Colorado Adult Protective Services (APS)

Annual Report – Fiscal Year 2014-15

COLORADO
Department of Human Services

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Colorado Adult Protective Services (APS) Program Overview

The Colorado Adult Protective Services (APS) program was established in 1983 to provide protective services for vulnerable persons age 65 and older. The program was expanded in 1991 to the current statute, which establishes protective services for at-risk adults[1] age 18 and older (Title 26, Article 3.1 of the Colorado Revised Statutes). The APS program is located within the Colorado Department of Human Services (Department). The purpose of the APS program is to intervene on behalf of at-risk adults to correct or alleviate situations in which actual or imminent danger of abuse[2], caretaker neglect[3], or exploitation[4] (termed "mistreatment"), or self-neglect[5] exist. APS does not have statutory authority to investigate allegations of verbal or emotional abuse, in the absence of other mistreatment categories or self-neglect. APS is charged in statute (Title 26, Article 3.1, C.R.S.) with accepting reports of mistreatment and self-neglect of at-risk adults and then investigating the allegations[6] and assessing the client for other health and safety needs. The APS program collaborates with law enforcement and/or the district attorney for criminal investigation and possible prosecution.

APS receives reports from professionals who work with at-risk adults, such as health care professionals and community non-profit agencies; from other government agencies, such as local health departments; from law enforcement, and concerned friends, neighbors, and family members. When the investigation of the allegations and the assessment of the adult's strengths and needs determines that the adult is

[1] **At-Risk Adult** means an individual eighteen years of age or older who is susceptible to mistreatment or self-neglect because the individual is unable to perform or obtain services necessary for his or her health, safety, or welfare, or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person or affairs. (Section 26-3.1-101, C.R.S.)

[2] **Abuse** means any of the following acts or omissions committed against an at-risk person:

1) The non-accidental infliction of bodily injury, serious bodily injury, or death;
2) Confinement or restraint that is unreasonable under generally accepted caretaking standards; and
3) Subjection to sexual conduct or contact classified as a crime under the Colorado Criminal Code, Title 18, C.R.S. (Section 18-6.5-102, C.R.S.)

[3] **Caretaker Neglect** means:

1) Neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health or safety of the at-risk adult is not secured for an at-risk adult or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult.
2) (b) The withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, any medication or medical procedure or device, in accordance with any valid medical directive or order, or as described in a palliative plan of care, is not deemed caretaker neglect, Section 18-6.5-102 (2.3), C.R.S.

[4] **Exploitation** means an act or omission committed by a person who:

1) Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive an at-risk adult of the use, benefit, or possession of anything of value;
2) Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the at-risk adult;
3) Forces, compels, coerces, or entices an at-risk adult to perform services for the profit or advantage of the person or another person against the will of the at-risk adult; or
4) Misuses the property of an at-risk adult in a manner that adversely affects the at-risk adult's ability to receive health care or health care benefits or to pay bills for basic needs or obligations; Section 18-6.5-102 (4), C.R.S.

[5] **Self-Neglect** means an act or failure to act whereby an at-risk adult substantially endangers his or her health, safety, welfare, or life by not seeking or obtaining services necessary to meet his or her essential human needs. Choice of lifestyle or living arrangements shall not, by itself, be evidence of self-neglect. Refusal of medical treatment, medications, devices, or procedures by an adult or on behalf of an adult by a duly authorized surrogate medical decision maker or in accordance with a valid medical directive or order, or as described in a palliative plan of care, shall not be deemed self-neglect. Refusal of food and water in the context of a life-limiting illness shall not, by itself, be evidence of self-neglect; Section 18-6.5-102 (10), C.R.S.

[6] **Allegation** is a statement asserting an act or suspicion of mistreatment or self-neglect involving an at-risk adult.

being mistreated or is self-neglecting, the APS program offers protective services to the adult to prevent, reduce, or eliminate risk and improve safety.

APS County and State Roles

The Colorado APS program is state-supervised and county administered. Specifically, as stated in Section 26-1-111(1), C.R.S., the Department is charged with the administration or supervision of all the public assistance and welfare activities of the State, including the APS program. And, by statute, County Departments of Human Services (Counties) are responsible for implementing the APS program. (Section 26-3.1-101, C.R.S., et seq.)

County APS programs receive reports of at-risk adult mistreatment and self-neglect, evaluate the report to determine whether an investigation is warranted, and conduct face-to-face investigations as deemed necessary. Counties provide protective services by offering casework services; arranging, coordinating, delivering, and monitoring services to protect adults from mistreatment and self-neglect; assisting with applications for public benefits; providing referrals to community service providers; and initiating probate proceedings, when appropriate. County APS programs exchange information and collaborate with local law enforcement, district attorneys, and other agencies authorized to investigate mistreatment and self-neglect. However, the role of APS is limited by the fact that the client has the choice as to whether or not to accept services. For example, if an at-risk adult who appears to be competent refuses services, he or she cannot be forced to accept services.

The state APS program located within the Department establishes statewide program policy (in consultation with counties and through the legislative process); provides technical assistance and consultation to counties, especially regarding the interpretation of state regulations and best practices; monitors statutory compliance and program operations; develops methods for inter-program coordination through the development and implementation of protocols and interagency agreements; develops and provides training to counties; provides management and oversight of the Colorado APS data system (CAPS); and handles consumer inquiries regarding APS.

Currently, there is no federal APS program or regulations for state APS programs. As a result, the population served, the mistreatment accepted for investigation, and program rules for implementation of the APS program vary from state to state. For example, some states only serve persons age 60 and older and do not provide protective services to younger adults who may also be vulnerable to mistreatment. The U.S. Department of Health and Human Services, Administration for Community Living (ACL) is in the process of developing guidelines for state APS programs. These guidelines, while voluntary, will establish a model for APS programs with the long-term goal of standardizing APS practice across all states and U.S. territories.

APS Funding

The Colorado Adult Protective Services program is funded through the APS Administration Allocation. In fiscal year (FY) 2014-15[7] the APS program received just under $14.7 million, $9.9 million in State General

[7] A fiscal year (FY) runs from July 1 through June 30 (i.e., FY 2014-15 was 7/1/2014 through 6/30/2015).

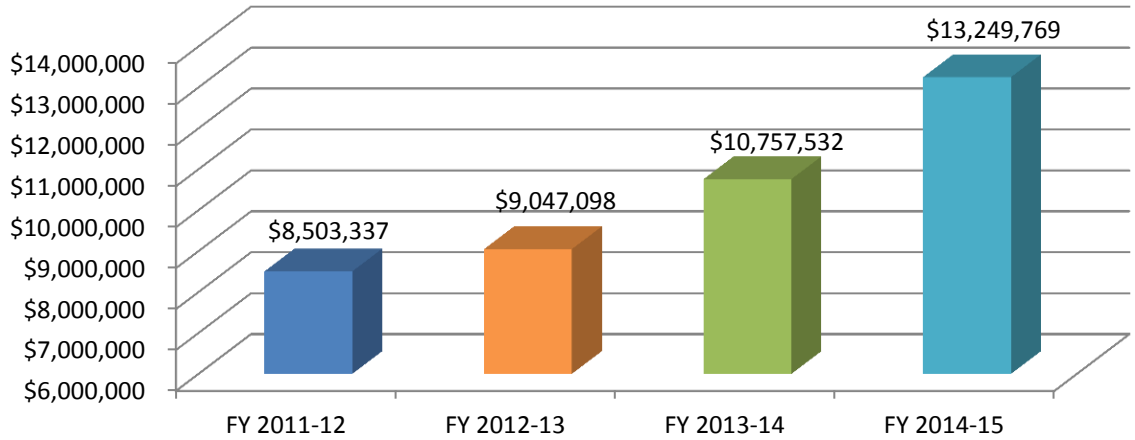
Funds, $2.8 million in local matching funds, and $1.9 million in federal funds. It is important to note that there are no dedicated sources of federal funding for APS programs in states, however the APS allocation includes approximately $1.9 million of Title XX federal funds dedicated to Adult Protective Services. The remainder of funding for APS is State General Fund and local county funds. County departments must provide 20% matching funds to receive State General Fund. Counties may also use additional local monies outside of the APS administration allocation, depending on county needs and priorities. The $14.7 million for the APS program was allocated as follows:

- Approximately $585,000 for State Department staff salary, benefits, operating, travel, and to provide training to county department APS staff and the community
- $160,000 for the Colorado Adult Protective Services data system (CAPS)
- Approximately $12.9 million for county departments' APS program administration costs
- $1 million for Client Services. The Client Services allocation was established in SB13-111 to purchase emergency, short term, and one-time goods and services that are unavailable through other programs and are necessary for APS clients' health and/or safety.

In FY 2012-13, additional State funds were provided to county APS programs prior to mandatory reporting of mistreatment of at-risk elders. These funds were appropriated to allow county APS programs to hire additional caseworkers in order to reduce caseload averages from 32:1 to the standard established by SB13-111 of 25:1. Additional funding was provided to ensure the county APS programs could maintain a 25:1 caseload average with an increase of 15% as a result of mandatory reporting. Despite the 23% total increase in funding, and the additional staff hired with these funds, a 41% increase in reports[8] prevented county APS programs from meeting the 25:1 standard, finishing FY 2014-15 at 32:1 statewide.

The chart below details county department APS administration expenditures since FY2011-12.

APS County Admininistration Expenditure FY 2011-12 through FY 2014-15



**Note: county administration expenditures do not include State administration expenditures or client service funds.*

[8] See page 8 for more information on the effects of the implementation of SB13-111 and mandatory reporting of at-risk elders.

APS Priorities

Adults have inherent rights to make their own choices and decisions, including the right to make decisions that other people would consider unsafe or unwise decisions. In other words, adults have the right to folly. When working with at-risk adults, APS works to reduce risk and improve safety for the adult while respecting the adult's right to live his/her life as he/she wants to live. APS will work to ensure that protective services are provided within the key priorities, outlined below.

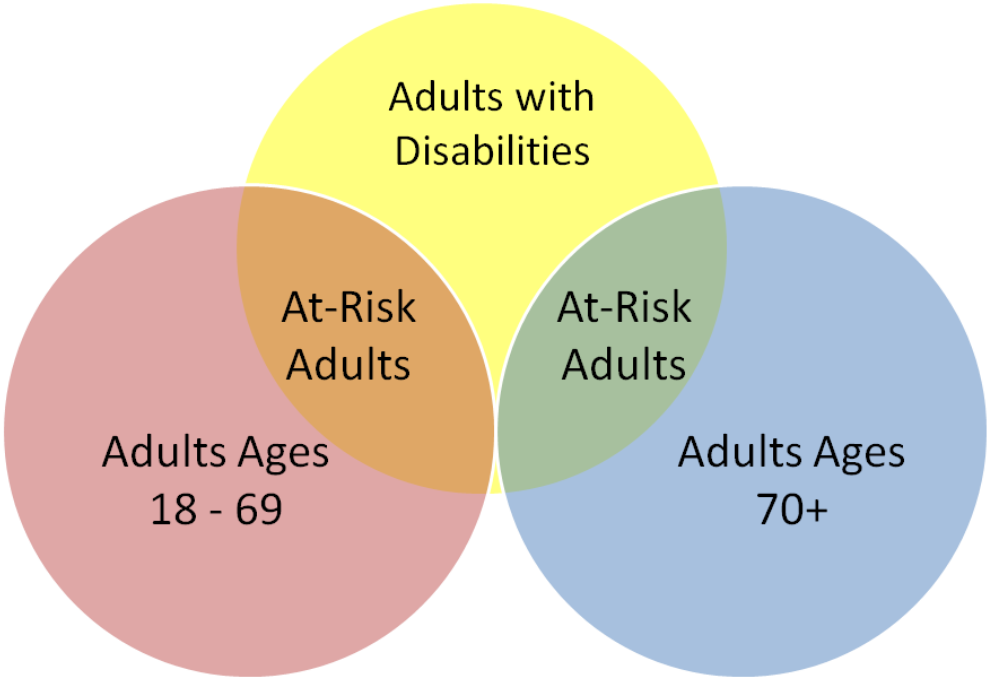
Confidentiality: By statute and rule (Section 26-3.1-102(7), C.R.S., and 12 CCR 2518-1, 30.250), all APS report and case information (written or electronic) is confidential and cannot be released without a court order except in very limited circumstances. For example, limited information can be shared with another agency, such as law enforcement, when conducting a joint investigation with that agency; or when necessary to set up services needed to improve safety such as with a home care provider.

Self-Determination & Consent: An adult has a right to make decisions for him/herself without interference from others. Therefore, unless the adult is breaking the law or a municipal code or does not have the cognitive capacity to make responsible decisions or understand the consequences of their decisions, adults have the right to refuse APS services if they appear capable of understanding the consequences of refusing those services. The client may choose to accept some services but not all services the APS caseworker determined necessary for their health and/or safety. The client may choose to continue living in an unsafe situation or with the perpetrator of the mistreatment. (Section 26-3.1-104, C.R.S. and 12 CCR 2518-1, 30.240)

Least Restrictive Intervention: APS will acquire or provide services, including protective services, for the shortest duration and to the minimum extent necessary to remedy or prevent mistreatment and/or self-neglect. For example, APS will attempt to implement services that keep clients in their homes, if it is safe to do so. Placement in an assisted living or other long-term care facility would only be considered if the client's needs were too great to remain safely in his/her home. Additionally, APS does not keep cases open for longer than is necessary to complete the investigation and implement services. As a result, the vast majority of cases are open for less than three months. (Section 26-3.1-104, C.R.S. and 12 CCR 2518-1, 30.240)

APS Client Demographics

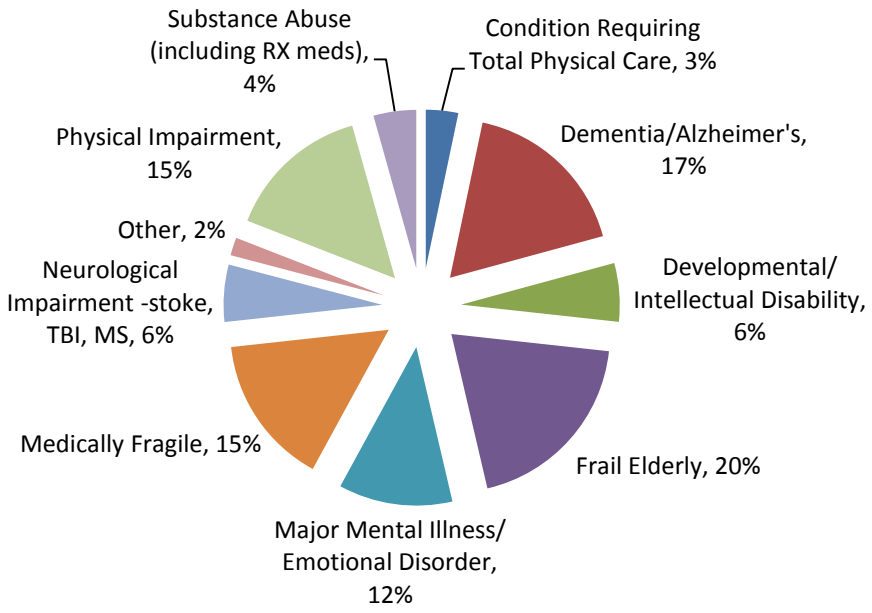
According to APS statute (Section 26-3.1-101, C.R.S.), at-risk adults are individuals age 18 or older who are susceptible to mistreatment or self-neglect because they are unable to perform or obtain services necessary for their health, safety, or welfare, or lack sufficient understanding or capacity to make or communicate responsible decisions. Examples of conditions that increase risk include: dementia, physical or medical frailty, developmental disabilities, brain injury, neurological disorders, and major mental illness. Persons are not considered "at-risk" solely because of age and/or disability.



Client Risk Factors

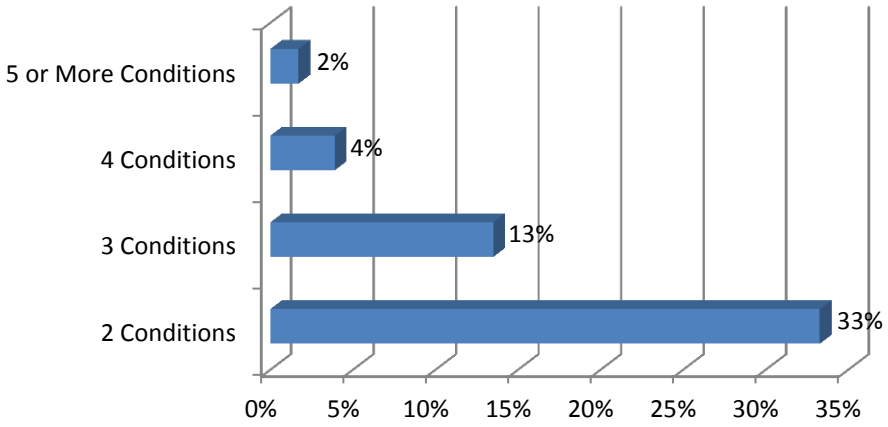
There are many physical, medical, and cognitive conditions, which may make an adult "at-risk" for mistreatment or self-neglect depending on the severity of the condition and how that condition impacts the adult's ability to provide for their health and safety or impacts their ability to make or communicate responsible decisions. In FY 2014-15, the most common conditions impacting APS clients were "Frail Elderly" (20%), "Dementia/Alzheimer's" (17%), "Medically Fragile" (15%), and "Physical Impairment" (15%).

Physical, Medical, and Cognitive Conditions



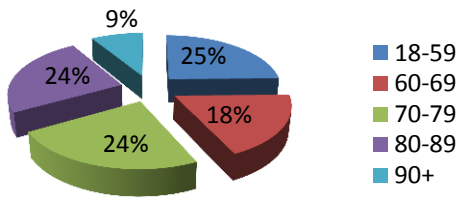
Furthermore, 57% of APS clients have two or more of these conditions, adding complexity to resolving the health and safety issues for the client.

Clients With Multiple Conditions



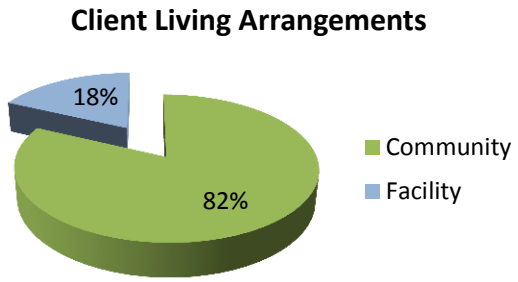
Client Gender and Age

A majority of APS clients are female (60%). Most APS clients are aged 70 or older (57%). The oldest client in FY 2014-15 was 105.

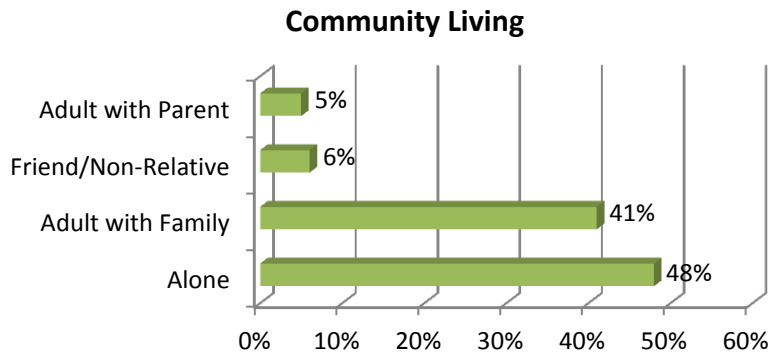


Client Living Arrangements

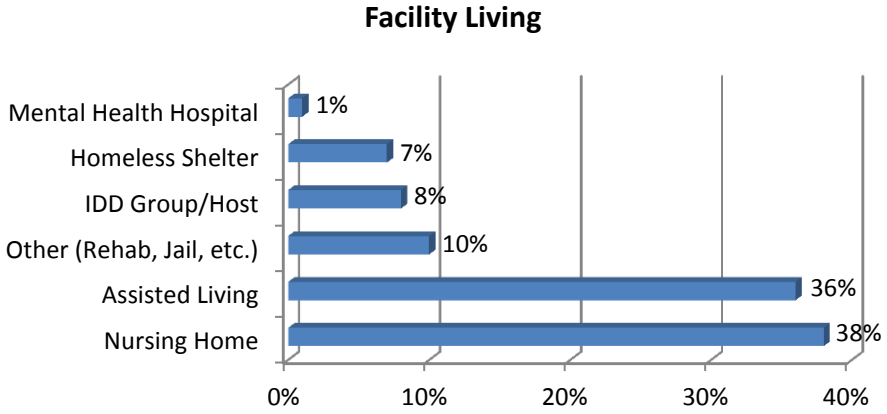
About 82% of APS clients in FY 2014-15 lived in a community setting, such as their own home or the home of a family member, while 18% lived in a facility, such as a skilled nursing facility or a group home.



Most clients in FY 2014-15 who lived in the community lived alone or with a family member other than their parent.

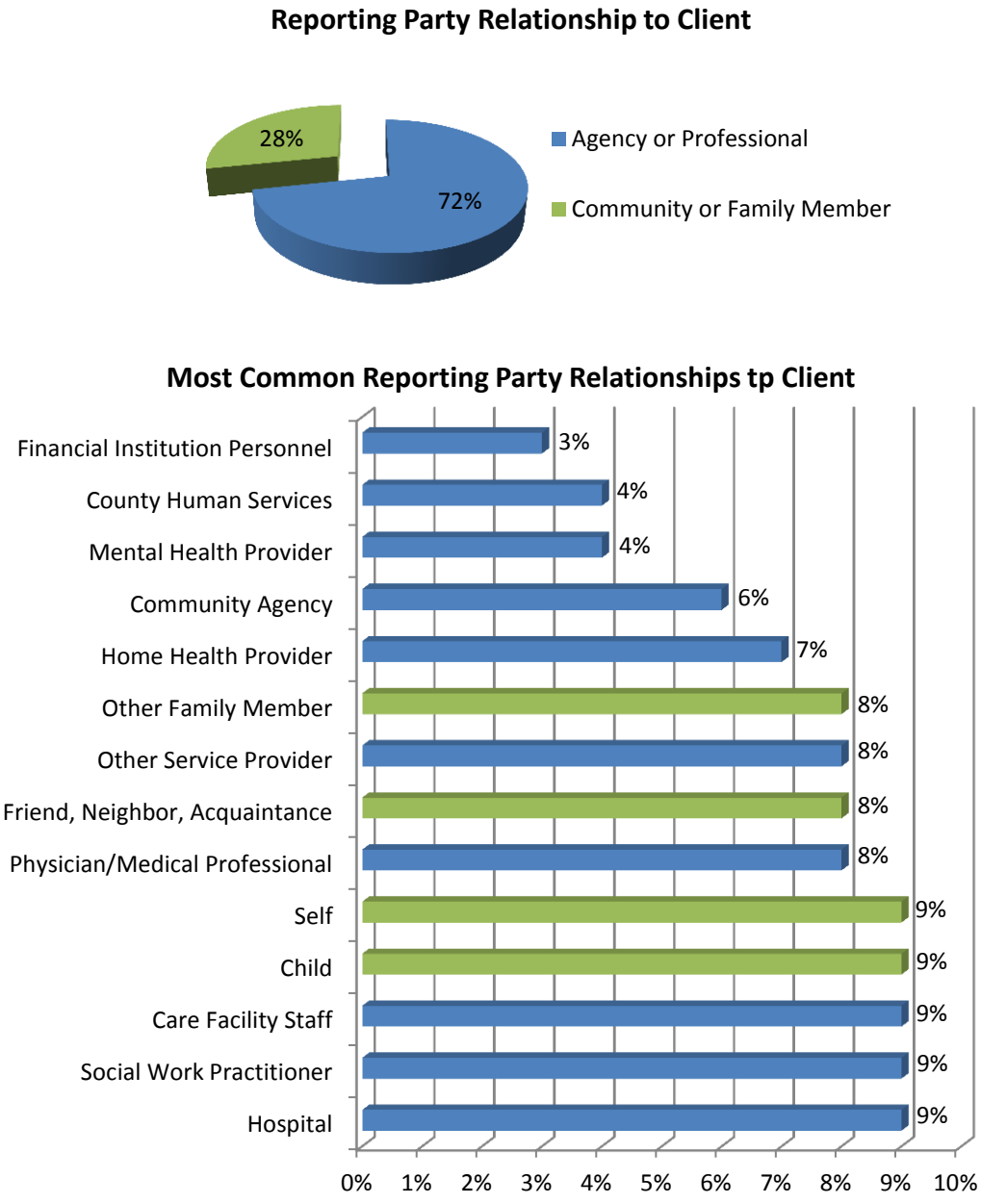


Clients who lived in a residential facility most often lived in a nursing home or assisted living facility.



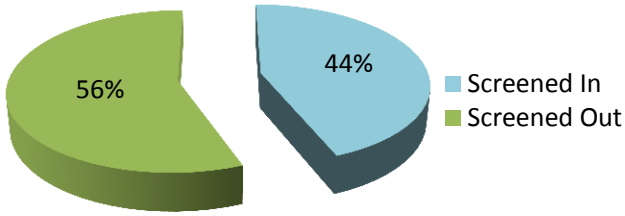
Reporting Party Relationship to Client

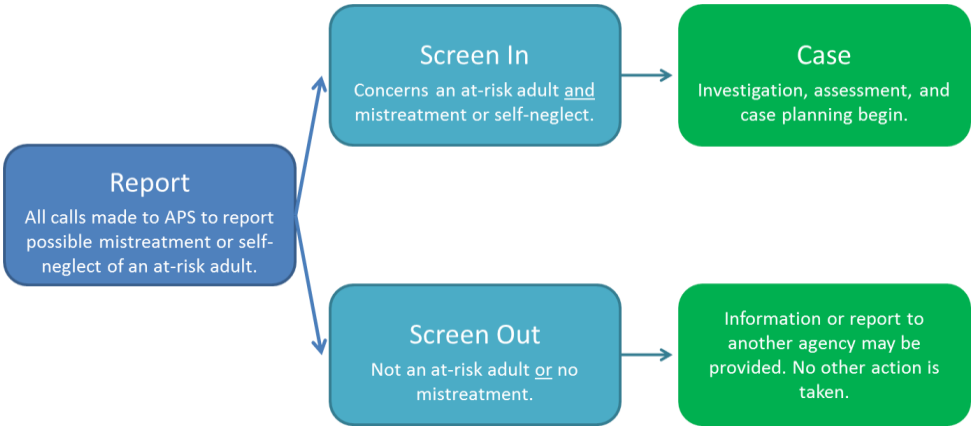
Reports are made to APS by a variety of professionals who work with at-risk adults, family, friends, neighbors, and sometimes by the adult themselves. The identity of a person reporting concerns about an at-risk adult to APS is confidential. If the reporter chooses, he or she may remain anonymous when making a report to APS. In FY 2014-15, a majority of reporting parties were professionals who work with at-risk adults (72%). The most common reporting party groups were hospital workers, social work practitioners, care facility staff, a client's child, and the client via self-report (9% each).



When a report is made to APS, county APS personnel evaluate the report to determine whether it meets eligibility criteria for investigation, which is twofold: (1) it involves an at-risk adult, as defined in the APS statute, (2) there is alleged or suspected mistreatment and/or self-neglect. Reports that do not meet criteria are "screened out" and are not investigated further. Regardless of whether the report meets criteria for APS intervention, the report will be shared with law enforcement within 24 hours so that law enforcement can review the report for potential criminal activity. APS does not have access to law enforcement records and so is not able to provide information on the number of these reports that were criminally investigated by law enforcement or prosecuted by district attorneys.

Once a report is determined to meet criteria for intervention by APS, the report is "screened in", meaning it will be assigned to a caseworker who will begin an investigation, and it is now considered a "case". In FY 2014-15, 44% of reports were screened in and became an APS case. In general, cases require a thorough investigation of the allegations and an overall assessment of the client's strengths and needs. In FY 2014-15, 99% of all cases resulted in an investigation. Some cases do not require an investigation (e.g., safety concerns are resolved by working with the client's case manager or the caseworker was unable to locate the client).



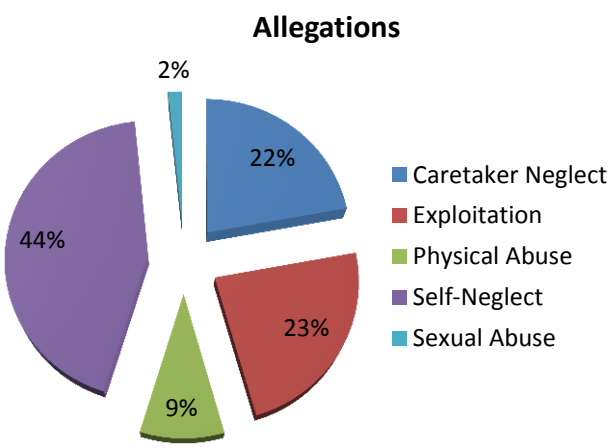


Investigation

Investigations and assessments are usually completed simultaneously. Investigations involve interviews with witnesses and other persons who have knowledge of the client and/or allegation. Caseworkers collect evidence to review such as photographs of bruising, medical records, and/or bank statements. A review of the evidence is then completed to determine if the allegations are substantiated, unsubstantiated, or inconclusive. A finding on the alleged perpetrator will also be made. A substantiated finding means that the investigation established by a preponderance of evidence that mistreatment or self-neglect has occurred and the alleged perpetrator was responsible. An unsubstantiated finding means the investigation did not establish any evidence that mistreatment or self-neglect has occurred.

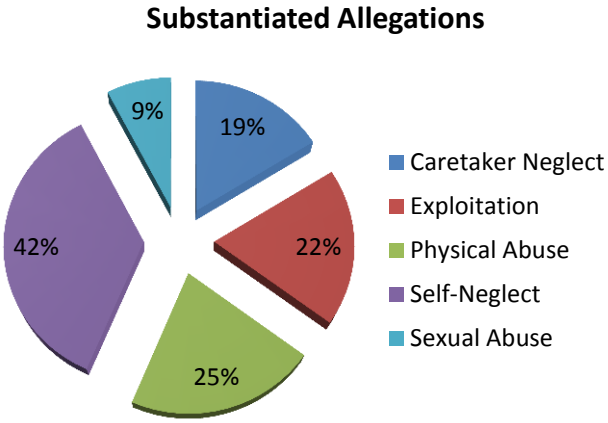
An inconclusive finding means that indicators of mistreatment or self-neglect may be present but the investigation could not confirm the evidence to a level necessary to substantiate the allegation.

FY 2014-15, 44% of clients were self-neglecting, that is, not providing for their basic needs. The most common form of mistreatment was exploitation at 23%, which was closely followed by caretaker neglect at 22%. There may be multiple allegations occurring in any given case. For example, a client may be self-neglecting and be exploited by a family member; or a client may be physically and sexually abused.



Over the years, the percentage of each type of mistreatment/self-neglect being alleged, when measured as a percentage of the total allegations received on all new reports, has remained relatively consistent, except for exploitation. In FY 2006-07, exploitation accounted for 16% of the total allegations made in reports to APS versus 23% in FY 2014-15. Exploitation is the only mistreatment allegation that has increased over the years.

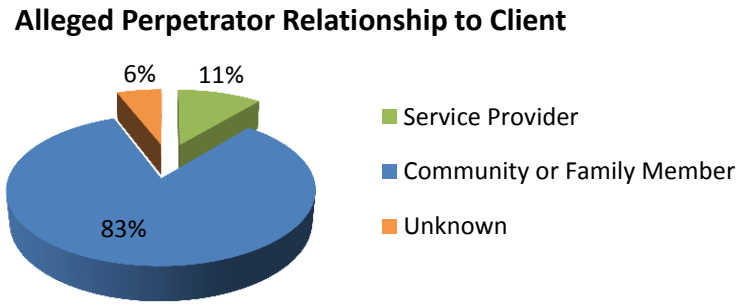
The approximate loss of money and property to clients who were exploited (the allegation was substantiated) in FY 2014-15 was almost $57.7 million. This approximate loss of assets does not include the loss that the State experienced as a result of these clients being exploited, which may have increased the need for public services and benefits, such as Medicaid, food assistance, or Old Age Pension. There were 405 cases in which APS recorded that a client experienced a financial loss, with six clients with approximate losses of $1 million to $40 million.



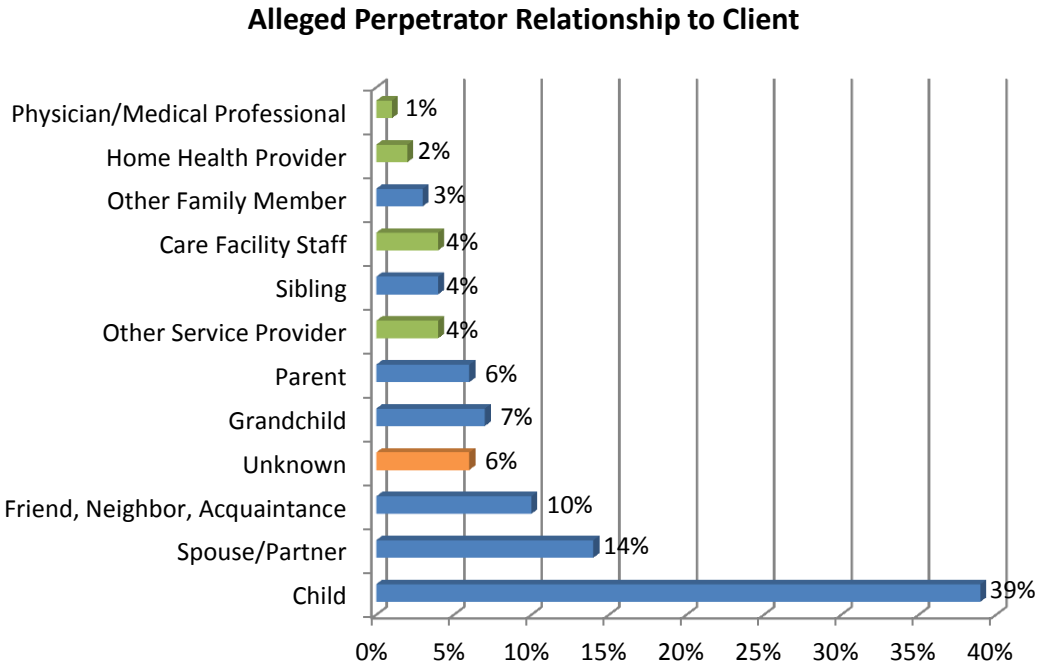
Approximately 30% of all the allegations made in FY 2014-15 were substantiated, 15% were inconclusive, 39% were unsubstantiated, and 16% could not be determined. It's important to note that FY 2014-15 was the first year that the State was able to review findings on allegations to determine whether the finding documented in the Colorado APS data system (CAPS) was consistent with the evidence collected. A review of a statistically valid sample of allegations findings indicated that approximately 33% of the findings were inaccurate. Training was provided to caseworkers and supervisors in April 2016 with the intent of improving the accuracy of the allegations findings in future years.

Alleged Perpetrator Relationship to Client

The great majority of alleged perpetrators identified in reports to APS programs across the state, about 83%, are either a family member or other person the victim knows, such as a neighbor, friend, or acquaintance. About 11% of alleged perpetrators are professionals who provide services to the client, such as home care or nursing care staff, and about 6% of perpetrators are unknown at the time of the report.



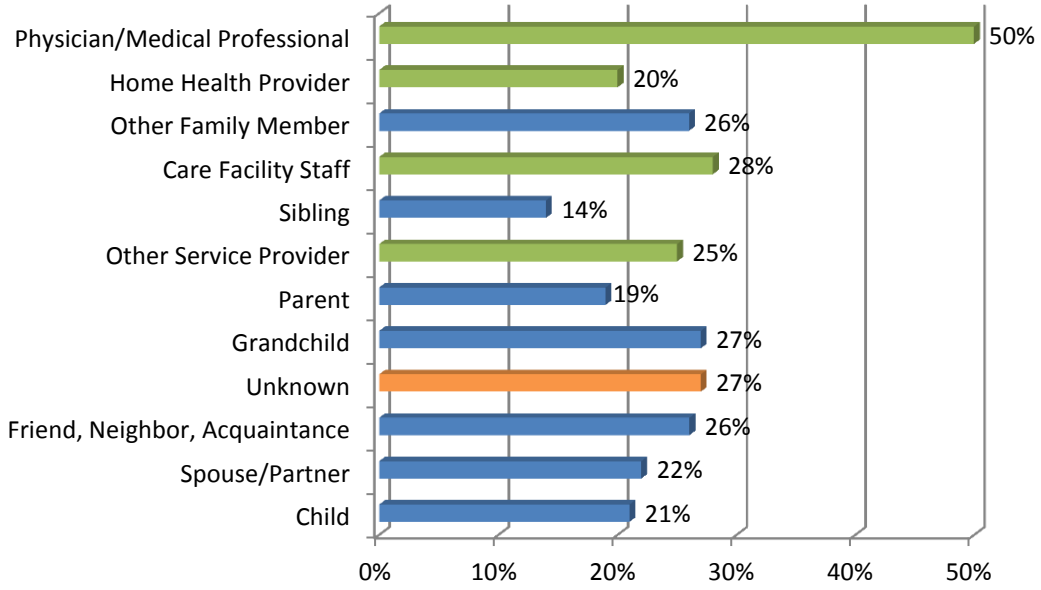
In FY 2014-15, APS client were most likely to be mistreated by their children (39%) or their spouse or partner (14%).



Approximately 23% of all allegations made against alleged perpetrators in FY 2014-15 were substantiated, 19% were inconclusive, 43% were unsubstantiated, and 16% could not be determined. Below is a chart with the percentage of substantiated allegations by relationship. For instance, 50% of all the allegations made against a physician/medical professional were substantiated. It's important to note that FY 2014-15 was the first year that APS caseworkers had been asked to make a finding on the alleged perpetrator and the first year the State was able to review perpetrator findings to determine whether

the finding documented in CAPS was consistent with the evidence collected. A review of a statistically valid sample of alleged perpetrator findings indicated that approximately 37% of the findings were inaccurate. Training was provided to caseworkers and supervisors in April 2016 with the intent of improving the accuracy of the alleged perpetrator findings in future years.

Substantiated Allegations by Relationship



Joint Investigations

Investigations may be conducted jointly with a partnering agency that has statutory authority to investigate mistreatment (i.e., a collaborative investigation). Typical agencies that conduct joint investigations with APS include:

- Law enforcement
- District attorneys
- Medicaid fraud investigators
- Community Centered Boards
- Colorado Department of Public Health and Environment Health Facilities Division
- Long-term care ombudsmen
- County department of human services fraud investigation units

County APS programs, law enforcement agencies, district attorneys, and other agencies responsible by law to investigate the mistreatment of at-risk adults are required by statute (Section 26-3.1-103(3), C.R.S.) to develop and implement cooperative agreements to coordinate these joint investigative duties to ensure the best protection for at-risk adults, to include:

- Local law enforcement

- District attorney (DA)
- Long-term care ombudsman - advocates for residents of nursing homes, assisted living residences, and similar licensed adult long-term care facilities.
- Community Centered Boards (CCBs) – organizations that provide services to adults with intellectual and developmental disabilities, such as: eligibility determination, coordination and arrangement of services, and oversight of direct care providers.

Assessment

An assessment involves an evaluation of the client's strengths and needs to determine risk[9] and safety[10]. In an assessment, caseworkers evaluate the client's physical, environmental, financial, medical, cognitive, and mental health status to identify areas that place the client at risk and areas that are strengths for the client. The client's current support system, such as caregivers in place or family or friends who help the client, is also noted. Caseworkers will identify any risk areas such as the client's ability to communicate, whether their plumbing, utilities, and appliances are working, whether the client is aware of their financial needs or if they have many unpaid bills, whether the client is experiencing delusions, their orientation to time/place, if they have an acute/unmet medical issue, and more. Caseworkers also record whether any services have already been implemented to help mitigate the risk of these factors and increase the client's safety. If a client has a risk and there is no adequate service or support in place to ensure the risk is mitigated, the APS, caseworker will identify a service or support in the case plan and work with the client to implement the service/support. For example, if a client is no longer able to prepare meals, do their laundry, or clean their home, the APS caseworker would work to get a homemaker to come into the client's home to assist with these daily chores.

Case Planning

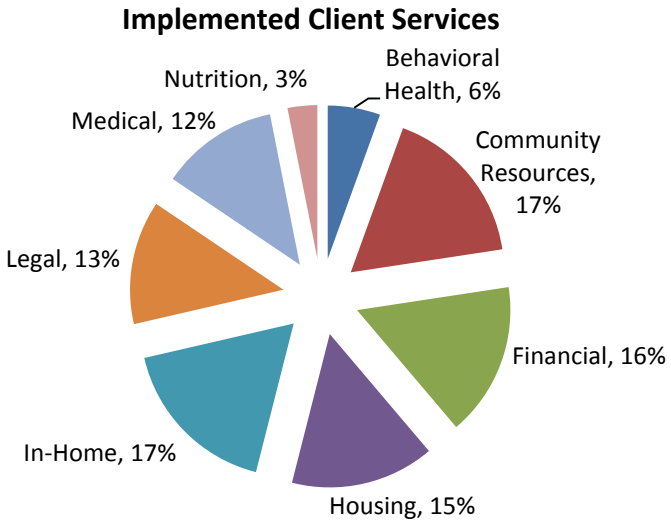
Case planning refers to using the information obtained from the investigation and assessment to identify, arrange, and coordinate protective services in order to reduce the client's risk and improve safety. Unless it has been determined that the client does not have a sufficient understanding or capacity to make responsible decisions, services may only be implemented with the client's consent. APS caseworkers strive to involve clients in the case planning whenever possible, in keeping with the APS principals of consent, self-determination, and least restrictive intervention. APS will attempt to identify and implement services that will allow the client to remain safely in their home, if that is their wish. However, a move to a family member's home, an assisted living residence, or a nursing home may be necessary if the client's level of care is so great that safety cannot be maintained by in-home services.

In FY 2014-15, APS implemented 7,483 services for clients in need. The most common type of service implemented was in-home services and other community resources (17% each). In-home services include items and services such as home health care or homemaker services and community resources

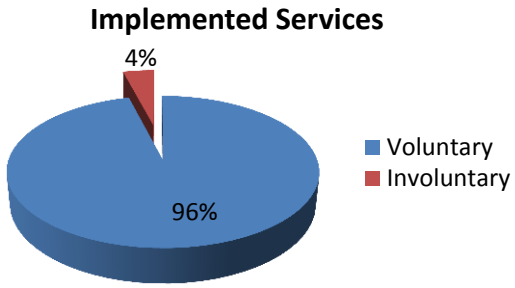
[9] **Risk** means conditions and/or behaviors that create increased difficulty or impairment to the client's ability to ensure health, safety, and welfare.

[10] **Safety** means the extent to which a client is free from harm or danger or to which harm or danger is lessened.

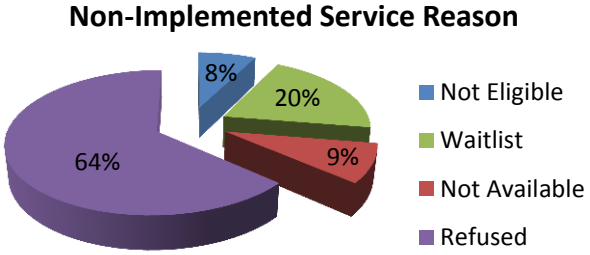
involve things like transportation or adult day care. The next most common services were securing financial resources (16%) and securing housing (15%) for the client. In FY2014-15 APS needed approximately $675,000 of the Client Services funds allocated to purchase goods and services for clients' health and safety. These funds are used when a client is unable to pay for the good/service and there is no other program available to provide the needed goods/services. These funds were used for home modifications (grab bars in showers, wheelchair ramps, etc.), short-term home health services, cleaning services and pest eradication, cognitive capacity evaluations, housing, transportation services, and more.



Approximately 96% of all of the implemented services were arranged with the client's cooperation. The other 4% of implemented services were carried out because the client was unable to consent (e.g., client lacks cognitive capacity or is in a coma) and/or the client's legal guardian consented to the service.



There were 2,641 services identified by APS caseworkers as needed to improve safety and reduce risk for their client that were not implemented. There are several reasons why a service may not be implemented. Clients with cognitive capacity have the right to refuse any or all suggested services, services may be unavailable in certain areas of the state, the client may not meet eligible criteria for the service, or the client may be on the waitlist to receive the service.

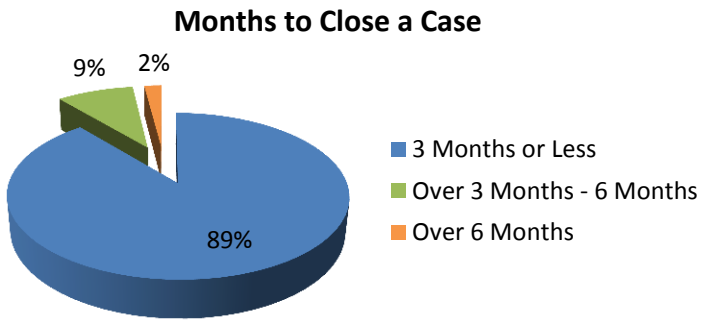


When analyzing those services that were not implemented, one trend stood out: 26% of all services unavailable was housing. Safe, affordable housing was unavailable for 59 clients who needed housing to improve safety and reduce risk. This housing shortage was present most frequently in the larger metro areas but was identified as an unmet need across the state.

Occasionally, the client may have cognitive deficits that are so great that they are unable to consent to or refuse protective services. In these cases, the only option to ensuring the client's health and safety might be to petition the court to have a guardian appointed to assist with decision making for the client. A client who is unable to manage his/her finances because of cognitive limitations may need a conservator or a representative payee. The APS program works to identify an appropriate family member or friend who can take on this responsibility for the client or, if a client has enough financial resources, a paid guardian, conservator, or representative payee could be appointed. Some counties have a Public Administrator who can be appointed the conservator for some clients. In keeping with the priority of ensuring the least restrictive intervention, less than 2% of new cases each year can only be resolved by the county APS program becoming the client's legal representative. Cases in which the county APS program is appointed as guardian, conservator, or representative payee remain open for as long as that legal authority is needed for the safety of the client.

Case Closure

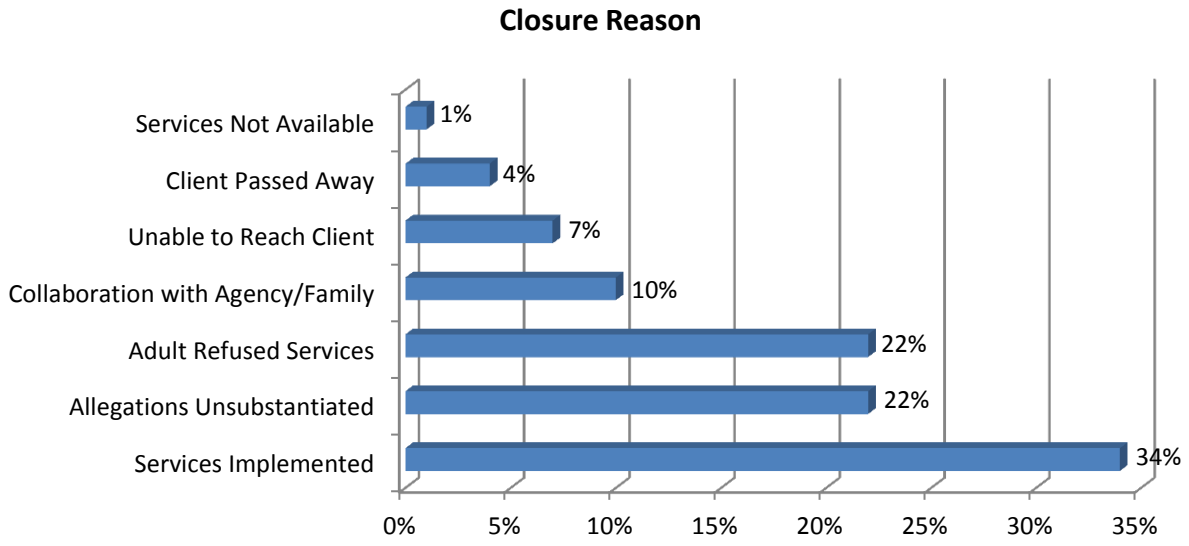
With the exception of cases in which APS holds legal authority for the client (guardianship, conservatorship, or representative payeeship) or the case is exceptionally complex, APS services are short-term. In FY 2014-15, about 89% of all cases were closed within three months and 98% were closed within six months.



Cases are closed once APS has completed its intervention. In 34% of cases, APS is able to implement services, sometimes with assistance from other agencies or family members, to improve the health and safety for the client. In about 22% of cases, the case is closed immediately following the investigation and assessment because the caseworker found that the allegations were unsubstantiated and the client had no other health or safety needs. In another 22% of cases, APS identified needs but the client was competent and refused any services or assistance from APS. In the APS program, clients often have a terminal illness, such as dementia, cancer, or a neurological disease such as Parkinson's disease. In other cases, the APS caseworker is unable to locate the client. Cases are closed when the APS client passes away or when the caseworker has exhausted all attempts to locate the client. For about 1% of cases, the

service(s) needed to improve safety for the client is not available in the community, or sometimes is not available anywhere in Colorado. Other times, the only provider for the service cannot safely provide the service because of the client's aggressive or violent behaviors. The APS case is closed when the caseworker has exhausted all options for the client.

Below is a chart of the most common closure reasons in FY 2014-15.



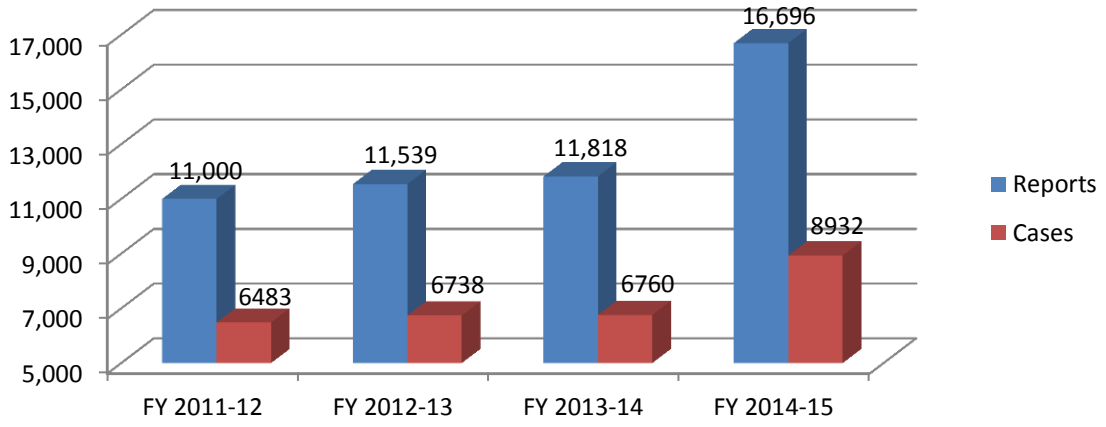
Impacts of Mandatory Reporting on Adult Protective Services

The Colorado Legislature passed SB13-111, which modified the criminal statute, making it mandatory for certain occupational groups to report physical and sexual abuse, caretaker neglect, and financial exploitation of at-risk elders (persons age 70 and older) to law enforcement within 24 hours, beginning July 1, 2014 (Section 18-6.5-108, C.R.S.). Under Section 26-3.1-102, C.R.S., the same mandated professionals are "urged" to report to APS the possible mistreatment or self-neglect of an at-risk adult age 18 and older. Once reports have been made, law enforcement shares the reports with APS. Law enforcement is responsible for ensuring criminal activity is investigated while APS focuses on identifying risk factors for the client and alleviating any safety issues.

From April through June 2014, Colorado APS led numerous training sessions for mandatory reporters as did county department APS programs and Adult Protection (AP) Teams in communities. Colorado APS developed an online training on mandatory reporting and informed organizations with mandatory reporters that this training was available through FY 2014-15. Nearly 24,000 people took the training for mandatory reporters. Additionally, county APS programs facilitated over 127 mandatory reporting training events with over 2,500 attendees in FY 2014-15.

Historically, there has been a 1-2% increase each year in the number of APS reports made statewide. With the implementation of SB13-111, it was expected that APS would receive an increase of 15% in the number of reports received statewide. However, the number of reports increased by 41% statewide from FY 2013-14 to FY 2014-15. APS realized a 48% increase in reports for clients aged 70 and older, but also saw a 32% increase in reports regarding clients aged 18 – 69. However, it is important to point out that being an "at-risk elder" under the mandatory reporting statute does not mean the person is an "at-risk adult" per the APS statute. APS cannot provide protective services to "at-risk elders" as defined by the mandatory reporting statute, unless they also meet the definition of "at-risk adults" under the APS statute. Given that distinction, with the surge in reports as a result of mandatory reporting, there was also a 104% increase in the number reports screened out. However, even with the increase in the percentage of reports that were not investigated, APS opened 32% more cases that required an investigation over the previous year.

APS Reports and Cases FY 2011-12 through FY 2014-15



Progress and Future Developments

APS Staff Training

Every new Colorado APS caseworker and supervisor must attend a four-day intensive Training Academy; other APS staff, such as case aides or administrators may attend Training Academy. This in-depth training on the APS program includes the rules and regulations, casework practice, client populations, investigations, and assessments. In FY 2014-15, 84 new workers attended one of the three Training Academy events. Of those attendees, 78% were caseworkers, 20% were supervisors, and 2% were case aides.

Quarterly Training Meetings (QTM) are provided in-person at various locations across the state, and are available to APS staff across the state via webinar. QTMs cover topics such as investigations and assessments, closure reasons and when they should be used, reasons to screen a report out, risk factor indicators, and other casework related topics. There were more than 300 attendees in the QTMs. Along with the QTMs, APS delivered regional training sessions on trauma informed care and investigations and assessments during FY 2014-15. Nearly 200 APS staff attended these regional training events.

Colorado APS also facilitates approximately 10 (ten) 90 minute webinar training opportunities, called Tuesday Topics, each fiscal year. Nearly 400 attendees took advantage of the Tuesday Topic opportunities in FY 2014-15, increasing their knowledge on a variety of casework topics, such as undue influence in financial exploitation and signs of abuse and neglect from a nursing standpoint.

In FY 2014-15, 63% of all county APS programs met the training hour requirements set by Colorado APS rules. APS county department staff attended more than 5,700 hours of continuing education.

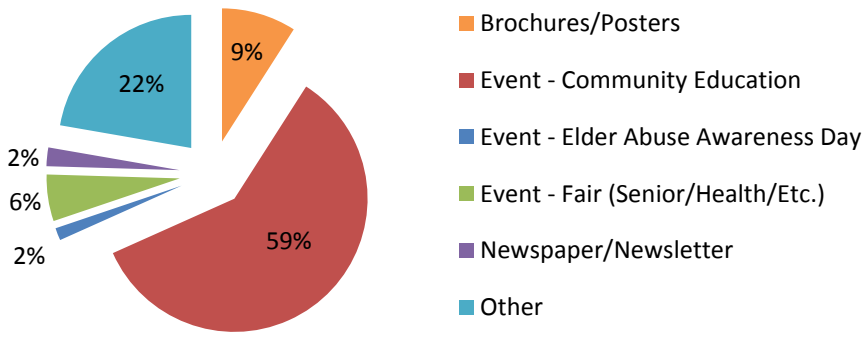
Adult Protection (AP) Teams and Community Education

The Colorado Adult Protective Services (APS) rules require counties that had 10 or more screened-in reports in the previous Fiscal Year to convene a multi-disciplinary Adult Protection (AP) Team. The AP Team is an advisory group that can review the processes used to report and investigate alleged mistreatment and self-neglect, review the provision of protective services, facilitate coordination of services, and provide community education on the APS program and the mistreatment and self-neglect of at-risk adults. Colorado currently has 48 AP Teams representing 52 counties.

AP Teams consist of representatives from collaborating service agencies in a variety of professional groups which includes attorneys, law enforcement, mental health professionals, hospital/facility staff, social workers, long-term care ombudsman, Community Center Board (CCB) staff, agencies that provide services to at-risk adults, and other professionals who have experience with at-risk adults.

As mandated by Rule, community education about at-risk adult mistreatment and self-neglect is a central function of AP Teams. During FY 2014-15, AP Teams provided 265 community educational opportunities to an estimated 15,828 professionals and community members in their respective counties. The most common form of community education opportunity in FY 2014-15 was a facilitated community education event (59%).

AP Team Community Education



Strategies for Improving Future Outcomes

In FY 2013-14, Colorado APS designed and implemented the Colorado APS Data System (CAPS) and throughout FY 2014-15, CAPS has proven to be a very effective data system. CAPS has enabled the State APS program to better identify client and program needs and track the progress of cases. CAPS allows for virtually every part of the case to be documented electronically, thus the entirety of the case can be viewed at once without referencing paper files. As a result, CAPS has facilitated a more efficient method of evaluating the quality of casework. As a result, any areas of improvement identified during quality assurance analyses can be addressed.

Colorado APS performs formal county and caseworker reviews and informal reviews of individual cases. Supervisors are required to perform case reviews on 15% or more of their county's caseload each month. Another quality assurance tracking method employed is C-Stat. C-Stat is the Department's monthly review of specific casework measures such as timeliness of initial responses, monthly contacts, investigations, assessments, case plans, and looks at the success of APS intervention in improving the safety of clients. This helps to create a clearer picture of how counties are performing across various measures of performance and over time.

APS Contacts

For more information visit the APS website (www.ColoradoAPS.com).

If you have questions concerning the APS program, please email us (cdhs_aps_questions@state.co.us). Do not email a report of mistreatment or self-neglect of an at-risk elder or at-risk adult.

If you are a mandatory reporter and need to make a report of abuse, caretaker neglect, or exploitation of an at-risk elder (aged 70 years or older) or at-risk adult with an intellectual and developmental disability, please notify law enforcement.

If you are not a mandatory reporter and want to make a report of abuse, caretaker neglect, self-neglect, or exploitation of an at-risk adult, please contact the county department's APS intake line in which the at-risk adult resides or law enforcement. County department's phone numbers are listed on the APS website or you can access them directly by clicking on the link here.