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admissions : legal, practice, and public
policy implications

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**THE “VOLUNTARY”
STATUS OF NURSING
FACILITY ADMISSIONS:
LEGAL, PRACTICE, AND
PUBLIC POLICY
IMPLICATIONS**

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April 1997



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**The “Voluntary” Status of Nursing Facility Admissions:
Legal, Practice, and Public Policy Implications**

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Executive Summary

Many nursing facilities in Ohio and nationally are increasingly reluctant, and sometimes unwilling, to admit as residents individuals whose legal status is unclear. This status may be unclear because the individual is mentally incapable of consenting to admission and (as an "unbefriended" person) lacks any legally authorized surrogate decision maker who can give consent. This report, based on a literature review and on individual interviews with hospital discharge planners, nursing facility admissions officials, advocates for older persons, and others, examines this problem and its practical ramifications.

Major findings:

- Many nursing facility admission directors are reluctant to accept new residents unless the resident or a surrogate has clear legal authority to voluntarily consent to admission. This reluctance is due to fear about potential legal (including regulatory) liability, although facilities with low bed censuses often are more flexible about accepting applicants who are in legal "limbo."
- Nursing facilities' reluctance to take certain applicants may cause excessively long hospital stays while the legal details concerning decision-making authority are being resolved. Delays in placement may expose prospective nursing facility residents to unnecessary medical risks in the hospital and may financially penalize hospitals, which are reimbursed according to a prospective payment system.
- Hospital discharge planners deal with the problem in a variety of ways, such as paying attorneys to initiate and carry out guardianships and working with public and volunteer guardianship programs.

This report outlines several possible policy interventions, both governmental and private, for addressing jeopardized nursing facility care for decisionally incapacitated, unbefriended older persons who require that level of care. These interventions include the following:

- Facilitation of appropriate guardianships by (among other things) enhancing legislative funding of county indigent guardianship funds, streamlining and economizing the guardianship process, empowering adult protective services agencies to initiate guardianships for individuals who are in a hospital or a nursing facility, instilling greater uniformity among probate courts in dealing with these issues, encouraging greater use of limited or partial guardianship, and studying the feasibility and desirability of establishing a public guardianship system that would cover the population addressed here and/or enhancing the ability of volunteer guardianship programs to meet the need;
- Recognition of a limited "good faith" exception to the usual informed consent requirements in the case of "obviously" incapacitated unbefriended nursing facility applicants and residents;
- Consideration of developing and implementing an administrative system for addressing consent issues as a less intrusive alternative to formal guardianship;

- Encouraging the application of advance directives to this area;
- Sponsoring and/or supporting continuing education for professionals on these issues;
- Using institutional ethics committees to help resolve difficult dilemmas regarding nursing facility admission;
- Supporting rigorous research in this sphere; and
- Facilitating ongoing communication and collaboration among the key participants in the nursing facility admissions process.

The proper public policy response to the challenge identified here will depend on (1) how we define the essential character of the modern nursing facility and (2) whether we are guided by a medical/therapeutic model, which emphasizes protection of the vulnerable and dependent from physical harm, or by a legal/rights model, which emphasizes due process safeguards against exploitation.

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Background

The Problem

In every jurisdiction in the United States, statutes permit the state to involuntarily hospitalize in a public mental health institution--or in a private institution that has been licensed by the state for this purpose--persons who are considered dangerous to themselves or to others because of mental illness.¹ By contrast, every admission of a new resident to a nursing facility (whether public, proprietary, or private not-for-profit) is voluntary, in theory. Legal authority to involuntarily commit an individual to a nursing facility does not exist. That is, the law presumes that every admission to a nursing facility (like every other health care decision) is based not only on a physician's order but also on the informed, competent, and voluntary agreement of either the new resident or a legally authorized surrogate decision maker.

For instance, many nursing facility admissions result directly from hospital discharge planning processes. Federal Medicare regulations pertaining to these processes require that the hospital "must discuss the results of the [patient's discharge planning] evaluation with the patient or individual acting on his or her behalf."² Other routes to a nursing facility include the hospital emergency department and the individual's home, particularly when the individual and/or family find, shortly after hospital discharge, that they cannot cope adequately with the demands of home care. In each of these situations, voluntary

informed consent to nursing facility admission is presumed as a matter of law.

In reality, however, many individuals have been "voluntarily" admitted to nursing facilities even though (1) the resident lacks sufficient mental capacity to engage in a rational decision-making process³ but has not been formally judged incompetent by the appropriate local court, and either (2) no interested family members are available at the time of admission or (3) interested family members are available but have not been formally authorized to act as surrogate decision makers through a guardianship/conservatorship order or durable power of attorney. In these situations, nursing facilities ordinarily have accepted decisionally incapacitated new residents despite the legal ambiguity surrounding their admission. They have suffered no negative legal consequences for proceeding in this manner.

Widespread anecdotal reports, however, primarily from hospital discharge planners and geriatric care managers, suggest that many nursing facility admission directors are increasingly reluctant and sometimes unwilling to engage routinely in these kinds of admissions. Current federal laws (mainly the Nursing Home Quality Reform Act included in the Omnibus Budget Reconciliation Act [OBRA] of 1987⁴ and implementing regulations,⁵ and the Patient Self-Determination Act [PSDA] of 1990⁶ and state laws, and the government surveyors who enforce them, emphasize residents' decision-making autonomy in nursing facilities, exercised either directly or through a surrogate.⁷ This emphasis creates uneasiness, in facilities, about possible regulatory sanctions and/or civil liability for violating residents' autonomy. Many nursing facility admission directors seem increasingly

to balk at accepting new residents as "voluntary" admissions unless either the resident's present decisional capacity or the putative surrogate's legal authority is clearly established and documented.

The greatest difficulty in nursing facility or other long-term care placement occurs in the case of mentally ill individuals with significant behavioral problems and no visible surrogates, because facilities are concerned about their legal authority (if necessary) to physically restrain and/or treat such individuals with psychotropic drugs that carry substantial risks. Nursing facilities are prohibited by Title III of the Americans With Disabilities Act (ADA)⁸ and the Rehabilitation Act of 1973⁹ from discriminating in admissions on the basis of an applicant's handicap. A facility, however, can deny admission to persons exhibiting dangerously aggressive behavior that the facility is not equipped to handle and care for properly.¹⁰

In addition, payment source still frequently affects the likelihood of admission to the nursing facility of one's choice, because some discrimination against Medicaid-eligible individuals persists despite its illegality in most states. Nursing facilities are subject to great pressure not to err in admitting individuals who will pose significant management problems, because legally it is extremely difficult to transfer or discharge a resident over objection after he or she has been admitted.¹¹

In light of nursing facilities' reluctance to admit certain types of individuals, some discharge planners and

care managers complain that transfers are delayed or disrupted for numerous persons who should be transferred to nursing facilities from hospitals (which are not allowed to abandon these persons) or from unsafe home environments, until clarification of the legal question: Who may voluntarily consent to the nursing facility admission? Such delays often cause physical and emotional harm to the eventual resident and financial harm to the hospital; the resulting "solution" is frequently to initiate and impose a guardianship¹² on the individual.

The legal and ethical literature is filled with discussions about individuals' autonomy in regard to decisions about treatment and daily living, once they have entered a nursing facility. Thus far, however, legal practitioners, lawmakers, and scholars have virtually ignored the informed consent status of the admissions themselves. For example, the extensive federal regulations and state statutes on residents' rights are totally silent on admission status. The current literature contains only a very few incidental allusions to the issue and deals mainly with ethical rather than legal considerations.

Potential Constitutional Considerations

The status of nursing facility admissions is complicated by the potential impact of the U.S. Supreme Court's decision in *Zinermon v. Burch*.¹³ In that case, the Court ruled that the State of Florida could be sued civilly for permitting an adult person (who was later held to be mentally incompetent) to "voluntarily" admit himself to a public mental institution without first ascertaining and documenting that the patient

had enough cognitive and emotional capacity to decide autonomously about his admission.

Although the reasoning in *Zinermon* has not yet been applied to nursing facilities either in any litigated cases or in the legal literature, we must consider the potential for such an application and its probable consequences. Admission practices of public facilities clearly implicate the "state action" that is needed to trigger constitutional protections for the resident. The extensive regulatory and financing relationships (i.e., Medicare and Medicaid) between privately owned nursing facilities and government also may be sufficient to satisfy the "state action" criterion.

The Admissions Issue in Larger Perspective

The legal status of nursing facility admissions in the absence of a resident able to make decisions or a legally authorized surrogate is only one part of a larger situation concerning medical and other decision making for incapable persons who lack families or close friends. The problem also arises, for instance, when a nursing facility resident who is or becomes severely cognitively and/or emotionally impaired (and most nursing facility residents belong to this category) needs specific interventions (such as restraints or particularly risky and invasive medications and medical procedures) and there is no clearly authorized surrogate willing and available to act.

Similarly, nursing facility residents often need to be transferred to acute care hospitals for treatment of specific problems.

The hospital (that is, the hospital's physicians, who issue all admitting and treatment orders) may refuse to accept a person from the nursing facility and/or may treat him or her in the absence of explicit legal authority. In extreme cases cited by nursing facility social service workers, hospitals may refuse to dispose of a deceased patient's body until the administrator of the transferring nursing facility requests (although without any legal authority to do so) that the body be taken to a funeral home.

In addition, hospital discharge planners may not easily find health agencies that will accept an unbefriended patient with questionable decisional capacity, particularly when the patient requests discharge to a physically risky home setting. These types of situations are difficult and need prompt public policy attention. Their resolution, however, is beyond the scope of this report, which concentrates on nursing facility admissions for incapacitated, unbefriended persons.

Methods

Information Sources

To explore the legal, practice, and public policy issues raised in the preceding section, I conducted qualitative research from late 1996 through early 1997. In addition to an extensive (but not highly productive) review of the relevant literature, primary legal sources, and selected secondary

materials, I held 30 structured interviews, either in person or by telephone, with hospital discharge planners, nursing facility admissions personnel, long-term care ombudsmen, regulatory officials, nursing facility trade association leaders in Ohio, and representatives of national nursing facility trade associations and consumer advocacy organizations. In this report I present my observations and reflections, based on these sources of data and on less formal conversations with numerous other individuals. The statements presented in quotation marks are direct quotes from interviewees.

Research Questions

I asked the following questions during the structured interviews:

Are nursing facility admission directors reluctant to accept new residents unless the resident or a surrogate has clear legal authority to voluntarily consent to admission? If so, to what extent and how does this reluctance influence actual nursing facility practices?

To the extent that a problem exists, how do hospital discharge planners deal with it? If there are delays in the transfer of individuals from the hospital to a suitable nursing facility, how do these delays affect the various actors medically, financially, and legally?

In practice, how are evaluations made concerning the decision-making capacity of individuals seeking admission to nursing facilities? What process is followed and who

makes these decisions? What substantive standards are used for this evaluation?

To the extent that legal uncertainty about the voluntariness issue exacerbates risk apprehension among nursing facilities and hospitals, and this apprehension is reflected in changed practice, has there been a significant impact on the number of guardianships initiated and awarded solely or primarily to authorize someone specific who can legally voluntarily consent to nursing facility admission for decisionally incapacitated persons? If so, who actually initiates and pays for these extra guardianship proceedings, and who becomes the guardian? Is the result unnecessary and/or premature guardianships, thus counteracting the autonomy-enhancing intent of current residents' rights laws?

To the extent that nursing facilities' legal apprehensions bring about socially undesirable outcomes regarding the care and placement of vulnerable individuals, what educational, public policy, and other types of interventions might be appropriate to address this problem?

Findings

Legal Anxieties and Implications for Practice

Most of the participants from nursing facilities expressed anxiety about the legality of admitting individuals whose legal decision-making status is not clearly

delineated: that is, persons who are seriously cognitively and/or emotionally impaired but who have not been judged incompetent and who have no willing, available family members or friends to act as surrogate decision maker ("unbefriended" persons). When *any* willing and available family member (of any degree of relationship) or friend can be located, facilities almost invariably accept that person automatically as surrogate decision maker for the resident. They do not inquire into the source of that person's formal authority, if any (and usually there is none). This practice is not enshrined in written protocols but is followed almost universally by long-term care professionals.

Lacking such a "warm body" with at least sufficient decision-making capacity (defined by one admissions officer as the ability "to put an X on a piece of paper"), contemporary nursing facilities are uneasy. Their anxieties stem from uncertainty not only about the legal validity of the admission itself, but also about potential legal difficulties in obtaining payment (including the filing of Medicaid eligibility applications correctly and on time), handling other financial matters, and obtaining consent for the initiation or discontinuation of specific medical interventions for the resident in legal limbo. Such interventions include, for example, transfers to acute facilities for emergency treatment or removal of a ventilator or artificial feeding tubes. Today's surrogates may disappear from the picture tomorrow as they die, become incapacitated themselves, or decide that the needs of an increasingly aging, demented resident exceed their own abilities and tolerance for stress. Some nursing facilities still use blanket

written consent-to-treatment forms at the time of admission, but such a practice makes it even more necessary to accurately determine the resident's decisional capacity and/or the surrogate's authority at that early point.

Respondents reported that nursing facilities formerly were willing to act informally in the best interests of incapacitated unbefriended individuals, but now tend to be considerably more sensitive to perceived liability considerations. Many nursing facility administrators described themselves as "paranoid" about decisional capacity and informed consent for a variety of reasons: federal OBRA provisions requiring that the resident's chart indicate the designated person to contact regarding the exercise of that person's rights; publicity about the PSDA and advance directives in general; anxieties that regulatory agency surveyors will act inconsistently and unpredictably; and the omnipresent exaggerated but sincere fear of the "daughter from California" who will suddenly show up and complain that "Dad shouldn't have been allowed to wander." This feeling is especially intense when the potential resident, even if not mentally capable of making such decisions, actively objects to institutional placement.

Most administrators and their staffs understand intellectually that regulatory and/or civil liability repercussions in this area are rare. When they materialize, however, these repercussions (or, equally important, their threat) are disruptive and consume time and resources. Several interviewees at nursing facilities were

initially cited by state surveyors for failing to identify a specific surrogate in a resident's chart, and were instructed "simplistically" to "just find somebody for this guy." The nursing facilities are made even more uneasy, according to one ombudsman interviewee, by the reaction of numerous probate judges; they are not happy to be bothered in the middle of the night with a request for emergency authorization to do something to, or for, a resident who lacks both decisional capacity and relatives.

Nursing facilities are most apprehensive about admitting seriously mentally ill or developmentally disabled persons with violent, aggressive behavioral problems--for example, those with a psychosis such as schizophrenia or a major mental disorder other than dementia. First, they are concerned about their ability to care properly for such individuals in light of available staffing and physical plant limitations. Also, they are worried about the future possibility that they will need someone to validly consent (over the resident's objection, if necessary) to the use of physical restraints, psychotropic medications, and/or transfer to a more secure facility. Finally, they are concerned about the handling of payment and other financial matters.

Nursing facilities that cater largely or exclusively to dementia populations (those in which control of behavior to limit danger is most challenging) usually insist most strongly on clear identification of a surrogate decision maker before admitting a new resident. According to several nursing facility admissions officers interviewed for this project, this position is based at least in part

on experiences with hospital psychiatric units that "refuse to accept" resident transfers unless a surrogate has been named in a durable power of attorney instrument or through a guardianship order. In this area the admissions policies of many nursing facilities and hospitals may be legally questionable; the PSDA prohibits requiring an advance directive as a precondition to a patient/resident's admission.¹⁴

Persons interviewed for this project also stated that it was usually more difficult to transfer incapacitated unbefriended individuals from their own homes to a nursing facility than from a hospital to a nursing facility. Reasons include nursing facilities' concerns about preadmission screening and annual resident review (PASARR) and about completing Medicaid eligibility applications in timely fashion. In some communities, physicians on the medical staff of the local hospital sometimes ask the hospital's social service personnel for help in attending to those details on behalf of community-dwelling patients who need admittance to a nursing facility.

Financial Influences

The general legal skittishness among nursing facilities seems to be translated into admissions practice to varying degrees, depending on how fully occupied a facility happens to be on a given day--that is, how competitive a facility needs to be in order to fill its revenue-producing beds. Legal fears often may be expressed as a pretext for financial considerations. "Adaptability," said one hospital social service director, "is a function of present census." Adaptability also

depends on the availability of someone who is willing and able to sign an admissions contract and/or Medicaid application that guarantees payment (and who can grant access to the applicant's financial records so that financial eligibility for this means-tested program can be verified). In the final analysis, said the social service director, "admissions are a business decision," and "we are not mom-and-pops anymore."

In Ohio in 1996, total nursing facility occupancy stood at 91.8 percent; the exact proportion varied widely across facilities. Today, largely because of the success of federal requirements for screening potential residents for mental health and retardation problems,¹⁵ state home- and community-based Medicaid waiver initiatives such as Ohio's PASSPORT program,¹⁶ and prospective utilization review requirements of private long-term care insurance policies, more older people with difficulties in performing activities of daily living (such as bathing and dressing) can live outside nursing facilities.¹⁷ Few are admitted unnecessarily or prematurely, at least directly from the community. (Below, under "Implications," I discuss the problem of physicians and managed care case managers who recommend an older person's placement in a nursing facility too readily after hospitalization.)

In recent years, in addition to these factors, certificate of need requirements have been loosened and venture capital has become more easily accessible, leading to more building of nursing facilities, assisted living units, and subacute entities. As a result, additional beds have been created and

the nursing facility industry has become increasingly competitive. One of the primary customers to be cultivated in such a competitive environment is the hospital discharge planner, who strongly influences the flow of post-hospital consumers and of the dollars that follow them. Discharge planners, in turn, have a symbiotic relationship with nursing facility admissions officers; these professionals need to work constructively with each other and thus have a strong incentive to do so.

Facilities with a significant number of beds to fill often manage to overcome their misgivings about applicants' legal status much more readily than those which enjoy the luxury of waiting lists. Facilities in the former category tend to employ a much more lenient working definition of decisional capacity. They rely more readily on the applicant's own signature during a "lucid" moment than do their fully occupied counterparts. (They claim, however, that they continue to worry and ask questions about the legal ramifications of the residents they have admitted in this condition.)

Thus, according to several of my interviewees, the most dependent and most vulnerable individuals sometimes are placed as a last resort in nursing facilities of the most dubious quality, because such providers are the most likely to temper their concerns about an unbefriended individual's legal status--and their own capacity to properly care for that individual--in order to fill (and pay for) their beds. These facilities are "most willing not to stand on technicalities," according to one ombudsman, when the individual has already been certified eligible

for Medicaid or has another definite source of financial coverage for services. The "hungeriest" nursing facilities may even initiate the Medicaid application process for a new resident; other facilities insist that hospital social service departments or community case managers shoulder this responsibility.

These "hungry" facilities are well known to hospital discharge planners. Although planners are frequently uncomfortable with such placements, they can take solace in the fact that ultimately "every applicant gets in somewhere." For especially undesirable unbefriended persons, such as older individuals with alcohol-related dementia and associated behavioral problems, specialized facilities in distant locations may be needed for placement.

Conversely, many of the best local facilities can afford to be more selective about admissions. Therefore they act most conservatively in restricting access to persons with clearer legal status; that is, they do not accept applicants who lack an available family member or friend to act as present or future surrogate. The most conservative facilities, usually those with the longest waiting lists, even may (illegally) require a third party to sign the admissions contract even if the applicant is not mentally impaired, in a move to avoid future management problems.

Several consumer advocates interviewed for this project observed cynically that when nursing facilities resist admitting an individual without a specific surrogate decision maker, they publicly

justify their conduct on grounds of residents' rights and "company policy." They do not claim to act from concern about their own liability risk or because they simply prefer not to admit particular categories of persons who are likely to demand an inordinate amount of work and attention. As one nursing facility admissions director admitted, it is "just easier" for the facility to deal with situations when an identified surrogate is in place: "That way, we know the paperwork will be done."

This picture varies slightly in the case of some comprehensive continuing care retirement communities that offer multiple levels of care. In such settings, when a person living in a community's independent or assisted living section develops an acute medical problem requiring hospital admission followed by transfer to nursing facility-level care, that community's nursing facility may be willing to accept the person (who is already known to the staff) despite a legally uncertain status and a healthy institutional census. Even in this situation, however, the nursing facility ordinarily attempts immediately to formally clarify legal decision-making authority for that resident. (See the discussion of guardianship below.)

Impact on the Parties

The practices described above exert a tangible, direct effect on the various parties involved. For the older individual who needs timely placement in a nursing facility, delays of days or weeks--and, in a few extreme cases, months--have been reported, not as a regular occurrence but frequently enough to be notable. During these delays, the

individual fails to receive appropriate nursing facility care and is unnecessarily exposed to potential infections and the other risks attending a stay in a hospital. These unduly extended hospitalizations ordinarily are compensated very inadequately under Medicare's prospective payment system of diagnosis related groups (DRGs);¹⁸ therefore the financial repercussions for hospitals (which vary widely in this regard) may be serious.

Understandably, the hospital always has strong financial, ethical, and clinical incentives to expedite appropriate placement of individuals. One hospital social service director told me about the patient whose unnecessarily extended stay in 1995 cost her hospital over \$100,000. No one had legal authority to sell the property that made the patient ineligible for Medicaid and therefore unable to be placed in a nursing facility. Numerous versions of this story were repeated in hospitals across Ohio. Most hospitals today have a computer system that tracks medically "avoidable patient days" as well as the department (such as social services) that is responsible for those money-losing days. In this way they can precisely direct the pressure to move the patient out.

Financial considerations aside, other factors also motivate hospitals (as well as nursing facilities) to seek legally definitive resolutions to dilemmas involving mentally impaired, unbefriended persons. When the individual's decisional capacity and/or the safety of the treatment plan are in doubt, hospital staff members are often tempted to circumvent the moral dilemmas by "letting the judge decide." Defensive medicine also

may play a role. If a hospital fears potential civil liability for injuries suffered by an incapacitated but unadjudicated person whom it improperly sends home to an unsafe environment, it has a reason to seek guardianship so that the individual can be placed in what is believed to be a more secure, more protective nursing facility.

Nursing facilities must deal chiefly with their apprehensiveness about potential regulatory liability. If state surveyors find that the provision of proper care for a mentally incapacitated resident has been hampered by the absence of a guardian or other legally authorized decision maker, the regulatory agency probably will require the facility to move to establish guardianship. In this way the facility can obtain informed consent to the care that it has withheld until this time. Some consumer advocates gave their own accounts (or those of volunteer guardians or long-term care ombudsmen) of residents who had been denied elective medical treatments that would have enhanced their quality of life (such as corrective cataract surgery or hernia repair) because there was no legally authorized surrogate decision maker to consent to these interventions. Surveyors are not considered likely to exert pressure toward guardianship as long as the quality of care rendered to an incapacitated resident seems acceptable. This expectation, however, gives only small comfort to most nursing facilities, especially in the absence of official, practical guidance from government agencies.

Current Strategies

In response to the financial, legal, and other incentives cited above, most hospitals have (often reluctantly) devised systems for initiating guardianships for mentally impaired, unbefriended patients who lack a legally authorized surrogate decision maker, and whose placement in a nursing facility is delayed as a result. Operating such a system may be expensive for the hospital, but generally it is extremely cost-effective. It reduces the losses that the hospital otherwise would incur as a result of such patients' unnecessarily extended, prospectively priced hospital stays.

Various surrogate delineation systems are currently used for incapacitated unbefriended persons who need placement in a nursing facility. These systems vary in several important details, which address the following questions:

- Who actually initiates the guardianship? Who acts as the guardian?
- Who pays for the processing of the guardianship petition? Who pays for the conduct of the guardianship itself?
- What is the extent of the guardian's authority?

In one common model, the hospital files the guardianship petition (often initially on an emergency basis¹⁹ and later as an indefinite order); provides and pays a professional team consisting of a psychiatrist, a psychologist, and a social worker to evaluate the individual's decisional capacity,

submit its report to the court, and testify if necessary; and hires a private attorney to serve as guardian. Usually the retained attorney accepts authority over financial matters while procuring and paying (on the hospital's behalf) for appointment of a nonprofit or proprietary social service agency by the court as the person's guardian. In return for the efficiency achieved in transferring the individual to a nursing facility, the hospital bears the associated expenses (unless the individual involved has sufficient assets from which the guardian may be paid by court order). In addition, the hospital is exposed to possible charges of at least the appearance of conflict of interest.

In another model, hospitals--as well as home health agencies, area agencies on aging, case managers, and others concerned with the proper placement of the unbefriended individual--work with volunteer guardianship programs to initiate and conduct a judicially appointed surrogate decision-making arrangement. Volunteer guardianship programs have been established by a variety of charitable organizations (often with religious or civic affiliations); these programs supply someone who is willing and able to be appointed as an incapacitated person's surrogate decision maker when no other suitable candidate is available.

In Ohio, volunteer guardianship programs presently operate in (among other places) Montgomery,²⁰ Franklin,²¹ Richland, and Cuyahoga Counties. These programs are funded from a variety of sources such as local hospital associations (although this arrangement may create an apparent conflict of interest), area agencies on aging, county

indigent guardianship funds,²² funds generated by litigation filing fees or interest on attorneys' trust accounts, United Way allocations, contributions by religious congregations and civic groups, private donations, and grants.

Several states have created public guardianship systems through legislation. In these systems, government agencies, or private agencies under contract or other arrangement with the government at the state or local level, are available for court appointment as the decision-making agent of last resort for the unbefriended in need of formal surrogacy. In Maryland, for example, the director of the state or local office on aging may be appointed guardian in such situations.

Many of these systems are limited and specialized. In Ohio, for example, public guardianship is available only for children and for decisionally incapacitated developmentally disabled adults, but not for adults who are severely cognitively and/or emotionally impaired because of dementia, depression, psychosis, or any reason other than developmental disability.

In the absence of one of the arrangements outlined above, it may be exceedingly difficult to obtain a guardianship for a mentally impaired, unbefriended elder in need of nursing facility placement. Attorneys are reluctant to agree to provide their services without assurance that they will be compensated reasonably. Private, proprietary guardianship corporations make themselves unavailable for appointment when an individual's estate lacks sufficient assets

to pay their fees. Private individuals, such as personal friends, clergy members, and fellow congregants, may be intimidated--and thus unwilling to accept guardianship--by the perceived heavy responsibilities of making difficult personal and financial decisions for an increasingly demented, often impoverished individual over what could be a long period. In addition, infrequent but invariably well-publicized scandals about a guardian's misuse of funds or abuse of a ward always discourage recruitment of guardians in the locality of the scandal.

Accurate national figures on the extent and nature of contemporary guardianship are difficult to obtain. Many (though not all) of the professionals interviewed for this project agreed that today, only a relatively small number of inappropriate or premature guardianships are imposed involuntarily on older persons. In other words, the great majority of my interviewees maintained that guardianship for mentally incapacitated unbefriended individuals is sought only as a last resort.

Hospitals initiate a significant number of guardianships, as a preliminary to nursing facility placement, directly from emergency departments. (Some of the larger hospitals now assign full-time social workers for this purpose.) In many of these cases the family needs the individual's Social Security retirement²³ check and therefore keeps caring for the person inadequately at home, bringing her to the emergency department for specific problems, taking her home again, and repeating the cycle until the hospital is ethically compelled to intervene. Such intervention is most likely when the

emergency squad has brought the individual into the hospital emergency department and has given the social service department a "social concerns" report on the individual's poor living conditions.

A guardianship petition is usually pursued because of a specific, immediate need for a third party (such as a health care provider and/or financial institution) to legally clarify legitimate decision-making authority. For example, a resident of a dementia unit may attempt to sign himself out of a nursing facility; as a result, the facility may be concerned about its own possible legal exposure.

Otherwise, especially for indigent persons who have no resources to support surrogate decision-making services, decision making for the incapacitated unbefriended tends to be a haphazard affair. Such muddling through may be marked by reliance on the emergency exception to informed consent to eventually justify medical intervention. Important decisions may be postponed dangerously, foregone altogether, or (at the other extreme) made by default in the form of maximum medical intervention. In another scenario, health care and human service providers often act either independently or in combination as surrogates, but often covertly and hesitantly.

Issues of Decision-Making Capacity

All of these approaches to surrogate decision making are based on the premise that a particular individual needs a surrogate because of personal incapacity. Nursing facility admissions personnel, hospital

discharge planners, case managers, and even consumer advocates make this determination in various ways before initiating a guardianship petition or other surrogate arrangement for an unbefriended nursing facility candidate. The procedure appears to be totally unstructured and unstandardized; it varies greatly across nursing facilities and even among staff members in the same facility, and from one candidate for admission to another.

This picture of capacity assessment for voluntary admission, which emerged from my interviews, is consistent with the situation described in a recent study. The following passage is quoted from that study, which examined the assessment of residents' capacity to discuss advance medical directives:

[W]hen nursing home staff were probed about how they determine whether residents have the decision-making capacity to discuss advance directives and make end-of-life treatment choices, no clear process or procedure was described; rather a variety of techniques were used to determine residents' capacity to discuss advance directives...[T]here was no ...explicit standard, and the judgment is left to the admissions staff...In no case was there a formal policy and process of assessing cognitive ability or decisional capacity. Instead, the process of assessing residents' capacity...is non-standard and often left to staff who have little procedural guidance from

either institutional policy or the legal system.²⁴

Adult Protective Services

Persons interviewed for this project were ambivalent about the role of adult protective services (APS)²⁵ in nursing facility admissions for the incapacitated unbefriended. Many believe that the APS agencies' potential helpfulness is severely limited by a number of factors. First, insufficient resources create an excessive burden on caseworkers. Second, persons who are already residents of nursing facilities are beyond the jurisdiction of APS on the theory that they are in a protective environment. (In some counties, however, APS will continue to pursue a guardianship for a hospitalized unbefriended individual when the petition was filed while the person was living in the community.) Third, many APS agencies have a widely shared reputation for not following through on the submission and processing of Medicaid eligibility applications for unbefriended individuals whom they have signed into nursing facilities.

Some interviewees also accused certain APS agencies of seeking guardianship and institutional placement too readily, without adequately exploring less restrictive alternatives; yet it is difficult to generalize when each county's APS system functions independently. In fact, many interviewees cited as a major weakness the APS agencies' lack of communication and of coordinated policies and procedures.

In the next section I discuss public policy implications of guardianship and its

several permutations and alternatives, as well as the process of evaluating decisional capacity. I also outline private initiatives for protecting the incapacitated unbefriended who are nursing facility candidates, without sacrificing their autonomy-based rights.

Policy Implications

Themes

The key public policy challenge in this arena is the need to achieve a balance between bureaucratic meddling, which is well-meaning but paternalistic and counterproductive, and excessive and unrealistic insistence on the hypothetical autonomy rights of an extremely vulnerable population. Incapacitated unbefriended individuals have neither true autonomy to empower them nor true beneficence to protect them; they live in constant danger of falling between the cracks of our modern social, ethical, and legal systems. At greatest risk are those who are so seriously impaired physically and/or mentally as to require care in a nursing facility.

How the policy challenge will be addressed and how a balance will be sought will depend largely on how we resolve two philosophical questions with very practical consequences: (1) What is the essential character of the modern nursing facility--health provider, mental health provider, and/or homelike residence? (2) Should we be

guided mainly by a medical/therapeutic model, which emphasizes protection of the vulnerable, dependent individual against harm and the maximization of that person's physical and mental well-being, or by a legal/rights model, which emphasizes substantive and procedural due process safeguards against exploitation and abuse?

Alternatives

With these overarching themes in mind, we may outline the principal alternatives. Most prominently, government might encourage and facilitate the appointment of guardians to act as official, legally authorized decision-making surrogates for incapacitated unbefriended candidates for nursing facility admission. This approach could resolve clearly, in a timely (and even possibly proactive) fashion, the legal status of those admissions, as well as the legal status of the decisions made on the residents' behalf at that time and later.

Approximately 25,000 adult guardianship cases are adjudicated in Ohio each year.²⁶ Ohio law,²⁷ in keeping with the least restrictive alternative (LRA) principle and the statutes of all other states,²⁸ permits courts to appoint guardians with limited or partial powers tailored to the ward's actual cognitive and/or emotional deficits. Even so, courts create virtually all guardianships as complete transfers of legal authority from the ward to the guardian. In the same vein, probate courts are empowered to appoint temporary guardians in situations where the ward may be expected to regain decisional capacity. They tend, however, not to favor this option and to appoint permanent

guardians instead. The ward then must subsequently seek termination of guardianship.

Most of the professionals interviewed for this project suggested that the overwhelming majority of current guardianships are necessary both for the welfare and protection of the nursing facility applicant/resident and to safeguard the risk management interests of the facility and other service providers. (They made this point without detracting from the desirability of more independent, more holistic geriatric assessments of potential wards to inform the probate courts.) Their key concern is the fate of unbefriended nursing facility candidates who ought to have guardians but are likely to suffer discrimination and mistreatment because of the difficulties in obtaining this needed source of protection. A typical comment was made by one long-term care ombudsman; her office will not accept appointment as guardian for a nursing facility resident because of conflicts of interest. In the past few years, however, when a resident truly has needed a surrogate and no better alternatives exist, her office has moved from automatic opposition to all guardianship petitions toward facilitating the accomplishment of guardianship orders (including identification of persons appropriate to be appointed).

Although the following recommendations were not endorsed by all of the interviewees, and although some expressed considerable misgivings, the substantial majority advocated government actions that would encourage and facilitate more guardianships in the following ways:

- By legislatively increasing county indigent guardianship funds.²⁹ The main purpose would be to induce more private attorneys and others to serve as conscientious (not merely formal) guardians for incapacitated unbefriended persons--including potential and actual nursing facility residents--who lack substantial income and assets. The setting of specific fees for paying appointed attorneys from indigent guardianship funds, rather than relying on individual payment decisions by each probate court, may be helpful in this regard.
- By streamlining and economizing the guardianship process ("forgetting the red tape"). The current expensive and cumbersome process, in addition to its other shortcomings, frightens away many low-income families of persons eligible for Medicaid, thus making those persons unbefriended. A more "user- friendly" guardianship process might encourage more, and more sustained, family involvement. In addition, many nursing facilities complain that although they will accept an applicant once a guardianship petition has been filed (on the almost always fulfilled assumption that the petition eventually will be granted), "the process takes much too long."
- By empowering APS agencies to initiate selectively (that is, not in order to "dump" a troublesome individual) guardianships for persons who are in a hospital or nursing facility.
- By instilling more uniformity among probate courts in dealing with these issues in place of the current "independent, inconsistent fiefdoms" prevailing in county probate courts. (Examples include differences in handling indigent guardianship funds and court investigators' varying degrees of receptivity to health care providers' requests for assistance.) This uniformity would include more of a case management and oversight role for the probate courts. (In late 1996, however, the Summit County probate court called a meeting expressly to advise health and human services providers *not* to continue calling the court investigator for help in managing the daily problems of the unbefriended.)
- By encouraging the courts' greater use of limited or partial guardianship. (Currently a significant percentage of all limited guardianships created in Ohio are awarded to Advocacy and Protective Services, Inc. [APSI] for developmentally disabled wards.) Interviewees also recommend increasing the courts' use of guardianship ad litem³⁰ when, for example, formal surrogacy is needed only for a specific decision or for several decisions grouped together within a short period, such as acute hospitalization during nursing facility residency.

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- By recognizing a limited "good faith" exception to the usual informed consent requirements in the case of "obviously" incapacitated unbefriended nursing facility applicants and residents.

In Ohio, public guardianship systems have been legislatively created only for children³¹ and developmentally disabled adults.³² In 1971 the Ohio legislature established procedures for nonprofit corporate guardianship of citizens of any age with developmental disabilities severe enough to impair decision-making capacity, as well as for unique trusteeship/protectorship programs.³³ The Association for Retarded Citizens was the driving force behind this enabling legislation: Parents of developmentally disabled children were worried about what would happen to those children after their own deaths. Presently the state contracts to APSI³⁴ the surrogacy function created by this legislation.

Public policy makers, including the Department of Aging, should study the developmental disabilities model, as well as public guardianship systems in other states, to determine what elements (if any) might be applicable to the situation of incapacitated unbefriended elders in need of nursing facility admission. Special attention might be given to the trusteeship/protectorship status as an intermediate step between total guardianship and complete neglect. The investigators in such a study, however, must keep in mind that the actual extent and effectiveness of public guardianship programs probably depend more heavily on the resources that a jurisdiction appropriates

for its operation (which generally are grossly insufficient) than on the terms of the enabling legislation. In addition, any new system establishing a contractual relationship with a private agency to perform public guardianship functions should avoid APSI-like conflicts of interest. It can do so by strictly separating the guardianship agency from direct supervision by its state funder, thereby maintaining a more appropriate arms-length relationship.

If actions to encourage and facilitate private, volunteer, and/or public guardianships are successful, guardianship petitions and orders will proliferate. Consequently nursing facilities will be even more reluctant to admit incapacitated unbefriended applicants without an explicitly authorized legal surrogacy arrangement. Is such a state of affairs desirable, as opposed to alternatives that might better promote the welfare of the unbefriended without unduly compromising their autonomy? To answer this policy question, sponsored research would be useful; the data could tell us whether the risk of abuse, neglect, or exploitation of nursing facility residents is tied in any way to the absence of formal guardians (and, if so, how), or whether residents with families and friends are equally likely to be mistreated or ignored.

At least two states (New York and California) have created an official but nonjudicial alternative to guardianship for unbefriended persons with mental disabilities. The California statute³⁵ creates an administrative mechanism for approving interventions in nursing facilities for decisionally incapacitated residents with no

legally authorized surrogate; this statute has been upheld against constitutional attack.³⁶

Harvard University geriatrician Muriel R. Gillick has proposed the development and dissemination of a new in-house surrogate system, which would use relevant nursing facility staff members to make decisions for incapacitated unbefriended residents.³⁷ There is no compelling reason why some version of this system could not be employed in making initial decisions about admitting particular applicants. In a similar situation, attorney Bruce Winick has urged use of informal administrative methods, rather than adversarial judicial proceedings, to determine a person's capacity to voluntarily consent to psychiatric hospitalization.³⁸ Gillick's proposal is guided by the medical/therapeutic model mentioned above, which gives primacy to the ethical principle of beneficence.

Gillick's proposal, however, has been criticized by a leading national nursing facility consumer advocate whose thinking is based on the legal/rights model. This advocate believes that this proposal is laden with real and apparent conflicts of interest, and prefers a high degree of role differentiation for nursing facility staff members.³⁹ This criticism was not shared by all of the long-term care ombudsmen I interviewed: Those who serve rural areas especially, where "everybody has known everybody forever," thought it "made natural sense" for staff members to act as surrogate decision makers of last resort.

Many existing volunteer guardianship programs are commendable; even so, it is probably unrealistic to expect this sector to be developed and funded well enough to fill the burgeoning need. By definition, these programs have only minimal paid staff and depend heavily on individual volunteers' time, generosity, and reliability. These elements are finite and largely unpredictable in a population of persons who tend to be older themselves. Individual volunteers come and go for numerous reasons. While participating in the program, they must be continually educated, reeducated, and supervised--no small task. The volunteer guardians' willingness and ability to "push the system where necessary" has been questioned as well.

In Ohio, to exacerbate this instability of volunteer guardianship programs (other than for children or developmentally disabled adults), probate judges may appoint as guardian only a real person, as opposed to an agency.⁴⁰ Thus, when an individual in a volunteer guardianship program ceases participating for any reason, the agency sponsoring the program may need to return to court to seek appointment of a new individual volunteer as guardian. Many (though not all) volunteer guardianship programs have recommended empowering the probate courts to appoint an agency as guardian; in this way the comings and goings of particular volunteers may be treated as an internal, administrative agency matter rather than necessitating additional time in court.

Some of the interviewees criticized current public guardianship programs for policies rejecting involvement in the cases of

unbefriended individuals with any financial assets. In many cases, these disqualifying assets are too modest to attract willing private guardians; as a result, the person with some but not many assets remains in legal limbo.

In another possible public policy approach, the concept of advance medical planning would be aligned more closely with the needs of incapacitated, unbefriended prospective nursing facility residents. Much attention has been given to the use of proxy directives, especially durable powers of attorney, as a less restrictive alternative to guardianship. Under these directives, an adult who is currently capable of making decisions can name in advance a proxy or substitute to act as decision maker if he or she becomes incapacitated.

The chief problem for the population discussed here is that its members have no willing, able persons to name as their future decision-making agents in a durable power of attorney document, or else that the persons whom they named as agents while they were still capable are now unavailable or unwilling. According to one legal commentator, this difficulty could be overcome if the state legislature authorized currently capable adults to appoint nonprofit (i.e., charitable) organizations as their surrogate decision makers to assume authority in case of the principal's future decisional incapacity. These organizations either could be social service providers or could be set up specifically to act as a surrogate decision maker of last resort. This approach would prevent the time, expense, administrative hassle, and emotional turmoil

of a formal guardianship proceeding; it would permit the affected individual to maintain some personal autonomy; and it would promote beneficent treatment of the individual--for example, by providing a protective but efficient means of securing appropriate admissions to nursing facilities, and treatment in those facilities, for those who cannot speak on their own behalf.

Assessments of individuals' decisional capacity before initiation of formal guardianship proceedings are improvised, unguided, and inconsistent. For this reason some of the interviewees called for a greater degree of legal and professional guidance for capacity evaluators. Standardization of capacity evaluations promises more objective, more reliable results, although quantitative measurements cannot completely take the place of clinical judgment.

Much of the nursing facilities' hyperdefensive activity stems from anxiety about possible regulatory liability and sanctions; therefore many interviewees suggested more concerted training and information dissemination for state nursing facility surveyors and other relevant regulators. Training would include information about OBRA, the PSDA, state residents' rights laws, surrogate decision making, and the informed consent doctrine in general. Such government-sponsored continuing education would produce greater consistency and predictability in enforcing legal requirements; more honest and more realistic proactive communication on these points between regulators and nursing facilities; and ultimately a climate of legal comfort in which nursing facilities would feel

freer to develop and implement more creative approaches to the clinical and ethical needs of incapacitated, unbefriended applicants and residents.

Nongovernmental Initiatives

Among nongovernmental initiatives, none of my interviewees mentioned the potential role of institutional ethics committees (IECs) in helping nursing facilities to handle difficult admissions questions. This may be because involved professionals conceptualize this subject as a matter of pragmatic risk management rather than as an area of serious ethical and policy dilemmas. Such a view is too narrow; nursing facilities should be encouraged to explore the possible contributions of IECs regarding help with formulating institutional policy, consultation on individual cases (concurrent or retrospective), and education of the nursing facility staff and others, including families.

Many interviewees called for more communication and education among hospitals, nursing facilities, and home care agencies about their respective environments and constraints. In 1996, to address what is widely perceived as a lack of mutual appreciation and understanding, at least one Ohio long-term care ombudsman established a working group to deal with behavioral problems in hospitals and nursing facilities, including those pertaining to admission, transfer, and discharge of residents. This project was received enthusiastically. Ombudsmen's offices also can provide an invaluable service by conducting in-service

training on numerous topics related to nursing facility admission.

Almost all of the interviewees proposed actions to educate physicians about post-hospital care of the chronically disabled, including incapacitated unbefriended patients. As discussed earlier, most discharge planners, nursing facility admissions staff members, and consumer advocates believe that programs to divert people from unnecessary institutionalization have been largely effective. Yet these persons also charge that many physicians are poorly informed about these less restrictive long-term care alternatives and about level-of-care issues in general. Consequently, they complain, physicians on the whole are not very helpful in handling the problems associated with nursing facility admissions for incapacitated unbefriended individuals; more formal training in this area is imperative.

Similarly, many interviewees observed that managed-care case managers often have limited backgrounds in long-term care; thus they tend to equate the entire area with nursing facilities. This increasingly powerful profession needs more education about the range of long-term care settings and opportunities.

Interviewees also endorsed more education for other service providers, particularly nursing facility administrators and staffs. Long-term care ombudsmen and other resident advocates said that providers do not know enough of the relevant law. Often, as a result, residents' wishes regarding treatment are ignored ("We're in

doubt, so we'd better provide the full-court press"), advance directives are overinterpreted, or other apparent refusals of treatment serve as an excuse to abandon troublesome residents rather than personalizing their care.

All of the interviewees deplored the lack of consistency and predictability in practice and policy. They recommended the creation of a process through which the persons most concerned with the problems raised by nursing facility care for this population could discuss from their multiple perspectives the issues outlined in this report. The goal would be to formulate and ultimately disseminate a set of broadly acceptable policies and procedures. In this way, a solid core of common expectations and uniform national approaches relating to the welfare and rights of this especially vulnerable and expanding group could be generated and promoted to service providers, regulators, and consumer advocates. This collaborative, consensus-building process could be supported by both public and private sources (such as foundations).

Conclusion

The population of unbefriended, severely and chronically mentally incapacitated older individuals in need of nursing facility-level care will continue to grow. As a result of increased life expectancy and other demographic trends, the elderly will constitute an increasing share

of the American population. By 2030, about one-fifth of our population will be at least 65 years old, compared with barely 13 percent today and less than 10 percent in 1970. The proportion of the population age 85 and older is expected to rise from 1.4 percent in 1996 to 2 percent in 2010 and to almost 5 percent by 2050.

Some members of this group will never marry or have children, will have children who themselves are geriatric when nursing facility admission becomes pertinent for the parent, will have children who live far from them, or will outlive spouses and children and will fail to execute advance directives while still capable of making decisions. In addition, many persons with severe mental disorders, especially when accompanied by serious behavioral problems, begin their long-term care with family support but eventually "wear out" the patience--and hence the involvement--of relatives and friends, who abandon them. In fact, the absence of a satisfactory informal support system in the home is one of the most important risk factors in the need for nursing facility admission.

Timely advance instruction and/or proxy directives may alleviate some of the current decision-making problems. Yet no matter how much public and professional attention is given to this topic, only a small proportion of persons will take advantage of this opportunity.

A significant percentage of future nursing facility residents will be admitted for short-term rehabilitative or subacute stays (for example, following surgery). Many of

these persons will be capable of making all or most of their own decisions about medical and financial issues: if not at the time of admission, then shortly thereafter. Many other residents, however, probably will be severely cognitively and/or emotionally impaired; as we increase our ability to keep people from permanent institutional placement as long as possible, those who eventually are admitted for the remainder of their lives will have much more severe acuity than did nursing facility residents in the past. As residents live longer and suffer more chronic illnesses, more decisions requiring appropriate decision makers will be necessary over extended periods.

Initial decisions about nursing facility placement will need to be made and implemented within increasingly shortened periods, as cost containment pressures continue to contract the process of discharge planning into a "whirlwind." We cannot ignore the imperative for public and institutional policies, procedures, and educational strategies that are both definitive and creative and that take into account the pertinent clinical, legal, ethical, and financial considerations.

References

1. See, e.g., Ohio Rev. Code chapter 5122.
2. 42 Code of Federal Regulations §482.43(b)(6).
3. Under Ohio's guardianship statute, Ohio Rev. Code §2111.01(D), "'Incompetent' means any person who is so mentally impaired as a result of a mental or physical illness or disability, or mental retardation, or as a result of chronic substance abuse, that he is incapable of taking proper care of himself or his property..." Under Ohio's Adult Protective Services statute, Ohio Rev. Code §5101.60(I), "incapacitated person means a person who is impaired for any reason to the extent that he lacks sufficient understanding or capacity to make and carry out reasonable decisions concerning his person or resources, with or without the assistance of a caretaker... Reasonable decisions are decisions made in daily living which facilitate the provision of food, shelter, clothing, and health care necessary for life support."
4. 42 United States Code §§1395r-i(3)(a)-(h) (Medicare); 1396r(a)-(h) (Medicaid).
5. 42 Code of Federal Regulations §483.10.
6. Pub. L. No. 101-508, §§4206, 4751, 104 Stat. 1388, codified at 42 United States Code §§1395cc, 1396a (1990).
7. See, e.g., Ohio Rev. Code §3721.13(B) ("A sponsor may act on a resident's behalf to assure that the home does not deny the resident's rights..."). 42 Code of Federal Regulations §483.10(B)(3) provides that, "In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf." Federal law continues, at §483.10(B)(4), "In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law."
8. 42 United States Code §§12181-12189 (1990).
9. 29 United States Code §794.
10. See Wagner v. Fair Acres Geriatric Center, No. 94-1275 (3d Cir. March 15, 1995).
11. 42 Code of Federal Regulations §483.12(a)(2); Ohio Rev. Code §3721.16.
12. Ohio Rev. Code §2111.01(A).
13. 494 U.S. 113 (1990). See also Estate of Cassara v. State of Illinois, 853 F.Supp. 273, 279 (N.D.Ill. 1994) ("[A] voluntary institutionalization may involve a restraint of personal liberty sufficient to trigger the due process clause").
14. §§4206(f)(1)(C) and 4751(A)(2)(C), Pub. L. No. 101-508.

15. 42 Code of Federal Regulations Part 483, Subpart C (implementing §1919(e) of the 1987 Omnibus Budget Reconciliation Act, requiring the states to implement preadmission screening and annual resident review--PASARR--of the need for admitting or retaining individuals with mental illness or mental retardation in nursing facilities that are certified by Medicaid). The requirement for annual review was subsequently repealed by Pub. L. No. 104-315 (1996). PassID is the Ohio evaluation procedure, resulting in a one-page summary, that is done as part of the PASARR process.

16. Ohio Rev. Code §5101.75 et.seq.

17. Nearly 13 percent of the elderly who live in the community have functional limitations. An estimated 9.2 percent of community elderly are limited in one or more ADLs. An additional 3.6 percent of community elderly have no ADL limitations, but are unable to perform one or more instrumental activities of daily living (IADLs) (i.e., using the telephone, doing light housework, preparing own meals, shopping, and managing money) because of a health problem. The prevalence of functional limitations increases dramatically with age. Among community residents age 85 and older, 36 percent have at least one ADL or IADL limitation. Nearly 12 percent of community residents age 85 or older have limitations in 3 or more ADLs, compared with less than 2 percent of those who are age 65-74. Harriet L. Komisar, Jeanne M. Lambrew, and Judith Feder, LONG-TERM CARE FOR THE ELDERLY: A CHART BOOK 20. New York: Commonwealth Fund (Dec. 1996). See also Shahla A. Mehdizadeh, Suzanne R.

Kunkel, and Robert A. Applebaum, PROJECTIONS OF OHIO'S OLDER DISABLED POPULATION. Oxford, OH: Scripps Gerontology Center, Miami University (Ohio Long-Term Care Research Project) (Dec. 1996).

18. 42 Code of Federal Regulations Part 412.

19. Ohio Rev. Code §2111.02.

20. CHUMS, Inc., 2611 Wayne Avenue, Dayton, OH 45420.

21. Franklin County Volunteer Guardianship Program, Central Ohio Area Agency on Aging, 174 East Long Street, Columbus, OH 43215.

22. Ohio Rev. Code §2111.51.

23. Social Security Act, title 2 (Old Age and Survivors Insurance).

24. Elizabeth Bradley, Leslie Walker, Barbara Blechner, and Terrie Wetle, “Assessing Capacity to Participate in Discussions of Advance Directives in Nursing Homes: Findings from a Study of the Patient Self Determination Act,” 45 JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 79, 82 (1997).

25. Ohio Rev. Code §5101.60. Under Section (B), “Adult means any person sixty years of age or older with [Ohio] who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents him from providing for his own care or protection, and who resides in an independent living arrangement.” Under

Section (N), “Protective services means services provided by the county department of human services or its designated agency to an adult who has been determined by evaluation to require such services for the prevention, correction, or discontinuance of an act of as well as conditions resulting from abuse, neglect, or exploitation. Protective services may include...guardianship services, and placement services...”

26. Judith Y. Brachman, Ohio Department of Aging, “Mediation in Adult Guardianship: State Application--Ohio,” submitted to The Center for Social Gerontology, Ann Arbor, MI (Dec. 13, 1996), at 4 (based on information supplied by Julia Nack, Central Ohio Area Agency on Aging).

27. Ohio Rev. Code §2111.02.

28. See generally Marshall B. Kapp, “Ethical Aspects of Guardianship,” 10 CLINICS IN GERIATRIC MEDICINE 501, 502, 508 (1994).

29. Ohio Rev. Code §2111.51.

30. Ohio Rev. Code §2111.23.

31. Ohio Rev. Code §2151.353, .413, .414.

32. House Bill 290 (1971), codified at Ohio Rev. Code §5123.55-59.

33. Id. See also John M. Seelig and Sandra R. Chestnut, “Corporate Legal Guardianship: An Innovative Concept in Advocacy and Protective Services,” 31 SOCIAL WORK 221 (1986).

34. 3200 Riverside Drive, Columbus, OH 43221

35. Calif. Health and Safety Code §1418.8.

36. Rains v. Belshe, 32 Cal.App.4th 157, 38 Cal. Rptr. 185 (Cal.App. 1 Dist. 1995).

37. Muriel R. Gillick, “Medical Decision-Making for the Unbefriended Nursing Home Resident,” 1 JOURNAL OF ETHICS, LAW, AND AGING 87 (1995).

38. See Bruce J. Winick, “How to Handle Voluntary Hospitalization After Zinermon v. Burch,” 21 ADMINISTRATION AND POLICY IN MENTAL HEALTH 395 (1994).

39. Iris C. Freeman, “One More Faulty Solution is Novelty Without Progress: A Reply to ‘Medical Decision-Making for the Unbefriended Nursing Home Resident’,” 1 JOURNAL OF ETHICS, LAW, AND AGING 93 (1995).

40. See Ohio Rev. Code §2111.10.