Colorado Adult Protective Services (APS)

Annual Report – Fiscal Year 2015-16

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 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).

Mandatory Reporting

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. The Legislature passed SB15-109, which expands the criminal mandatory reporting law to include at-risk adults with an intellectual and developmental disability (IDD) beginning in FY2016-17. 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.

Historically, there has been a 1-2% increase each year in the number of APS reports made statewide. With the implementation of SB13-111, the number of reports increased by 47% statewide from FY 2013-14 to FY 2015-16. The SB15-109 Task Group projected that APS would see another 30% increase in reports as a result of expansion of mandatory reporting as a result of SB15-109 in FY2016-17. However, it is important to point out that being an "at-risk elder" or an "at-risk adult with IDD" 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" or "at-risk adults with IDD" as defined by the mandatory reporting statute, unless they also meet the definition of "at-risk adults" under the APS statute. So, while total reports receives has gone up significantly, the percentage of reports that meet criteria for APS intervention has decreased significantly, from approximately 60% before mandatory reporting to approximately 40% since mandatory reporting.

APS Funding

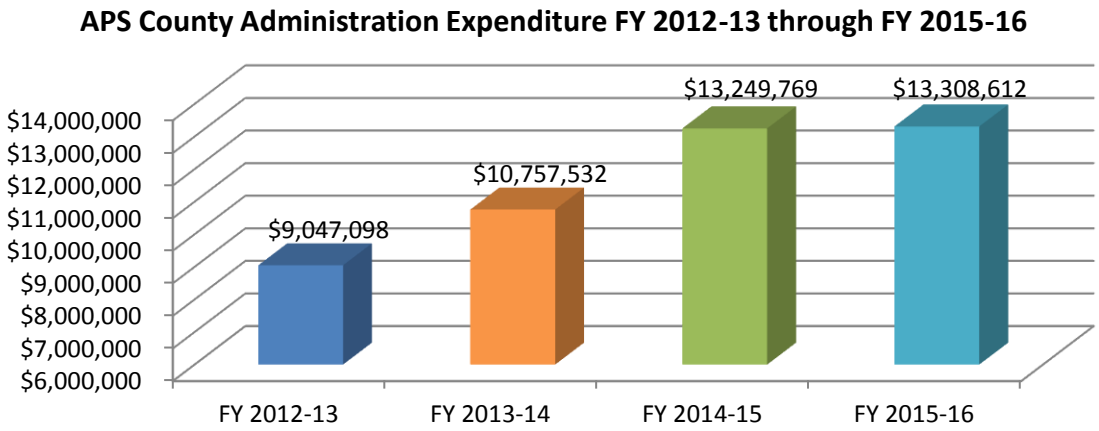
The Colorado Adult Protective Services program is funded through the APS Administration Allocation. In fiscal year (FY) 2015-16[7] the APS program received just over $14.9 million, approximately $10 million in State General Funds, $2.8 million in local matching funds, and $2 million in federal funds. 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 $2 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 $14.9 million for the APS program was allocated as follows:

- Approximately $593,000 for State Department staff salary, benefits, operating, travel, and to provide training to county department APS staff and the community
- Approximately $179,000 for the Colorado Adult Protective Services data system (CAPS)
- Approximately $13.1 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 preparation for the implementation of mandatory reporting of mistreatment of at-risk adults with intellectual and developmental disabilities (S.B.15-109) the Legislature provided approximately $1 million more funding for APS as a supplemental late in FY2015-16. The supplemental funds were primarily allocated to the county departments to begin hiring additional APS staff in order to manage the projected 30% increase in reports as a result of this new law. Approximately $55,000 was allocated to provide training to district attorneys across the state.

[7] A fiscal year (FY) runs from July 1 through June 30 (i.e., FY 2015-16 was 7/1/2015 through 6/30/2016).

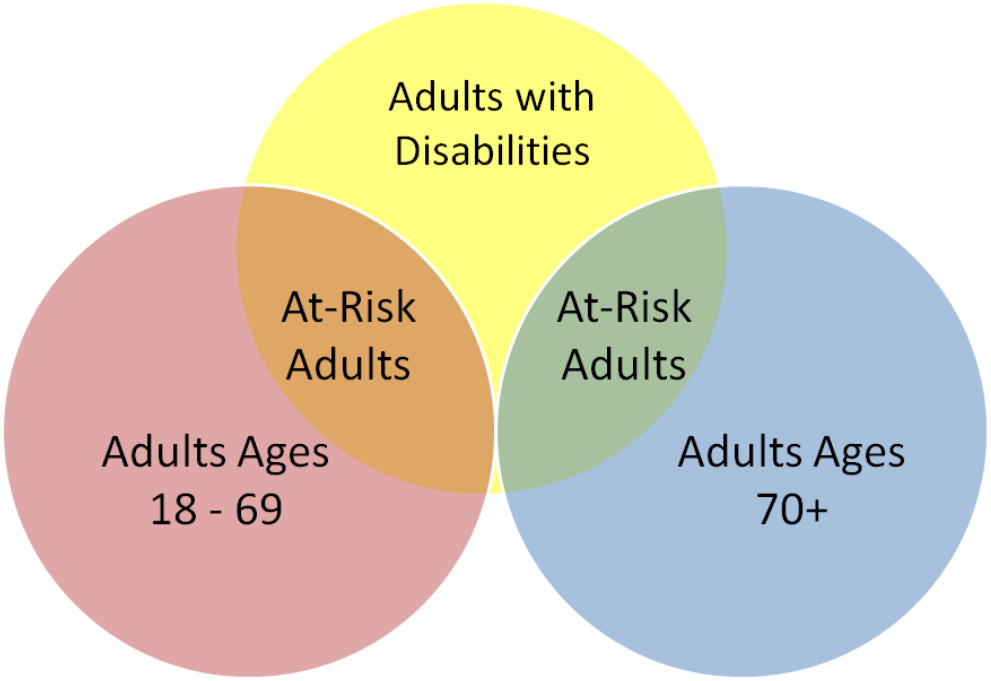
The chart below details county department APS administration expenditures since FY2012-13.



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

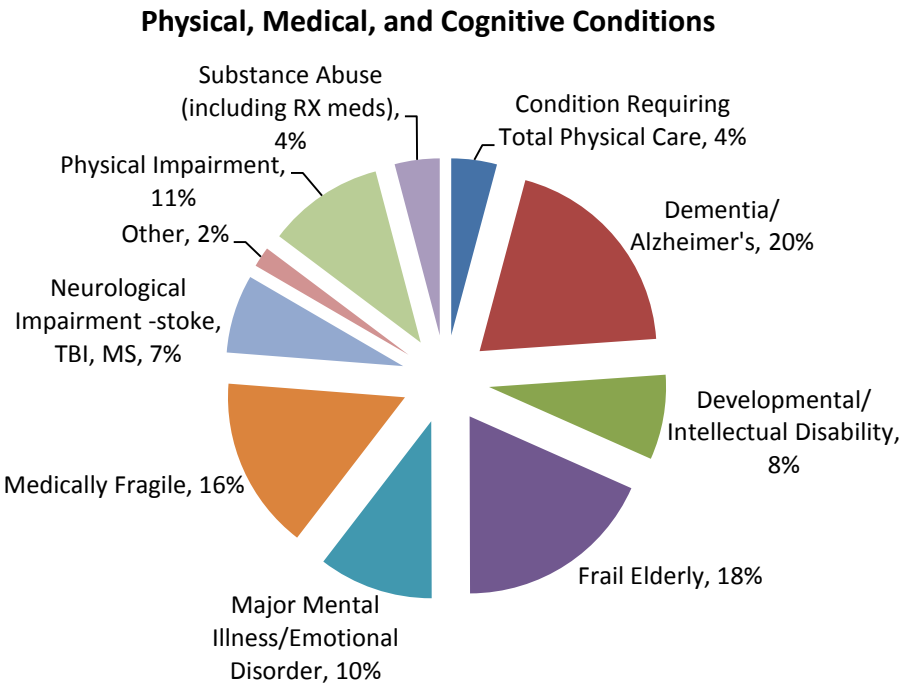
APS Client Demographics

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.

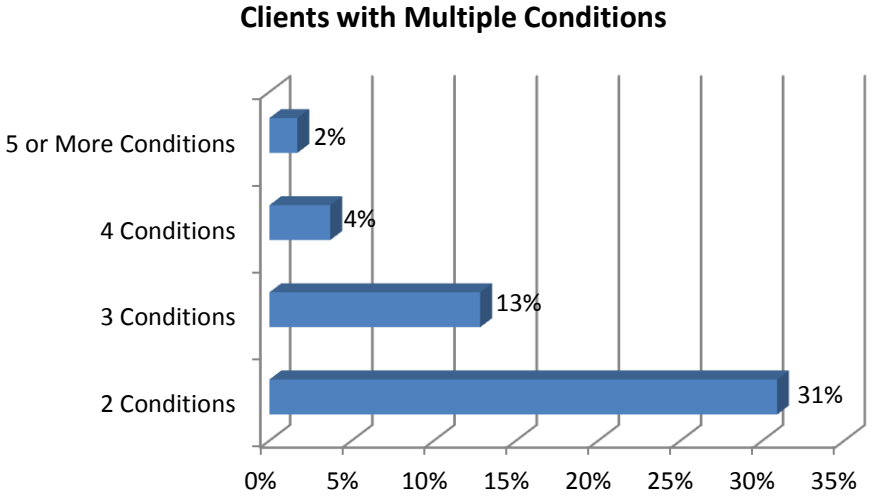


Client Risk Factors

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 2015-16, the most common conditions impacting APS clients were "Dementia/Alzheimer's" (20%), "Frail Elderly" (18%), "Medically Fragile" (16%), "Physical Impairment" (11%), and Major Mental Illness/Emotional Disorder (10%).

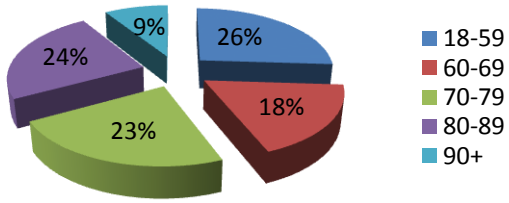


Furthermore, 49% of APS clients had two or more of these conditions, adding complexity to resolving the health and safety issues for the client.



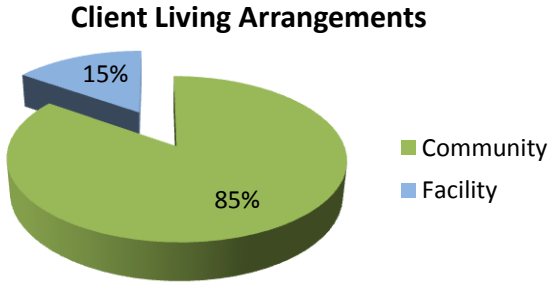
Client Gender and Age

A majority of APS clients were female (60%). The majority of APS clients were aged 70 or older (56%). The oldest client in FY 2015-16 was 104.

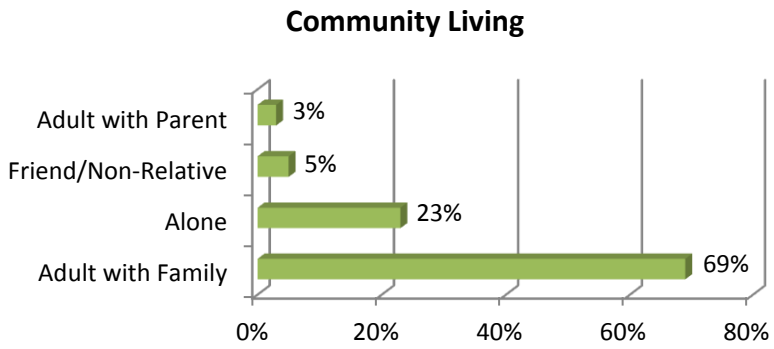


Client Living Arrangements

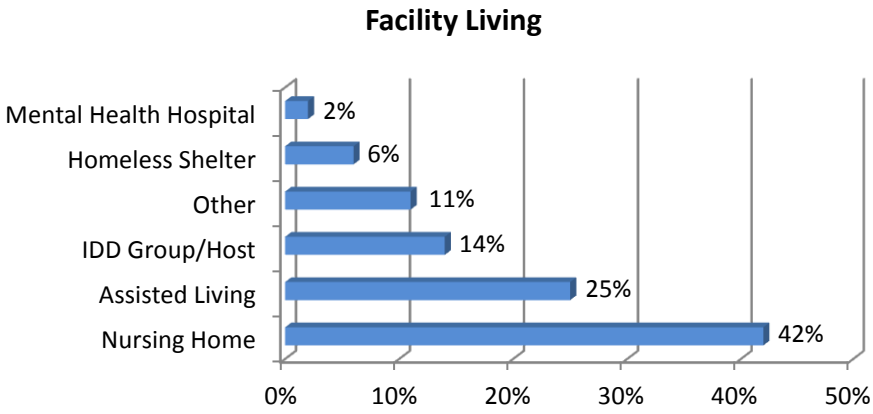
In FY 2015-16, about 85% of APS clients lived in a community setting, such as their own home or the home of a family member, while 15% lived in a facility, such as a skilled nursing facility or a group home.



Most clients in FY 2015-16 who lived in the community lived alone or with a family member other than their parent.



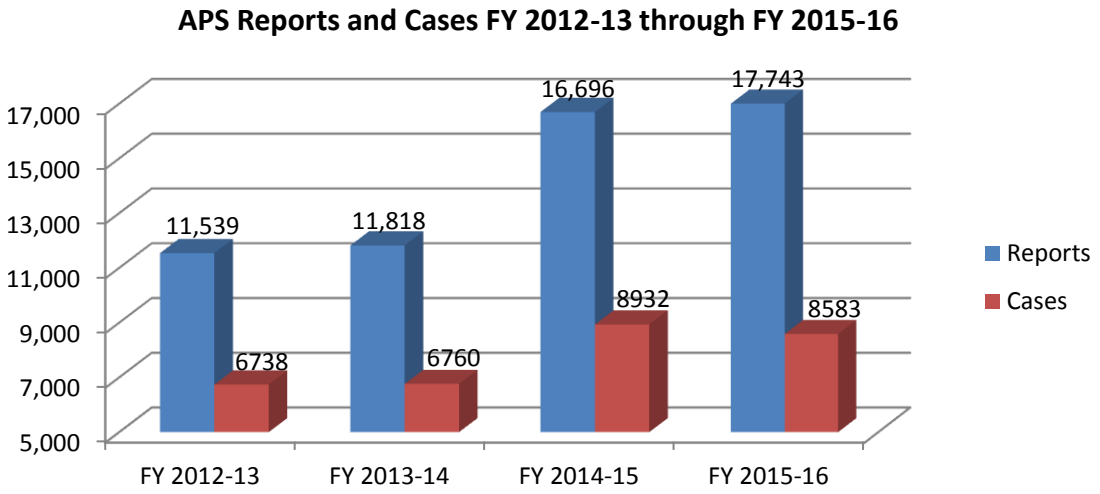
Clients who lived in a residential facility most often live in a nursing home or assisted living facility.



The APS Case Process

Reports and Cases

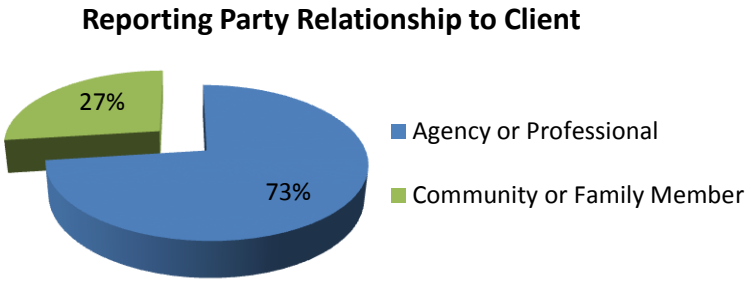
Historically, there has been a 1-2% increase each year in the number of APS reports made statewide. However, in July 2014, a new law became effective that requires certain professionals to report mistreatment of persons age 70 and older to law enforcement; law enforcement must then share those reports with APS. Since the implementation of this mandatory reporting law, the number of reports received by APS has increased 47% statewide. An expansion of mandatory reporting went into effect July 1, 2016 to include reporting of mistreatment of at-risk adults with an intellectual and developmental disability. More professional groups were added as mandatory reporters, as well. This expansion is projected to increase the number of reports made to APS by another 30% over the course of FY2016-17.

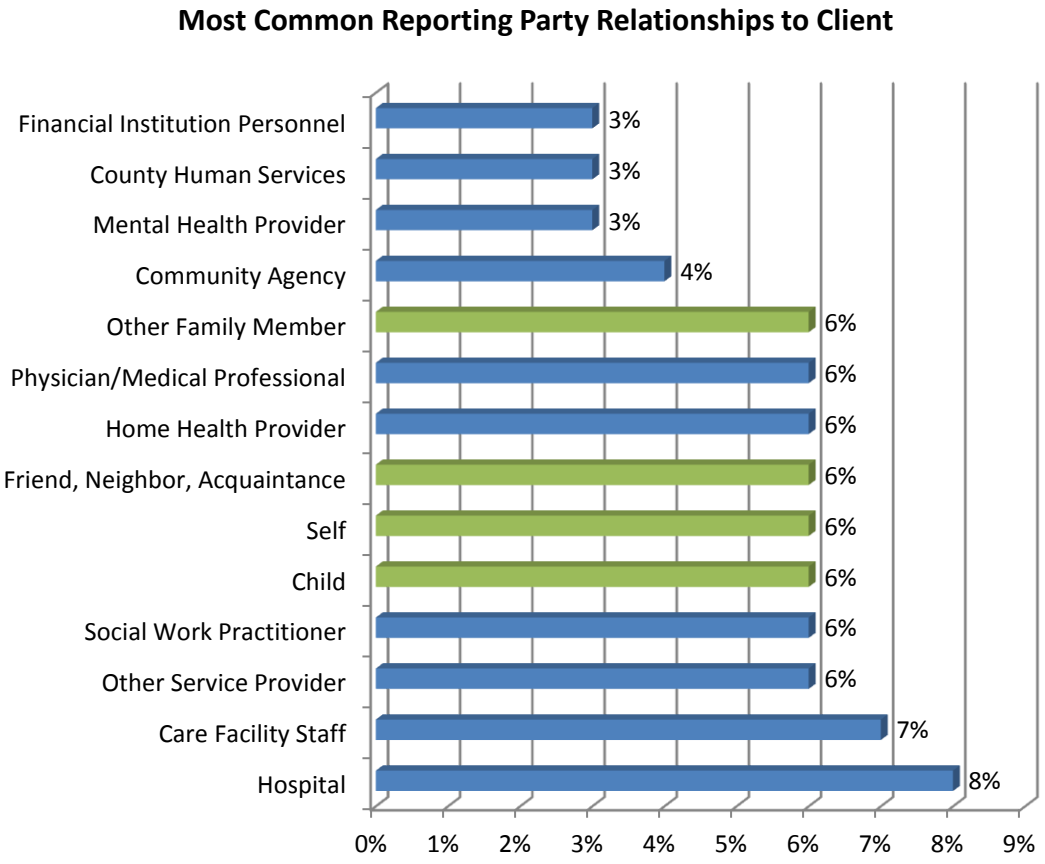


However, it is important to point out that being an “at-risk elder” under the mandatory reporting statute does not mean the person is an “at-risk adult” per the APS statute. APS cannot provide protective services to “at-risk elders” as defined by the mandatory reporting statute, unless they also meet 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 15% increase in the number reports screened out in FY 2015-16 compared to FY 2014-15. While APS screened in fewer reports for investigation in FY 2015-16, APS continues to have 27% more open cases over the number of cases in the year prior to mandatory reporting.

Reporting Party Relationship to Client

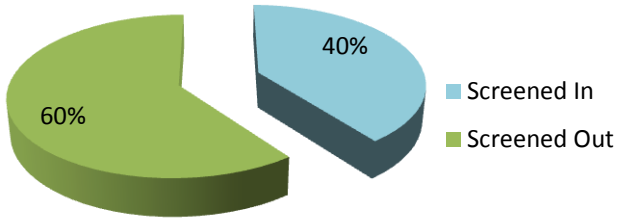
Reports are made to APS by a variety of professionals who work with at-risk adults, family, friends, neighbors, and sometimes by the adult themselves. The identity of a person reporting concerns about an at-risk adult to APS is confidential. If the reporter chooses, he or she may remain anonymous when making a report to APS. In FY 2015-16, a majority of reporting parties were professionals who work with at-risk adults (73%). The two most common reporting parties were hospital workers (8%) and care facility staff (7%).

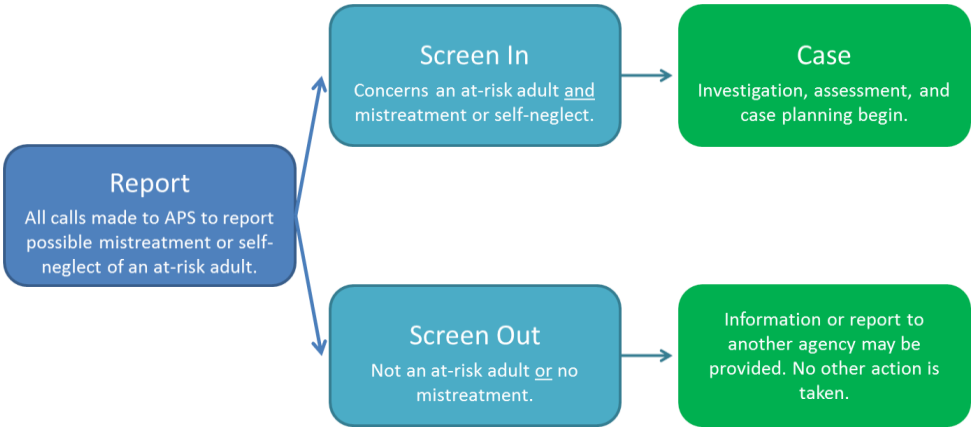




When a report is made to APS, county APS personnel evaluate the report to determine whether it meets eligibility criteria for investigation, which is twofold: (1) it involves an at-risk adult, as defined in the APS statute, (2) there is alleged or suspected mistreatment and/or self-neglect. Reports that 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 2015-16, 40% 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 2015-16, 96% 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).



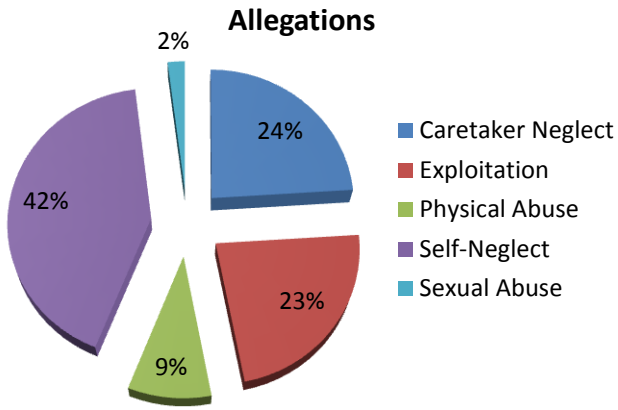


Investigation

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

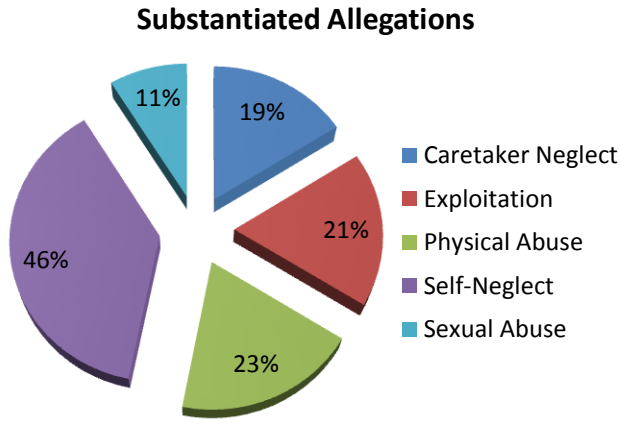
means the investigation did not establish any evidence that mistreatment or self-neglect has occurred. An inconclusive finding means that indicators of mistreatment or self-neglect may be present but the investigation could not confirm the evidence to a level necessary to substantiate the allegation.

FY 2015-16, 42% of clients were self-neglecting, that is, not providing for their basic needs. The most common form of mistreatment was caretaker neglect at 24%, which was closely followed by exploitation at 23%. 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 and self-neglect. In FY 2006-07, exploitation accounted for 16% of the total allegations made in reports to APS versus 23% in FY 2015-16. Exploitation is the only mistreatment allegation that has increased over the years. APS has been receiving fewer reports of self-neglect in relation to all allegations received; self-neglect allegations have decreased from 53% of all allegations in FY2006-07 to just 42% in FY2015-16.

The approximate loss of money and property to clients who were exploited (the allegation was substantiated) in FY 2015-16 was approximately $8.9 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 415 cases in which APS recorded that a client experienced a financial loss, with seven clients with approximate losses of $200,000 to $2 million.

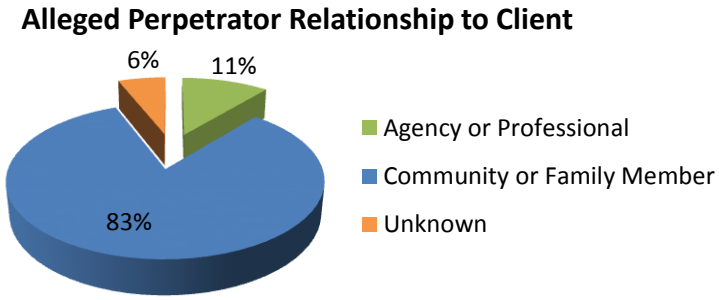


Approximately 31% of the total number of allegations made in FY 2015-16 were substantiated, 15% were inconclusive, 36% were unsubstantiated, and 18% could not be determined. However, it is important to note that this data is somewhat unreliable since FY 2014-15 was the first year that the State was able to review findings on allegations to determine whether the finding documented in the Colorado APS data system (CAPS) was consistent with the evidence collected. In FY 2015-16, State APS staff conducted a review of a statistically valid sample of allegations findings and determined that approximately 33% of the findings were inaccurate. As a result, training was provided statewide to

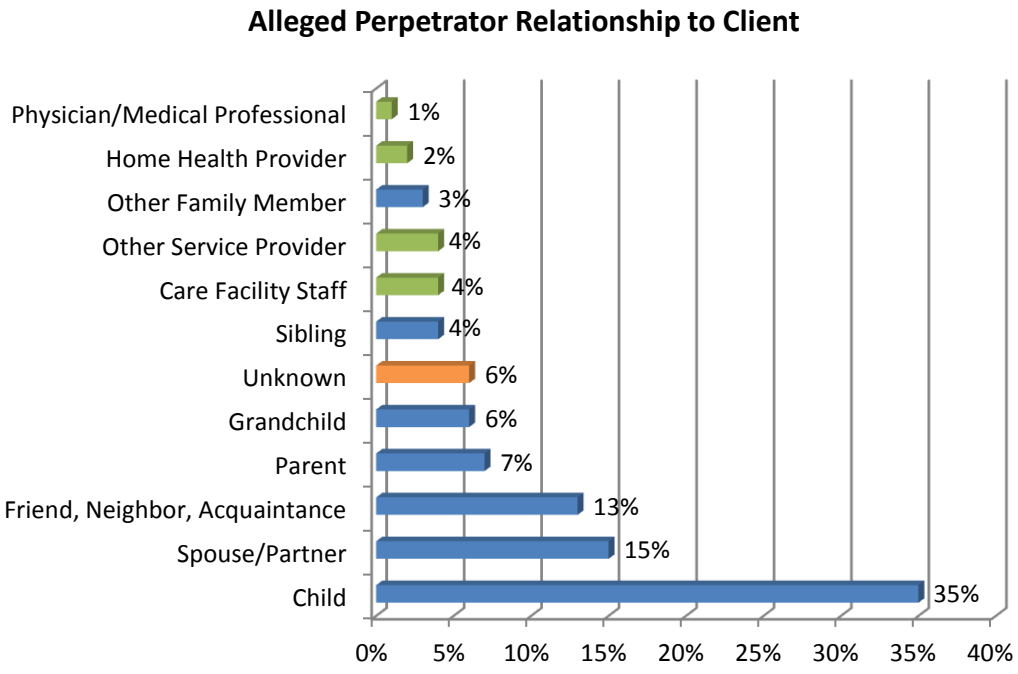
caseworkers and supervisors in April 2016 with the intent of improving the accuracy of the allegations findings in future years.

Alleged Perpetrator Relationship to Client

The great majority of alleged perpetrators identified in reports to APS programs across the state in FY 2015-16, about 83%, were either a family member or person the victim knows, such as a neighbor, friend, or acquaintance. About 11% of alleged perpetrators were professionals who provide services to the client, such as home care or nursing care staff, and about 6% of perpetrators were unknown at the time of the report.



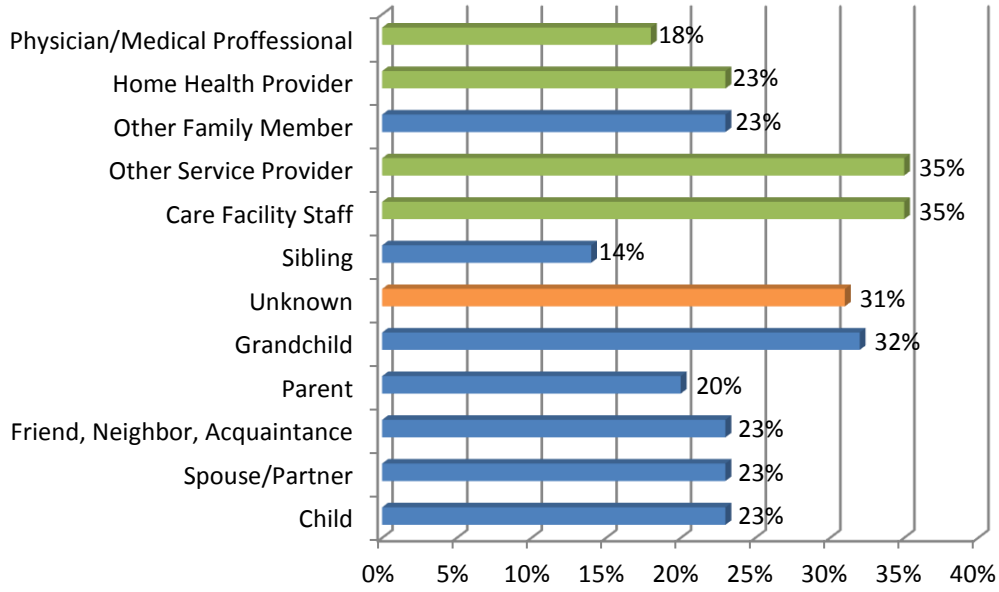
In FY 2015-16, APS clients were more likely to be mistreated by their children (35%) or their spouse or partner (15%).



In terms of allegations against a specific alleged perpetrator, approximately 23% of all allegations made against alleged perpetrators in FY 2015-16 were substantiated, 20% were inconclusive, 41% were unsubstantiated, and 16% could not be determined. Below is a chart with the percentage of substantiated allegations by relationship for FY 2015-16. For instance, 35% of all the allegations made

against care facility staff 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. As a result, 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[8] and safety[9]. 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.

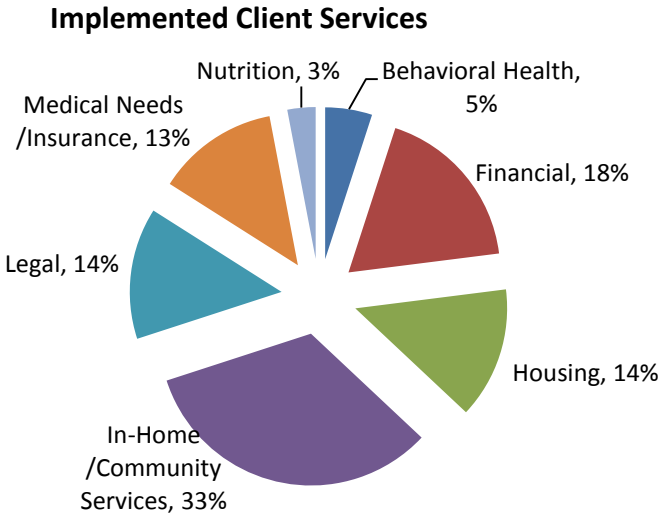
Case Planning

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.

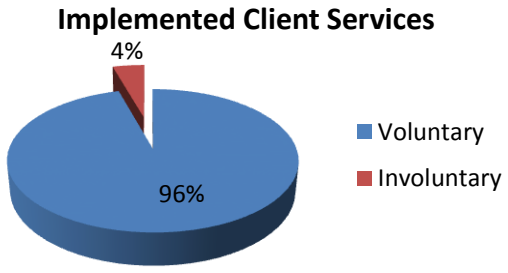
[8] **Risk** means conditions and/or behaviors that create increased difficulty or impairment to the client's ability to ensure health, safety, and welfare.

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

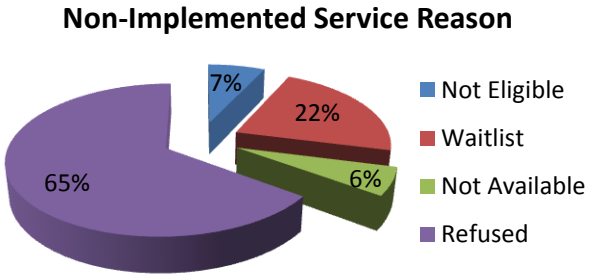
In FY 2015-16, APS implemented 7,408 services for clients in need. The most common types of services implemented were in-home/community services (33%), securing financial assistance (18%), and housing (14%). In-home/community services include items and services such as home health care or homemaker services, community resources involve things like transportation or adult day care, and financial and housing services include the application for and the receipt of public assistance programs (i.e., food assistance or low-income housing). In FY2015-16 APS needed approximately $725,000 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 2,585 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,



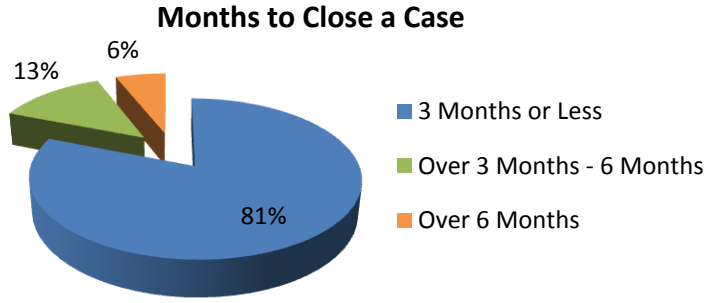
the client may not meet eligible criteria for the service, or the client may be on the waitlist to receive the service.

When analyzing those services that were not implemented, one trend stood out: 29% of all unavailable services were in-home/community services (homemaker services, home health providers, etc.). Another 28% of all unavailable services were housing. Safe, affordable housing was unavailable for 45 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 0.5% 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

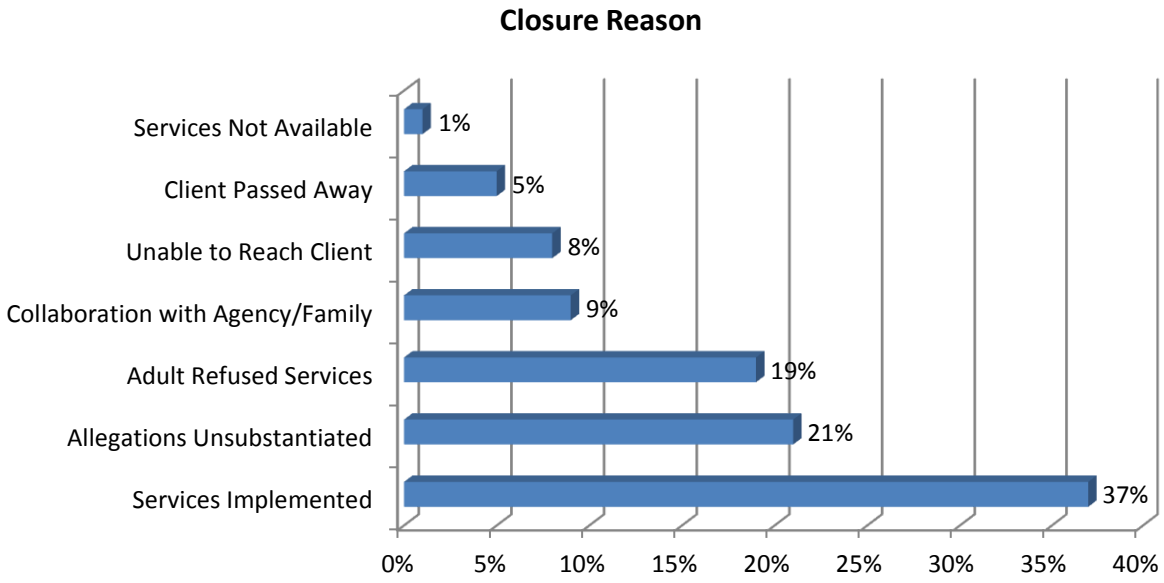
With the exception of cases in which APS holds legal authority for the client (guardianship, conservatorship, or representative payeeship) or the case is exceptionally complex, APS services are short-term. About 81% of all cases are closed within three months and 94% are closed within six months. Only 1% of cases are open longer than a year, these primarily those cases in which APS holds legal authority for the client.



Cases are closed once APS has completed its intervention. In 37% 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 21% 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 19% 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 2015-16.



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 2015-16, 46 new workers attended one of the four Training Academy events. Of those attendees, 87% were caseworkers and 13% were supervisors.

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 communication with the IDD population and critical thinking during FY 2015-16. More than 200 of 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 2015-16, increasing their knowledge on a variety of casework topics, such as the early stages of dementia, insurance and managed care, Medicaid fraud, investigations and assessments, hospice, substance abuse disorders, and elder abuse screening and assessment.

In September 2015 Colorado APS held a two day statewide conference for APS staff, law enforcement, Community Centered Board staff, and long-term care ombudsmen. The conference focused on various aspects of investigations, such as the impact of cognitive impairment or undue influence in the investigative process, interviewing persons with intellectual and developmental disabilities, using abuse screening tools, detecting deception through statement analysis, collaborative investigations, and much more. Nearly 300 people attended the conference.

In addition to the regular training options outlined above, in FY2015-16, APS provided training to all APS staff via webinar on the changes to APS practice and mandatory reporting as a result of the implementation of SB15-109 and HB16-1394, which made changes to the mandatory reporting law (Title 18, Article 6.5) and the APS statute (Title 26, Article 3.1) effective July 1, 2016.

Adult Protection (AP) Teams and Community Education

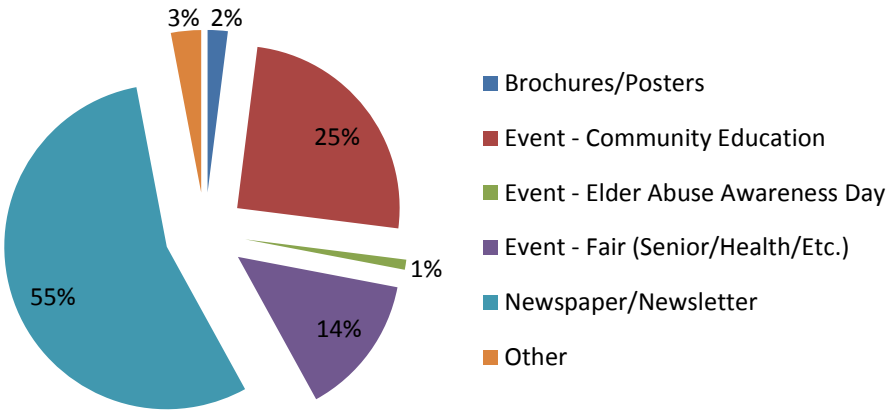
The Colorado Adult Protective Services (APS) rules require counties that had 10 or more screened-in reports in the previous Fiscal Year to convene a multi-disciplinary Adult Protection (AP) Team. The AP Team is an advisory group that can review the processes used to report and investigate alleged mistreatment 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 51 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 (12 CCR 2518-1, 30.830), community education about at-risk adult mistreatment and self-neglect is a central function of AP Teams. During FY 2015-16, AP Teams provided 329 community educational opportunities to an estimated 61,786 professionals and community members in their respective counties; 94 of these training events with over 3,500 attendees focused on mandatory reporting.

The most common form of community education opportunity in FY 2015-16 was a newspaper or newsletter (55%).

AP Team Community Education Events



Strategies for Improving Future Outcomes

Colorado APS Data System (CAPS)

In 2014, Colorado APS designed and implemented the Colorado APS Data System (CAPS) and 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 and any areas of improvement identified during quality assurance analyses can be addressed.

For the first time in history, the U.S. Department of Health and Human Services, Administration for Community Living (ACL) offered state APS programs the opportunity to apply for one of eleven grants

for research and/or data system development. Colorado APS was awarded one of the grants in September 2015. APS was awarded the grant to improve two of the areas in CAPS so that research related to improved client outcomes could be undertaken in subsequent years. To achieve APS' goal of increasing positive outcomes for at-risk adults in need of protective services, the grant will be used to improve two functions in CAPS: 1)Intake, and 2) the client strengths and needs assessment tool.

First, it is critical that the APS program is focusing its limited resources on at-risk adults who are being mistreated and providing those adults with optimal services to improve safety and reduce risk where possible. Therefore, because the information obtained during the screening process is used to determine whether a report is screened in for investigation, it is imperative that sufficient and complete information is acquired during the screening process so the decision as to whether to investigate is an informed one. The grant funds the development of a new intake process in CAPS that will dynamically generate additional follow up questions based upon the story that the reporter is telling the screener and the answers to some key questions. These "enhanced screening questions" are designed to gather more complete information to ensure that reports of an at-risk adult experiencing mistreatment are screened in for investigation, while at the same time, ensuring that APS is not spending time and resources investigating reports that do not involve an at-risk adult and/or mistreatment and therefore should not be screened in. The new Intake function was implemented in CAPS on July 1, 2016. During FY2016-17, Colorado APS will analyze the impacts of this new intake functionality.

Second, Colorado APS developed an assessment tool in CAPS that measures both the adult's risk and safety. Assessment tools used by other states measure risk, but omit safety. Colorado APS wanted a tool that would provide a quantitative measure of improved outcomes for APS clients as a result of APS intervention for both risk and safety. APS is collaborating with University of Denver Associate Professor, Dr. Leslie Hasche, Ph.D, M.S.W. on this portion of the grant to scientifically validate the assessment tool. After the assessment has been validated, Colorado APS will be able to accurately compare clients' risk and safety before APS involvement and after APS intervention. Being able to see risk and safety will allow Colorado APS to analyze those areas where risk is most likely to be reduced and/or safety increased, and the services and supports that are most likely to improve safety. This validation study is ongoing and expected to be completed in FY2017-18.

Quality Assurance

Colorado APS performs formal county and caseworker reviews and informal reviews of individual cases. In addition, county APS Supervisors are required by rule (12 CCR 2518-1, 30.340) to perform case reviews on 15% or more of their county's caseload each month. A monthly review of specific casework measures such as timeliness of initial responses, monthly contacts, investigations, and safety improvement is also conducted to create a clearer picture of how county APS programs are performing across various measures of performance and over time. Finally, each year a statewide review of specific program requirements is conducted. In FY 2015-16, a review of required continuing education (12 CCR 2518-1, 30.330) and a review of required cooperative agreements (Section 26-3.1-103, C.R.S.) was completed.

In FY2015-16, APS conducted formal reviews of four county APS programs. Overall, areas for improvement were identified and APS State staff met with staff for these four counties to share the results of the reviews and provide feedback for improvement. These reviews included a review of three areas of compliance:

1) A review of screened out reports to determine if the county APS program was screening out appropriately, i.e., screening out only those reports that did not meet criteria for APS intervention; two of the four counties met or exceeded the 90% quality standard.
2) A review to determine if the county supervisor completed the required case reviews to ensure workers were investigating and providing services appropriately; one of the four counties met or exceeded the 100% quality standard.
3) A review of APS cases for each caseworker in the county; while no county met the quality standard, 20% of the individual caseworkers whose cases were reviewed met or exceeded the 90% quality standard.

Continuing Education Requirements

In FY 2015-16, 100% of all new workers completed required training for new APS staff. However, only 84% of all experienced APS supervisors, caseworkers, and case aides met the annual continuing education training requirements set by Colorado APS rules (12 CCR 2518-1). As a result, only 65% of all county APS programs were fully compliant with training requirements. APS county department staff completed 7,361 hours of continuing education.

Cooperative Agreement Requirements

Per Section 26-3.1-103, C.R.S., each county department APS program is required to develop a cooperative agreement with their local law enforcement agencies; district attorney; Community Centered Board (CCB), which provides services for adults with intellectual and developmental disabilities; and the long-term care ombudsman agency, which investigates concerns and advocates for residents of nursing homes and assisted living facilities. In FY2015-16, compliance with this requirement was as shown:

- 43% of counties had an agreement with their law enforcement agencies, a 5% increase over FY 2014-15
- 43% had an agreement with their district attorney, a 9% increase over FY 2014-15
- 41% had an agreement with their CCB, a 16% increase over FY 2014-15
- 34% had an agreement with their long-term care ombudsman a 14% increase over FY 2014-15

Increasing Resources for APS Program Administration and Oversight

The Legislature set a recommendation for caseload average for the APS program through SB13-111. That recommendation is that counties should have a caseload average of 25:1 or less. Caseload average is calculated by adding the number of ongoing cases plus the number of new reports and dividing by the number of caseworker FTE. In FY 2015-16, the caseload average remains over the recommended standard, finishing FY2015-16 at 29:1 statewide, while the ten largest APS programs had a 32:1 caseload average. This was an improvement over the statewide caseload average of 32:1 in FY 2014-15.

Child Protective Services (CPS) is a program located within the Department that is state-supervised and county-administered and provides protective services to children, a vulnerable population. Since CPS and APS are similar in their operation and goals, a comparison of the capacity and resources of CPS and APS was conducted during FY2015-16. During this comparison, significant disparities in available resources were identified. While CPS receives approximately five (5) times as many reports as is received by APS and CPS opens approximately six (6) times as many cases as APS, the disparity in funding and staff resources available to successfully respond to those reports and provide oversight to ensure program requirements are met are much greater than the 5:1 ratio of reports or the 6:1 ratio of open cases. The table below highlights some key areas and the disparity between APS and CPS resources.

Program Process	CPS	APS	CPS vs APS Ratio
Reports Received	91,000	17,000	5:1
Cases Open for Investigation	48,000	7,500	6:1
State Program Staff (policy, county assistance, program implementation)	65 FTE[1]	3 FTE	22:1
Quality Assurance Staff (compliance and quality reviews and oversight)	26 FTE	0.5 FTE	52:1
State Training Staff	6 FTE	1 FTE	6:1
State Training Funding (to provide training to county staff)	$6,700,000	$150,000	45:1
Data System Maintenance and Data Analysis Staff	26 FTE	2 FTE	13:1

[1]FTE = Full Time Equivalent (or full time employee)

In practical terms, these disparities in resources impact the APS program's effectiveness. The number and types of training opportunities available to APS staff to improve their knowledge and skill in conducting investigations and working with the various vulnerable populations is extremely limited in comparison to the available training opportunities for CPS staff. CPS is able to contract with specialists to develop and deliver training that's available throughout the year. This type of training is not available to APS due to the limited funding for training development and delivery. CPS conducted quality assurance reviews of more than 10,000 cases in FY 2015-16, while APS was only able to conduct reviews of approximately 75 cases this past fiscal year. The ability of state staff to provide one-on-one technical assistance and guidance to counties when training needs are identified through CAPS data analysis or quality assurance activities is also severely limited due to a lack of adequate staff resources.

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), 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.