Public Summary Report
Ombudsman Investigation A20180791
Department of Administration, Office of Public Advocacy, Public Guardian
April 15, 2020 (revised September 18, 2020)

Alaska State Ombudsman J. Kate Burkhart provides this public summary, pursuant to AS 24.55.200, of the investigation of complaint A20180791. Identifying information is removed from this report to protect the confidentiality of the complainant, their family, and others. Ombudsman investigations are confidential according to law, although the Ombudsman is permitted to disclose information that is necessary to perform statutory duties and to support recommendations under AS 24.55.160(b).

In June 2018, the Ombudsman received a complaint from a relative of an Alaska Native man who was a ward of the Public Guardian at the Office of Public Advocacy (OPA). The complainant explained that they had become concerned when the ward stopped phoning them after Christmas of 2017. The complainant alleged that they called OPA multiple times, but the ward's guardian was unresponsive to their concerns.

On or about April 19, 2018, OPA learned that the ward had died on December 27, 2017. The ward's guardian had been unaware of his death for nearly four months. The complainant felt that OPA failed to take adequate care of the ward. When asked what they wanted from OPA, the complainant wrote: "For them to do better for the Native people that they are taking care of and make sure that they know where their clients are at all times and actually do a welfare check on them and not just call to places that they place them."

Assistant Ombudsman Beth Leibowitz investigated this complaint. Notice of the investigation was provided, as required by AS 24.55.140, to the agency on June 22, 2018. The guardian at issue in the complaint retired from the agency during the course of the investigation.

The Ombudsman concluded the investigation and hosted a consultation, pursuant to AS 24.55.180, with OPA leadership on January 29, 2020. The Ombudsman's preliminary findings and possible recommendations were discussed with agency leadership. Information provided by the agency

during the consultation was considered by the Ombudsman in the development of the proposed findings and recommendations to the agency. The Ombudsman forwarded a confidential preliminary report to OPA on February 7, 2020 and requested a written response by March 11, 2020. The agency provided a formal written response on March 10, 2020 (a redacted copy of the agency's response is attached in Appendix A).

The Ombudsman found the allegations investigated to be justified by a preponderance of the evidence and made ten recommendations to help address the deficits identified in the investigation. OPA agreed to implement two of the recommendations, declining the others in whole or in part.

Allegations

The Ombudsman investigated three allegations:

1. Contrary to law:[1] The Office of Public Advocacy did not conduct quarterly visits with the ward, as required by AS 13.26.720.[2]

2. Unreasonable:[3] The Office of Public Advocacy did not spend the ward's funds on safe and consistent shelter.

3. Performed inefficiently:[4] After the ward's death, the Office of Public Advocacy continued to receive Supplemental Security Income and Adult Public Assistance benefits on his behalf and disbursed those funds for unnecessary services, leading to a loss of $385.00 to the estate.

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[1] In an ombudsman investigation, "contrary to law" means that the agency did not comply with statutory or regulatory requirements; misinterpreted or misapplied a statute, regulation or comparable requirement; failed to follow common law doctrines; or failed to comply with court or administrative orders.
[2] The Ombudsman notes in this report that the public guardian did not follow agency policy or procedure related to contacts with the ward but declined to investigate the same allegation under a second standard of "unreasonable."
[3] In an ombudsman investigation, "unreasonable" means that the agency adopted and followed a procedure in managing a program that is inconsistent with, or fails to achieve, the purposes of the program; adopted and followed a procedure that defeats the complainant's valid application for a right or program benefit; or placed the complainant at a disadvantage relative to all others through actions inconsistent with agency policy.
[4] In an ombudsman investigation, "performed inefficiently" means that the agency exceeded a time limit established by law (statute, regulation, or similar enacted source) or a limit or balance established by custom, good judgment, sound administrative practice, or decent regard for the rights or interests of the person complaining or the general public.

Relevant Statutory, Regulatory, Policy Authority

Alaska law authorizes guardianships for incapacitated adults and defines the scope of a guardian's powers and responsibilities in AS 13.26. A full guardian of an incapacitated person "has the same powers and duties respecting the ward that a parent has respecting an unemancipated minor child except that the guardian is not liable for the care and maintenance of the ward."[5] The full guardian's powers and duties include:

> (1) the guardian is entitled to custody of the person of the ward and shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward's physical health and safety;
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> (2) the guardian shall assure the care, comfort, and maintenance of the ward;
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> (3) the guardian shall assure that the ward receives the services necessary to meet the essential requirements for the ward's physical health and safety and to develop or regain, to the maximum extent possible, the capacity to meet the ward's needs for physical health and safety.[6]

Alaska law provides that OPA serves as the Public Guardian when neither a family member nor a private professional guardian is able and willing to be the incapacitated person's guardian.[7] The public guardian "has the same powers and duties with respect to the public guardian's wards and protected persons as a private guardian or conservator."[8]

OPA also has specific statutory duties toward its wards, including ensuring that public guardians have adequate training and support:

> (c) The public guardian shall
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> (1) establish and maintain relationships with governmental, public, and private agencies, institutions, and organizations to assure the most effective guardianship or conservatorship program for each ward and protected person;
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> (2) visit each of the public guardian's wards and protected persons at least once every quarter to monitor their welfare;
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> (3) keep and maintain financial and statistical records of all cases in which the public guardian provides guardianship or conservatorship services;

[5] AS 13.26.316(c).
[6] AS 13.26.316(c)(1)-(3).
[7] *See* AS 13.26.700.
[8] AS 13.26.720(a).

> . . .
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> (5) assist guardians and court-appointed visitors of wards and respondents in the preparation and revision of guardianship plans and reports;
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> (6) assist guardians to understand the disabilities of wards and to foster the increased independence of wards;
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> (7) assist guardians in securing the rights, benefits, and services to which their wards are entitled;
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> (8) develop and maintain a current listing of public and private medical, mental health, social advocacy, educational, rehabilitative, counseling, therapeutic, homemaking, recreational, and financial services and programs available to assist wards and protected persons and their families.[9]

The public guardian's duty to visit wards every quarter (AS 13.26.720(c)(2)) was interpreted in a recent case in which the plaintiffs attempted to bring a class action lawsuit against OPA.[10] The superior court concluded that the public guardian's duty to visit each ward meant in-person visits.[11] The court also ruled that the public guardian could substantially comply with the visitation requirement through a contracted service provider, at least under the circumstances described in that case.[12] AS 13.26.720(d)(1) provides that OPA "may contract for services necessary to carry out the duties of the public guardian's office."

OPA's Policies and Procedures cite the visitation requirement in AS 13.26.720(c)(2).[13] OPA Policy and Procedure §3.10 acknowledges that public guardians do not necessarily meet the statutory requirement:

> Alaska Statute 13.26.380(c)(2)[14] requires a Public Guardian to visit each ward or protected person at least once every quarter to monitor his or her welfare. A Public Guardian shall strive to have face-to-face contact with a client at least once each quarter. When logistical problems arise (e.g. emergencies involving other clients, bad weather), which prevent a quarterly visit from occurring, a Public Guardian

[9] AS 13.26.720(c).

[10] *See M.M. through his next friend, Erin Kirkland v. State of Alaska, Department of Administration, Sheldon Fisher, Office of Public Advocacy, and Richard Allen*, 3AN-15-10448 CI (Alaska Super. Ct. 2018). The Alaska Supreme Court heard oral argument in the appeal on April 10, 2019. No decision has been issued. *See M.M. et al. v. State of Alaska, et al.,* S16970 (*filed* Jan. 30, 2018).

[11] *See* Final Order on Defendant's Motion to Dismiss and Plaintiff's Cross-Motion for Partial Summary Judgment, at 1-2, *M.M. v. State of Alaska* (Alaska Super. Ct., June 23, 2017); *see also* Order Clarifying Ruling re: Substantial Compliance Defense at 1, *M.M. v. State of Alaska* (Alaska Super. Ct., Nov. 11, 2016).

[12] *See id.* at 2.

[13] *See* OFFICE OF PUBLIC ADVOCACY, DEPARTMENT OF ADMINISTRATION, PUBLIC GUARDIAN POLICIES AND PROCEDURES §3.10 (2012).

[14] AS 13.26.380 was re-numbered AS 13.26.720 in 2016.

> shall maintain communication with the client by phone or other means and shall arrange a face-to-face visit as soon as possible.[15]

The National Guardianship Association has set a standard for monthly visits with the ward to "assess the person's physical appearance and condition and assess the appropriateness of the person's current living situation."[16] OPA Policy and Procedure §3.8 directs guardians to "take appropriate and timely measures to protect clients who are missing from their usual place of residence from the harm they might experience without adequate supervision or shelter."[17]

Guardianship of Ward

OPA was appointed the ward's guardian in 2006, and was his guardian until 2015, when the complainant's spouse petitioned for guardianship. The court transferred the guardianship and the ward, who had been homeless in Anchorage, moved to the village where his family lived. In mid-2016, the family relinquished the guardianship, and the court reappointed OPA.

OPA was appointed temporary conservator in July 2016. At that time, the court visitor described the ward as an Alaska Native man, over the age of 55, diagnosed with serious mental illness for which he was not receiving medication or treatment. The court visitor reported that the ward had no permanent place to live in the village, that he required assistance with daily activities, such as taking medications, cooking/eating and personal hygiene, and concluded that it would be in the ward's best interest to be housed in an assisted living facility.

The court reappointed OPA as guardian on August 31, 2016. OPA assigned the guardianship case to a senior (experienced) guardian. The guardian promptly initiated applications for the ward's Medicaid and APA benefits (which had lapsed during the family guardianship) and to be reappointed his representative payee. The guardian filed a Guardianship/Conservatorship Plan in September 2016.

[15] OPA PUBLIC GUARDIAN POLICIES AND PROCEDURES §3.10 (2012).
[16] NATIONAL GUARDIANSHIP ASSOCIATION, STANDARDS OF PRACTICE (4th ed. 2013), at 13.
[17] OPA PUBLIC GUARDIAN POLICIES AND PROCEDURES §3.8 (2012).

The guardian asked the former family guardian, on September 29, 2016, to assist with having a health aide fill out a General Relief for Assisted Living Physician's Report, so the guardian could look for an assisted living home in Anchorage for the ward. There is no evidence in the case file that the guardian received, or continued to pursue, assistance with the Physician's Report from the family member.

For the rest of 2016, the ward remained in the village where his family lived. The ward was living in a relative's vacant house. When the guardian spoke with the court visitor, on September 2, 2016, the court visitor reported that the ward was causing problems such that he was no longer welcome in the village. On September 2, 2016, the guardian documented a conversation with the complainant, during which the complainant asked if OPA had made arrangements to move the ward to Anchorage. The guardian responded that OPA had just been appointed his guardian and did not yet have the order from the court.

Two months later, in November 2016, the village administrator contacted the guardian about the ward's behavior, saying that he was not safe in the village. The guardian pointed out that the ward had not been safe in Anchorage, where he had been homeless. The guardian contacted a supportive housing program in the regional hub community to see if the ward could move there. There is no evidence in OPA's case file of a response, if the guardian received one, and no evidence the guardian attempted additional contacts with the supportive housing program.

In January 2017, the ward was medevac-ed to the Alaska Native Medical Center (ANMC) in Anchorage and treated for pneumonia. The guardian contacted a medical social worker at ANMC, explaining that they would need to work with the discharge planner about placement when that time came. By January 31, the ward had recovered and the physician concluded that he was well enough to live at a homeless shelter.

The guardian asked the physician to complete the physician's portion of the General Relief application for the ward, to assist with obtaining an assisted living home placement. There is no evidence that the guardian received, or followed up on, the information needed from the physician to apply for General Relief for the ward.

The ward was discharged from ANMC to the Brother Francis Shelter, an emergency shelter for homeless adults, on January 31, 2017. On February 1, 2017, the guardian met with the ward at the OPA office. The guardian told him that they needed to apply for funding for housing, and that he would need to stay at the Brother Francis Shelter in the meantime. The guardian set up a $100 weekly allowance, to be paid to the ward at Beans Café (an Anchorage non-profit organization providing meals and day shelter to homeless and other clients).

The guardian arranged for the ward to move to a hostel/rooming house/motel ["motel"] in Anchorage on or about February 6, 2017. Rooms at the motel have shared bathrooms and no kitchen facilities. The ward paid $900 per month for a room there.

The guardian provided a $20 weekly allowance for the ward to buy snacks from the vending machines and/or snack bar in the motel, but expected the ward to get his meals at Bean's Café and/or the Brother Francis Shelter – almost three miles away from the motel.[18] The guardian said that most of the ward's income was used to pay rent and he did not have enough income to buy food without relying on Bean's Café for most of his meals. There is no evidence that OPA, after being reappointed his public guardian in 2016, applied on the ward's behalf for Supplemental Nutrition Assistance Program/Food Stamp benefits, despite recognizing that his income was insufficient to provide adequate food.

OPA Contacts with the Ward and Motel

Motel management periodically locked the ward out of his room because of his disruptive behavior at the motel. The motel locked the ward out in July or August, October, and December of 2017. The ward had paid rent in full for all of these months.

The ward was locked out of his room on or about July 31, 2017. There is no evidence in the guardianship file that the motel manager or staff contacted the guardian at the time the ward was locked out. The ward called OPA, from the Brother Francis Shelter, and left a message for the

[18] Walking distance of 2.8 miles (estimated time of 54 minutes) determined with Bing Maps, directions from the motel location to 1101 East 3rd Avenue, Anchorage (https://www.bing.com/maps, last visited December 16, 2019).

guardian on August 8, 2017. He reported he had been "kicked out" and asked for help getting his clothes from his motel room.

OPA Policy and Procedure §3.8 directs guardians to "take appropriate and timely measures to protect clients who are missing from their usual place of residence from the harm they might experience without adequate supervision or shelter."[19] There is no evidence in the case file that the guardian responded to or took action based on the ward's August 8 call.

The ward called again on August 23, 2017, from the shelter, and spoke to the guardian. Based on the guardian's case notes from that conversation, the ward had been locked out of the room for which he had paid rent for most, if not all, of August so far. During that conversation, the guardian asked the ward if he wanted to stay at the motel or live at Brother Francis Shelter; he preferred the motel.

There is no evidence in the case file showing when OPA arranged for the ward to be given access to his room after August 23, 2017. There is no evidence that OPA attempted to recover the rent paid for August, for the time that their ward was denied access.

On October 10, 2017, the motel manager emailed the guardian to report that the ward forced his way into a bathroom that was "broken," urinated in the shower and vomited in the sink, and "when confronted about it he starts yelling and cursing at my staff. Then he wonders why I lock him out." This email demonstrates that the motel was not an appropriate placement for a person experiencing challenging behaviors due to serious mental illness and an apparent substance use disorder. It also demonstrated that motel staff were not equipped to deal with disabled adults who require a high level of assistance with daily activities, such as taking medications, cooking/eating and personal hygiene.

On October 23, 2017, the motel manager notified OPA that, after the ward allegedly entered another guest room, he "sent him to the shelter for a few days. . . Maybe with the temperature changing he'll get the point," alluding to the dangers of exposure as a way of modifying the ward's behavior. According to historic weather records from NOAA National Environmental Satellite,

[19] OPA PUBLIC GUARDIAN POLICIES AND PROCEDURES §3.8 (2012).

Data, and Information Service, the low temperatures in Anchorage during the week of October 23, 2017 ranged from 16-34 degrees Fahrenheit.[20]

In response, the guardian emailed:

> Thanks for the heads up. I fully expect that he lost his phone and ID while drunk. I swear he has lost so many phones and ID's. I'm not getting him another phone.

This is the only evidence of the guardian's response to their ward being locked out of his room in October. There is no evidence that the guardian followed OPA Policy and Procedure §3.8 and contacted the ward at the Brother Francis Shelter. There is no evidence the guardian inquired about or corroborated the motel manager's allegations, or took any action to help the ward regain access to his housing.

The ward called OPA on December 8, 2017, to report he was again locked out by motel management. The guardian was not available, so another OPA guardian spoke with the ward. That guardian contacted the motel and was told that the ward "got crazy, yelled, and spit" at motel staff. Motel staff stated that the ward was excluded until December 19, and OPA staff accepted that without further conversation.

There is no evidence in the case file that the guardian or anyone else at OPA contacted the ward or otherwise checked on his welfare or housing status after December 8, 2017. Daytime temperatures were below freezing (32 degrees Fahrenheit) for ten days between December 8 and the day of the ward's death, December 27, 2017.[21]

The ombudsman investigator interviewed the guardian and asked if the ward had been rehoused prior to his death. The guardian responded that they "assumed" that the motel had let him return, based on the fact that he had not called the guardian again. The ombudsman investigator later asked the guardian by email, "Do you have any recollection of when and how you learned that [the

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[20] Weather data accessed through the NOAA Climate Data Online Search at https://www.ncdc.noaa.gov/cdo-web/search (last visited Oct. 16, 2019).

[21] *See* "Record of Climatological Observations, October 23-December 31, 2017," NOAA National Environmental Satellite, Data, and Information Service, accessed through the NOAA Climate Data Online Search at https://www.ncdc.noaa.gov/cdo-web/search (last visited Oct. 16, 2019).

ward] had been locked out of his room again?" The guardian responded, "I honestly have no recollections of if or when [the ward] was locked out of his room again." The guardian reported that, "to my recollection I did not have any further contact with [the ward] after the 12/8/17 note was taken."

The Ward's Death

The ward was found unresponsive, outside in downtown Anchorage, on December 27, 2017. He was transported to ANMC, where he was pronounced dead. ANMC staff identified the ward. Even though ANMC had been in contact with OPA in January 2017 and received a copy of the guardianship order, there is no evidence in the OPA case file that ANMC notified OPA or next of kin about the ward's death.

According to the State Medical Examiner's Investigation Narrative, the ward was "homeless," and there was no known next of kin. The narrative also noted no last date known alive. The State Medical Examiner concluded that the ward died of valvular and arteriosclerotic cardiovascular disease. Toxicological examination was negative for ethanol and other drugs.

OPA did not document the ward's lack of contact until March 22, 2018, approximately three months after his death. Case notes entered that day reflect that the complainant had called the guardian in February and again in March to ask for the ward's phone number. The guardian provided the phone numbers for the motel and Beans Café. However, the complainant reported that they had tried and could not reach the ward at either location.

The guardian called the manager at the motel, on March 20, 2018, and asked that he have the ward call. On March 22, 2018, the guardian received a message from the former family guardian, who was concerned about the ward. The guardian called the motel manager again that same day:

> I called [the manager] and he said he hasn't seen [the ward] in a while. He said the night guy did see him the other night and he tried to give [the ward] the message to call me but [the ward] was mad and would [not] stop to take the note.

The guardian mailed a letter to the ward on March 22, 2018, in care of the motel and Beans Cafe, requesting that he contact the guardian. On March 23, 2018, the guardian called Brother Francis Shelter. A case manager told the guardian that the ward had not been there since the end of December. The guardian called the motel again on March 23, and spoke with an employee who reported that the ward "has been there recently." The guardian reiterated that it was important for the ward to call.

On April 2, 2018, the guardian emailed the motel manager. The motel manager replied:

> I haven't seen him during my shift, my night guy said he came by Saturday morning at about 2 or 3 am tried to talk to him to give him his mail and your message but wouldn't respond when he was calling him. I don't know what his problem is.

On April 18, 2018, the guardian received calls from the complainant and another of the ward's relatives, asking when the guardian had last seen the ward and how to get in contact with him. The guardian emailed the motel manager on that day, demanding specific information about which motel staff had seen the ward and when, and asking for security camera footage that would show the ward was at the motel.[22] The guardian also stated:

> I am going to have to request that the Anchorage Police do a welfare check and look into this[23] because my office has an obligation to [the ward] and his family- as his guardian we are responsible for his welfare and finances. As things are now he has not cashed any of the checks that I have sent to him in months and I have not heard from him in many months and I don't believe that you have seen him in quite a while either.

On April 19, 2018, the guardian called the three Anchorage hospitals and the jail, only to learn the ward was at none of these facilities. The guardian contacted the Anchorage Police Department (APD) to report the ward missing. After contacting APD, the guardian contacted the State Medical

[22] There is no evidence in the record showing that the guardian received the requested surveillance camera video from the motel.

[23] There is no evidence in the record showing why the guardian decided to request a welfare check rather than going to the motel to check on the ward. There is no evidence in the record showing that the guardian requested a welfare check by Anchorage Police Department.

Examiner's Office, provided a copy of the guardianship order, and requested the Medical Examiner's report on the ward's death.

Deputy Director Elizabeth Russo called the complainant on April 20, 2018, but was not able to speak with them until April 23, 2018. Deputy Director Russo explained that the ward had died, and that the complainant could contact the funeral home about arrangements. On April 24, 2018, the guardian began notifying the Division of Public Assistance and other entities of the ward's death.

Management of the Ward's Estate

According to the guardianship records, OPA paid $900 for the ward's room at the motel through April 2018. A total of $3,600 was paid in motel rental fees after the ward's death.

According to the guardianship records, OPA had been issuing checks for $20.00/week to the motel for the ward to purchase food in the motel snack bar. On January 4, 2018, OPA discontinued the food checks to the motel. The guardian told the ombudsman investigator that they did not recall why they stopped issuing the $20 checks to the motel for snacks, but thought that probably the motel staff had called and said the ward was not using the money. There is no evidence in the OPA case file documenting this communication with the motel staff, nor is there any documentation related to the decision to stop issuing the weekly checks for the snack bar.

According to the guardianship records, OPA had been mailing $25.00/week directly to the ward for his personal allowance. OPA continued to issue the weekly allowance checks until March 22, 2018. However, on March 9, 2018, the financial ledger shows allowance checks issued from December 19, 2017 through February 1, 2018 being refunded to the ward's account as uncashed. There is no evidence that this prompted the guardian to contact the ward to find out why he was not cashing his allowance checks. OPA issued two more allowance checks, on March 15 and March 22, and then stopped. There is no documentation in OPA's case file regarding why the guardian stopped issuing the ward's allowance.

Analysis

Allegation 1: Contrary to law: The Office of Public Advocacy did not conduct quarterly visits with the ward, as required by AS 13.26.720.

AS 13.26.720 describes specific powers and duties of a public guardian, including, "The public guardian shall… visit each of the public guardian's wards and protected persons at least once every quarter to monitor their welfare."[24] OPA's Public Guardian Policy and Procedure provides that a public guardian "shall strive to have face-to-face contact with a client at least once each quarter."[25] The standards of the National Guardianship Association state that the "guardian shall visit the person no less than monthly."[26]

OPA records show that the guardian did not have any visits with the ward in 2016 after OPA was reappointed as his guardian. The ward lived in a village, making face-to-face contact expensive, if not completely impractical. However, even telephone contact was limited to conversations with the complainant and their spouse, and the village administrator. There is no evidence of any contact directly with the ward from September 2016 through January 2017, when he was medevac-ed to Anchorage with pneumonia. This fails to meet the requirements of AS 13.26.720.

OPA records show that OPA staff saw the ward face-to-face twice: on February 1, 2017 and November 14, 2017. Although AS 13.26 does not expressly define a "visit" as face-to-face contact, in *M.M. v. State of Alaska, Office of Public Advocacy*, the superior court ruled that the duty of quarterly visits means in person visits.[27] Similarly, National Guardianship Association Standards of Practice specify that one of the purposes of a monthly visit is for the guardian to "assess the person's physical appearance and condition and assess the appropriateness of the person's current living situation."[28]

OPA did not conduct quarterly face-to-face visits with the ward in 2017. OPA records show that staff did have telephone contact with the ward on the following dates in 2017: May 17, August 8,

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[24] AS 13.26.720(c)(2).
[25] OPA PUBLIC GUARDIAN POLICIES AND PROCEDURES §3.10 (2012).
[26] NATIONAL GUARDIANSHIP ASSOCIATION, STANDARDS OF PRACTICE, *supra* n. 22.
[27] *See* Final Order on Defendant's Motion to Dismiss and Plaintiff's Cross-Motion for Partial Summary Judgment at 1-2, *M.M. v. State of Alaska, supra* n. 11.
[28] NATIONAL GUARDIANSHIP ASSOCIATION, STANDARDS OF PRACTICE, *supra* n. 22.

August 23, and December 8. These contacts do not constitute "visits" as contemplated by AS 13.26.720.

OPA did not meet the statutory quarterly visit requirement, nor did OPA meet the National Guardianship Association's professional standard of monthly visits to assess the ward's physical condition and the appropriateness of his current living situation and existing services. Even when the guardian became concerned about the whereabouts of the ward in April 2018, they considered requesting a welfare check by law enforcement rather than conducting a visit themselves.

While AS 13.26.720(d)(1) permits the public guardian to contract for services to assist the guardian in carrying out the guardian's duties,[29] there was no express contract for anyone to conduct visits with the ward. The guardian relied on staff at the motel to report whether they had seen the ward and that nothing was amiss. However, there was no contract with the motel to provide more than an ordinary motel room.

The guardian explained to the ombudsman investigator that OPA relies on wards' housing providers to report if a ward is missing or if there are other problems. The guardian believed that, since the motel was "congregate housing," it had some general obligation to monitor the ward. Deputy Director Russo confirmed this expectation: "As a general matter, we expect the staff at [the motel] to alert us to any major issues such as behavior problems and to be responsive to any inquiries made by the guardian."[30]

The evidence shows that OPA's reliance upon motel staff to monitor the ward's well-being and living conditions was not a reasonable proxy for quarterly visits by the guardian. The motel is not an assisted living facility nor a contracted provider of services other than motel rooms. Motel staff

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[29] *See* Final Order on Defendant's Motion to Dismiss and Plaintiff's Cross-Motion for Partial Summary Judgment at 2, *M.M. v. State*, *supra* note 11. In that order, the judge ruled that OPA had substantially complied with the requirement of quarterly visits by using the service provider Assets: "The undisputed facts before this court show several 'in person' visits with the ward by contracted service providers on a regular basis – certainly weekly, monthly, and several times each quarter. The undisputed facts also demonstrate that these providers regularly report to the assigned public guardian, at least several times each quarter." In an earlier order, the judge had earlier ruled that the use of "alternate individuals" in place of the guardian might constitute substantial compliance with AS 13.26.720, although the court did not provide much guidance for when a non-guardian's visit would be an adequate substitute for the guardian conducting the in-person visit. *See* Order Clarifying Ruling Re: Substantial Compliance Defense at 1, *M.M. v. State,* 3AN-15-10448 CI (Alaska Super. Ct. Nov. 11, 2016).

[30] Email from Elizabeth Russo, Assistant Public Advocate, OPA, to Beth Leibowitz, Assistant Ombudsman (Mar. 30, 2019).

excluded the ward from his room without notice to the guardian when he was alive, and repeatedly asserted they had seen or had contact with the ward after his death.

At the end of 2017, the guardian had a caseload of 99 wards. Deputy Director Russo explained that this was a typical caseload for experienced OPA guardians, with the average caseload in March, 2017 of 98 wards. As of October 2019, OPA reported serving 1,645 wards with a staff of 23 public guardians, two of whom focus exclusively on wards' benefits appeals.

The last quarter of 2017 had 13 weeks — 61 working days (not including state holidays). Given the guardian's caseload of 99 wards, they would have had to visit 1-2 wards each workday in order to meet the statutory requirement of quarterly visits. To meet the National Guardianship Association standard of monthly visits, the guardian would have had to conduct visits for 3-4 wards a day. Understanding that the lack of adequate staff impairs OPA guardians' ability to meet with wards as required by law and professional practice standards, the evidence shows that the guardian failed to perform, or to contract with a qualified and responsible third-party to perform, quarterly visits with the ward as required by AS 13.26.720.

The Ombudsman finds Allegation 1 ***justified*** by a preponderance of the evidence.[31]

Agency Response

OPA responded that it "fundamentally agrees" with the finding for Allegation 1, regarding OPA's noncompliance with the statutory visitation requirement in AS 13.26.720(c)(2).[32] OPA explained that this is a prolonged, systemic inability to conduct quarterly visits:

> OPA acknowledges that it is required to perform quarterly visits with its wards, and it has been unable to do so for several years. The number of individuals appointed to the Public Guardian has steadily increased over the years while the staff numbers, until recently, has remained unchanged. This has led to an increase in Public Guardian dockets to upwards of 3-4 times the recommended national average of clients. Experienced Public Guardians such as the one assigned to [the ward], have

[31] The standard of proof used to evaluate all ombudsman complaints is the *preponderance of the evidence*: if the evidence indicates that, more likely than not, the administrative act took place and the criticism of it is valid, the allegation should be found justified.

[32] *See* Office of Public Advocacy (OPA) Response and Objections to Ombudsman Report and Recommendations at 1 (received Mar. 10, 2020) [hereinafter OPA Response].

> had 100+ individuals on their caseload at any one time. Numbers of this level prevent the guardians from being able to see their clients on even a quarterly basis because the job is continually hijacked by crisis management.[33]

OPA expects the inability to make consistent quarterly visits to continue for at least five years, while new employees are trained and become able to carry a full caseload.[34]

However, OPA requested that the Ombudsman remove the discussion of AS 13.26.720(d)(1):

> The Ombudsman mistakenly construes AS 13.26.720(d)(l) as permitting the Public Guardian to contract out its duties in all cases. As was discussed during the consultation, this is incorrect. OPA can contract out services for an individual ward if that ward has their own funds to obtain additional services - such as hiring a case manager.[35]

The Ombudsman agrees that OPA's ability to contract for services on a ward's behalf is limited by the ward's funds and OPA's ability to access public benefits on the ward's behalf. That does not change the fact that the trial court in *M.M. v. State*[36] ruled that OPA can substantially comply with the quarterly visitation requirement by having a direct service provider conduct face to face visits with the ward and report to the guardian:

> The court does not find the public guardian substantially complied with "in person" visits herself by visiting 8 times in 5 out of 10 quarters reviewed. The question remains whether this requirement (duty) for "in person" visits can be contracted out to a person who is not qualified under AS 13.2 .740? The short answer from this court is "yes". . . The court does not find that the public guardian is "delegating" it's [sic] duty by using contracted services, but merely contracting for services that assist in the public guardian carrying out the duties required by statute.[37]

The Ombudsman considered whether OPA had substantially complied with the quarterly visitation requirement through a direct service provider's visits with the ward. The evidence shows that there were no direct service providers involved in the ward's care, beyond staff at the homeless shelter and soup kitchen where he received services when he was left homeless and/or without food.

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[33] *Id.* at 2.
[34] *See id.* at 3.
[35] *See id.*
[36] *M.M. v. State*, *supra* note 10.
[37] *See* Final Order, *supra* note 11. The court's order is attached in Appendix B.

Therefore, the Ombudsman maintained the finding that OPA had not substantially complied with AS 13.26.720(c)(2).

Allegation 2: Unreasonable: The Office of Public Advocacy did not spend the ward's funds on safe, consistent shelter.

The statutory powers and duties of a guardian, unless expressly limited by the court, include the duty to "assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward's physical health and safety."[38] The guardian must also "assure the care, comfort, and maintenance of the ward."[39]

The ward's primary income was from Supplemental Security Income (SSI) and Adult Public Assistance (APA) benefits. His APA benefits were $362/month. His SSI benefits fluctuated, in part because of a suspension of benefits in March 2017 that OPA had to appeal to the Social Security Administration. However, August through December 2017, his SSI benefit was $661.50/month. In addition to public benefits of $1,023.50/month, he received periodic dividends from the village corporation. He also received a Permanent Fund Dividend (PFD) of $1,100 in October 2017. There is no evidence that OPA applied for Food Stamp benefits for the ward.

The $900/month that OPA paid in rent to the motel represented nearly 90% of the ward's regular monthly income. In August 2017, the ward was locked out of his room in the first week of the month, as indicated by his August 8 phone call to OPA. It is reasonable to conclude that he remained unhoused until he called OPA again on August 23, after which the guardian spoke with the motel manager to negotiate the ward's return. The ward was locked out for an unknown number of days in October. He was locked out again on December 8, and it is unknown whether he returned to that room before his death. This cannot reasonably be considered safe or consistent housing, nor was it a prudent use of resources, in light of how much of the ward's income was consumed in paying for it.

[38] AS 13.26.316(c)(1).
[39] AS 13.26.316(c)(2).

The guardian explained why OPA placed the ward at that motel: "Although it is not an ideal place for clients to live it is often the only option for clients such as [the ward] who have been evicted from most places." The guardian also offered the opinion that the motel would not have continued to rent to the ward unless OPA allowed the manager to "take breaks" by locking him out when his behavior became unacceptable. Such lockouts are illegal in normal residential rentals, but the motel is exempt from the Alaska Landlord-Tenant Act.

There is evidence that the guardian sought assistance on two occasions to complete the information needed to apply for General Relief to help fund placement in an assisted living home. However, the guardian did not complete this process, and did not apply for General Relief for the ward. There is no documentation of the guardian's reasons for not completing the General Relief applications.

The guardian also attempted, once, to contact a long-term supportive housing program operated in the ward's hub community. The guardian did not pursue further communication about this supportive housing option — despite evidence that the ward needed supportive services to live successfully in the community. There is no evidence in OPA's records documenting why the guardian did not follow up on this housing option.

During the consultation, OPA leadership supposed that the decision not to pursue General Relief was based on the ward's unwillingness to accept placement in an assisted living home. There is no evidence in OPA's records that the guardian discussed the option with the ward, or that the ward expressly refused this type of housing in 2017. The court visitor reported in 2016 that he had previously been unable or unwilling to maintain in an assisted living home prior to 2015.

There is evidence that the guardian regarded the ward's only options as the motel or the Brother Francis Shelter, an emergency shelter housing people on a first-come, first-served basis each night. However, there is also evidence that the guardian started on three separate occasions to pursue assisted living or supportive housing, indicating that placement in an assisted living home was a possibility for the ward.

The ward had periodic episodes of binge drinking and a criminal record. He also experienced serious mental illness, for which he did not engage in treatment. This affected his ability to function.

The ward's history meant that he did not have good prospects for a private rental apartment, even though $900/month might have paid for an efficiency apartment in Anchorage. The ward had no family members willing to care for him. Even considering these challenging behaviors, a motel room from which the ward was repeatedly locked out is not safe or consistent housing.

During the consultation with the agency, Deputy Director Beth Goldstein and Director James Stinson maintained that there was no safer or more consistent housing available to the ward, given his limited income, challenging behaviors, and criminal history. They explained that, from OPA's point of view, the inadequate and expensive placement at the motel was the best that OPA could find, given circumstances outside of the agency's control.

Even if the motel was the only housing OPA could find for the ward, OPA did not mitigate the risks inherent in their choice to use this motel for their ward's housing. AS 13.26.316(c)(1) requires guardians to assure that wards are housed in places that meet the "essential requirements for the ward's physical health and safety." Guardians are further required by AS 13.26.316(c)(2) to "assure the care, comfort, and maintenance of the ward." OPA is constrained by the limits of a ward's resources when choosing housing options, but is still required to take action to address and mitigate risks to the ward's health, safety, care, and comfort.

The ward called OPA on August 8, 2017, and said that he was staying at the Brother Francis Shelter because he had been "kicked out" of the motel. According to the evidence, the guardian took no action regarding his lack of housing until two weeks later, when the ward phoned again to report that he was still homeless. On December 8, 2017, the ward called to report being locked out again. OPA called the motel about the lockout, but accepted without argument the motel staff's statement that the ward was locked out until at least December 19. OPA took no further action regarding their ward being homeless in December. There was no effort to contact the ward or the Brother Francis Shelter to confirm whether the ward was actually sheltered there after being locked out of the motel room.

The evidence shows that placing the ward at this motel, especially when OPA had such limited and infrequent contact with the ward, did not satisfy the public guardian's duty to ensure that "the ward has a place of abode in the least restrictive setting consistent with the essential requirements

for the ward's physical health and safety." The Ombudsman notes that OPA continues to place wards at this motel. Deputy Director Russo reported that OPA paid rent to this motel for 24 individuals from January-September, 2019.

Agency Response

OPA objected "to the finding that it did not spend [the ward's] finds [sic] on safe and consistent shelter." [40] OPA responded that the use of $900/month for the motel was reasonable, because the motel provided the ward with housing most of the time, and a place to store his belongings when he was locked out, and because OPA did not believe that the ward could be housed anywhere else.[41]

OPA responded that the ward "had no desire or willingness to be in an ALF [assisted living facility], and consistently demonstrated an inability to comply with the rules of such facilities."[42] There is no evidence in OPA's guardianship records, and the guardian offered no evidence, of the guardian discussing the option of assisted living or other supportive housing with the ward. There is no evidence in the records of OPA's 2016-2017 guardianship, and the guardian offered no evidence, that the ward declined placement in assisted living or supportive housing.

OPA had notice that the motel management repeatedly locked the ward out of his room. Even if OPA could not locate consistent housing, OPA still had the ability – and duty – to actively determine that the ward was sheltered when he was locked out, rather than simply assuming that he was at the Brother Francis Shelter. OPA had the ability – and duty – to advocate for their ward to be rehoused as soon as possible.

OPA responded in part:

> OPA stresses that while it is one thing to espouse a societal ideal that you wish could be achieved, or to point out that a housing situation is less than optimal where there are other options available, it is entirely another thing to impute failure to properly house an individual to an agency when societally, there are no other

[40] See OPA Response at 3.
[41] *See id.* at 3-4.
[42] *See id.* at 4, footnote 4.

> options available besides homelessnes [sic] and a placement such as [the motel]. In short, the Ombudsman holds OPA to an impossible Catch-22 standard.[43]

OPA further stated:

> As set forth above, there were only two housing options available to [the ward], homeless shelters and [the motel]. There were no mental health waivers available to [the ward] and he didn't meet any other housing waiver requirements. The Ombudsman report refrences [sic] an email stating, "[t]his email demonstrates that the motel was not an appropriate placement for a person experiencing serious mental illeness [sic] and an apparent substance use disorder, who is not reciving [sic] treatement [sic] or support services, and who "requires assistance with daily activities, such as taking medications, cooking/eating and personal hygiene." While OPA wholeheartedly agrees with that statement, no other housing placement options were available for [the ward] and losing his one option of [the motel] would have placed him at even more risk.[44]

OPA acknowledges that the ward required assisted living or other institutional level of care. However, the evidence does not support the statement that "no other housing placements options were available." The evidence shows that the guardian had identified other options but did not follow through with attempts to access those options for the ward.

OPA responded that "there were no mental health waivers available" to the ward. The Ombudsman notes that is because Alaska did not offer a Medicaid waiver specific to adults experiencing serious mental illness at the time of the ward's guardianship. The Home and Community Based Waivers managed by the Department of Health and Social Services are available to Medicaid recipients experiencing physical or intellectual disabilities resulting in severe limitations requiring an institutional level of care. [45] OPA provided no evidence that the guardian considered or applied for a community-based Medicaid waiver. OPA provided no evidence that the guardian identified "other housing waivers" that may have benefited the ward. There is no evidence that the guardian

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[43] *Id.* at 4.
[44] *Id.* at 8.
[45] More information about the Home and Community Based Waiver Programs is available from the Department of Health and Social Services at http://dhss.alaska.gov/dsds/Pages/HCBWprogram.aspx (last visited Apr. 7, 2020). The Department of Health and Social Services applied for an 1115 Demonstration Waiver for Medicaid-reimbursed behavioral health services in 2018. The Centers for Medicaid and Medicare Services provided partial approval in November 2018, and the remaining approval in 2019. More information about the Alaska 1115 Demonstration Waiver is available at http://dhss.alaska.gov/dbh/Pages/1115/default.aspx (last visited April 7, 2020).

contacted Alaska Housing Finance Corporation or other special needs housing providers (beyond the one call to the supportive housing program in the hub community) related to these "housing waiver requirements."

In its response, OPA asserts that a finding that Allegation 2 is justified by a preponderance of the evidence requires the Ombudsman to "explicitly state that [the ward] was better off completely homeless."[46] That is not the case. The Ombudsman can take notice of how external forces affect an agency's ability to perform its legal obligations, and still find — based upon the evidence — that the agency has acted unreasonably by not fulfilling those obligations. This investigation highlights several missed opportunities to seek supportive housing for this ward, whose mental illness, age, physical health, and substance use disorder all compromised his ability to live safely and independently in the community.

The Ombudsman understands how limited the housing options are for indigent and disabled Alaskans, particularly those with challenging behaviors. However, that does not negate the Public Guardian's statutory obligation to assure their wards' care, comfort, and maintenance, and to assure that their wards receive services essential to their health and safety. Based on the preponderance of the evidence, the Ombudsman finds Allegation 2 ***justified.***

Allegation 3: Performed inefficiently: After the ward's death, the Office of Public Advocacy continued to receive Supplemental Security Income and Adult Public Assistance benefits on his behalf and disbursed those funds for unnecessary services, leading to a loss of $385.00 to the estate.

Between December 27, 2017, when the ward died, and April 19, 2018, when OPA learned of his death, OPA received $2,449.56 in SSI benefits and $1,448 in APA benefits for him. From the $3,897.56 benefits received, OPA disbursed $3,600 in rent to the motel. OPA disbursed $255 in fees to itself for guardianship services January – March 2018. In 2018, OPA also issued multiple $25 allowance checks. None of these checks were cashed, so the funds were eventually returned to the estate's account.

[46] OPA Response at 5.

OPA disbursed $4,380.42 for the ward's burial expenses. As of June 22, 2018, OPA had $414.22 remaining in the ward's trust account. On July 20, 2018, the Social Security Administration recouped $2,499.56 from OPA (all the SSI benefits paid posthumously). This left a deficit of $1,985.34.

The guardian said that OPA paid the remaining SSI overpayment, since the ward's estate did not have the funds (OPA having previously disbursed them to the motel and others). The guardian added that DPA should have recouped the $1,448 in APA benefits paid after the ward's death, but did not. OPA's collection of $255 in fees for January – March 2018, after the ward died, contributed to the estate's negative balance.

In July 2018, OPA made a demand for refund from the motel of the $3,600 in rent payments made January – April 2018. The motel owner refused:

> I do not know how I am responsible to repay this balance when that room was occupied the entire time and I was unable to rent that room to anyone else.
>
> I cherish my OPA guests and do not want to be in this predicament. I have recently reorganized out of a Chapter 11 and am not in a position to cut a check. I have no idea when that will be possible as I am struggling to repay the debt of chapter 11 as promised and required by the bankruptcy conditions. I would like to work with you to resolve this matter and put some new guidelines in place so this cannot happen again.

The guardian said that Deputy Director Russo decided not to continue to pursue collection of the $3,600.

On October 12, 2018, OPA received the ward's last PFD, $1,600. This was after OPA had filed the Final Guardianship Report. OPA applied the $1,600 to the ward's account's negative balance, leaving it at -$385.34. The loss to the estate would have been greater if DPA had recovered the $1,448 in APA benefits issued after the ward's death.

The consequences of OPA not monitoring the health and whereabouts of their ward resulted in overpayment of public benefits, and the disbursement of posthumous income for a motel room of no use to the deceased ward. The losses caused by OPA's lack of action were borne by the estate and the State of Alaska.

Agency Response

OPA disputed the proposed findings for Allegation 3. Specifically, OPA responded that "the Ombudsman Report appears to disparage OPA's fee collection from the estate…. The Public Guardian statutes (AS 13.26.700 et seq.) specifically allow OPA to collect fees after death and before turning over the estate to the heirs."[47]

While AS 13.26.750(a) requires OPA to charge and collect fees for guardian services, the law also provides that OPA "may waive collection of a fee upon a finding that collection is not economically feasible." Further, 2 AAC 60.100(a) limits collection of fees to "using a method . . . that prevents a financial hardship to the client." Despite written assurance from the guardian to the ward that OPA would not collect fees for their services if it would cause financial hardship or for the ward to go without food, shelter, medical care, or other necessities, OPA collected its monthly fees from the ward throughout the guardianship, totaling $1,590 – while allocating only $20/week for snack bar purchases to cover the ward's basic need to eat. The agency's response does not address the Ombudsman's finding that OPA collected guardianship fees for unnecessary services rendered for months after the ward's death.

OPA offered several reasons why it did not pursue recovery from the motel:

- The ward's estate did not have funds for attorney's fees for litigation against the motel;
- OPA had no obligation to use agency funds for such a lawsuit;
- OPA might lack statutory authority to sue on behalf of a deceased ward's estate; and
- OPA believed it would probably not win such a lawsuit because the motel had held the room for the ward and allowed his belongings to remain in it in exchange for the rent payments.[48]

Although the motel manager provided the guardian with inaccurate assurances that the ward had been seen in residence – when he had been dead for months – OPA did not believe it would be able to establish fraudulent intent on part of the motel owner if it sued the motel for recovery of the $3,600.[49] OPA responded that the motel owner had filed for Chapter 11 bankruptcy.[50] Federal

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[47] OPA Response at 12.
[48] OPA Response at 13.
[49] *See id.*
[50] *See id.* at 12-13.

bankruptcy court records indicate that the motel owner was in Chapter 11 bankruptcy proceedings from April 25, 2017 – March 19, 2018. The motel owner was no longer in bankruptcy when OPA sent a demand letter for reimbursement in July 2018. The motel owner filed a new Chapter 11 bankruptcy petition several months later.

OPA also indicated that it did not want to sue the motel because it wants to continue housing wards there:

> Moreover, jeopardizing its relationship with [the motel] for the estate of a deceased ward is asking OPA to risk a current and future housing placement it needs to fulfill its duties to its existing clients to satisfy the heirs of a deceased client.[51]

OPA did not dispute that it received four months of SSI benefits, totaling $2,499.56, for the ward after his death, or that the agency disbursed those funds to the motel for a room that the ward no longer needed. OPA did not dispute that the ward's estate did not have sufficient funds to pay back the Social Security Administration when it recouped the $2,499.56. OPA did not dispute that it received four months of Adult Public Assistance benefits, totaling $1,448, for the ward after his death, or that the Alaska Division of Public Assistance could have recouped that amount, but instead absorbed the loss.

The Ombudsman finds Allegation 3 ***justified*** by a preponderance of the evidence.

[51] *Id.* at 13.

Recommendations

Recommendation 1: OPA should establish a regular schedule of guardian site visits to facilities and locations where multiple OPA wards are housed or congregate.

OPA has provided a credible explanation as to why each public guardian is unable to visit each of their assigned wards quarterly (the statutory minimum) and cannot begin to meet the professional standard of monthly visits. However, it is possible for one or two public guardians to visit a facility, meet with multiple wards, and report to the guardians assigned to those individuals. During the January 29, 2020 consultation, OPA reported that a guardian who is planning to visit a ward at a facility will email other guardians to ask if they would like them to contact any other wards during the visit. In such instances, the guardian's primary purpose is to meet with the ward assigned to them. Contacting any other wards is only at the specific request of another guardian.

The Ombudsman recommends that OPA establish a schedule of regular and ongoing site visits to wards at key facilities. In the Anchorage area, OPA wards are frequently housed or held in common facilities (assisted living homes, emergency homeless shelters, Alaska Psychiatric Institute, correctional facilities, hostels, halfway houses, and low-rent motels). There is also evidence that a significant number of Anchorage wards depend on Bean's Café and other soup kitchens for meals. The schedule of visits should be developed in partnership with the facility providers, and then posted in the facility so that wards, family members, and service providers are aware of when a guardian will be on site.

The Ombudsman recommends that all guardians be included in the rota for site visits, and if possible, that they go in pairs. Guardians would have a list of wards who should or are likely to be at the facility, with information from the primary public guardian about any new or ongoing issues, or information to be solicited, from the ward. OPA should implement a tool or practice to ensure that information from site visits (including the absence of a ward) is communicated efficiently to the primary public guardian.

Routinely and consistently visiting sites where wards congregate will increase the guardians' contact and communication with wards and caregivers, while efficiently using limited OPA staff

resources to maximum effect. This practice of site visits will also serve to enhance the agency's relationships and communications with community safety net service providers, upon whom OPA relies so heavily to provide for indigent and challenging wards.

The Ombudsman also recommends that the site visit schedule be developed to provide for more frequent site visits to wards in sub-standard facilities. Housing options of last resort create their own hazards for wards living there. When OPA places a ward in a facility like this, for lack of any other option, OPA should be alert and ready to respond to the possibility that lack of adequate hygiene or kitchen facilities, exposure to unsafe living conditions, risk of assault or predation, etc. will compromise the health and safety of the ward.

Agency Response

OPA responded that "Public Guardians already routinely visit multiple wards who are located at one housing placement when a visitation occurs."[52] This is contrary to the description of the ad hoc system of conducting visits at congregate settings provided by OPA leadership on January 29, 2020. OPA declined to formalize or expand its current practice, for the following reasons:

> As explained above, the issue is the number of clients vs. the number of guardians. That is slowly being handled with the addition of funds and PCN's, but it will take a number of years to see the fruit of bringing caseloads down to the point that regular visits can be scheduled in this manner.[53]

Recommendation 2: OPA should continue to expand staff capacity until the Public Guardian is able to meet its statutory, professional, and ethical obligations.

In FY2019, the Legislature appropriated $1,000,000 in unrestricted general funds for ten (10) additional positions for the Public Guardian.[54] During the consultation, OPA reported that after

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[52] *Id.* at 14.
[53] *Id.*
[54] Alaska Legislative Finance Division, 2018 Legislature-Operating Budget, Department of Administration, Transaction Change Detail at 37 (http://www.legfin.akleg.gov/BudgetReports/LY2018/Operating/Enacted/DOA-TransactionChangeDetail.pdf, last visited February 6, 2020). During the consultation, OPA leadership reported receiving additional funding for guardian positions in FY2017. However, review of the enacted FY2017 budget shows no appropriation for additional guardian positions. *See* Alaska Legislative Finance Division, 2016

these funds were received, they initially hired four (4) staff. A year later, OPA hired two (2) more. They described the recruitment as a "struggle," and reported having to lower the minimum qualifications for the public guardian position in order to recruit a sufficient pool of candidates. Deputy Directors Russo and Goldstein explained that it takes two (2) years to fully train and onboard a new public guardian.

The FY 2021 budget signed April 7, 2020 includes two new positions for the Public Guardian, and $250,000 in unrestricted general funds "to fill and retain public guardian positions" previously funded by the Department of Health and Social Services.[55] One position would be a Public Guardian, and the other a Legal Office Assistant I/II.[56] This means there are four (4) public guardian positions remaining from the FY2019 appropriation, with the addition of another guardian and a support position in FY2021, that could increase OPA's ability to meet the needs of its wards. The Ombudsman recommends that OPA prioritize hiring for the existing positions immediately, and plan for a timely recruitment for the new positions funded in FY2021.

Agency Response

OPA responded: "OPA continues to both request appropriate position additions and recruit and train new guardians."[57] OPA declined to prioritize hiring for already funded positions,[58] or to plan for timely recruitment of new positions in FY2021.

Recommendation 3: OPA should allocate personal services funds to provide overtime pay for guardians so that they can meet the minimum standards required of a guardian by law.

The Ombudsman recommends that, until OPA has sufficient staff to reduce caseloads to manageable levels, OPA provide all guardians with the opportunity to request and be authorized

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Legislature-Operating Budget, Department of Administration, Transaction Detail – Conference Committee Structure at 18.

[55] Alaska Legislative Finance Division, 2020 Legislature-Operating Budget, Department of Administration, Transaction Change Detail – Governor Structure at 29-30; *see also* Email from Beth Goldstein, Deputy Director, OPA, to Kate Burkhart, Ombudsman (Dec. 18, 2019).

[56] Email from Beth Goldstein, Deputy Director, OPA, to Kate Burkhart, Ombudsman (Dec. 18, 2019).

[57] OPA Response at 14.

[58] OPA posted a recruitment for a public guardian position to Workplace Alaska on April 9, 2020, after the ombudsman investigation had concluded. *See* https://www.governmentjobs.com/careers/alaska/jobs/2763622/ (last visited April 13, 2020).

for overtime to accomplish necessary casework. Experienced guardians at OPA currently have caseloads of over 100 wards and protected persons. During the consultation with the Ombudsman, OPA reported that senior guardians can request and are routinely authorized for up to five hours/week of overtime. Deputy Director Goldstein reported that other public guardians are working unpaid overtime, as their caseloads are not manageable within a normal workweek.

Based on information from Payroll Services, 8 hours/week of overtime for a public guardian paid at Range 18, Step D, would be $482.58/week or $554.45/week, depending on the employee's PERS Tier. OPA has reportedly hired only six (6) of the ten (10) guardian positions funded in FY2019, which should leave personal services funds available for overtime for the equivalent of at least 10 guardians working 8 hours/week overtime for a year. If OPA has insufficient funds in its budget for overtime pay, the Ombudsman recommends that OPA request additional funding in FY2021 to support public guardians' overtime on a regular basis.

Agency Response

OPA declined to implement Recommendation 3:

> OPA asserts that overtime is not a sufficient remedy to the lack of time the guardians have to handle their work. There are only so many hours in the day and even where overtime is granted, the workload capacity exceeds the amount of time available to complete the work. The additional PCN's and training and recruiting of guardians is the most appropriate solution.[59]

Given the response to Recommendation 1, that hiring and training new public guardians "is slowly being handled with the addition of funds and PCN's, but it will take a number of years to see the fruit of bringing caseloads down to the point that regular visits can be scheduled in this manner," OPA's refusal to use the tools available now to increase existing guardians' capacity continues to leave wards at risk of outcomes like those documented in this investigation.

[59] OPA Response at 14.

Recommendation 4: OPA should expand its partnerships with community agencies to increase access to safe housing for its wards.

Several years ago, OPA was an active participant in a partnership with Anchorage Community Mental Health Services to provide supportive housing to individuals experiencing serious mental illness who did not have access to other housing programs. The Bridge Home project, funded by the Alaska Mental Health Trust Authority and Department of Health and Social Services, provided rental subsidies and related housing costs and intensive on-site residential support services (including 24-hour outreach and response) to 40 individuals in Anchorage. Public guardians participated in case conferences to plan, monitor, and evaluate/modulate services for wards in the program. Some of the senior guardians still working with OPA were involved in the Bridge Home project, providing an opportunity to build upon experience and knowledge of how community partnerships can maximize the agency's limited resources to improve outcomes for wards.

OPA reports being engaged in community efforts to address homelessness and housing insecurity in Anchorage. OPA is participating in the Home for Good project within the larger Anchored Home Plan. Home for Good relies on social impact funding to provide supportive housing to high need individuals. Home for Good provides housing and services to individuals identified from data collected from municipal emergency responders, the Department of Corrections, and homelessness services providers. Because needs are the result of a data-driven process, rather than by application, Home for Good is not available to all OPA wards who may fit the target population.

In addition to Home for Good, the Anchored Home Plan includes priorities related to emergency shelter, increasing permanent supportive housing, prevention and diversion from homelessness, and increased coordination of community services.[60] A significant number of OPA wards access emergency shelter, in lieu of adequate permanent supportive housing options. These wards have a heightened risk of homelessness due to challenging behaviors and lack of qualified staff to support them in housing placements. Actively participating in the Anchored Home efforts is a way for

[60] *See* Anchored Home Strategic Action Plan to Solve Homelessness: 2018-2021, August 27, 2019 Presentation (available online at https://anchoragehomeless.org/anchored-home/, last visited February 6, 2020).

OPA to identify and advocate for additional housing services for the people for whom they are responsible.

OPA can also take advantage of opportunities to identify and expand housing options for difficult-to-house wards through the Anchorage Coalition to End Homelessness. Regular convenings of emergency shelter and supportive housing providers, residential services providers, municipal and state policymakers and funders, advocates, etc. provide opportunities for OPA to coordinate services for wards.

Agency Response

OPA responded that it has already substantially implemented this recommendation: "OPA routinely reaches out as well as maintains relationships with community agencies for housing."[61] OPA also indicated that its existing relationships with community agencies are not expected to improve housing outcomes for wards who are difficult to house: "The issue this will not address is the lack of affordable and appropriate housing for OPA's client pool."[62] This response overlooks the fact that most if not all of the special needs housing projects developed in Alaska in the past twenty years have been the result of extensive planning, advocacy, and funding by community organizations and governmental organizations seeking to better serve vulnerable adults.[63]

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[61] OPA Response at 14.
[62] *Id.*
[63] Examples include but are not limited to Karluk Manor (developed by the Alaska Mental Health Trust Authority, RurAL CAP, Alaska Housing Finance Corporation and local community organizations); Housing First in Fairbanks (developed by Tanana Chiefs Conference with the Fairbanks Downtown Business Association, Alaska Housing Finance Corporation, the Alaska Mental Health Trust Authority); Housing First in Juneau, developed by the Juneau Homeless Coalition and Glory Hall, Juneau Alliance for Mental Health, Inc., Tlingit and Haida Regional Housing Authority, and others); Trillium Landing affordable senior housing, planning for which was led by the Juneau Assisted Living for Seniors Task Force, Juneau Economic Development Council, Alaska Mental Health Trust Authority, and City and Borough of Juneau, and developed by public and private partners. Including the Senior Citizens Support Services, Inc.; Soboleff-McCrae Veterans Village in Haines, which offers low-income assisted living, was developed by the Haines Assisted Living, Inc. with state capital funding and Rasmuson Foundation funds and is sustained in part by rent from non-profit organizations located on-site.

Recommendation 5: OPA should implement business practices to ensure that guardians receive and return messages from and about wards in a timely fashion.

This complaint arose from a lack of response to calls from family members concerned about the ward. Investigation of the complaint showed that the public guardian was also unresponsive to communications from the ward himself. This is not a unique occurrence: a guardian's lack of timely response to communications was an issue in 46% of complaints to the Ombudsman about OPA in 2018-2019.

During the consultation, the Ombudsman asked how visits and phone calls were tracked by OPA reception staff. OPA leadership explained that reception staff will take a message if someone calls for a guardian who is not available, then forward the message to the guardian. In some cases, a ward will be transferred to speak to another guardian if theirs is not available. OPA does not have a system for tracking the guardians' responses to messages or making sure a response is made.

Phone messages are not tracked in the electronic case management system. Reception staff do not have access to the system. This limits the ability of reception staff to provide basic information to the ward, or to record information from the ward for later review by the guardian. Deputy Director Russo explained that reception staff do not have a visitor log or other way to track when a ward comes into the office, unless the ward asks to leave a message or causes an "incident."

OPA should provide reception and support staff, who are often the only person in the office the ward or family are able to talk to when they call/visit, with access to the electronic case management system. These staff should be trained and empowered to check the electronic case file and share basic information with wards. They should also be trained and expected to solicit and record information from wards, family, and caregivers in the system in a way that supports a timely response from the guardians.

OPA should train all staff on use of tools in the electronic case management system (or Outlook if none are available in the system) to ensure that urgent issues — like sudden homelessness — are brought to the guardian's and a supervisor's attention immediately. Finally, OPA should identify

and deploy tools (whether in the electronic case management system, Outlook, or another system) to ensure that communications from wards, family, and caregivers receive a timely response.

Agency Response

OPA declined to implement Recommendation 5. OPA responded:

> The workload currently on the guardians is such that guardians only have the time to return calls on and address crisis issues. As additional PCN's are obtained and filled with trained guardians and the caseloads per guardian decrease, the ability to address non-crisis issues and to timely return communications will improve and better processes can be developed.[64]

OPA did not respond to the specific recommendation: that reception/front line staff be given access to the case management system and that the agency implement a call tracking system to improve the flow of information between wards and guardians.

Recommendation 6: OPA should implement a business practice for prioritizing and responding to information that a ward is homeless or at imminent risk of becoming homeless.

The Ombudsman initially considered recommending a 24-hour (or less) response time for any report of ward becoming homeless. However, during the consultation, OPA pointed out that the urgency of a ward being evicted from housing varies, depending on the ward's ability to find shelter. A ward experiencing dementia who has just become homeless is more vulnerable than a ward who has an established pattern of going to an emergency shelter. OPA described how guardians prioritize responding to a ward's homelessness as a case-by-case matter.

The Ombudsman acknowledges that the urgency of each situation varies, but not so much that any ward's homelessness becomes a non-priority. In this case, the ward reported being locked out on August 8, 2017, and neither his assigned guardian, nor OPA collectively as the Public Guardian, took any action until he called again on August 23, 2017. On December 8, 2017, the ward told OPA staff that he was locked out of his room again. OPA took no action to help him regain access

[64] OPA Response at 15.

to housing, or to confirm where he was, until his family contacted the guardian repeatedly months later.

OPA provided no evidence that there was an actual process by which the guardian considered the ward's vulnerability when he became homeless. The record reflects that the guardian assumed he would shelter at the Brother Francis Shelter, but never confirmed that. Thus, the Ombudsman recommends that OPA provide a decision tree or similar tool for guardians to use to make – and to document – their decision as to when and how to respond to a ward's sudden or imminent loss of housing. The Ombudsman also recommends that OPA implement a policy that, in all cases of homelessness or imminent risk of homelessness, the guardian will at a minimum contact the ward within two (2) business days to assess the ward's health, safety, and housing situation.

Agency Response

OPA declined to implement any changes in response to Recommendation 6. OPA responded:

> OPA does address homeless issues immediately. That does not mean that OPA can house an individual someplace more than a shelter immediately. The individual's income, waiver eligibility, needs and the availability of placements are all factors that dictate the ability to obtain housing beyond a shelter for an individual on an immediate basis. This is not a problem that the guardian alone can solve immediately.[65]

This investigation documents that OPA did not address this ward's homelessness "immediately." OPA did not respond directly to the Ombudsman's recommendation that OPA implement a standard procedure that guardians will contact a newly homeless ward within two (2) business days to assess safety and housing options.[66]

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[65] OPA Response at 15.

[66] *See id.*

Recommendation 7: OPA should apply for Supplemental Nutrition Assistance Program/Food Stamp benefits for all wards who are not institutionalized.

The ward's only regular monthly income was SSI and APA. Based on our review of eligibility standards in effect at the time of his death, the ward appears to have been eligible for Food Stamp benefits. However, there was no record that OPA applied for Food Stamp benefits on his behalf.

The guardian told Assistant Ombudsman Leibowitz that there was not enough money to buy food for the ward, so he needed to go to Bean's Café to supplement the limited options he could buy from the snack bar. Public guardians have a statutory obligation to "assure the care, comfort, and maintenance" of their wards. When a ward's own resources are too meager to meet their basic needs, it is the guardian's responsibility to apply for all public benefits and resources available to fill those gaps. In order to assure that the guardians are exercising due diligence in the pursuit of all benefits for which their wards are eligible, OPA should implement a policy that guardians will in all cases, upon receiving the guardianship orders, submit an application for Food Stamp benefits to the Division of Public Assistance on behalf of the ward, unless they are institutionalized.

Agency Response

OPA agreed to implement Recommendation 7.[67]

Recommendation 8: OPA should use electronic health records/information systems, including the Emergency Department Information Exchange, to ensure timely access to wards' emergency and ongoing health information.

When he died, the ward was brought to ANMC and identified by staff there. ANMC did not contact his guardian, even though ANMC had communicated with the guardian on the ward's discharge planning less than a year before. ANMC's lack of communication is inexplicable and outside the role of the Ombudsman to address. However, this investigation shows that OPA needs to expand its capacity to acquire and respond to health and safety information about its wards.

[67] *See id.*

Initially, the Ombudsman suggested that OPA 1) use medical providers' patient portals into electronic health records to access wards' health information and receive notifications; and 2) become a user of Alaska's Health Information Exchange (HIE). The Ombudsman facilitated discussions between OPA and healtheConnect Alaska (the operator of the HIE) in late 2019.

At the consultation in January 2020, OPA explained that they felt that using the HIE would not bring as much value to the guardians because the Anchorage-area tribal health organizations and the Department of Corrections do not yet use it. OPA reported that they were still considering whether and how guardians could use patient portals for Southcentral Foundation and Alaska Native Medical Center.

According to Alaska State Medical Director, Dr. Anne Zink, the Emergency Department Information Exchange (EDIE) is an opportunity for OPA to have more timely access to wards' emergency health information.[68] The EDIE is operated by Collective Medical, with support from the State of Alaska and the Alaska State Hospital and Nursing Home Association. All of Alaska's hospital emergency departments participate in the EDIE, entering patient admission, diagnosis, treatment, and aftercare information at the time of patient encounter. The Department of Health and Social Services is also moving forward with Alaska Psychiatric Institute (API) using the EDIE.

The EDIE provides an opportunity to more consistently provide information about a patient's public guardian to hospitals, particularly emergency departments, so that medical providers can contact public guardians about health care needs and treatment authorizations more efficiently. The EDIE provides a notification function that could be set to alert OPA whenever a ward presents or is admitted to an emergency room — and potentially to API. Because the EDIE is financed through fees paid by the participating hospitals, and the public guardians would be limited users, there should be no (or a nominal) fee to use the system.

The Ombudsman recommends that OPA move forward with the use of patient portals at large regional medical providers to access and receive notifications about wards' health care. The Ombudsman also recommends that OPA become a user of the EDIE.

[68] Telephone Interview of Dr. Anne Zink, Alaska State Medical Director (February 7, 2020).

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Agency Response

OPA declined to implement Recommendation 8. The agency responded: "OPA has met with the Health Exchange individual however, neither ANMC nor DOC will participate in the Health Information Exchange network - 2 of the largest providers to OPA clients. Therefore, this recommendation will not prove as useful to OPA as hoped."[69]

As noted above, the Ombudsman accepted OPA's assessment of the limited value of the HIE to the agency after the consultation and therefore focused the recommendation to the EDIE and wards' electronic patient records. OPA did not address whether it had considered participation in EDIE.[70] The need for real-time information about the health care needs and admission to a hospital of OPA's wards is even more critical, given that OPA declined to implement any recommendation related to improving guardians' contact or communication with wards or their caregivers. During a public health emergency such as the COVID-19 pandemic occurring at the time this report is issued — when people who are older or experience chronic health conditions/disabilities are at greater risk — the need for public guardians to be informed and immediately responsive to wards' health emergencies or deaths is imperative. The Ombudsman encourages OPA to reconsider the Public Guardian Program's utilization of the EDIE.

OPA also did not address whether it would implement any changes to increase guardians' utilization of medical providers' patient portals

Recommendation 9: OPA should identify and implement a function within its electronic case management system to track check cashing patterns and provide an alert when a ward has not cashed an allowance or food check within 30 days.

As discussed above, there were two red flags in the ward's financial activity that indicated he was in trouble. First, he stopped cashing his weekly $25.00 allowance checks as of December 19, 2017.

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[69] OPA Response at 15.
[70] *See id.*

Second, he stopped using the $20.00/week that the guardian had been sending the motel for the ward to use at the snack bar.

The guardian explained that if they had had time to actively check the ward's financial records, they could have seen the change in his check cashing, but they did not have time to actively monitor wards' spending patterns. The change in the ward's financial activity was valuable information but the guardian did not have time to look for it. Therefore, the Ombudsman recommends that OPA use its electronic case management system, which is integrated with its accounting system, to alert guardians whenever there is a significant change in a ward's financial behavior.

The Ombudsman notes that the second spending change – discontinuation of the snack bar checks provided to the motel – was a decision made by the guardian in early January 2018.[71] Even while the guardian was discontinuing this weekly amount, apparently because the ward had stopped eating at the snack bar, there is no record that the guardian contemporaneously sought information regarding the ward's location or welfare. The use of an automated alert will not address that issue.

Agency Response

OPA accepted Recommendation 9 and responded that the agency is in the process of putting functions in place to track when client checks are not being picked up or cashed.[72]

Recommendation 10: OPA should develop and implement adequate supervision of all guardians.

The guardian in this case was considered a senior, experienced guardian. The investigation shows that there were critical mistakes or omissions that could have been resolved had OPA offered adequate supervision. Had the guardian's work been routinely reviewed by a supervisor, matters like finishing the General Relief application process, following up with the supportive housing program, applying for Food Stamps, and mitigating the risks arising for substandard housing could have been addressed. Had there been a mid-level supervisor, the ward's and his family's calls could have been directed to them to resolve or to ensure that the guardian responded.

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[71] *See id.*
[72] *See id.*

During the consultation, OPA leadership explained that there is a single supervisor for the Public Guardian, a deputy director who also serves as in-house counsel for the program. The majority of public guardian employees report directly to Deputy Director Beth Goldstein. In addition to supervising the staff and managing the program, she is responsible for providing legal counsel to the Public Guardian program.

During the investigation and at the consultation, Deputy Director Goldstein explained that she is implementing a "pod" structure for the guardians to provide better support, oversight, and workflow management. Each pod will have a "pod leader," an experienced senior guardian. The senior guardian is expected to provide coaching and support to the less experienced guardians, and to manage the pod's overall workflow.

The Ombudsman notes that OPA has reported that senior guardians' caseloads approach 100, if not more, cases. This new structure imposes additional responsibilities in an environment where these guardians already cannot meet statutory requirements or professional standards. It also creates supervisory duties for staff who are not in supervisory job classes. Public guardians are either members of a general government collective bargaining agreement or are partially exempt employees. None, other than Deputy Director Goldstein, are considered supervisors.

The Ombudsman recommends that, in implementing the pod structure, OPA train, equip, and compensate the senior guardians taking on additional responsibility. Specifically, OPA should immediately initiate a class study for a supervisory guardian position, based on a formal position description that accurately reflects the guardianship case work and supervision work to be completed. Given the specialized nature of the work of the Public Guardian, the Ombudsman recommends that OPA conduct the classification study with an organization or entity with expertise in the profession.

OPA should also conduct a budget analysis to ensure that the agency has or requests sufficient personal services funds to compensate the supervisory guardians. Public guardians are a range 18 position, which indicates that the supervisory guardian position should be a range 19 or above. OPA should also ensure that all pod leaders have initial training (such as the State of Alaska Academy for Supervisors) and ongoing training in effective supervision.

Once the mid-level supervision structure is established, OPA should implement a structure for providing regular and robust supervision of the pod leaders. As seen from this investigation, senior guardians need to be supported and held accountable in their work, like any other guardian. Depending on the number of pods, the pod leaders could report directly to the deputy director. However, given that the deputy director is also in-house counsel for the Public Guardian, OPA should consider whether a bright line should be drawn between the provision of supervision and the provision of legal advice and representation to staff.

Finally, OPA should identify specific strategies to reduce senior guardians' caseloads before or soon after appointment to the role of pod leader. During the consultation, OPA leadership expressed intent to reduce pod leaders' caseloads by about half (to 50-60 cases). When and how that will be accomplished was not explained. In order for the new structure, and the new supervisors, to succeed, the already overloaded senior guardians must have the individual time, energy, and capacity to perform both the supervisory and guardianship duties being asked of them.

Agency Response

OPA responded: "OPA is requesting a reclassification of PCN's to create a supervisory level of guardians."[73] This response indicates that OPA intends to implement a crucial element of Recommendation 10, to create mid-level supervisors for groups of guardians. However, OPA's response to the recommendation did not provide any further specific strategies for reducing senior guardians' caseloads, or how the agency plans to train and support these new supervisors in their duties.

Conclusion

An elderly, disabled man was found alone and unresponsive outside in December. He died, but his death went unnoticed by his public guardian for four months. This was despite multiple indicators that he was missing or in trouble, and multiple concerned calls from his family.

[73] *Id.*

Public guardians have an important and heavy responsibility, serving as the legal representative and decision maker for Alaskans with challenging disabilities and often extremely limited resources. When there is no family or other responsible adult willing or able to serve as a person's guardian, OPA is appointed to "assure the care, comfort, and maintenance of the ward" and "assure that the ward receives the services necessary to meet the essential requirements for the ward's physical health and safety."

This ward was not unique in the acuity of his disability, the level of his needs, or his poverty. Many of the people OPA serves do not just tax the resources of the agency – they tax the resources of their families, communities, and support networks. This investigation has documented significant limitations in the agency's ability to meet its obligations to its wards.

The Ombudsman recognizes the commitment and good intentions of OPA guardians. The Ombudsman proposed recommendations designed to ensure that the guardians' intentions and outcomes for wards are more closely aligned. While OPA declined the majority of those recommendations, the Ombudsman looks forward to opportunities to support the agency's efforts to improve the quality of guardianship services it provides.

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APPENDIX A

OFFICE OF PUBLIC ADVOCACY RESPONSE, MARCH 10, 2020

APPENDIX B

Final Order on Defendant's Motion to Dismiss and Plaintiff's Cross-Motion for Partial Summary Judgment at 2, *M.M. v. State of Alaska, Department of Administration, Sheldon Fisher, Office of Public Advocacy, and Richard Allen*, 3AN-15-10448 CI