensus is needed when multiple individuals are considered as the surrogate.

3. **Ensure the paid Guardians are qualified to provide the necessary services.** Pay will attract Guardians, but the Commonwealth must ensure it attracts high quality candidates to the pool of Guardians. Guardians should be trained, certified, and monitored. Interviewees and the literature alike indicate that without these additional requirements, paying Guardians may increase the size of the pool of Guardians, but result in less-than-optimal client outcomes.

Based on the review of other states' best practices, Massachusetts should consider required training and monitoring of Qualified Professional Guardians as follows:

- ***Requiring training and certification for Qualified Professional Guardians.*** For example, the nationally-recognized Center for Guardianship Certification (CGC) requires that a Guardian completes coursework, pass a background check, and successfully pass an examination. CGC certification must be maintained through ongoing continued education and renewal every two years.[60] Training should align with the foundational topics in the NGA's Standards of Practice, which are regularly updated by experts in guardianship, aging, disability advocacy, and law, and may be tailored as appropriate by the Commonwealth.[61]
- ***Placing minimal training requirements on nonprofessional Guardians.*** Patients with guardianship provided by family members and friends are significantly more common than those cared for by Qualified Professional Guardians. Ties of kinship or friendship alone are not adequate to ensure vulnerable patients will receive appropriate care, and, therefore, the need for training in the fundamentals of guardianship is recommended. Training should educate Guardians who are family members or friends about their responsibilities and the resources available to assist them in fulfilling those responsibilities.
- ***Ensure Guardians and patients are adequately monitored.*** Both interviews and published research illustrated that guardianship monitoring is key to providing the information needed to help manage guardianship efforts, provide patients the care that they need, investigate and adjudicate complaints, and collect data that can help inform statewide guardianship decision-making and funding requests.

  As evidenced by the tracking system implemented by Pennsylvania (see Section **Error! Reference source not found.**), the type of system implemented there may help foster the development of critical information and also help create efficiencies within the state's guardianship structure by reducing documentation and monitoring issues for all parties involved. Finally, monitoring might help fill significant data gaps for understanding the nature of guardianship for unrepresented individuals.

4. Promote Health Care Proxy education and execution. Scale and promote programs designed to encourage people to designate healthcare proxies, such as the MHA/DPH/Honoring Choices Massachusetts Simple Steps Campaign.

[60] A complete list of certification requirements from CGC is available at https://guardianshipcert.org/certification-requirements/.

61 National Guardianship Association. (2022). Standards of Practice – Fifth Edition. Retrieved from: https://www.guardianship.org/wp-content/uploads/NGA-Standards-2022.pdf

Appendix A: Literature Review Bibliography

Aggarwal, N. et al. (2024). Exploring the Ramifications of Delayed Hospital Discharges: Impacts on Patients, Physicians, and Healthcare Systems. *Cureus 16*(5): e61249. DOI 10.7759/cureus.61249

Alvarez, S. & Yoder, G. (2023) Colorado Office of Public Guardianship: 2023 Annual Report. Retrieved from: https://colorado-opg.org/wp-content/uploads/2024/03/COPG_2023-Annual-Report_Final.pdf

American Bar Association. (2016). PRACTICAL tool for lawyers; Steps in supported decision-making. *Commission on Law and Aging; Commission on Disability Rights; Section on Civil Rights and Social Justice; Section on Real Property, Trust, and Estate Law*. Retrieved from www.ambar.org/practicaltool

American Bar Association. (2017). State Adult Guardianship Summary: Directions of Reform. *Commission on Law and Aging*. Retrieved from https://ltcombudsman.org/uploads/files/issues/2017-legislative-summary.pdf

Anderson-Shaw, L. & Elster, N. (2018) Protecting the Most Vulnerable of our Patient Populations: The Unbefriended. *The Nursing Voice, 13*. https://issuu.com/portal4nurses/docs/illinois_nursing_voice_9_18

Anderson-Shaw, L. (2018) How to Protect Vulnerable Patients Admitted to Hospitals without Legal Guardians. *Scholars Strategy Network*. https://scholars.org/brief/how-protect-vulnerable-patients-admitted-hospitals-without-legal-guardians

Anderson-Shaw, L. (2019). Regional Unrepresented Patient Advocacy Committee as an Alternative for Decision Making. *AMA Journal of Ethics, 21*(7), E594-E599. DOI 10.1001/amajethics.2019.594.

Appelbaum, P.S. (2023). Preventing Abuses in Guardianship Cases. *Psychiatric Services, 74:*1108-1111. DOI 10.1176/appi.ps.20230374

Arias, J.M. (2023). Default Surrogate Statutes. *Bifocal, 44*(3), 54-57. Journal of the American Bar Association Commission on Law and Aging. https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bifocal-vol-44-issue3/recent-updates-to-default-surrogate-statutes/

ATI Advisory. (2024). Opportunities for Oregon to Promote Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs. Retrieved from https://atiadvisory.com/resources/wp-content/uploads/2024/09/Opportunities-to-Promote-Timely-and-Appropriate-Hospital-Discharge-in-Oregon.pdf

Babb, E. et al. (2021). Hospital Guardianship: A Quality Needs Assessment of "Unbefriended" Patients Who Lack Decisional Capacity. *Journal of the Academy of Consultation-Liaison Psychiatry, 62*(5), 538-545. https://doi.org/10.1016/j.jaclp.2021.04.002

Bell, H. et al. (2024) Are We Missing Opportunities to Avoid Guardianship Proceedings in Unrepresented Hospitalized Patients? *American Journal of Respiratory Critical Care Medicine,* 209, A6727. https://doi.org/10.1164/ajrccm-conference.2024.209.1_MeetingAbstracts.A6727

Bennet-Woods, D. et al. (2017) Giving Voice to the Voiceless: The Colorado Response to Unrepresented Patients. *The Journal of Clinical Ethics, 28*(3), 204-211. PMID: 28930706.

Berzonsky, E. (2021). Nebraska Public Guardianship of Unbefriended Patients: a Preliminary Review of Health Outcomes and Cost Savings. *Capstone Experience*. 151. https://digitalcommons.unmc.edu/coph_slce/151

Bhowmik, D. et al. (2024). Top Ten Tips Palliative Care Clinicians Should Know About Caring for Patients Under Guardianships. *Journal of Palliative Medicine*. https://doi.org/10.1089/jpm.2024.0318

Blanck & Martinis. (2015). The right to make choices: The National Center for Supported Decision-Making. *Inclusion, 3*(1): 24-33. https://doi.org/10.1352/2326-6988-3.1.24

Boswell, T. et al. (2025). *The Cost and Savings of Person-Centered Guardianship.* Retrieved from: https://projectguardianship.org/sites/default/files/inline-files/2025%20Cost%20Benefit%20Analysis_Final.pdf

Brenner et al. (2023). Adults without advocates and the unrepresented: A narrative review of terminology and settings. *Gerontology & Geriatric Medicine, 9*, 1-8 https://doi.org/10.1177/23337214221142936

Brierley-Bowers, P. et al. (2022). The Cost of Medically Unnecessary Days Due to Waiting for Guardianship in a State Acute Hospital System. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 29.* DOI: 10.1177/00469580221086912

Carlson, K et al. (2021) Best Practices in Support Decision Making: How to Be an Effective Supporter. *Center for Excellence in Supported Decision Making.* Retrieved from https://www.voamnwi.org/center-excellence-supported-decision-making

Carlson et at. (2023) CESDM Guide to Supported Decision Making in Minnesota: A Resource for Families and Other Supporters. Accessed from: https://www.voamnwi.org/sites/default/files/download-file/CESDM%20Guide%20To%20SDM%20Revised%202023%20Final%205-8-23_0.pdf

Catlin et al. (2022). Unrepresented Adults Face Adverse Healthcare Consequences: The Role of Guardians, Public Guardianship Reform, and Alternative Policy Solutions. *J Aging Soc Policy 34*(3): 418–437. DOI:10.1080/08959420.2020.1851433.

Center for Guardianship Excellence. (2020) *Guardianship Oversight: Is Massachusetts Applying Best Practices?* Retrieved from: https://guardianship.institute/wp-content/uploads/2021/03/Colloquium-Report-REWRITE-for-website.pdf

Chamberlain, S. A. et al. (2018). Going it Alone: A Scoping Review of Unbefriended Older Adults. *Canadian Journal on Aging, 37*(1), 1-11. DOI: 10.1017/S0714980817000563

Chen, J. et al. (2015). Barriers Beyond Clinical Control Affecting Timely Hospital Discharge for a Patient Requiring Guardianship. *Psychosomatics, 56(*2), 206-209 DOI: 10.1016/j.psym.2014.07.006

Chen, J. et al. (2016) Discharge Delays for Patients Requiring In-Hospital Guardianship: A Cohort Analysis. *Journal for Healthcare Quality, 38*(4), 235-242 DOI: 10.1097/01.JDQ.0000462680.47759.53

Courtwright A, Rubin E. (2015). Who Should Decide for the Unrepresented? *Bioethics 30*(3):173-80. DOI: 10.1111/bioe.12185.

DeMartino et al. (2017) Who Decides When a Patient Can't? Statutes on Alternate Decision Makers. *The New England Journal of Medicine, 376*(15), 1478-1482. https://doi.org/10.1056/NEJMms1611497

Dempsey, T.M. & DeMartino, E.S. (2019). How Should Clinicians Navigate Decision Making for Unrepresented Patients? *AMA Journal of Ethics, 21*(7), E559-565. DOI: 10.1001/amajethics.2019.559

Dillon, K. & Thomsen, D. (2019) Delays in Hospital Discharges of Behavioral Health Patients. *Wilder Research*. Retrieved from: https://www.wilder.org/sites/default/files/imports/MarylandHospitalAssociation-Report_1-19.pdf

Dillon, K. & Thomsen, D. (2016) Reasons for Delays in Hospital Discharges of Behavioral Health Patients. *Wilder Research*. Retrieved from: https://www.wilder.org/sites/default/files/imports/MHA_Report_7-16.pdf

Dimla, B. et al. (2023) Hospital discharge planning: A systematic literature review on the support measures that social workers undertake to facilitate older patients' transition from hospital admission back to the community. *Australasian Journal on Ageing, 42*, 20-33. DOI: 10.1111/ajag.13138

Disability Law Center (2017) Alternatives to Guardianship and Guardianship: Self-Advocacy Materials. Retrieved from: https://www.dlc-ma.org/wp-content/uploads/2017/12/Alternatives-to-Guardianship-and-Guardianship.pdf

Dixon, J. et al. (2024). American Geriatrics Society Position Statement: Making Medical Treatment Decisions for Unrepresented Older Adults. *Journal of the American Geriatrics Society;*1-12. DOI: 10.1111/jgs.19288

Farrell, T. et al. (2017) American Geriatrics Society Position Statement: Making Medical Treatment Decisions for Unbefriended Older Adults. *Journal of the American Geriatrics Society 65*(1), DOI: 10.1111/jgs.14586

Farrell, T. et al. (2021) Caring for Unbefriended Older Adults and Adult Orphans: A Clinician Survey. *Clin Gerontol, 44*(4): 494-503. DOI: 10.1080/07317115.2019.1640332

Filler, D. (2025). MassHealth Long Term Care [PowerPoint slides] Greater Boston Legal Services, Inc. Retrieved from: https://www.masslegalservices.org/system/files/library/BBT%20LTC%20MassHealth%20PPT%202025%20-%20Filler_0.pdf

George, K. (2025) Federal cuts will deepen New York's guardianship crisis. *Times Union*. https://www.timesunion.com/opinion/article/commentary-federal-cuts-deepen-new-york-s-20239936.php

Healthcare Association of New York State. (2021). *The complex case discharge delay problem*. Retrieved from:

https://www.hanys.org/communications/publications/complex_case_discharge_delays/docs/complex_case_discharge_delay_problem.pdf

Hickman, C. (2022) Guardianship issues lead to unnecessarily prolonged hospitalizations. *The Hospitalist, Society of Hospital Medicine*. Retrieved from: https://www.the-hospitalist.org/hospitalist/article/31597/pediatrics/guardianship-issues-lead-to-unnecessarily-prolonged-hospitalizations/#:~:text=Guardianship%20issues%20lead%20to%20unnecessarily%20prolonged%20hospitalizations,-By&text=Minors%20requiring%20guardianship%20are%20sometimes,of%20guardianship%20prior%20to%20discharge.

Hirschel, D. & Smetanka, S. (2022) The Use and Misuse of Guardianship by Hospitals and Nursing Homes. *Syracuse Law Review, 72(*255-289*).* Retrieved from: https://lawreview.syr.edu/wp-content/uploads/2022/09/255-289-Hirschel-2.pdf

Hurme, S. (2024). State Guardian Certification. Unpublished, provided by author.

Hurme, S. & Robinson, J. (2021) What's Working in Guardianship Monitoring: Challenges and Best Practices. *Syracuse Law Review, 72*(291-367). Retrieved from: https://lawreview.syr.edu/wp-content/uploads/2022/10/8.-HURME-ROBINSON.pdf

Karp, N. & Wood, F. (2008) Guardianship Monitoring: A National Survey of Court Practices. *Stetson Law Review, 37*(143-192). Retrieved from: https://www2.stetson.edu/law-review/wp-content/uploads/2022/02/37.1.05.Karp_-1.pdf

Kelly, A., et al. (2021) A 50-State Review of Guardianship Laws: Specific Concerns for Special Needs Planning. *Journal of Financial Service Professionals, 75*(1): 59-79. Retrieved from: https://digitaleditions.sheridan.com/publication/?i=687379&article_id=3838808&view=articleBrowser

Kohn, N. et al. (2013) Supported Decision-Making: A viable alternative to guardianship. *Penn State Law Review, 117*(4): 1111-1157. Retrieved from: https://www.pennstatelawreview.org/117/4%20Final/4-Kohn%20et%20al.%20(final)%20(rev2).pdf

Langlois, WO & Yacovone, D. (2019) Improving the guardianship process: Better for patients and better for hospitals. Boston Medical Health Center. *HealthCity*. https://healthcity.bmc.org/guardianship-process-change-better-patients-and-hospitals/

Lazar, K. (2023). Who will be guardians for legions of 'unbefriended' elders? It's becoming an alarming problem in Mass. *The Boston Globe*. https://www.bostonglobe.com/2023/02/27/metro/who-will-be-guardians-legions-unbefriended-elders-new-push-ease-an-urgent-growing-problem/

Lazar, K. (2022). 'It makes you think how lucky you are.' The painstaking mission to find guardians for hospital patients in legal limbo. *The Boston Glove* https://www.bostonglobe.com/2022/12/26/metro/it-makes-you-think-how-lucky-you-are-painstaking-mission-find-guardians-hospital-patients-legal-limbo/

Levine, E. et al. (2020). Outcomes of a Care Coordination Guardianship Intervention for Adults with Severe Mental Illness: An Interrupted Time Series Analysis. *Administration & Policy in Mental*

Health and Mental Health Services Research, 47:468-474. https://doi.org/10.1007/s10488-019-01005-1

Levine, E. (2017). Fiscal Implications of Establishing a Public Guardianship Agency in Massachusetts: Evidence from Four State Studies. *University of Massachusetts Donahue Institute*. Retrieved from: https://donahue.umass.edu/our-publications/fiscal-implications-of-establishing-a-public-guardianship-agency-in-massach

Massachusetts Health & Hospital Association. (2025). *Throughput Survey Report*. https://mhalink.informz.net/mhalink/data/images/250605April%202025%20Throughput%20Report%20Final%20v2.pdf

Massachusetts Health & Hospital Association. (2023). *A clogged system: Keeping patients moving through their care journey*. https://www.mhalink.org/reportsresources/acloggedsystem/

Massachusetts Guardianship Policy Institute. (2025). *Report on Public Guardianship: Ten Year Review & Recommendations*. Retrieved from: https://guardianship.institute/report-on-public-guardianship/

Massachusetts Guardianship Policy Institute. (2020). *Annual Report: 2019-2020.* Retrieved from: https://guardianship.institute/wp-content/uploads/2020/06/GPI-Annual-Report-19-20.pdf

McIntosh, N., et al. (2025) The Impact of a Guardianship Social Worker on Inpatient Time-To-Guardianship and Costs: Preliminary Findings. *Journal of Gerontological Social Work, 68*:2, 269-278. DOI: 10.1080/01634372.2024.2424421

Minnesota Department of Human Services. (2023). CESDM Guide to Supported Decision Making in Minnesota: A Resource for Families and Other Supporters. Accessed from: https://www.voamnwi.org/sites/default/files/download-file/Guardianship%20Decision%20Tree.pdf

Minnesota Hospital Association. (2023). MHA's Survey and Analysis of Hospital Discharge Delays in 2023. https://mn.gov/dhs/assets/MHA%20Discharge%20Delays%20Survey%20Overview_accessible_tcm1053-661138.pdf

Moye, J. et al. (2021) End-of-life Care for Persons Under Guardianship. *Journal of Pain and Symptom Management, 62*(1), 81-93. DOI: 10.1016/j.jpainsymman.2020.11.008

Moye, J. et al. (2017). Ethical concerns and procedural pathways for patients who are incapacitated and alone: Implications from a qualitative study for advancing ethical practice. *HEC Forum, 29*(2), 171-189. https://doi.org/10.1007/s10730-016-9317-9

Moye, J. et al. (2016). Examining the need for a public guardian in Massachusetts: Phase 1. *Guardian Community Trust* https://guardianship.institute/wp-content/uploads/2019/02/1-Examining-the-Need-for-a-Public-Guardian-in-Massachusetts-PROOF-for-PRINTING-2d-Printing.pdf

Moye, J. et al. (2023) Guardianship Before and Following Hospitalization. *HEC Forum, 35*(3), 271-292. DOI: 10.1007/s10730-022-09469-9

Moye, J. et al. (2018). Guardianship for adults without surrogates in Massachusetts (*Guardianship Community Trust [report]*) https://guardianship.institute/wp-content/uploads/2019/02/1.-Guardianship-for-Adults-without-Surrogates-in-Massachusetts-April-11-2018.pdf

Oregon Joint Interim Task Force on Public Guardian and Conservator (HB 2237) Report. (2012). Retrieved from: https://www.oltco.org/ewExternalFiles/Joint%20Interim%20Task%20Force%20on%20Public%20Guardian%20and%20Conservator%20%28HB%202237%29%20Report%2C%202012.pdf

Oregon Joint Task Force on Hospital Discharge Challenges (2024) *Recommendations of the Joint Task Force on Hospital Discharge Challenges*. Retrieved from: https://www.oregonlegislature.gov/lpro/Publications/Joint%20Task%20Force%20on%20Hospital%20Discharge%20Challenges%20-%20Report%20and%20Recommendations%20(2024).pdf

Parekh, M. & Adorno, G. (2016) Health Care Decision Making for Unbefriended, Incapacitated Adults: A Value-Committed Policy Transfer Analysis. *Journal of Policy Practice*. http://dx.doi.org/10.1080/15588742.2016.1222925

Pope, T. (2017) Unbefriended and Unrepresented: Better Medical Decision Making for Incapacitated Patients Without Healthcare Surrogates. *Georgia State University Law Review, 33(*4), 923-1019. Retrieved from: https://readingroom.law.gsu.edu/gsulr/vol33/iss4/3

Purvis Lively, C. (2023) Medical-Legal Partnerships and Prevention: Caring for Unrepresented Patients Through Early Identification and Intervention. *HEC Forum 36*: 527-539. https://doi.org/10.1007/s10730-023-09518-x

Raymond, A. (2023) The Hospital to Guardianship Pipeline. *Bifocal,* 44(6), 105-110. Journal of the American Bar Association Commission on Law and Aging. Retrieved from: https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bif-vol44-issue6/hospital-guardianship-pipeline/

Ricotta et al. (2018). The burden of guardianship: A matched cohort study. *J Hosp Meds. 13*(9):595-601 DOI: 10.12788/jhm.2946

Robinson, D. et al. (2021) Adult Guardianship Monitoring: A National Survey of Court Practices. *National Center for State Courts*. Retrieved from: https://ncsc.contentdm.oclc.org/digital/collection/famct/id/1690

Schweikart, S. J. (2019). Who makes decisions for incapacitated patients who have no surrogate or advance directive? *AMA Journal of Ethics, 21*(7), E587–593. https://doi.org/10.1001/amajethics.2019.587

Sparber, L. et al. (2018) Unbefriended Patient: What is the True Cost of Caring for This Vulnerable Population? *Journal of the American College of Surgeons 227*(4): S92-S93. DOI: 10.1016/j.jamcollsurg.2018.07.185

Sperry, B. et al. (2020) Decision-making Las for "Unrepresented" Patients. *Annals of the American Thoracic Society, 17(*11), 1484-1486. https://doi.org/10.1513/AnnalsATS.202005-492RL

Teaster, P. et al. (2023) Environmental Scan of Guardianship Abuse and Fraud. *National Criminal Justice Reference Service*. https://www.ojp.gov/pdffiles1/nij/grants/307525.pdf

Teaster, P. et al. (2018) Incapacitated, Indigent, and Alone: Meeting Guardianship and Decision Support Needs in New York. *The Guardianship Project.* Retrieved from: https://www.vera.org/publications/incapacitated-indigent-and-alone

Teaster, P. et al. (2007) Public Guardianship After 25 Years: In the Best Interest of Incapacitated People? *American Bar Association Commission on Law and Aging*. Retrieved from: https://civilrighttocounsel.org/wp-content/uploads/2024/04/Public-Guardianship-After-25-Years-Teaster.pdf

Teaster, P. et al. (2008) Wards of the State: A National Study of Public Guardianship. *Stetson Law Review, 37, 193-241*. https://www2.stetson.edu/law-review/wp-content/uploads/2022/02/37.1.06.Teaster.pdf

Tompkins, J. et al. (2024) Seize the Data: An Analysis of Guardianship Annual Reports. *Journal of Aging and Social Policy,* DOI: 10.1080/08959420.2024.2349494

Yadav et al. (2017). Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health Affairs, 36*(7), 1244–1251. https://doi.org/10.1377/hlthaff.2017.0175

Zietlow, K. et al. (2022) Guardianship: A medicolegal review for clinicians. *Journal of the American Geriatric Society, 70*(11): 3070-3079. DOI: 10.1111/jgs.17797